CHAPTER 7 NEW STANDARDS FOR RESIDENT PROFESSIONALISM: DISCUSSION AND JUSTIFICATION

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Introduction

Professionalism forms the core of a good physician. There have been numerous efforts by medical educators, associations, and specialty boards to elevate the awareness of professionalism throughout all levels of training and into the lives of practicing physicians.[1–3] 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 1 of the 6 core competencies.[1] There are many definitions for professionalism but one that is all inclusive is espoused by Stern[4] in his book titled *Measuring Medical Professionalism*:

> Professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability and altruism.[4]

In the American Board of Internal Medicine's review of this topic in 2002, the working group,[5] led by Sax, created a physician charter and enumerated 3 core principles related to professionalism: (1) the primacy of patient welfare, (2) patient autonomy, and (3) social justice. The document further listed 10 professional responsibilities, including commitments to the following:

- Professional competence;
- Honesty with patients;
- Patient confidentiality;
- Maintaining appropriate relationships with patients;
- Improving quality of care;
- Improving access to care;
- Just distribution of finite resources;
- Scientific knowledge;
- Maintaining trust by managing conflicts of interest;
- Professional responsibilities.

This professionalism charter became an important bedrock in the ACGME deliberations and recommendations regarding the new standards on professionalism.

Resident Professionalism

The principal aim of graduate medical education in the United States is to prepare young doctors for the safe, independent practice of medicine on completion of residency or fellowship.[6,7] An important part of graduate medical training is that it exposes residents to the demands of real-life practice, including the long work hours of physicians in practice (50 to 60 hours a week on average,[8] with a sizable percentage of physicians in a number of specialties working more than 80 hours a week).[9,10] In 1998, realizing the power of the ''hidden curriculum'' on the values that are being communicated to residents, members of the profession called for a significant change in the way residents were treated,[11] and in 2003 the ACGME adopted a set of duty hour regulations in a report about resident hours and conditions to optimize patient safety, which made prominent reference to supervision and other factors that collectively contribute to the quality and safety of care in teaching settings, which provide the setting for the development of resident professionalism.[12]

Professionalism and Duty Hours

In considering a revision of the duty hour standards, the basic tenets of professionalism often were at the core of Task Force deliberations. Many individuals and professional organizations expressed concern that residents not be reduced to shift workers with resultant erosion of their sense of duty and professionalism. There was a strong belief among the members that a major factor in the professional development of residents is that they personally must take primary responsibility for how their hours are spent, to ensure their personal readiness to work and learn. Many advisors to the process also spoke passionately about how graduated physicians must efficiently manage their time and responsibilities and stressed that gaining facility with time management during their training years was important. Managing work and other life responsibilities is critical to the long-term success of physicians and can be directly linked to their job satisfaction and longevity in medical practice.

Studies and testimony heard by the Task Force showed that among residents there often was a stated conflict between issues of professional commitment—such as being with a needy patient in the hospital at a time past the allowed duty hours versus being at home to rest or study in preparation for the next day's work. This was a prominent finding in research on the effect of the regulation of duty hours in New York and in studies of resident perceptions of the effect of the national duty hour standards.[13–16] Resident sentiments regarding duty hours often were stated as 2 divergent positions:

Resident 1: Strict limitation of my duty hours is antiprofessional. I need to be with my patients when my patients need me. A professional should not punch a time clock.

Resident 2: Duty hours should be restricted. I need time to think, to rest, and to live my life. That will prepare me to come to work the next day and give it my all. Eighty hours is more than enough.

Both residents are making important and valid points and the position that each one is taking needs to be addressed. This diversity reflects the fact that professionalism, personal responsibility, and patient safety always are inseparable.[17] The Task Force focused on patient safety and recognized that, in a patient-centered model, graduate medical education must stress the personal responsibility physicians must have for their patients. Although professionalism is emphasized from the first day of medical school, increasing responsibility and skill during residency must be aligned with professional growth and a growing sense of individual responsibility as residents move through supervised, guided settings toward independent practice.

Requirements for Duty Hours and Professionalism and their Rationale

The aim of the new requirements for professionalism is to ensure that residents understand their personal responsibility to their patients, including their responsibility for maintaining alertness and fitness for duty and the effect that all activities, including those outside of their educational program may have on this.

> Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
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> The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility.
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> Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
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> 1. assurance of the safety and welfare of patients entrusted to their care;
> 2. provision of patient- and family-centered care;

3. assurance of their fitness for duty;
4. management of their time before, during, and after clinical assignments;
5. recognition of impairment, including illness and fatigue, in themselves and in their peers;
6. attention to lifelong learning;
7. the monitoring of their patient care performance improvement indicators; and,
8. honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

The Task Force recognized that responsibility for building professionalism is a collaborative process involving programs, program directors, institutions, and most important, the residents. All must be involved and have shared goals. Education of faculty (who may have trained under different standards) and residents/fellows is the responsibility of programs and sponsoring institutions. The onus of responsibility extends beyond the individual program to the institution, to ensure that programs are provided appropriate resources and that education occurs in a suitable learning environment. This fosters both patient safety and resident well-being, which are important outcomes of quality graduate medical education.

