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Professionalism in Anesthesiology

"What Is It?" or "I Know It When I See It"

Editor's Note: This is the fourth in a four-part editorial series on the topic of excellence in anesthesia, which includes how it is designed, how it is measured, and how interventions to improve it might be assessed.

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IN this editorial, the fourth in a series of four on excellence in anesthesiology, I will present the concept of professionalism and how it is uniquely defined within anesthesiology. The series was introduced by Andrew Smith, F.R.C.A. (Consultant Anesthesiologist and Honorary Professor, Royal Lancaster Infirmary and Lancaster University, Lancaster, United Kingdom), who highlighted the risk we take of losing sight of our professional work as a whole when we pay attention mainly to measurable competencies. He also reviewed research into how knowledge is acquired and used in anesthesiology.[1] In the second editorial, Ronnie Glavin, F.R.C.A. (Consultant Anesthesiologist, Anesthetic Department, Victoria Infirmary, Glasgow, United Kingdom), discussed anesthesiologists' nontechnical skills, which emerged as a result of a study based on qualitative methodology.[2] In the third editorial, Jan Larsson, M.D. (Consultant Anesthetist, Clinic of Anesthesia and Intensive Care, Uppsala University Hospital, Uppsala, Sweden), presented a brief introduction to the concept of tacit knowledge and a discussion as to how qualitative studies can clarify its role in anesthesia.[3] In this editorial, I will define concepts related to professionalism and reflect on them within the context of anesthesiology practice.

Just as professionalism is a part of the practice of medicine, teaching and learning professionalism should be a part of anesthesiology residency. Reflecting on the successes and failures of the teaching and learning of professionalism allows identification of the best and worst behavior within the anesthesiology world. Excellence in professionalism is a prerequisite for effective participation and leadership of anesthesiologists in the operating room, the intensive care unit, the pain clinic, and the preanesthesia testing clinic.

Physician professional behavior can be divided arbitrarily into four parts. Accountability is a requirement that the physician place the needs of the patient above self-interest. This requires altruism, a commitment to excellence (not just "good"), optimum preparation for patient care, and an unwavering sense of duty. Humanism fosters the doctor–patient relationship. It includes integrity, compassion, an understanding of diversity, excellent communication skills, dependability, and collegiality. Ethical behavior requires that the physician be invariably honest and demonstrate the highest level of moral behavior, demonstrating tolerance and respect for all human beings. Physician well-being implies that physicians must be aware of the need for physical and mental health for themselves and colleagues. An understanding of the signs of impairment and a commitment to support the well-being of colleagues are assumed.

The converse— unprofessional conduct— can be manifest in a variety of themes, including abuse of authority, bias, sexual harassment, intimidation, poor handling of confidential information, arrogance, greed, dishonesty, laziness, conflict of interest, waste, and fraud. In the critical care setting, there are the issues of authority and the proper role of consultants. In pain medicine, a source for conflict is the additional burden of dealing with opioid-dependent patients and drug-seeking behavior of chronically ill patients.

Most specialties have some measurement of professionalism embedded in their residency program requirements. For example, internal medicine has created "Project Professionalism," a physician charter for professionalism that is signed by internal medicine residents across the country.[4] Anesthesiology residency training has focused on "acquired characteristics" and placed emphasis by requiring that any failure in acquired characteristics results in an unsatisfactory rating for the 6-month training interval. To objectify professionalism in anesthesiology, it would be relevant to define behavior in the setting where anesthesiology practice occurs, including the interface with patients, surgeons, consultants, colleagues, and members of the support team. The beginning of this process is occurring within anesthesiology residency programs, where professionalism is one of the six core competencies. As a result, programs must demonstrate that they teach and assess professionalism throughout clinical anesthesia training. Because they are accredited fellowships, critical care and pain medicine have the same obligation. The challenge for all is to

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define measurable endpoints that define professionalism. Because these measures will be defined and validated, the potential for outcome studies that measure the value of interventions is obvious.

One critical element of professionalism in the perioperative period occurs in the brief, important intervals with patients before procedures. The anesthesiologist has two different responsibilities: to collect the information necessary for safe patient care and to reassure and support the patient. Rapidly recognizing the patient's communication skills and anxiety level and obtaining informed consent all must occur simultaneously, without unduly raising the patient's anxiety. The goal is to leave the patient informed, calm, and motivated to cooperate. In the operating room, the anesthesiologist is responsible to control the environment (noise, inappropriate conversation, and so on). This extends into the postanesthesia care unit, where appropriate experience must be assured clinically as well as esthetically. The postanesthesia obligations continue in the postoperative visit, consultation (awareness, positioning injury, and so on), and continuation of the appropriate handling of confidential patient information. One of the least pleasant but most important obligations is to effectively interact with the unhappy patient. Empathy, effective communication, and advice can reassure an angry patient and reduce the need for this same kind of communication from subsequent anesthesiology teams. Technology has clearly improved patient care and safety but can in some circumstances reduce human interaction in care provided in the operating room or intensive care unit. In the critical care setting, communication about prognosis and the ethical implications of clinical decisions is a daily obligation. For pain medicine, discussing chronic illness and the implications of pain behavior are critical communication issues with each patient. Measuring and reporting these elements of communication have become more common with the increasing effort to determine patient satisfaction with clinical care. The potential to use this as a measure of professionalism is clear.

