Professionalism in anesthesia

Le professionnalisme en anesthésie

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Abstract

Purpose *Is professionalism in medicine just another bureaucratic imposition on our practice or a fundamental concept for physicians at all stages in their career? In this review, the historical perspectives of professionalism are explored as well as the what, why, and how questions concerning this topic.*

Source *The key words “professionalism” and “anesthesia” were used to conduct a search of the PubMed database, the policies and publications of relevant Canadian and international physician regulatory bodies and organizations, historical documents, and other internet publications.*

Principal findings *Professionalism in anesthesia has a long history. While there are many definitions for professionalism, some very dated, all are based on virtues, behaviour, or professional identity. Professionalism plays a central role in the balance between physician autonomy and social contract, and it has a significant impact on patient safety and medicolegal litigation.*

Conclusion *Considerable evidence exists to suggest that professionalism must be treated seriously, particularly in these times of social accountability and budgetary pressures.*

Résumé

Objectif *Le débat fait rage quant à savoir si le professionnalisme médical n'est en fait qu'un élément de plus imposé à notre pratique par la bureaucratie ou s'il s'agit d'un concept fondamental pour les médecins, quel que soit le stade de leur carrière. Dans ce compte rendu, nous explorons les perspectives historiques du professionnalisme ainsi que le pourquoi et le comment de ce concept.*

Source *Les mots clés « professionnalisme » et « anesthésie » ont été utilisés (en anglais) pour réaliser une recherche dans la base de données PubMed, dans les politiques et publications des organismes et organisations de réglementation des médecins pertinents au Canada et à l'international, dans les documents historiques et dans d'autres publications en ligne.*

Constatations principales *Le professionnalisme bénéficie d'une longue histoire en anesthésie. Bien qu'il existe de nombreuses définitions de ce terme, dont certaines très surannées, toutes se fondent sur des vertus, des comportements ou une identité professionnelle. Le professionnalisme joue un rôle central dans l'équilibre entre autonomie du médecin et contrat social, et il a un impact majeur sur la sécurité des patients et les litiges médico-légaux.*

Conclusion *Il existe un nombre important de données factuelles soutenant qu'il faut prendre le professionnalisme au sérieux, particulièrement à l'heure de l'imputabilité sociale et des pressions budgétaires.*

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“You are in this profession as a calling, not as a business; as a calling which exacts from you at every

turn self-sacrifice, devotion, love and tenderness to your fellow men.”—William Osler¹

Professionalism has a long history in medicine and in anesthesia. James Young Simpson discovered chloroform as an anesthetic at a dinner party on November 4, 1847 and reported its properties and uses in the *Lancet* in 1847.² Another pioneer, John Snow, published a series of manuscripts on anesthesia administration.³⁻⁷ In 1853, Snow was called to administer chloroform to Queen Victoria for the birth of Prince Leopold, and *chloroform à la reine* provided legitimacy for labour analgesia. There are three fundamental principles in the 2002 Physician Charter of the American Board of Internal Medicine (ABIM) and in the European Federation of Internal Medicine (EFIM), namely, the primacy of patient welfare, patient autonomy, and social justice.⁸ Simpson’s work on labour analgesia – despite opposition suggesting that labour analgesia was “contrary to God’s will” – and his scientific conviction to discover chloroform are cited as exemplars of professionalism.⁹ John Snow illustrated professionalism by his commitment to improve his understanding of anesthesia and to direct his medical practice entirely toward this purpose, a first at the time.

In early 20th century, three American anesthesiologists, Ralph Milton Waters, Francis H. McMechan, and Elmer I. McKeeson, demonstrated exceptional professionalism.¹⁰ Waters instituted rigorous anesthesia training programs for medical students and residents. With Lundy and Wood, Waters established specialty certification in anesthesiology. Despite crippling rheumatoid arthritis, McMechan helped organize the American Association of Anesthetists, and in 1914, McMechan persuaded the *American Journal of Surgery* to begin publishing the *Quarterly Supplement of Anesthesia and Analgesia*. In 1915, McMechan, Long, and McKeeson co-founded the International Anesthesia Research Society, and in 1922, *Current Researches in Anesthesia and Analgesia*, the first journal exclusively for anesthesia, was launched with McMechan as editor.

A strong commitment to patients, the profession, and society, qualities at the core of professionalism, ran deep in these early pioneers.