To properly fulfill their professional responsibilities, residents must understand the systems in which they function, and the interprofessional nature of health care. Thus, the Task Force emphasized the regular, meaningful involvement of residents in program and institutional quality improvement and patient safety initiatives. Such an expansion of the educational model should have the benefit of an immediate focus on ensuring patient safety; it also sets the stage for lifelong behaviors directly toward enhancing patient care through improving the systems for health care delivery.

When designing learning objectives, programs in essence are creating the atmosphere of professionalism.[6,11,17] Residents learn by doing (patient care responsibilities), by being mentored (supervision during these patient care responsibilities), by observing and listening to those more senior in their level of competence (clinical learning), and by acquiring medical knowledge necessary for state-of-the-art management of disease and other conditions (didactic learning). To acquire the judgment to determine how various conditions resemble, yet differ, from one another, a balance must be achieved between the expertise gained by repetitive exposure to specific diseases and accrual of the didactic information covering the spectrum of presentations and findings in any particular diagnostic category.

Since residents have limited time to acquire medical experience and knowledge necessary to sharpen their judgment, programs must not allow service obligations to take precedence over activities that have true educational value. The new standards reemphasize this mandate, seeking to eliminate instances where residents are asked to perform tasks not normally relegated to physicians.

As part of a modern medical education environment, residents' involvement in patient care must continually focus on patient safety and individual responsibility. This should be accomplished by the program director and faculty leading by example, and by the institution providing a learning environment that emphasizes patient safety not only in policies but also through its actions. The optimal patient care environment stresses 7 principles:

1. *Patient safety is at the core of all patient care*. This simple statement requires support from all care providers and a seamless interaction among many hospital systems and policies. There should be adequate support staff; protocols for preventing wrong-side surgery or patient falls must be in place; quality laboratory testing and imaging must be readily available; and patients' rights must be clearly written and easily accessed by patients and their families. Patients are vulnerable, and must perceive the

environment in which care is rendered as deserving of their trust.

2. *Care must be patient centered and family centered*. This key concept of the Institute of Medicine's report, ''Crossing the Quality Chasm,''[18] is equally important in the teaching hospital environment, where research, education, or departmental needs may on occasion appear to take precedence over the needs of patients and their families. Such an emphasis is inappropriate and must be redirected. An excellent clinical learning milieu can be achieved without sacrificing focus on patients, and education in such an environment is likely to positively shape the future practice of graduates.
3. *Physicians must be fit for duty*. Physicians—whether faculty or resident—must be fit for duty and able to effectively care for their patients. That ''[p]atients have a right to expect a healthy, alert, responsible, and responsive physician''[19] has been a key tenet of the dialogue about work hours since the American College of Surgeons formally issued this statement in 1994. Residents and faculty, even when ''off duty,'' are still responsible for appropriately managing their time to enable them to report for their next scheduled duty well rested and alert. Program directors and supervising faculty cannot mandate that residents or other faculty members get sufficient rest at home, or place any other limitations on activity (other than external moonlighting for residents) away from work. They can, however, demand that resident physicians on duty are well rested and capable of performing their duties.
4. *Impaired physicians must be recognized and removed from patient care activities*. Residents and faculty are human and on rare occasion are found to be impaired. Such impairment, which can be as serious as drug or alcohol addiction or as temporary as a significantly fatigued resident, can adversely affect patient safety and must be recognized and addressed in a timely manner. It is the responsibility of anyone in the health care system observing impaired behavior to report it to a supervisor or other individual who can intervene.
5. *Physicians must be committed to lifelong learning*. In a time when medical knowledge is rapidly advancing, it is incumbent on faculty members to model the behaviors of ongoing critical review of the literature and to participate in programs that document ongoing medical competence (such as Maintenance of Certification and Maintenance of Licensure).
6. *Patient care must be monitored for overall quality*. Institutions must have in place quality and performance improvement initiatives, outcomes assessment, and peer review programs designed to constantly monitor patient safety, the quality of care rendered, and the competence of physicians. While these functions have long been the purview of the faculty and an essential element of self-regulation, it will now be required that residents participate actively in these processes as part of the new emphasis on patient-centered care.
7. *There must be honest and accurate reporting of all elements of resident training and patient care*. In the past, there has been concern that residents reported what they thought faculty wanted to hear when answering questions about duty hours, clinical experiences, and patient outcomes. The new requirements emphasize honesty in reporting as yet another essential element of professionalism. This applies to individuals, programs, and institutions.

The ACGME's emphasis on professionalism, evidenced by the development and

implementation of more detailed standards, reflects a belief that this core competency underpins many elements of residency training, especially in the arena of fitness for duty and compliance with duty hours. It is felt that these standards are in keeping with the broader principles already espoused by the medical profession. In addition to reasonable limits on resident work hours, there is a new emphasis on immersing residents in all aspects of patient care including diagnosis and treatment of disease, and inculcating in them a commitment to care for patients as human beings. This should result in a more altruistic physician and set the stage for a lifetime of highly professional behavior.

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