Teaching and Training in the Workplace

DEVELOPING PROFESSIONAL BEHAVIOUR AND A LEARNING CULTURE

ANAESTHETISTS as EDUCATORS

The Royal College of Anaesthetists

DEVELOPING PROFESSIONAL BEHAVIOUR

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Aims

This chapter explores the set of values that underpin professional behaviour in anaesthesia and explores ways in which learning can be promoted in the clinical environment.

Intended learning outcomes

By the end of this chapter you should have a better understanding of:

1. The values that underpin professional behaviour (TM_BK_01, TM_BK_02, TM_HK_02, TM_HK_11, TM_HS_03, TM_HS_22).

2. The behaviours that match these values (TM_BS_13, TM_IK_04, TM_IK_10, TM_IS_06, TM_IS_09, TM_HK_12, TM_HS_09, TM_HS_20).

3. The frameworks that can help the learner reflect on his/ her performance in terms of these behaviours (TM_BS_10, TM_BS_11, TM_BS_14, TM_BS_16, TM_IK_01, TM_IK_08, TM_HS_24).

4. The learner will be expected to evaluate his or her own local learning culture (TM_BK_08, TM_BS_09, TM_IS_08, TM_HS_17, TM_HS_19, TM_HS_25).

5. The learner will become familiar with some strategies that may bring about positive change in the learning culture (TM_BS_02, TM_IK_11, TM_HK_04, TM_HK_14, TM_HS_01, TM_HS_08, TM_HS_26).

Activity

Basic – Try to remember the last time you returned from a coffee break or when a colleague left you in charge of a patient. Write down what *types* of information were conveyed in the handover? What made you feel comfortable about the exchange? Had the current plan been communicated to the other members of the theatre team? How could the conversation have been conducted better?

Intermediate – Identify someone whom you view as a 'good' anaesthetist or 'role model'. What characteristics make this person someone whose behaviour you would aim to replicate?

Higher - Think of an occasion when you had a clash of professional and personal commitments. How did you decide what to do? Has there ever been a time when you made the wrong choice? If so, what did you learn from this event?

Introduction

Although we all consider ourselves professionals, many clinicians have difficulty articulating what is actually meant by 'professionalism' and how this might translate into the everyday world of clinical practice.

The concept

Consider the connection between a used car salesman and their client. We will use this analogy to compare and contrast the relationship between professionals and their clients, or doctors and their patients.

Analogy

There is an equality of power between the second-hand car dealer and the client. The dealer has the car but the client has the money. The client has the option to take their custom elsewhere. The client may know a lot or little about cars. If the client does not know very much about cars and is sold a second hand car under false pretences, then the client may choose to seek redress from the various regulatory agencies. However, if the client chooses a car that turns out to be inappropriate for his or her needs, then that is the client's responsibility, rather than the dealer's.

The relationship between a used car salesman and their client is one where each party has an equal division of power within a regulatory framework of consumer rights. In contrast, a professional person is perceived to have knowledge and expertise beyond that of their client. In such a relationship, there is the potential for the professional to have more power or positional authority than the client and in such a relationship, there is the potential for that power to be abused. The relationship between a patient and his or her doctor must therefore be based on 'trust'.

A client trusts the professional to provide a valuable service and the professional in return agrees to practice to a certain code of conduct that will not exploit that power difference to the professional's advantage.

At the level of society, it is the responsibility of the members of a profession to determine whether the behaviour of any individual member is within the accepted code of practice. Professionals also use the autonomy, granted to them by society, to decide how best to respond to the needs and demands of their clients.

In the case of anaesthesia here in the UK, the expansion of our clinical domain to include pain management and peri-operative care, came from within the profession itself. Nobody from outside anaesthesia told us to do it; anaesthetists identified the problems, developed solutions and built up a body of expertise from which came institutional change.

Like most professionals, doctors are said to have a 'fiduciary' relationship with their patients; a relationship built on trust and confidence. Each party *trusts* that their counterpart will fulfil their individual obligations. A second-hand car salesman may adhere to a *voluntary* code of practice or they may not, but the consumer must rely on a legislative framework to ensure their rights are being recognised. Professionals, on the other hand, choose to work within a 'code of practice' and the regulatory framework comes mainly from within the profession.

