Presently, there is a major initiative to rekindle the humanistic qualities in the practice of medicine. Although there have been many suggestions on ways to rejuvenate this initiative, it has not been a primary focus of graduate medical education until recently. Surgery residents are expected to maintain a high standard of ethical behavior; demonstrate a commitment to continuity of patient care; and demonstrate sensitivity to the age, gender, and culture of patients and fellow health care professionals. We in surgical education must accept the responsibility for the renewal in teaching and evaluating the professional and ethical principles of surgery residents. This change will not happen quickly, but it should be done skillfully because future generations will look back on this time of renewal in medicine and critique us on our ability or inability to achieve this goal.

Professionalism
Lifelong Commitment for Surgeons
Richard E. Welling, MD, FACS; John T. Boberg, PhD

Presently, there is a major initiative to revive the humanistic qualities in the practice of medicine. There have been many suggestions on ways to rejuvenate this enterprise, but it has not been a primary focus of graduate medical education until very recently.1-3 One of the most significant efforts is the outcome project that is being jointly developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties. The goal of this project is to educate and evaluate all physicians, both in graduate medical education programs as well as in practice, in 6 competencies. These competencies are closely interrelated. Professionalism, one of these competencies, must be the thread that is woven throughout the fabric of this entire outcomes project. Professionalism is a learned human behavior. It transcends specific job-related functions and can and should be a part of every individual’s life. Simply put, professionalism is a behavior that describes our relationships. In medicine, these relationships are multiple and varied. They occur with patients and their families, peers, students, other health care personnel, and the community. Physicians are expected to act with integrity and skill in all these relationships and are evaluated on their behavior in them.

For many years, progress in medicine was focused on technological advances. Even in graduate medical education, for many of the specialties, the focus of accreditation has been on procedural competence and the knowledge base. A renewed initiative focusing on the humanistic qualities of a medical practitioner from the patient’s perspective is a welcome change. In their mission statement, most hospitals have a commitment to ethical care of patients; however, relatively little time and energy has been devoted to this important behavior, which affects physicians multiple times on a daily basis.

APPLICATION TO SURGERY

Industry support for research, newer reproductive technologies, the present reimbursement system, and the initiative to reduce the cost of health care has spawned many ethical issues. In addition, surgery residents are asked to balance require-
ments for reduced work hours with the primacy of patient welfare. The tension of this dilemma is perhaps one reason for a decrease in the quantity and quality of medical students selecting a surgical career. The latter was evident in the 2001 National Residency Matching Program (NRMP) for surgery, where 68 categorical positions went unfilled. This was a sentinel event for general surgery. The data for 2002 are very similar.

What can be done? There are no easy answers but the recent publication of a Charter on Medical Professionalism provides some helpful guidelines for implementing the ACGME and American Board of Medical Specialties requirements. In late 1999 the American Board of Internal Medicine Foundation collaborated with the European Federation of Internal Medicine and the American College of Physicians—American Society of Internal Medicine Foundation, to launch the Medical Professionalism Project. Members of the project developed the charter that encompasses a set of 3 basic principles and 10 commitments for all medical professionals. The 3 principles of the charter are the primacy of patient welfare, patient autonomy, and social justice.

Primacy of patient welfare has always been and should continue to be the main focus of surgical education, and the hallmark of the surgical professional. In the educational process we must never lose sight of this most important principle.

Patient autonomy is a relatively new concept. In the past, patients relied on the physician to make the best decision on their behalf. With a wealth of information now available to patients, many patients are aware of all the treatment options prior to seeing a surgeon. The patient’s autonomy in his choice of medical treatment must be taken into consideration in deciding the best treatment option. Teaching by example will probably be the most effective way to help residents learn this behavior.

Social justice is another relatively new principle in the care of patients. Our past practices and educational systems have demonstrated a 2-tiered system of patient care in many areas. Indigent clinics staffed with residents and with minimal faculty supervision was touted as a good thing in the recruitment of trainees into a surgery residency. With the initiation of Medicare, this has changed, and more recently, there are stringent requirements for faculty supervision of resident physicians. In some areas, there is still a 2-tiered system that exists, and as we strive toward improving professionalism in medicine, we must likewise strive to eliminate the 2-tiered system of health care in this country.

Expanding on these 3 principles, the charter presents 10 professional responsibilities that define the ethical practice of medicine. Two of these responsibilities are critical in the surgical profession. One is commitment to professional competence. Surgical educators must continue to be role models for lifelong learning for our surgery residents, and evaluate them based on their commitment to lifelong learning. The second is commitment to professional responsibilities. This can be very difficult sometimes since it goes beyond direct involvement with patients and requires participation in a process of self-regulation, including “remediation and discipline of members who have failed to meet professional standards.” Such participation has often been neglected, but it is an absolutely essential behavior and a social responsibility.

**HOW TO DO IT**

There are many common themes that are recognized under the banner of professionalism (ie, etiquette, competency, and social justice). However, ethical integrity must be the primary component of professional behavior regardless of the specific theme. The most effective way to teach ethics and professionalism in surgery is through acting as role models to trainees. This assumes, however, that the teacher understands the responsibilities of professionalism and acts in ways that reflect these responsibilities. Some surgical training programs have incorporated a surgical ethics curriculum into the conference schedule. A format of presenting ethical dilemmas for discussion by the attendees has proven successful in heightening a resident’s awareness of ethical issues during a surgery residency, and it gives the teaching staff the opportunity to share their perspectives on a broad range of issues.

