Teaching Professionalism through Discussions Based on the History of Anesthesiology

William A. Shakespeare, M.D.,* Douglas R. Bacon, M.D., M.A.,† Dale C. Smith, Ph.D.,‡ Steven H. Rose, M.D.§

THE Accreditation Council for Graduate Medical Education (ACGME) has mandated professionalism be taught and assessed in all ACGME-accredited training programs as one of six core competencies. The professionalism curriculum may vary significantly at different institutions, but teaching and assessing professionalism is a common challenge to program directors and faculty who wish to capture the spirit of this core competency.1 Professionalism training is challenging, and efforts to teach professional behavior can range from nominally posting a list of rules of conduct to formal didactic sessions during which faculty leaders “preach” to trainees on the perils and pitfalls of unprofessional behaviors. Institutions vary widely in both the content and tone by which this competency is taught.

One source of difficulty in teaching professionalism is the difficulty in defining this competency.1,2 Professionalism is an ideal that is more easily recognized than described. The ACGME has called professionalism a “commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.”[1] Another source defines professionalism itself in terms of specific core competencies and character traits.3 In Britain, the Working Party of the Royal College of Physicians has called the ideal a “set of values, behaviors, and relationships that underpin the trust the public has in doctors.”[4]

Although difficulty arises in finding a philosophical and practical consensus on the definition of professionalism, perhaps an even greater challenge arises when educators set out to teach this nebulously defined quality to their trainees. In the medical world—which is arguably held to a higher code of professional conduct than any other vocation—many approaches to teaching professionalism have been employed. There are professionalism lectures that focus on ethics and are delivered to large classes addressing principles such as autonomy, beneficence, and informed consent. There are pamphlets on professionalism that include self-assessments. There are small group sessions in which experienced preceptors lead a discussion as learners puzzle over an ethical quandary. Other approaches to teaching professionalism have included community service projects instituted by medical schools or an assignment for medical students to follow a patient with a chronic disease throughout their medical school years to focus on the doctor-patient relationship. Efforts to engender professionalism have ranged from single symbolic events, such as a “white coat ceremony,” to time-intensive courses such as an 8-week summer internship focused on professionalism that is taught after the first year of medical school and then followed by a 1-month clinical elective during the third and fourth years.2

Many approaches to teaching professionalism have been described, and the literature includes emerging studies to evaluate whether teaching professionalism translates into an increase in professional behaviors by students. These studies understandably fall on hard times in trying to quantify a human quality, to identify a change in this human quality, and then for the teachers to detach themselves sufficiently to judge whether a legitimate change in professionalism has occurred or whether the student has learned elements of professionalism. However, the teaching of professionalism appears to be critical; students who have been cited for unprofessional behavior in medical school have a higher incidence of disciplinary action by their respective medical boards later in their professional life.5 Perhaps at the same time, medical educators bring their mental toolbox to the pursuit of professionalism, looking to treat professionalism like pneumonia—isolating the perfect regimen that will maximally improve the odds ratios in professionalism—perhaps at the same time we could borrow a “multimodal” understanding from the education world that has long recognized the benefit of pooling diverse didactic ideas, understanding that cyclical teaching with differing approaches will improve learning in a heterogenous population of learners.
USING HISTORY TO TEACH PROFESSIONALISM


Table 1. Fundamental Principles and Professional Responsibilities

<table>
<thead>
<tr>
<th>Fundamental Principles</th>
<th>Professional Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Principle of primacy of patient welfare</td>
<td>1. Commitment to professional competence</td>
</tr>
<tr>
<td>2. Principle of patient autonomy</td>
<td>2. Commitment to honesty with patients</td>
</tr>
<tr>
<td>3. Principle of social justice</td>
<td>3. Commitment to patient confidentiality</td>
</tr>
<tr>
<td>4. Commitment to maintaining appropriate relations with patients</td>
<td>4. Commitment to maintaining appropriate relations with patients</td>
</tr>
<tr>
<td>5. Commitment to improving quality of care</td>
<td>5. Commitment to improving quality of care</td>
</tr>
<tr>
<td>6. Commitment to improving access to care</td>
<td>6. Commitment to communication with patients</td>
</tr>
<tr>
<td>7. Commitment to a just distribution of finite resources</td>
<td>7. Commitment to a just distribution of finite resources</td>
</tr>
<tr>
<td>8. Commitment to scientific knowledge</td>
<td>8. Commitment to scientific knowledge</td>
</tr>
<tr>
<td>9. Commitment to maintaining trust by managing conflicts of interest</td>
<td>9. Commitment to maintaining trust by managing conflicts of interest</td>
</tr>
<tr>
<td>10. Commitment to professional responsibilities</td>
<td>10. Commitment to professional responsibilities</td>
</tr>
</tbody>
</table>

The Physician Charter

A professional theme was introduced into the normal academic year’s schedule of Anesthesiology Journal Clubs attended by residents and faculty of the Mayo School of Graduate Medical Education anesthesia residency program in Rochester, Minnesota. All residents and faculty were extended an invitation to the meeting and supplied copies of the readings to be discussed. The Physician Charter (table 1) and four articles (table 2) on historical topics in anesthesiology were assigned for prereading by the residents and faculty by the faculty moderator (DRB). The Physician Charter is a statement that was first published simultaneously in the Lancet and in the Annals of Internal Medicine and subsequently adopted by numerous medical specialty groups. The Physician Charter sets forth three fundamental professional principles, and then enumerates ten professional responsibilities. Four resident physicians were assigned an historical article to present and were charged to discuss the elements of professionalism found in the Physician Charter as they related to their assigned article. The resident received no coaching before the session on the “right” themes to discuss. On the evening of the Journal Club, the resident presented an overview of the historical article and then led a discussion on the elements of professionalism in the article. After the presentation, the senior moderator summarized and discussed additional issues from each article in turn.