What is professionalism?

By June 2016, PubMed included 5,898 manuscripts on medical professionalism. Not surprisingly, the definition of professionalism can be confusing.¹¹ In 2005, the Working Party of the Royal College of Physicians stated, “Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.”¹² Some have a “...I know it when I see it...”¹³

approach to professionalism. The Canadian Medical Protective Association (CMPA) states, “Professionalism is at the core of medical practice and the basis of medicine’s contract with society. Physicians are expected to demonstrate their commitment to patients, society, and the profession through ethical practice.”¹⁴

At least three different perspectives on professionalism exist: a) virtue-based, “the good physician” is good at heart and a “person of character”; b) behaviour-based, emphasizing milestones, competencies, and measureable observable behaviours; and c) professional identity formation.¹⁵ There may be areas of incongruence in these different perspectives during implementation, and two additional cross-currents, professional autonomy and social accountability, also deserve comment.

Virtue-based professionalism

The Royal College of Physicians in the UK stated the following values in their 2005 Working Group Report: “integrity”, “compassion”, “altruism”, and “excellence”. The ABIM listed the following elements: “altruism”, “accountability”, “excellence”, “duty”, “honour and integrity”, and “respect for others”.¹⁶ The Australian Medical Association (AMA) lists the following values of professionalism: “respect, trust, compassion, altruism, integrity, advocacy and justice, accountability, protection of confidentiality, leadership, collaboration, advancing knowledge and innovation, teaching, mentoring and collegiality, and practicing and promoting responsible stewardship of health care resources”.¹⁷ In CanMeds 2005 and 2015, the Royal College of Physicians and Surgeons of Canada (RCPSC) cited the following values: “integrity”, “honesty”, “altruism”, “humility”, “respect for diversity”, and “transparency”.^{18,19} The Canadian Medical Association (CMA) states that the “Ethic of Care” is “characterized by the values of compassion, beneficence, non-maleficence, respect for persons and justice”.²⁰ In 2015, the ePanel Survey by the CMA showed that the top adjectives to describe a medical professional were “dedicated”, “compassionate”, “competent”, “available”, “altruistic”, and “collaborative”.²¹

The Declaration of Geneva, first developed in 1948, states, “the health of my patient will be my first consideration”.²² The same principle is reflected in the Physician Charter,⁸ the CMA Medical Professionalism Policy,²⁰ the AMA,¹⁷ the New Zealand Medical Association (NZMA)²³ and the New Zealand Medical Council,²⁴ the College of Physicians and Surgeons of Ontario (CPSO),²⁵ and le Collège des médecins du Québec (CMQ).²⁶ Similarly, patient autonomy, as stipulated in the ABIM – EFIM Physician Charter,⁸ is echoed in many

organizational policies.^{20,23,26,27} Social justice, last of the fundamental principles in the Charter, is a call “upon the profession to promote a fair distribution of health care resources”.⁸ Justice, an axiom of medical ethics, is also echoed in many of the policies.^{17,23,26-28}

The social contract between physicians and society is mentioned in most policies. The CMA Medical Professionalism Policy states, “Medical professionalism includes both the relationship between a physician and a patient and a social contract between physicians and society.”²⁰ The Physician Charter,⁸ the AMA,¹⁷ and the NZMA Code of Ethics²³ all echo this principle.

Behaviour-based professionalism

Virtues are difficult to measure and evaluate; however, the same cannot be said of behaviour. Indeed, CanMeds 2015 identifies “professional duties” and “milestones” that are evaluated,¹⁸ and the Physician Charter stipulates “a set of professional responsibilities” as being important.⁸ The CMA outlined that fundamental responsibilities, including those to the patient, society, profession, and to oneself, guide professionalism through physician behaviour.²⁸ Responsibilities to the profession and to oneself (i.e., wellness) are expectations found in many organizational policies.

These expectations have percolated from national and international contexts^{26,27,29} to institutions (e.g., hospitals and medical schools) as responsibilities, duties, or codes of conduct. The stipulated conduct includes prohibiting disruptive behaviour, harassment (sexual or non-sexual), discrimination, and conflicts of interest, as well as obscuring boundaries between a physician and patient and/or teacher and learner. More recently, issues of professionalism involving the Internet have escalated in importance, ranging from posting inappropriate videos and cyberbullying to breach of confidentiality with e-mail or images. Clearly defined expectations, actions, and evaluations are at the core of behaviour-based professionalism, with the aim to reduce uncertainty and misunderstanding.

