

Professionalism: The “Forgotten” Core Competency

Julie L. Huffmyer, MD,* and Susan E. Kirk, MD†

The anesthesiology residents in our program were recently asked to define one of the core competencies of the Accreditation Council for Graduate Medical Education (ACGME): professionalism. They mostly returned lengthy, blank stares. Finally, 1 courageous woman said, “Professionalism is honoring the Anesthesia family name.” We think she delivered fairly close to the mark. A simple, layperson’s definition of professionalism might be: “The skill, good judgment and polite behavior that is expected from a person who is trained to do a job well,”¹ but we believe that professionalism for physicians extends beyond a job well done. Important components of professionalism involve noncognitive skills, including communication (language, empathy, integrity, compassion), collaboration (responsibility, respect, duty), and continuous improvement (recognition of limitations, motivation to improve).² Defining professionalism, however, is considerably easier than teaching it, as highlighted in the article by Mitchell et al³ in this issue of *Anesthesia & Analgesia*.

Professionalism in medicine is a critically important competency to master, yet teaching communication and professionalism to Graduate Medical Education (GME) trainees remains one of the more challenging issues facing training programs’ faculty. Not surprisingly, most educational projects and initiatives during residency tend to focus on improving medical knowledge and patient care, both of which are also ACGME-required core competencies.⁴ However, there is more to being a physician than the accumulation of medical knowledge or delivering technically sound patient care. In order to succeed as an anesthesiologist and a physician, one must possess both the medical knowledge and the humanistic desire to help and communicate with others. To have one without the other would lead to an incomplete professional, one who is not wholly competent.

The importance of professionalism, as well as the association of medical knowledge and clinical expertise with

professional behaviors, is well established.⁵ Medical students with professionalism lapses early in their educational process have higher likelihood to demonstrate issues with professionalism and communication in residency training and later in practice.⁶ Conscientious behaviors, such as attention to administrative detail and completion of evaluations, have been associated with higher professionalism scores as assessed by resident peers, senior residents, faculty, and nonphysicians (nurses), as well as higher standardized, in-training examination and clinical examination performances.⁵

Faculty interested in education of residents and those with experience in GME acknowledge that professionalism is important and that professionalism lapses are associated with future unprofessional behaviors and disciplinary action. As educators, perhaps it is possible to identify residents who are at risk for lapses in professionalism, but we have been reticent to take an active role in “teaching” professionalism. Historically there was an assumption by faculty that residents in training would “learn” professionalism skills, just like surgical and technical skills, by observation and apprenticeship of senior faculty. While having good role models and a culture that encourages professional behavior is critical to a good training and learning environment, professionalism skills are not instinctual; indeed, professionalism is not learned if left to the observation and apprenticeship model.⁷ Moreover, if role modeling is the only tool we use to teach professionalism, what happens when GME trainees are exposed to unprofessional behavior? A landmark study by Asch et al⁸ in 2009 demonstrated that residents in obstetrics and gynecology programs who trained at institutions with high rates of patient complications carried those traits into practice. Several decades later, practicing obstetricians and gynecologists’ complication rates reflected those of their original training programs, suggesting that a type of imprinting had taken place during their formative years. We can only speculate whether similar imprinting takes place with other competencies such as professionalism or interpersonal communication. However, it gives us pause when we consider the lasting impact that role modeling by faculty physicians might have on trainees.

Some anesthesiology training programs have incorporated case-based group discussion, reflection, and evaluation of resident professionalism in the care of patients and interaction with other professionals.⁹ Aside from these methods, academic anesthesiology has not developed curricula to teach and train our residents in matters of professionalism and communication. We all know instances of newly minted physician faculty who possess

From the *Department of Anesthesiology, University of Virginia, Charlottesville, Virginia; and †Graduate Medical Education, University of Virginia, Charlottesville, Virginia.

Accepted for publication May 3, 2017.

Funding: None.

The authors declare no conflicts of interest.

Reprints will not be available from the authors.

Address correspondence to Julie L. Huffmyer, MD, Department of Anesthesiology, University of Virginia, PO Box 800710, Charlottesville, VA 22908. Address e-mail to jh3wd@hscmail.mcc.virginia.edu.

Copyright © 2017 International Anesthesia Research Society
DOI: 10.1213/ANE.0000000000002269

great potential to teach trainees, perform research, and provide patient care, but whose careers become derailed as a result of unprofessional behavior or poor communication with resulting disciplinary action. Thus, as anesthesiology educators, we have an obligation to our trainees to more effectively teach and train them in the core competencies of professionalism and communication prior to graduation from residency programs. If, instead, we allow residents to graduate without fully mastering these key skills, we have failed them and their future patients.

