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Creating a Culture of Professionalism in Your Department

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Stem Case and Key Questions Content

CASE: Your department is going through a difficult time. Finances are OK, though not fantastic. The OR's are very busy with lots of cases running late, requiring even non-call people to have to stay late on a regular basis. Morale is low throughout. The residents appear unhappy, though when confronted about this they don't want to talk. Faculty have been trickling away, straining the already tight staffing situation. Each one who leaves just says they can make more money elsewhere. Patient care doesn't seem to have been affected but you've been selected by your chair to assess the situation, find a solution and fix things. The chair tells you that he thinks may be a professionalism issue because the salaries paid to staff are comparable to those in the area. "Be careful," he says. He doesn't want to be committed to professionalism ideals that he can't maintain.

1. How would you go about assessing professionalism issues in your department?
2. Are the issues felt by staff, residents and CRNA's likely to be very different from each other? How would you expect them to differ?

You decide to create a survey for the department as a needs assessment. You also decided to look carefully at the resident evaluations of faculty to see what they are saying to get hints of what their issues may be. You realize you have to craft your instrument very carefully to maintain anonymity in the hopes of getting maximum truthfulness from everyone.

3. How would you go about doing this?
4. Who is most vulnerable to "discovery?"

Your plan is to list in your survey the nationally published criteria on professionalism then ask which of the criteria are most important to the various members of the department and if they are aware of "violations" to give examples. People grumble about the survey but actually do take the time to fill it out. You get about a 60% response from the residents and nurses and 30% from the faculty, about what you'd expect. The faculty complain about long hours, wanting more pay, lack of respect from surgical colleagues and residents who aren't what they used to be - "they all grumble about long hours, don't seem to be reading about their cases ahead of time 'like I used to', want to be spoon-fed, are always on the computer/smart phone even during cases..."

5. Which of these issues can you reasonably tackle in the short term?
6. What would you do?

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The residents have totally different things they worry about. They complain about a lack of support from staff, saying they are berated in front of surgeons, don't get help when they call for it and get very little teaching in the OR. They are often left working late without anyone telling them why/how long they'll be there, etc. They also have issues with perioperative staff, nurses in the OR and PACU staff "not respecting them."

7. Which of these can you tackle in the short term?
8. What would your long term strategy be?

The nurses also have issues. They state that they have specific hours to work and are often working overtime when they don't want to. "At least ask me if I can stay late - I may have plans". They also feel the surgeons don't respect them because they are "nurses".

9. What can you do about this?

Your chair also has issues he wants addressed. Faculty hasn't been filling out billing paperwork appropriately, preventing adequate collections. Notes and phone calls don't seem to be getting any results.

10. What can be done about this?

Model Discussion Content

In common with many difficult issues, professionalism is often in the eye of the beholder. Therefore, when tackling issues that fall under the professionalism umbrella it is important to get the viewpoints of those involved. Everyone sees things differently. By surveying the department and separating out the different groups it is easier to target changes for the right people. Changing the culture of a department is a challenge because, as the issues brought out here point out, they often involve other people and other departments. It may be difficult, indeed impossible to change other areas of a hospital while you are trying to fix yours. If you are fortunate, you may work in a hospital such as the University of Washington (UW), the University of Texas or McGill University, where the entire institution was striving for change.^{1,2,3} In those situations "local" changes can be made with the support of the institution and as part of a larger plan. For instance, the department of urology at UW decided to make the teaching, learning and evaluation of professionalism explicit as opposed to merely implicit as part of the larger university initiative.⁴ At McGill a faculty development plan to improve the teaching of professionalism was part of an institutional curriculum redevelopment.³ The Northeastern Ohio Universities College of Medicine (NEOUCOM) used the medical school as its base to raise the consciousness of professionalism in their faculty and students.⁵ University of Pennsylvania asked the residents, fellows and students in the Internal Medicine department about behaviors they had witnessed in order to develop programs for improvement.⁶

Other institutions have courses that run the gamut from electives for fourth year students⁷ to asking matriculants what qualities they thought were important in physicians, then using that information in the selection process of the next class.⁸ Matveevskii et al⁹ reported on their department of anesthesiology at Cincinnati Children's Hospital. They felt it key to first define professionalism in their context. They felt that professionalism and competency were often used interchangeably and that caused confusion. They stated that competency is "the ability to

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perform a certain task required for a work situation.” It is contextual. Professionalism, on the other hand included competencies but also encompassed “specific behaviors required to successfully perform in a certain specialty”. They may change with time. Matveevskii goes on to define levels of competence among residents by the Dreyfus model, which rates them as novice, advanced beginner, competent, proficient and expert. The paper maintains that teaching and evaluating residents can be done with this five-stage model of adult skill acquisition. But they emphasize that though medical knowledge, and manual skills are key to the development of the anesthesiologist, non-technical skills must be taught and evaluated as well. These include task management, team-working, situation awareness and decision-making. Green et al¹⁰ put together a survey that questioned patients, physicians and nurses about their views on professionalism. Key to their survey was a focus on behaviors as opposed to traits. Behaviors can be observed and adjusted over time. 68 behaviors were asked about and as might be expected the different groups focused on different things. For instance, patients didn’t think it was particularly important how health care workers interacted with each other, while health care workers did. In the above case several things can be done. The faculty seems to be complaining about poor learning habits of resident learners. Assessment of people cannot fairly be done if the evaluatee does not know what is expected of them. If faculty can say to the resident “read this and we’ll discuss for tomorrow” then the resident has a specific goal to strive for. If she/he then doesn’t do the reading, the faculty teacher has a specific behavior to highlight, making assessment much easier. Computers and smart phones can also be used as learning tools, making sure that this is how they are used in the OR context, and not as party planning tools. Residents can be taught to be proactive in their learning and ask/communicate with their faculty about what they should be reading for the next day’s discussion. Learning is a two-way street. They have a right to know about how long they will be working and it would be easy enough to incorporate this information in the end-of-day turnovers. Getting respect from the perioperative staff is a different matter. Changing other departments can be very challenging. The ideal would be to have interdepartmental meetings and workshops isolate grievances and iron out problems. In the short term, helping your residents to see the benefits of always acting politely even when not receiving that treatment in return can slowly change behavior towards individuals, if not to the group as a whole. CRNA’s are part of the anesthesia care team and should be treated as such. If the faculty treats them politely and inclusively, eventually surgeons will see them that way, too. If you witness rudeness to the staff in any capacity, jump on it and point out the inappropriateness of the behavior. At least residents and nurses will know you’re on their side.

Faculty seem to respond well to financial incentives. The chair may find satisfaction in docking pay to those members of the staff who are most egregious in not filling out paper work appropriately.

Finally, there is evidence in the literature that lapses in professionalism can lead to poor patient outcomes.¹¹ If it can be made clear to all members of a department that their behaviors can adversely affect patient outcomes there may be more compliance with the culture changes being attempted.

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