“Organized professionalism” codifies expectations between the institution and the healthcare profession³⁰ but may risk disenchantment among healthcare professionals. “Multiple institutional logics”³⁰ derived from professional, organizational, and policy perspectives may be distinct and divergent. Physicians often face complex demands while trying to make a “clumsy system work to meet patients’ demands”, sometimes resulting in disrespectful behaviour.³¹ Instead, “a culture of respect requires that the institutions develop effective methods for responding to episodes of disrespectful behavior while also initiating the cultural changes needed

to prevent such episodes from occurring.”³² In the CPSO Disruptive Behaviour Guidebook, whether “behaviour truly disrupts” depends “... also on the context in which it arises and the consequences flowing from it.”³³ Context matters. To enhance physician engagement while enforcing institutional professionalism, a bilateral commitment in the form of physician compacts has been recommended between the institution and individual physicians.^{30,34-36}

Professional identity formation (PIF)

To focus solely on behaviour assessments may limit opportunities to internalize what it means to be a physician,³⁷ i.e., focusing on “who one is” may be as important, if not more, as “what one does”. Cruess³⁸ reported on Merton’s work from 1957 that PIF is to “transmit the culture of medicine and... to shape the novice into an effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician.”

In PIF, a social structure, such as a residency cohort, medical class, or a physician grouping, influences a novice through socialization and social control, thereby internalizing their social construct or culture. In time, as experience is gained, the social construct can be modified.³⁹ The social structure’s perspective on reality – i.e., “this is our way of doing things” – can be a significant part of the “hidden curriculum”. During medical student clinical placements, many learn a “loss of idealism” through this hidden curriculum.⁴⁰ With increases in social accountability and public scrutiny into physician practice, however, tension develops in the social construct or in the professional identity.

Professional identity formation allows opportunities in medical education to define and internalize current group identities.³⁸ The transition junctures (e.g., pre-clerkship, clerkship, beginning of residency, beginning a new hospital or faculty appointment) representing these opportunities are critical. At each point, one must navigate the dual identities³⁹ of becoming a physician and joining a transitory social group (medical student, resident, etc.) Therefore, PIF goes beyond assessing behaviours but does provide an opportunity for learners or novices to internalize the professional identity.

Physician autonomy and social accountability

Recent resurgence in social accountability comes from a perception that the medical profession is unable to address many societal healthcare problems.⁴¹⁻⁴³ Over 30,000 articles on social accountability are listed in PubMed. In the Global Consensus for Social Accountability of Medical Schools,

which has strong Canadian representation, the first strategic direction for medical schools is to “respond to current and future health needs and challenges in society”.^{44,45}

Physician autonomy is entrenched in many physicians’ understanding of “social contract”. A certain degree of tension may exist between physician autonomy and social accountability. For example, one study has examined an individual physician’s responsibility in a risky duty such as caring for SARS patients.⁴⁶ The current debate on abortion and physician-assisted dying^{47–49} will likely keep this tension alive.

Mirvis cited four reasons for the origin of physician autonomy: 1) medicine is a specialized body of knowledge; 2) society values the work by the medical profession and trusts the profession to act in the public’s best interests; 3) there is an expectation that public interests are promoted by medical professional organizations; and 4) the state, the government, or, in Canada’s case, the provincial legislature has granted autonomy to the profession.⁵⁰ In other words, autonomy is *quid pro quo* for the profession’s social accountability.

Professionalism and cultural competency

Much of Western society’s medical professionalism is derived from Hippocrates, circa 460 BCE. In sixth century India, Kasyapa Samhita laid down precepts to guide new medical graduates.⁵¹ In China, the Huangdi Neijing (Inner Canon), from the fourth century BCE to the first century CE, served the same role, and the “ideal physician envisioned in the Inner Canon combines ‘supreme virtue’ (zhi de) with ‘supreme skill’ (zhi qiao)”.⁵² Differences exist^{53–57} when professionalism is compared among modern day cultures, including indigenous peoples, with “...substantial differences between indigenous and non-indigenous populations in their expectations of doctors...”.⁵⁸ With respect to virtues, there is generally more commonality between cultures; however, with regard to behaviour and PIF, there is divergence between cultures that may need to be heeded.