The dinner meeting was not a mandatory event for faculty or residents but was one of the most well-attended Journal Clubs of the year. The evening also differed from other Journal Clubs in the democracy of the discussion and the willingness of junior residents and senior faculty alike to voice opinions on the professional implications of the articles. Resident presenters had varied styles of presentation, some with flash cards and formal presentation and some with overhead slides, while others presented with a less formal spontaneity. The representation was approximately equal, with the number residents slightly outnumbering the faculty present. Informal feedback from residents and faculty collected by the Journal Club program coordinator, the faculty moderator, and the Chief Residents, was positive. Residents, through informal feedback with the Chiefs, related that they enjoyed a topic of discussion in which their insight and voice was equally authoritative with that of senior faculty, the faculty enjoyed discussing values and the history and heritage of the specialty.

Discussion

As described above, there are multiple modes for addressing the ACGME requirement for teaching and assessment of the professional competency. One particular benefit of the discussion of professionalism in a historical context is the sense of heritage that is invoked. Discussing the pioneers and “giants” of a medical specialty gives training physicians a sense of the dignity and the legacy that is theirs. In addition, an historical context presents a safe intermediary for discussion on professionalism, rather than faculty introducing their own values and behavioral priorities in a heavy-handed manner. An historically remote scenario is presented; then, through the course of free discussion, participant opinions are set forth and challenged and decisions are evaluated. All of this occurs without any overt finger-wagging at the trainees to avoid this or that lapse of professionalism.

During our session, one particularly animated source of discussion was a World War II scenario. A battlefield American anesthesiologist, Norman Kornfeld (1914–1995),

Table 2. Selected Historical References for Teaching Professionalism

Waisel DB. The role of World War II and the European theater of operations in the development of anesthesia as a physician specialty in the USA. ANESTHESIOLOGY 2001; 94:307–14.
tells of a severe blood shortage in a front-line hospital. Early in the battle he had a wounded enemy soldier who was brought in bleeding. If his supply was limitless, he could transfuse the enemy combatant, but he also realized that in the hours to come he would doubtlessly want that same unit of blood for an allied soldier. He withheld the blood and the enemy soldier died. The discussion on this topic was lively, with participation from many residents and faculty, including a veteran physician from the military, and a parallel was drawn to a current situation when a police officer and his suspect needed simultaneous care without the resources present to save both. In anesthesiology, professional behavior needs to be intuitive; in the operating room setting, there is little time to reflect upon behavior. Compressed time for decision-making, especially in trauma situations like Kornfield’s, or the hypothetical care of the officer and suspect brought into the emergency room, makes the integration of the elements of professional behavior in anesthesiology both necessary and in many respects unique.

Conclusions

Professionalism is a competency that will continue to challenge program leader’s innovation. In the ongoing process of presenting and representing, we offer this report as consideration for incorporation into the larger “hidden curriculum” of professionalism. In the course of the evening, such topics as plagiarism, responsible research, media relations, and allocation of resources were discussed without the sterile or preaching environment that a direct discussion of these matters would have elicited.

Professionalism is, of course, intangible, and competence in professionalism cannot be guaranteed by a program in the same way as competence in central line placement can. One definition invoked is that professionalism is a contract between the individual and society. Both individual and societal expectations change over time, and “competence” in the sense of a fixed acquired skill is immeasurable. Like locating Heisenberg’s elusive electron, it is also likely a silly proposition to try to measure if faculty or residents have “got it.” History allows the resident and the attending staff some distance from incident under discussion. It permits open and free discussion without the onus of a current case or set of societal assumptions entering into the debate.

Probably the unstudied sense of a resident’s professional demeanor and integrity is at least as valid as any results from a scored inventory or formalized evaluation process. In teaching this “competency”—like teaching quality improvement or teamwork—there is no one right way to proceed. One thing is certain though: we must keep talking about professionalism or it will lapse from the priority list. If residents do not believe that faculty and healthcare system leadership value professionalism, they will certainly not prioritize it either. Thus, in the spirit of keeping the topic of professionalism in the air, we offer this review of the benefits and staff response to the session on professionalism through a discussion of historical readings.

References

11. Waisel DB: The role of World War II and the European theater of operations in the development of Anesthesiology as a physician specialty in the USA. ANESTHESIOLOGY 2001; 94:907–14

Anesthesiology, V 110, No 6, Jun 2009