Briefly, Mitchell et al³ from 4 academic anesthesiology departments across the United States investigated the training that anesthesiology faculty receive in providing feedback regarding communication and professionalism to anesthesiology residents. The authors implemented a video-based educational intervention for faculty designed to encourage high-quality feedback regarding the way trainees interacted with patients. In general, across the 4 institutions, the authors found no significant changes in feedback quantity, quality, utility, or percentage of feedback with constructive comments related to professionalism and communication. Despite having the same video-based educational intervention, some of the individual institutions demonstrated variable, yet transient, improvement in feedback related to professionalism and communication, occurring mainly during the faculty development intervention period. Thus, Mitchell et al suggest that a more sustained approach to faculty development, along with the focus on departmental culture and trainee receptivity to feedback, may indeed lead to enduring improvements in the quality, quantity, and utility of feedback, especially with regard to professionalism and communication to residents. To frame this in the perspective of Asch and his earlier studies, are there ways to imprint these important traits in our graduates of anesthesiology residency programs?

In July of this year, the ACGME will enact requirements that deliver new expectations in the area of professionalism.¹⁰ Notably, key elements of the learning and working environment must include the concept that excellence in professionalism (must be demonstrated through) faculty modeling of (1) the effacement of self-interest in a humanistic environment that supports the professional development of the physician and (2) the joy of curiosity, problem-solving, intellectual rigor, and discovery. Specifically, "programs, in partnership with their sponsoring institutions, must educate residents and faculty members concerning the professional responsibilities of physicians." Although these expectations might be clear, and the reasoning behind them easily inferred, the mechanism of how they should be enacted is left up to the individual programs and institutions.

Therefore, despite its statistical insignificance, this study in this issue of *Anesthesia & Analgesia* represents an important

first step in the conversation of how to teach professionalism and communication as well as provide better feedback in those competencies. This is an aspect of anesthesiology training in which most of us in our role as educators have not provided sufficient focus. Teaching professionalism and good communication skills to anesthesiology residents may indeed be more important, in the long run, than the number of different methods taught for intubation or peripheral nerve blockade. Regardless of the lack of statistical effect here or in fact because of it, we need more studies and a consensus for how to better provide feedback to trainees regarding professionalism and communication. Our anesthesiology resident trainees today will become our anesthesiology faculty and colleagues tomorrow; the time has come for us to find better ways of teaching professionalism in anesthesiology. ■■

DISCLOSURES

Name: Julie L. Huffmyer, MD.

Contribution: This author helped review the manuscript and write the editorial.

Name: Susan E. Kirk, MD.

Contribution: This author helped write the editorial.

This manuscript was handled by: Edward C. Nemergut, MD.

REFERENCES

- Merriam-Webster Learner's Dictionary. Available at: <https://www.learnersdictionary.com/definition/professionalism>. Accessed March 21, 2017.
- Kirk LM. Professionalism in medicine: definitions and considerations for teaching. *Proc (Bayl Univ Med Cent)*. 2007;20:13–16.
- Mitchell JD, Ku C, Diachun CAB, et al. Enhancing feedback on professionalism and communication skills in anesthesia residency programs. *Anes Analg*. 2017;125:620–631.
- Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements. Available at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf. Accessed April 16, 2017.
- Reed DA, West CP, Mueller PS, Ficalora RD, Engstler GJ, Beckman TJ. Behaviors of highly professional resident physicians. *JAMA*. 2008;300:1326–1333.
- Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med*. 2005;353:2673–2682.
- Hochberg MS, Berman RS, Kalet AL, Zabar S, Gillespie C, Pachter HL. Professionalism training for surgical residents: documenting the advantages of a professionalism curriculum. *Ann Surg*. 2016;264:501–507.
- Asch DA, Nicholson S, Srinivas S, Herrin J, Epstein AJ. Evaluating obstetrical residency programs using patient outcomes. *JAMA*. 2009;302:1277–1283.
- Dorotta I, Staszak J, Takla A, Tetzlaff JE. Teaching and evaluating professionalism for anesthesiology residents. *J Clin Anesth*. 2006;18:148–160.
- Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements Section VI with Background and Intent. Available at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_Section%20VI_with-Background-and-Intent_2017-01.pdf. Accessed April 16, 2017.