Code of practice

A patient is entitled to expect that a doctor will adhere to a 'code of practice'. This *code* is an explicit statement of what the public can expect from the profession and its practitioners.

The last ten years have seen projects in Canada (RCPS 2001), the USA (ACGME 2013) and the UK (GMC 2010) begin to set out a template for the different roles or professional domains of medical practitioners working in those countries.

The Canadian and US frameworks both suggest doctors should demonstrate a commitment to their professional responsibilities as well as to their patients. Interestingly, the General Medical Council does not have 'professionalism' as one of the duties of a doctor, but it does codify the principles by stating that:

> *'Good Medical Practice sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors.'*
>
> (GMC 2010)

David Stern, an expert on the subject, describes medical professionalism as:

> *'A set of core values that have as their foundation clinical competence, communication skills and an ethical and legal understanding.'*
>
> (Stern 2006)

The core values he lists are: excellence, humanism, accountability and altruism. These are fine sounding words, but when we try to look for behaviours corresponding to each of them in the day-to-day world of clinical anaesthetic practice, we may have a bit more difficulty. Ambiguity may exist in the interpretation of these terms or an observed action may be erroneously ascribed to a particular underlying value.

Professional Behaviours

Observing behaviours is only the beginning of the story, when trying to ascertain whether others possess desired values, whilst helping them to become aware of and develop those that they do not. The observed episode should be used as a platform to engage in a dialogue that can be used to discuss those core beliefs suggested in, or by, an individual's behaviour. This process is made more straightforward by having a shared framework and a common language to describe the focus of training and development.

Analogy

Engaged in a conversation about the cinema and comparing enjoyable films, one would probably refer to aspects of a film such as: dialogue, the characters, plot, the pace of the story, the camera work and the sets. The conversation may not actually include any of these exact terms but the framework would be present and would be influencing the dialogue even if the specific terms remained unspoken.

It is easy to discuss conventional aspects of the curriculum with colleagues, such as pharmacology or physiology, and the underlying knowledge from which these principles are derived, as there is a reasonably clear and shared framework. However, most of us are less comfortable when it comes to discussing non-technical skills or behaviours and their underlying values.

A 'value' framework

Our *actions* are driven by *needs* and *motives*; these in turn will be influenced by our innate and acquired beliefs and values. We can describe the values that influence our actions in the workplace as belonging to three distinct categories; *personal* values*, professional* values and *institutional* values.

Personal values are those core beliefs that are important to us as individuals and will be influenced by our cultural background, social roles (partner, parent or friend) and all the other things, which matter to us. As indicated above, professional values are those core behaviours expected of an individual by virtue of being part of a professional body. Institutional values will be influenced by the goals of the organisation in which we work. Many of the problems that arise in professional behaviour do so when there are clashes between values from these different categories.

Analogy

Imagine an ST5 grade anaesthetist who has just completed a solo theatre list that included a patient who had undergone an extensive orthopaedic and plastic surgical procedure. The case had overrun but the patient is now in the recovery area, albeit later than expected. The anaesthetist had earlier promised their spouse and child that they would attend a dance display, which has, by this point, already started. The anaesthetist is contacted, whilst changing, to be told that the patient is desaturating.

What will/should our anaesthetist do?
What behaviours do we expect our ST5 or indeed any level of anaesthetist?

Consider instead if the personal commitment was to attend their child's hospital appointment and our patient was a chronic pain sufferer, experiencing mild pain everyday and is now reporting a moderate pain score. The hospital in question is staffed by a senior registrar through out the night and an appropriate acute pain protocol has already been commenced.

Would or should this alter the ST5's decision or behaviour?

Should decisions like this be affected by circumstances? For example: the severity of the clinical problem or importance of the personal commitment or indeed the level of support available in the hospital?

Any judgement or *assessment* of this colleague will be influenced by the set of circumstances prevailing on this or any other occasion and it may not be so straightforward to say which behaviours are acceptable and which ones are unacceptable.

When should professional and institutional values override the personal ones? One might easily imagine a set of circumstances in which the personal values may override the professional values in the above case.

