Medical Professionalism: Promoting Patient and Physician Safety.

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Editorial

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Realisation of the importance of medical professionalism has been increasing over recent years as evidenced by publications by regulatory bodies, education bodies and the media. Multiple definitions exist in the literature with significant consistency[1,2]. The current working definition from the Irish Medical Council[3] includes the *set of intrinsic values, expressed as extrinsic behaviours which justify the trust between patients and good doctors and between the public and the medical profession.* These values and behaviours include respect for patients, demonstrated by patient–centred practice; ethical standards including honesty, integrity, empathy and altruism; reflection/self-awareness demonstrated by reflective practice; personal responsibility for actions including safeguarding one's own health and well-being; teamwork commitment demonstrated by effective communication and teamwork, leadership and social responsibility demonstrated by commitment to the health of the community. The primary aim of the practice of medical professionalism is patient centred care.

The Accreditation Council for Graduate Medical Education has long focused attention on the critical importance of professionalism in graduate medical education by incorporating it as one of six key, core competencies. In 2002, the American Board of Internal Medicine reviewed professionalism[4] and created a physician charter which identified three principles of professionalism including the primacy of patient welfare, patient autonomy and social justice. By 2011, in Ireland, it had become a legal requirement for doctors to maintain their professional competence. The eighth edition of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners was published in 2016[5]. Multiple drivers of professionalism exist from a patient, staff and the healthcare system viewpoint. These include patient safety and a positive patient experience; staff morale, prevention of the "*second victim*", recruitment, retention and rising indemnity costs; healthcare system reputation, licencing or accreditation (Joint Commission) and business viability. Litigation and medico legal claims impact patients, staff and healthcare systems. In practice the pillars of professionalism include clinical risk management, quality improvement, the clinical working environment, good communication, teamwork, self-care, prevention of the second victim, open disclosure, education (under and post graduate), training, clinical practice, continuous professional development and research. It is imperative to teach and practice professionalism at a postgraduate level and though out one's career (lifelong learning).

But is there evidence to demonstrate that teaching professionalism at undergraduate level is important? Sir James Paget (1814-99), considered to be the first person to undertake recognisably modern research into medical education, published an article in1869[6]. He followed in excess of 1,000 students at St. Bartholomew's Hospital for between 10 – 30 years and identified that behaviours in medical students may be reflected in their behaviours as physicians. Those whose outcome was labelled as "*failed entirely*", Paget had described as "*failed because of scandalous misconduct…..through their continuance in the same habits of intemperance or dissipation as had made us, (even while they were students), anticipate failure"*. More recent research has demonstrated that "lack of thoroughness and inability to perceive their own weakness in the first two years of medical school is associated with unprofessional behaviour in clinical years"[7]. Furthermore, unprofessional behaviour in medical schools, including "severe irresponsibility" and "severely diminished capacity for self-improvement" is associated with disciplinary action as a practising physician and this behaviour may be sustained over decades[8]. However, it has been shown that professionalism can be taught and modelled[9].

Medical professionalism should be taught explicitly in the under and post-graduate curriculum and be a key component of continuous professional development. The curriculum should reflect the "3 Rs": it should be "real", "relevant" and make the student and clinician do the "right thing". Professionalism in practice promotes patient safety by ensuring patient centred care is its goal and through its incorporation of evidence based medicine, ethical based practice, cultural sensitivity, good communication, teamwork and the characteristics as outlined above. Physician wellbeing and self-care is central to professionalism while the latter is essential to the provision of effective and compassionate patient care. There is significant evidence that as a profession, doctors are at an increased risk of depression, suicide, substance abuse and burnout. Therefore, professionalism promotes physician safety in addition to patient safety: both are intimately interlinked. A recent national report by the State Claims Agency[10] analysed five years of data pertaining to clinical, patient safety incidents, claims and costs. Clinical claims have increased in Ireland over recent years as have the associated, overall, financial costs. Patient safety incidents may lead to multiple costs which can be measured in different ways: cost to the patient regarding morbidity incurred, cost to the clinician regarding second victim symptoms; cost to the healthcare enterprise regarding reputation and cost to the tax payer regarding finances.

The clinical working environment is increasingly stressful, patient expectations rising and healthcare resources limited. With patient centred care at its core, the practice of professionalism can lead to improved patient safety, more positive patient experience, better staff morale and wellbeing, increased staff recruitment and retention, lower risk of litigation and lower indemnity costs. It has been documented that while doctors report a high incidence of stress they are only moderately willing to seek support regarding this. Support may be offered in the form of group peer support and/or "one to one" peer support, as in some centres of excellence in the USA. The RISE (Resilience In Stressful Events) programme was developed at the Johns Hopkins Hospital by Prof Albert Wu. This programme provides peer support for second victims following a stressful, patient–related event. The RISE team deliver psychological first aid and emotional support to traumatised healthcare colleagues. It helps prevent the development of the physical and psychological symptoms associated with the "second victim". The RISE programme

responded to 119 calls involving ~ 500 individuals in the first 52 months, saving an estimated $ 2 million per annum.
Ensuring professionalism is taught and practiced at under and post-graduate level and throughout continuous professional development will help ensure the safety of patients and physicians.

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