Learning From Others:

A Case Report From the Anesthesia Incident Reporting System

Anesthesia Quality Institute
ANESTHESIA INCIDENT REPORTING SYSTEM (AIRS)

Review of unusual patient care experiences is a cornerstone of medical education. Each month, the AQI-AIRS Steering Committee abstracts a patient history submitted to the Anesthesia Incident Reporting System (AIRS) and authors a discussion of the safety and human factors challenges involved. Real-life case histories often include multiple clinical decisions, only some of which can be discussed in the space available. Absence of commentary should not be construed as agreement with the clinical decisions described. Feedback regarding this article can be sent by email to Heather Sherman: **h.sherman@asahq.org**. Report incidents or download the AIRS mobile app at **www.aqiairs.org**.

Professionalism: Will We Know It When We See It?

"The patient was undergoing a laparoscopic pancreatectomy, possibly open. Epidural catheter was placed in case of open, resident told not to dose the catheter unless the surgeons converted to an open procedure, and in any event not to administer epidural narcotics without speaking to me.

I was really busy – returned to the pancreatectomy two hours later. The abdomen had not been opened. The patient was sleepy and breathing slowly. Resident said that he had given 2 mg of hydromorphone. I assumed that this was I.V.; we discussed that this dose was very high given the patient and the procedure. I gave naloxone (80 mcg), patient awakened and responded normally.

Two hours later, the patient became unresponsive and required more naloxone and finally an infusion. She had absolutely no pain. The resident casually mentioned that he had no idea that 2 mg of epidural hydromorphone would have this response."

This edition of the *Monitor* is focused on the topic of professionalism, a term widely used but difficult to define. This case will be used here to open the discussion of what professional behavior can and should look like and how we should approach teaching it. This case could be used to discuss many topics, including the vagaries of communication (did the resident hear and understand the instructions about the epidural?), or it could spark a conversation about the definition of appropriate supervision: Is two hours away from the room too long? This discussion about professionalism will hopefully spark further introspection and commentary about this important topic. Perhaps most important, it will enforce the critical concept that professional behavior is learned, not innate, and that professionals at every level of their career need to continually examine their own behavior to recognize and correct potentially unprofessional actions.

It is hard to define unprofessional behavior, but most of us believe we "know it when we see it" and would see several examples in this case. Unfortunately, it is easier to recognize unprofessionalism than to teach or assess it. Professionalism exists in the context of a profession, which is defined by acquisition and application of a body of knowledge, technical skills and values. Members of a profession typically have a shared commitment, in our case to the well-being of patients, and regulate themselves individually and collectively throughout their careers. Therefore, responsibility for assessment and management of professionalism is not limited to academic institutions who train medical students and residents, but is required of all of us, both in self-assessment (self-reflection, recognizing and correcting errors) and in assessment and regulation of our colleagues (hospital privileges, state medical boards). Epstein and Hundert define professionalism as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served."[1]

The Accreditation Council for Graduate Medical Education (ACGME) added professionalism as a core competency in 1999. With the advent of the Milestones Project, we were forced to better define the concept. A professionalism charter was developed by an international group of physician boards and published in 2002 (see table on page 28).[2,3] The charter focused on three key principles:

- **Patient welfare** – altruism, patient interest, trust
- **Patient autonomy** – honesty with patients, education and shared decision-making
- **Social justice** – the contract physicians have with society and fair distribution of medical resources.

Each of us is aware of colleagues who do not evince correct behaviors and yet who are not counseled or disciplined. The most obvious of these are disruptive behaviors, such as demeaning nurses or other staff, belittling and bullying. When we add other classes of unprofessional behavior, such as delays in signing charts, inattention to test results and how we supervise our team, the list becomes long and most of us would admit that we evince unprofessional behavior at least some of the time. The "hidden curriculum" in a teaching program is "do as I say, not

as I do," and faculty may model unprofessional behaviors such as devoting more time and concern to "private patients" compared to "service patients." Such behavior contributes to the erosion of students' idealism and commitment to patients, and to our profession.[4] As described by one medical student: "However, medical school is an utter drain. For two years lecturers parade up and down describing their own particular niche as if it were the most important thing for a student to learn. And then during the clinical years, life is brutal. People are rude, the hours are long, and there is always a test at the end of the rotation …."[5] This student's description is unfair and inaccurate for most settings, but it contains more than a grain of truth and is in fact how he felt.

Espousing an explicit commitment to professional behaviors of altruism, compassion, empathy and patient-centered care when in reality we often model a tacit commitment to detachment and physician-centered interests is unprofessional and hypocritical.

It is hard to argue with the lofty professionalism values defined above. However, significant challenges lie in translating them into discrete, definable behaviors. This is because of the difficulty in measuring values, per se. We find it relatively easy to measure cognitive or technical skills such as the ability to perform procedures and knowing the right treatment for ketoacidosis. Assessing non-cognitive skills such as communication or collaboration is more difficult. But assessing values borders on the impossible because it requires that we know the motivations and intent behind the individual's behavior, a daunting task no matter how unprofessional that behavior might appear. How do we know if a resident is basing her decisions on altruism or only on staying out of trouble with her attending? Even when we feel that we see unprofessional behavior, it can be difficult to put that into explicit terms that can provide helpful feedback. Lynne Kirk offers a solution – that of using a "behavior-based orientation," as behaviors relating to "responsibility" such as being late for rounds or failing to follow up on a diagnostic testing are specific, measurable and remediation can be very specific.[6] Jim Wagner, at the University of Texas Southwestern Medical School, has linked specific behaviors to some non-cognitive skills. This linkage makes it easier for us to assess professionalism and remediate when necessary.