Why professionalism?

“What happens if you fail to meet the obligations under the social contract? Canadians will change that contract and redefine professionalism for you. Regulations and changes will be forced upon you—quite possibly in forms that diminish or remove your self-regulatory privilege.

One of the best ways for you and for men and women in any profession to avoid having change forced upon

you is to relentlessly embrace new ideas, tenaciously set and reach higher standards and, most importantly, passionately strive to ensure your profession serves the public good.” —Governor General David Johnston⁵⁹

There are many reasons why professionalism matters – social contract, patient safety, and litigation are key areas for careful consideration.

Social contract

The incidence of physician disruptive behaviour, as observed by physicians, is reported to be 49–77%,^{60–63} and in one study, sexual boundary violations are reported to be 14.5%.⁶⁴ After a number of high-profile scandals, changes were made to self-regulation under the General Medical Council in the UK after 150 years: “Powers of setting standards, monitoring practice, and managing defaults have been relocated to outside the profession”.⁶⁵ A general surgeon in the UK was recently charged with manslaughter for not performing surgery in a timely fashion, and he was found guilty.⁶⁶ In China, the incidence of violence against physicians tripled from 2002 to 2010 as physicians were perceived to be motivated by profit and poorly trained.⁶⁷ Society does not grant autonomy and self-regulation to physicians with impunity but with the proviso that the social contract is honoured.

Patient safety

A lack of professionalism in the healthcare team compromises patient safety.

Physician burnout has been correlated with emotional exhaustion and depersonalization, leading some to “...become more callous toward people”.⁶⁸ Risk factors for burnout include number of hours worked and night calls, and burnout itself increases the incidence of self-reported medical errors.^{69,70} In one study, the odds ratio (OR) of self-reported medical errors in the presence of burnout was 1.89 (95% confidence interval [CI], 1.56 to 2.28).⁷¹ In the Canadian physician health practices survey, 21% of respondents admitted to anhedonia for $\geq$ two weeks in the past year; 23% admitted to depression for $\geq$ two weeks, and 37% of those “thought about death a lot during those $\geq$ two weeks”.⁷² There is good reason why physician wellness is a key commitment under professionalism.

In an analysis of surgical errors, two of the three most frequent causal factors were communication breakdown among personnel and fatigue/excessive workload at 43% and 33%, respectively.⁷³ In one perioperative study, participants thought that disruptive behaviour caused loss

of concentration (84%), reduced collaboration (89%), reduced information transfer (86%), and reduced communication (89%) at the time.⁶³ In the Institute of Medicine report, *To Err is Human*, it is stated that “health care organizations [must] develop a ‘culture of safety’ such that their workforce and processes are focused on improving the reliability and safety of care for patients.”⁷⁴ The TeamSTEPPS program, an initiative resulting from the report, focuses on “medical teamwork ... to ensure that the RIGHT INFORMATION is provided to the RIGHT PERSON(S) at the RIGHT TIME resulting in the RIGHT ACTION(S).”⁷⁵ Teamwork and communication, another essential part of professionalism, has been confirmed as a key ingredient of patient safety.⁷⁶⁻⁸³

Litigation

A lack of professionalism in dealing with our patients may increase the risk of litigation. In one study, mothers of infants with permanent injuries or deaths were interviewed by telephone using a structured questionnaire and open-ended questions. Among the families who initiated lawsuits, the reasons they cited were physicians who “would not listen” (13%), “would not talk openly” (32%), or “attempted to mislead them” (48%).⁸⁴ Negative communication behaviour by physicians has also been shown to increase the risk of malpractice lawsuits.⁸⁵ Patients who were left “feeling rushed”, “never receiving explanations for tests”, or “were ignored” were more likely to file complaints against physicians.⁸⁶ Similarly, physicians with the most unsolicited patient complaints have been shown to have the most “risk management files” which possibly lead to legal action.⁸⁷

How to improve professionalism?

Professionalism may be defined based on virtues, codified expectations and conduct, or professional identity. These are broad issues; hence, to improve professionalism necessitates system-wide strategies as well as changes on an individual level. Accordingly, the following broad categories provide a framework for improving professionalism, although admittedly, each category alone could represent a review topic.