Professionalism with our surgical colleagues can be a challenge at times. It is natural to regard the surgical team as "the other side." Confrontation may be the natural instinct, but problem solving is the essence of excellent professionalism for the anesthesiology team. It is particularly important to defer confrontation as much as possible during surgery, because the ultimate goal is the best patient care. Conflict, if necessary, should occur when patient care is finished. Vigilance in the operating room, an essential element of professionalism, is compromised by conflict. Another element of professionalism for anesthesiologists is the role of a consultant. Physicians who schedule patients to undergo procedures that require anesthesia are the primary care physicians for surgical patients, and they are entitled to the courtesy of consultation. The anesthesia team should intervene with the consent of the primary care physician, especially when the care of the patient is altered. This includes being informed about changes in the patient's condition, which influences how they communicate with the family. In some critical care units, the intensivist acquires the responsibility for primary care of patients, but also retains the responsibility of a consultant to update the surgical team about patient condition and changes in the treatment plan. The pain specialist has the same obligation to referring physicians. Measuring the quality of this communication in the future could become a measure of professionalism.

Professionalism within anesthesiology is a critically important issue within groups and training programs. Dependability is the lifeblood of team care in all elements of anesthesiology. The willingness to help a colleague is a vital element of problem solving when challenging or unusual clinical problems become evident. Sharing work is essential, with reasonable equity between individuals. This is also true for departments that provide all elements of anesthesiology practice—a reasonable sharing of staff time is the only way to provide clinical coverage in an equitable fashion within increasing complex departmental structures. Sharing of resources is important, especially appropriate use of expensive resources (drugs, equipment, and others).

The individual anesthesiologist should be encouraged by peers toward lifelong learning and evidence-based medicine. Participation in the business of the hospital, state, and national societies is a professional obligation, handled by each anesthesiologist differently and based on skill and preference. Similarly, clinical care and patient safety improve as a result of research, and leadership in research is an element of excellent professionalism, as long as the research is beyond reproach. Conflict of interest, ghostwriting, plagiarism, and other extremes have plagued academic medicine, and anesthesiology is not exempt. Quality improvement requires honest reporting of outcomes; this is either encouraged or, sadly, discouraged by the attitudes of individual providers within groups. The plague of substance abuse within anesthesiology makes recognition of impairment an element of professionalism. Recognizing the impact of stress, isolation, illness, and family strife on the performance of a colleague can be obvious; however, responding in a collegial manner demonstrates excellence in professionalism.

Professionalism in our interactions with members of the support team requires that the anesthesiologist should recognize the skill and education level of all members and the unique elements they bring to the table. Being the "captain of the ship" can be problematic, whereas being the "leader of the team" can be more effective. Leadership begins at the top—senior members should demonstrate respect for all members of their teams and should be models for good behavior. This

good example by leaders will encourage respect by all members of the team. Imitation of bad behavior is a sadly common human characteristic, and an opposing force to professionalism.

So why pay attention to professionalism? One reason is to maintain the practice of medicine as a profession. For anesthesiologists, it is a matter of keeping anesthesiology a part of the practice of medicine. Behavior within groups is known to be a major source of unprofessional incidents in undergraduate medical education.[5] Anecdotal experience suggests that this continues into residency education and beyond. Perhaps more interestingly, there is a strong correlation between physicians in practice who were disciplined by state medical boards, and reports of unprofessional behavior during medical school.[6] The same data have not been collected for anesthesiology residency, but the result would be intriguing. The null hypothesis would be that the same correlation would exist, or perhaps be even more evident. Conversely, some people are undoubtedly better at resolution of conflict,[7] and identifying these characteristics could be a means of raising the standard for professional behavior within anesthesiology. We can also become better at understanding the needs of our colleagues by an open dialogue and increased communication. Given the nature of anesthesiologists to adapt to the infinite variety of perioperative medicine, perhaps we can use this skill to adapt our practices to the unique needs of our members.[8]

A starting point to improve specialty-specific professionalism is to create a curriculum and means to measure any resulting changes.[9] It is possible to behaviorally define professionalism in every aspect of a clinical curriculum and measure progress during training. This can be used to define progress within mastery of this competency during residency. However, the impact of these kinds of interventions on professionalism remains to be determined. The challenge for residency programs is to reach out beyond training, and obtain information about the competency of its graduates and adjust the curriculum to improve the outcome. This certainly could apply to professionalism, perhaps as well as any of the six core competencies. A natural extension is for competency assessment to become part of the maintenance of certification process, and professionalism evidence could be required, if it were substantively defined and widely accepted.

These opportunities are in contrast with our challenges. The media (*e.g.*, the movie *Awake*) and the lay press[10] have raised issues in our patient's minds. Only our behavior can counteract damaging and controversial allegations about our specialty; truly the future is in our hands now.

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