IS OUR LEVEL OF PROFESSIONALISM WHERE IT SHOULD BE?

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In the last several years, many surgeons have questioned our level of professionalism and for a number of reasons. Issues that force surgeons to consider whether we behave in a professional manner range from the public's perception of adverse trends in health care delivery, and our often aggressive publicity approaches that seem to indicate our concern only with self-interest, to concerns that have arisen about a possible increase in medical student mistreatment. Information about this last unexpected but disturbing trend came from annual graduation questionnaires that have been distributed nationally for the last decade.

In response to all these concerns, leaders of many national organizations dealing with health care education and delivery have concluded that some physicians may exhibit behaviors that challenge our longstanding principles of professionalism. Organizations addressing this subject include the American Medical Association (AMA), the American Association of Medical Colleges,[1] the Accreditation Council on Graduate Medical Education (ACGME), the American Board of Internal Medicine, and our own American College of Surgeons.[2] These groups have made a commitment to enhancing professional

behavior and personal interactions between patients and physicians and medical educators and students. This topic should be of great importance to all of us, regardless of whether we are clinical surgeons or surgical teachers.

Before addressing our possible shortcomings, we need to define "professionalism." This rather vague term means many things to many people, but generally it implies a commitment to and training and competence in a specific area of endeavor. The professional athlete, police officer, or soldier would be expected to have all of these attributes, yet would not necessarily be expected to possess certain other qualities that we demand of members of the "learned professions." Traditionally, law, religion, and medicine have fit into this category, and the essence of professionalism in all of these fields is best encapsulated in the word "ethics."

Unfortunately, this term also is so broad that it prevents an accurate assessment of medical professionalism for the purpose of the question posed by the title of this piece. How do we define *medical* professionalism (or even the lack thereof), and what can we do to promote it in our own environments?

Previous efforts

Responding to a need for a strong statement on the principles and ethics of professionalism, the AMA Council on Ethical and Judicial Affairs arrived at the following seven principles of professionalism in 1980:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall be honest with patients and colleagues and strive to expose those physicians deficient in character or competence or who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, or colleagues, and of other health professionals and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Although it outlined important principles of medical professionalism, the AMA Council report seemed to deal with a broader set of principles than was appropriate for our educational institution.

In more recent years, the AMA Council on Medical Education has responded to concerns about evidence of student mistreatment revealed in the medical school graduation questionnaires. The council developed policies and recommendations in this area that relate specifically to the medical educator-student relationship. Their general statement regarding a code of behavior is as follows: "The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a *professional* manner and in a learning environment that places strong focus on education, high-quality patient care, and ethical conduct."

Institution forms committee

At our institution, the Medical College of Virginia, Virginia Commonwealth University, the dean, H.H. Newsome, MD, was pleased to see the external interest in professionalism and was concerned about potential internal problems. To address these issues relating to professionalism, I was given the charge of chairing a committee to both study this topic and to "fix" any problems. At first, I interpreted this new responsibility as an honor, implying that I possessed both good judgment and leadership ability. Later, it became apparent that the dean chose a surgeon to chair this project for other reasons. Specifically, the data from the graduation questionnaires indicated that student reports of abuse, with some exceptions, often highlighted the unprofessional behavior of certain surgical house

staff or faculty surgeons. Although this circumstance should certainly lead surgeons to take this subject seriously, it did dampen the "honor" of my appointment.

The committee appointed to both study and make recommendations regarding professionalism in our medical school community included faculty (both clinical and nonclinical), clinical house staff, and students and, although the deliberations were thoughtful, discussions were often chaotic due to the vagueness of some of the concepts being considered. Nonetheless, we did reach a consensus on a number of aspects of medical professionalism and made some specific recommendations that are now being implemented at our institution. A brief summary of our work may interest other surgeons, because the principles may be applicable in other institutions that are dealing with questions of professionalism.