We can see from the above example how difficult assessment can become especially when the assessor may have a different perspective on the relative merits of the value-sets from the person being assessed. How representative are one colleague's rankings of a set of values when compared to their peers? This aspect of our practice has a substantial measure

of subjectivity when compared to some of the other elements reviewed in Workplace Based Assessment tools. It is therefore not surprising that many assessors feel uncomfortable when they are providing written and verbal feedback on professional behaviour. This area of the curriculum presents some major challenges to both the assessor and to those being assessed.

Teaching values

As clinicians and members of one of the oldest professions, we have a responsibility within the code of practice to promote "good" behaviour. We should make every effort to promote professional values in our learners but what about personal values? Education is about helping people develop themselves through awareness raising, understanding and application.

If an individual does not want to change their behaviour to act in a way that is consistent with the agreed professional values, then our ultimate sanction might be to remove them from the profession. An anaesthetist who deliberately and knowingly puts patients at risk, for example, by leaving anaesthetised patients unattended, would have no place within our specialty.

As advocates and teachers within our profession, each of us must behave in a way that is consistent with the values that we promote. We can help by making such behaviour explicit when necessary. We may have to modify or make our behaviour more explicit when working with novices to get some of these important points across.

Reflection

'Do what I say not what I do……..'

When teaching a novice anaesthetist the 'rapid sequence technique', what do you teach?

Should a novice be taught the *textbook* rapid sequence using thiopentone and suxamethonium and without opiates or the technique that you most commonly employ (if it is not this)?

Analogy

When teaching a young child how to cross the road safely, we would make explicit the rule about only crossing when the 'green man' is showing and the road is clear. We would only cross at a pedestrian crossing and always wait until the 'green man' appears even if there were no obvious vehicles.

If we were crossing the road alone and the road were clear, then we would probably not pay attention to the crossing sign, however, we modify our behaviour when with and teaching young children.

This process fits in with 'normalisation' – the way in which we as humans learn how to behave in a new setting (Kugel 1969). We copy what other people do if we want to become part of that society or group. Sometimes the rationale or thinking behind the behaviours that we wish others to adopt may not be overtly apparent and providing a commentary can help to make them explicit. However, normalisation is more strongly influenced by what we *do*, rather than by what we *say*. If we say that it is wrong to read magazines in theatre but do so ourselves, then others will, most often, go with what we do.

In his book, Forgive and Remember, Charles Bosk (1979) describes how surgical training in an American hospital copes with *errors*. Bosk divides errors into two categories; errors due to poor technical skill or judgement and errors due to breaches of standards (normative errors). He writes:

> *'A technical or judgemental error then says something to the attending about a recruit's level of training; a normative error says something about the recruit himself'.*
>
> (Bosk 1979)

Bosk gives the example of an orthopaedic surgeon incorrectly positioning and draping a patient. If the error is technical, for example if he or she has not done it before, then the error would be corrected promptly and swiftly forgiven by the Attending (Consultant) physician. However, if the junior surgeon had been shown how to 'prep and drape' a patient correctly but chose not to, then this would be a *normative* error (or violation) and such behaviour would not be tolerated. In the training programmes studied by Bosk, habitual transgressions of normative behaviour resulted in removal from the programme.

While it is essential to obtain the proper technical skills and acquire good judgment during a training programme, a trainee is also learning the appropriate normative behaviours and acceptable standards. Interestingly, the Attendings at the institution studied by Bosk were not expected to be perfect, but they were expected to adhere to certain standards, and breaches of those standards resulted in disciplinary measures and sometimes even major career changes.

Role models

An American sociologist, Robert King Merton, is credited with creating the phrase 'role model', in a study on the socialisation of medical students, at Columbia (Merton 1936). Merton wrote about the concept of a 'reference group'. Individuals compare themselves to a group of people who occupy the social role to which they aspire, but do not necessarily belong.

Simply stated, a role model is an aspirational figure whose behaviour is emulated by others. An individual cannot choose to be a role model or indeed choose not to be one. The aspirational social group is often only one or two levels above the individual's current stage. For example, junior trainees often choose more senior trainee colleagues as their role models, rather than consultants, perhaps perceiving that at their current stage a consultant is too far removed from their aspirational social role.

Task

Think about someone who you see as a 'role model'.