In the incident described above, the resident acted unprofessionally in a number of ways. The mistake in the epidural dosing may have been simply an error. Many mistakes are simple human error and unrelated to lack of professionalism. This error was more likely related to an overestimation of his knowledge about epidurals in that he was not sure the dose he was giving was correct, *but he gave it anyway.* That is a professionalism failure. We are charged with knowing that our intended actions are correct and with asking when we are not sure. He also showed poor communication skills, as he either did not listen well (did not hear the attending say to not dose the epidural with any narcotics) or failed to collaborate (decided to give an epidural narcotic based on his own decision). He also did not communicate his actions to the rest of the team (when the patient failed to awaken, he did not immediately state what he had given). He did not make an appropriate and timely diagnosis (epidural hydromorphone causing respiratory depression). Finally, although it is not explicitly stated, the resident may have been dishonest, at least at the onset of the respiratory depression, in that he did not tell the attending what he had done. And dishonesty to the patient may also have occurred, depending on whether or not the error was disclosed to the patient at some later date. Each of these behaviors is clearly problematic and they do not appear to be patient-centered, honest or in line with the fair distribution of resources (i.e., failing all three principles of professionalism).

This incident may also highlight unprofessional behavior by the attending – is a two-hour period away from the case too long for adequate supervision? With our case management model, we daily supervise others and must balance production pressures with safety. While supervision from across town is clearly unprofessional, is supervision of a GI suite case from the O.R. unprofessional? Supervision of an emergency case done by a CRNA from home? Difficult questions, but ones that we need to be aware of and grapple with to be professional. We hope that the attending was able to effectively educate the resident about his deficiencies around professionalism in this case. The attending clearly modeled professionalism through reporting this incident to AIRS so that we could all learn from that incident. There was clear self-reflection, identification of errors made and, one hopes, remediation with the resident.

The errors in communication point to systemic contributions to unprofessional behavior, including production pressure and a lack of standardized communication protocols. A systemic commitment to professional behavior is an important component of safety, and when lacking, may set teams up for errors such as this one. The demands placed on the attending physician that necessitated a long period of absence were the system factor that contributed to this error.

In order to develop appropriate professionalism, we must first set appropriate expectations for our institution, staff and students, beginning with policy statements and even providing a listing of expected behaviors (for staff, for faculty, for students). Examples include timeliness of charting and appropriate communication with referring physicians, timely response to a request for consult, and expectation that clinics or surgeries will not be cancelled on a physician's whim. These expectations should be readily available to patients and families as well so they can provide feedback about whether or not we are meeting the expectations.

Once expectations are set, assessment of all providers should occur on a regular and ongoing basis, both via self-reflection and via internal quality committees, medical staff review and so on. Where deficiencies are noted, remediation needs to occur. Once unacceptable behaviors have been

Continued on page 26

Continued from page 25

identified, the individual should be counseled to review these unprofessional behaviors and to set a specific remediation plan. Leaders in every institution have a responsibility to develop a supportive and just institutional culture that expects professionalism, defines it and tracks it.

It is critical to understand that professional behaviors are an important part of the training process for clinicians, and not simply inherent character traits (thus the significance and potentially negative impact of the hidden curriculum). We can and must train our residents (and continue to train our staff) to act professionally. The importance of training in professionalism is underscored by a recent study correlating students' unprofessional behavior in medical school with subsequent disciplinary action by medical boards. Papadakis and colleagues identified 235 physicians who had been disciplined by U.S. state medical boards and matched each with two controls from the same medical school. Students who had been cited for unprofessional behavior in medical school were three times more likely to have disciplinary action than those not cited for unprofessionalism. Furthermore, those who were identified as showing "severe irresponsibility" (irresponsibility noted ≥3 times in their medical school record) were 8.5 times more likely to have disciplinary action in their career. Whether we can change these trajectories by improving professionalism education is to be determined, but maintaining the status quo is not an option.

We do not believe that the resident in this case "was unprofessional" but that he "showed unprofessionalism." Professionalism must be taught and unprofessional acts can be remediated. An appropriate approach in this case would be for the attending to meet with this resident in private for a frank discussion. The resident could be told: "This was a mess, and you contributed. I want to help you remediate, and I am on your side." The resident could then be asked four questions:

1. Do you have an understanding of your contribution?
2. In what ways did the system set you up?
3. What can you do to be ready for a better performance the next time a similar situation comes up?
4. How can I help you reflect on this challenge?

We are grateful to the attending who reported this to AIRS. It would have been very positive and productive to have the resident participate in the report. In answering the question and making the report, the resident and attending would have engaged in reflective practice together.

As anesthesiologists, we share a common body of knowledge and skill sets, we tend to be extremely dedicated to our patients and to our profession, and we strive to provide the highest standard of care. We have been leaders in patient safety, and we can and do lead in professionalism.

Linking Professionalism Values to Specific Values (as reported in Kirk, 2007)[6]

Values	Behaviors
Responsibility	• Follows through on tasks • Arrives on time
Maturity	• Accepts responsibility for failure • Doesn't make inappropriate demands • Is not abusive and critical in times of stress
Communication	• Listens well • Is not hostile, derogatory, or sarcastic • Is not loud or disruptive
Respect	• Maintains patient confidentiality • Is patient • Is sensitive to physical/ emotional needs • Is not biased or discriminatory

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