Defining professionalism

Although ethics are the underpinnings of medical professionalism, we decided that a working definition that included examples of various desired behaviors would be required for us to be effective in this project. The major components of medical professionalism that were identified by a group from the Kansas University Medical Center (KUMC), and based on principles espoused by a number of organizations, summarize the desired behavior as well as any.[3]

The positive characteristics listed are: altruism, accountability, excellence, respect for others, a personal commitment to lifelong learning, duty, honor, and integrity. Challenges to these principles of professionalism are abuse of power, discrimination, bias, breach of confidentiality, arrogance, greed, misrepresentation, lack of conscience, and conflict of interest. Some descriptors of unprofessional behavior were: unmet professional responsibility, lack of effort toward health improvement and adaptability, poor interaction with patients and families, and inappropriate relationships with other health care professionals.

These concepts gave us a "working definition" of medical professionalism that we could use as a basis for the rest of our project—that of "fixing the problem."

Evaluating professional behavior

The efforts to arrive at a definition of professionalism led us to believe that we needed some specific standards of behavior that could be used to evaluate all of the professionals in our environment, including faculty, house staff, and students. If our ultimate goal was to promote professionalism in our community, we felt an ongoing prospective assessment of these behaviors by and of everyone was a necessity.

After considerable discussion of specific standards for each of the groups in our environment, we concluded that the standards were really universal. The list of standards that we determined could be applied to all these groups was as follows:

- Recognize their positions as role models for other members of the health care team.
- Carry out academic, clinical, and research responsibilities in a conscientious manner, make every effort to exceed expectations, and make a commitment to lifelong learning.
- Treat patients, faculty, house staff, and students with humanism and sensitivity to the value of cultural, social, age, gender, disability, economic diversity, and sexual orientation without discrimination, bias, or harassment.
- Maintain patient confidentiality.
- Be respectful of the privacy of all members of the medical campus community and avoid promoting gossip and rumor.
- Interact with all other members of the health care team in a helpful and supportive fashion, without arrogance and with respect for and recognition of the roles played by each individual.
- Provide help or seek assistance for any member of the health care team who is recognized as impaired in his or her ability to perform professional obligations.
- Be mindful of the limits of one's knowledge and abilities, and seek help from others whenever appropriate.
- Abide by accepted ethical standards in the scholarship, research, and standards of patient care.

The ACGME has already developed more detailed standards and a thorough evaluation process for house officers only. Our more limited list is consistent with that produced for postgraduate trainees.

Effect on the institution

The committee's discussions and resultant initiatives have affected our institution in a number of ways. Professional behavior at the Medical College of Virginia has been highlighted by some of the activities described below, has become more visible in all of our personal interactions, and should enhance professionalism throughout our environment. Our efforts to implement a program on professionalism in response to the deliberations are still relatively preliminary. However, the enthusiasm generated among those individuals involved in the project convinces me that our endeavors will interest colleagues who may choose to follow a similar course at their own institutions. The initial efforts have included:

1. *Widespread dissemination of the "Standards of Professional Behavior" listed previously.* Initially dissemination of the standards was accomplished via e-mail and memoranda sent out from our dean's office establishing this list of standards as a credo for our institution. The importance of this message was emphasized by requesting a signed statement from everyone confirming their receipt, their reading, and their acceptance of these principles. At Virginia Commonwealth University, the dean's office is an appropriate source for such proclamations, but other environments may have different lines of authority.

Another means of communicating our commitment to the Standards of Professional Behavior is our institutional Web page, which allows us to promote the principles internally and with the public. We plan to use this vehicle to highlight individual standards at intervals in an innovative way to keep us all continually focused on appropriate professional behavior in our work place. Already our university hospital and affiliated Veterans Affairs hospital have expressed interest in distributing some of these concepts to other institutions and organizations.