Others have pointed out that increased didactic exposure to medical ethics may not improve the character of physicians since the discussion of ethical dilemmas is too often reduced to problem-solving conducted in a way that leaves the physician as a person uninvolved. A more basic and laudable goal is moral development (ie, “growth in character”). Success is achieved when the residents can be involved in a way that engages them as people, not simply as professionals. Teaching surgical residents to become more compassionate and to demonstrate respect for patient autonomy needs to be part of the goals and objectives for a curriculum. As these humanistic qualities are enhanced in the educational process, Sheehan7 states that “… physicians, hopefully, would begin to perceive their life as a unity and appreciate that their actions as physicians are not simply reflective of what goes on in their practice, but reflect what sort of person they are.” Is this possible? Are the above humanistic qualities already ingrained in the individual prior to beginning their training in medicine?

We believe the moral character of a person can be changed at any time during one’s life. This change requires recognition of the need for change and, usually, for a mentor or role model to facilitate the process. The success of this process must be the responsibility of those of us in surgical education.

**THE ACGME REQUIREMENTS**

Presently, in the program requirements for general surgery, surgery residents are expected to maintain a high standard of ethical behavior; demonstrate a commitment to continuity of patient care; and demonstrate sensitivity to the age, gender, and culture of patients and fellow health care professionals. In July of 2002, programs will be evaluated on their success in teaching these principles and in evaluating residents as a result of their achievement of these educational goals.

Best methods for evaluating residents in the achievement of these goals have been suggested on the ACGME Web site. Chief among these are the Objective Struc-
tured Clinical Examination, patient surveys, and 360° evaluations—all of which can be cumbersome and/or expensive, and perhaps, not as effective in changing behavior.

Others have suggested peer evaluation as a way to evaluate physician performance. This evaluation method has 2 very positive consequences in the process of heightening one’s awareness of professionalism. The first is that as this is inculcated into the graduate medical education training program, it will be more readily accepted in practice when an individual completes their training. That is, it would become the standard for peer relationships. Secondly, putting this evaluation method in the hands of peers would heighten their awareness of its importance and put this in the forefront of their daily lives.

The Physician Achievement Review, developed by the College of Physicians and Surgeons of Canada, has a tool for the peer assessment of professional behavior. Combining these results with the results of the self-assessment could draw the trainees’ attention to areas in their behavior where there is room for improvement. Focusing on a nonthreatening method for improvement is more likely to attain a positive result.

The most important factor in our effort to evaluate professionalism is to keep in mind its integral relationship with the other competencies of communication, medical knowledge, patient care, and systems-based practice. They are all intimately related in maintaining competency in the practice of surgery.

Ethical principles are taught and learned very early in life. Our parents, our initial teachers, and our peers are all part of the process of how we learn ethics in life. Recruiting individuals into a residency program that have the fundamentals of sound ethics make the job of teaching and evaluating professionalism much easier. Looking for these qualities as part of assessing candidates during recruitment interviews should be part of the process.

CONCLUSIONS

The baton has been passed to us for the next lap. We in surgical education must accept the responsibility for the renewal in teaching and evaluating professional and ethical principles in surgical residents. This change will not happen quickly, but it should be done skillfully because future generations will look back on this time of renewal in medicine and critique us on our ability or inability to achieve this goal. We are committed to this because above all, it is in our patients’ best interests.

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REFERENCES


Invited Critique

The authors’ timely discussion of professionalism and its relationship to the other 5 competencies, as defined by the Accreditation Council on Graduate Medical Education and the American Board of Medical Specialties, is commendable. They correctly note that to secure the sanctity of surgery, all surgeons must maintain a high level of professionalism and instill this trait in surgical trainees.

The authors point to the medical professional project of the American College of Physicians–American Society of Internal Medicine as a blueprint for heightened professionalism. This charter outlines the defining characteristics of professionalism, and the Board of Regents of the American College of Surgeons (ACS) has endorsed it. However, while this document may elucidate the meaning of professionalism, it does not offer concrete suggestions regarding how we boost professionalism.

Historically, the mission and vision of the ACS have been consonant with increasing the standards of surgical professionalism and ethics. For instance, the ACS has taken strong positions on ethical issues, such as fee-splitting and itinerant surgery.

We are currently developing educational programs to elevate professionalism, including an ethics curriculum for residents that will be pilot-tested in 2003. Furthermore, we are creating an Educational Task Force on Professionalism to address competencies not taught in the past, including professionalism, communication skills, systems-based practice, and practice-based learning.

Clearly, education is the most objectively measurable means of inculcating professional behavior. However, as the authors note, surgical educators can enhance professionalism within our field through other means. First, we must ensure that the individuals accepted into training programs are committed to the patient-physician relationship. We must also remind ourselves that this relationship makes our work satisfying.

Whether it is through ethics training or attempts to heighten the joy of surgery, the ACS and other organizations must lead and set the standards to which all professional surgeons will adhere.

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