Expectations

Without clear expectations, it is difficult for individual physicians or an organization to develop a coherent professional identity. Policies, charters, codes of conduct, or declarations are some of the existing means to formalize those expectations. Many medical schools have instituted

white coat ceremonies to make the commitment to professionalism clear to their students. Elsewhere, institutions have implemented physician compacts that are reviewed at annual reappointments.³⁴

Studies have also shown that physicians whose licences are suspended by State Medical Boards have a higher prevalence of prior unprofessional behaviour in medical schools (OR, 3.0; 95% CI, 1.9 to 4.8)⁸⁸ and in residency (hazard ratio, 1.7; 95% CI, 1.3 to 2.2).⁸⁹ This affirms the imperative that medical schools must introduce professionalism with defined expectations and strategies. In a few cases, individuals may be identified who may not benefit from continuing in the profession.

Education

Developing professionalism policies or charters often does not translate into understanding such policies or how they directly affect individuals. This is the “knowledge translation” aspect of professionalism policies. Also, times change and expectations evolve. For example, the convenience of storing research or patient care information on a USB drive without the capability to encrypt was relatively common, but these days, it is absolutely inappropriate. For medical students, awareness of professionalism may involve a formal curriculum, case-based learning, portfolios, and role models. Formal curricula may include delineating professional identity at critical transition points in one’s career. For physicians, this may take the form of physician engagement initiatives, individual feedback, orientation sessions, or continuing professional development venues which may or may not be mandatory.

Wellness

“Physician wellness is a critical component of the professional practice of medicine. Wellness is defined as the condition of good physical and mental health necessary to provide high quality care to patients and to fulfill the duties...”²⁹

The association between a lack of wellness and disruptive behaviour and patient safety events has already been discussed.⁶⁹⁻⁷² The Ontario Medical Association has a Physician Health Program to assess at-risk physicians as well as physician wellness. Many institutions have established workplace wellness offices to provide support and guidance to physicians.

Feedback/awareness

Feedback on professionalism concerns is essential. Many physicians are unaware that their behaviour may be a

concern unless direct feedback is provided. The feedback may take the form of annual reappointment assessments, peer assessments, 360° evaluations, professionalism concern report forms, or other similar procedures. For feedback/awareness to be effective, a consistent and transparent process must be in place, even though the feedback itself remains confidential.

Inter-institutional collaboration

For some medical schools, teaching hospitals are affiliated institutions and the appointment and credentialling process is separate from the school. Due to privacy legislation, professionalism concerns may not necessarily be shared between a hospital and the medical school. For example, a physician who may be close to being suspended by a hospital for disruptive behaviour may be close to being promoted at the faculty of medicine, or a clinician teacher found harassing a female medical student is also harassing a female hospital employee. Physicians with professionalism concerns have also moved from one institution to another or from one province to another without the receiving institution gaining knowledge of the prior concerns. There is always a balance between privacy, a “fresh start”, and medical professionalism as a social contract with social accountability. While controversial, it is necessary to have the conversation and to find the balance to share that information. Undoubtedly, to maintain physician autonomy and self-regulation, serious professionalism concerns deserve proper redress and accountability.

Professionalism models

Many models have been developed to advance professionalism,^{38,42,90-93} and I encourage the reader to peruse the abundant literature. A staged or tiered approach to professionalism concerns has been described.⁹⁴ The CMPA,⁹⁵ the CPSO,³³ the University of Ottawa,⁹⁶ and others have adopted a tiered approach. Early discussions at stages 1 and 2 are generally opportunities for formative interventions. Measures at stage 3 tend to be for egregious or persistent behaviour despite formative intervention and can involve disciplinary action.

Conclusion

Professionalism is both a focused and multifaceted topic. Disruptive behaviour, harassment, discrimination, not to mention the requisite responsibility to society, the patient, the profession, and to oneself are all components to recognize and balance. In this article, the current knowledge regarding professionalism is organized into

the “what”, “why”, and “how” approaches to this principle. Some issues are still unresolved – e.g., the tension between physician autonomy (self-regulation) and social accountability (social contract). Nevertheless, there is enough evidence to suggest that our profession should not be complacent, particularly in these times of social accountability and budgetary pressures. William Osler made the following remark in his address to medical students in 1905:

“The times have changed, [conditions] of practice have altered and are altering rapidly, but when such a celebration takes us back to your origin in simpler days and ways, we find that the ideals which inspired them are ours to-day — ideals which are ever old, yet always fresh and new” — William Osler⁹⁷

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