2. *Evaluation process.* Early on, we concluded that the achievement of optimal professional behaviors by all of us required some form of objective evaluation of performance. Although not totally original, we developed our own processes for evaluating the professionalism of faculty, house staff, and students, an assessment similar to those used to determine academic and clinical performance. These specific evaluation mechanisms are currently being tested over a one- to two-year period to determine both their feasibility and reliability. Already, some people believe the evaluation process we have developed is more complex than desired, but we anticipate ultimately developing an acceptable evaluation process for professionalism that effectively supplements our current process for determining competence in other areas. In the long run, we hope this process will have a broad and positive effect on student grading, recommendation letters, and faculty promotions. Also, the inclusion of professionalism in the evaluation process for all groups has helped us establish this behavior as a major concern of the culture of the institution overall. Our medical school includes students, house staff, and faculty, but these same concepts of evaluation are clearly applicable to individuals and institutions that have somewhat different sets of players.

3. *Grievance process.* Another specific and possibly helpful process resulting from these deliberations on professionalism has been the development of an informal grievance process for students and house staff who feel they have experienced some form of abuse or mistreatment from a superior. The usual formal grievance procedures are in place at this institution for specific transgressions that relate to gender discrimination, racial discrimination, and so on. However, our committee felt that a less formal process for correcting unprofessional behavior (including mistreatment of students) was needed, despite the fact that incidents were thought to occur relatively infrequently.

Our professionalism committee has now implemented such an informal process for dealing with these types of issues, a process that was designed to allow people to bring forth these issues comfortably. The individuals acting as intermediaries (or ombudsmen) in this process are currently the committee members who are not authority figures or teachers of those bringing the concerns forward. We anticipate that this approach will prove useful for both identifying and resolving problems that are less than major grievances. Admittedly, this process should be most applicable to the student in the student-

educator relationship, but our early experience has shown it may have broader applications. Informal complaints have included other situations and categories of individuals in our environment. Although used rather infrequently so far, establishing this process has demonstrated our institution's commitment to professionalism.

4. *Promulgating high standards of professionalism.* At the outset of this project, several of the committee members felt that curricular changes focusing on professionalism would be a major final recommendation. After review of the available literature, and extensive committee deliberations, we concluded that all members of our academic community needed to become more aware of this problem, not just our students. Also, making an impact on teachers (clinical and otherwise), rather than students must be a top priority if we are going to "raise the bar" in this area. On the other hand, developing clinical teachers as role models in this area is just the beginning, and refinement of the curriculum, in terms of professionalism, will be a major activity as we move forward. Currently, we are planning new curricular materials relating to cultural competency, but this is only a beginning.

Our committee unanimously agreed that bringing visibility to the area of professionalism was the most effective approach for optimizing professional behavior at all levels. Because clinical leaders and other teaching faculty will always serve as role models, they must be our prime target for this campaign, but the standards described are universal for all groups from the bottom to the top of the system. It is clear that "training" in medical professionalism needs to reach all groups, and the approaches we use need to be innovative to capture the attention and the interest of everyone involved. Our early efforts have included: (a) a white coat ceremony for beginning medical students that focuses on medical ethics, the Hippocratic Oath, and so on; (b) faculty development seminars and orientation sessions on professionalism for new faculty, house staff, and students; (c) a library of audiovisual presentations in our computer-based student library; and (d) periodic, interactive case discussions of thought-producing scenarios presented at departmental conferences and "grand rounds." This latter project has been initiated and well received, and we believe it will be one of the strongest aspects of our professionalism project.

Conclusion

What of the question posed in the title of this commentary? At this point, we have detected no serious breaches of professionalism by surgeons or other individuals in our environment, but we have identified enough minor concerns to respond in the negative. Our experience has convinced the committee that the entire topic of professional behavior deserves our close scrutiny.

As so many opposing forces participate in our health care and health education environment, surgeons must continue to vigilantly guard the values that have led us to our career choice. Whether some of the perceived transgressions in professional behavior are real or not, we must continue to take positive steps to maintain the ethics of our noble profession and specialty. As strong patient advocates, surgeons will, I believe, take the lead in this process. Ω

References

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