- Why have you identified them?
    - Their knowledge?
    - Their Practical skills?
    - Something else entirely?
- What specific behaviours would you would like to emulate?

Assessing and developing behaviours

Behaviour assessment follows a sequence of: *observing* the behaviour, *discussing* the factors contributing to the behaviour and then finally *judging* the behaviour. It must be remembered that individuals will try to 'please' their observers and quickly learn how to modify their behaviour to meet approval. As a minimum, it at least demonstrates that the individual knows how they *should* behave. Finding out what a doctor is like when not being directly observed is difficult, however Multi-Source Feedback (MSF) tools may be of use here. MSF or 360 degree appraisal is a way of sampling opinion from a variety of different sources, not only from healthcare professionals but also from clerical and portering staff and more importantly, from patients (GMC 2012).

Reflection

Think about when you have worked with another anaesthetist. Were roles assigned during induction of anaesthesia? What might happen if no one assigned specific roles? As a team, did you run through any contingency plans?

Observation - It is easier to look out for something if we *know* what we are looking for. By identifying 'events' that occur regularly during a routine workload, one can build up a portfolio of occasions when observing an individual in the workplace can offer information regarding their clinical behaviour.

For example, observing a junior colleague during the 'first surgical stimulus' can yield valuable information about their planning, observational and anticipation skills. Is the individual engaged in another anaesthetic task, for example siting a larger bore cannula? Or are they engaged in a non-clinical task, such as checking the football scores on their smart phone? Or have they positioned themselves to enable observation of the anaesthetic machine, patient and the surgical team, opiate in hand, ready to deal with anticipated or indeed any unforeseen event post the first surgical stimulus?

Not only are these observations complex, but the behaviours being observed are composite. The junior colleague must have an appropriate working knowledge, previous experience, exercise good clinical judgement and have contingency plans for dealing with the unanticipated. The observer must then correctly unpick these behaviours in order to make an assessment about what he or she has observed and more importantly what they are thinking.

Discussion - Whether the observation is being performed as part of a formal Workplace Based Assessment or whether it is happening informally, additional knowledge will be shared by engaging in a dialogue. These conversations will enable the observed individual to unpick their behaviours, often acquired subconsciously, for use in other situations and the observer will be able to identify qualities that should be promoted and those that should be questioned or discouraged.

Judgement - The use of a framework to offer structured feedback is invaluable. The categories on the reverse side of the Workplace Based Assessment forms can act as a guide to offer feedback in a logical sequence. The Anaesthetists' Non-Technical Skills (ANTS) system (Fletcher 2003), can also offer a structure when making a coherent picture of an individual's actions.

Intrinsic values influence good professional behaviour. However, knowledge, judgement, non-technical skills and many external factors play a role. These must all be explored during

the dialogue phase, to really understand the thought processes behind the decisions made and why particular actions were carried out during a clinical encounter.

Earlier reference was made to the importance of the potential clash between professional and personal values. Discussion of personal values is not always easy. In fact it is something most of us shy away from, unless we have come to know an individual and establish a good working relationship with them. Current working patterns, including rotations and shift work, may limit the personal contact between a trainer and trainee. This may have an adverse effect on the development of an effective professional relationship, especially when mutual trust, which takes time to develop, is the cornerstone of that relationship.

A learning culture

At its most simple level, this can be defined as: an environment that promotes educational activity. This environment influences teaching strategies and assessment methods within an anaesthetic department.

As Kruse and Louis (2009) suggest, culture describes 'how things are' or 'how things operate'. A positive learning culture does not come from one individual but is born out of the outlook and effort of every member of a department or team. To improve the learning culture within an organisation, one must first appreciate the current situation and understand that a culture is inherited rather than created. Changing the way a department thinks and feels about educating trainees is a long-term venture and one where work is never finished.

In the same way that personal and professional values may clash, there may be conflict between institutional values and professional values. Professions and professionals are expected to develop the next generation of professionals and should aim, not only to maintain a high standard of practice, but also to raise that standard. Institutions, such as NHS hospitals, will have a variety of goals or targets, some of which may not overlap entirely with a core set of professional values.

With great pressure on NHS institutions to save large amounts of money, short-term financial targets can affect working practices. It is the responsibility of the profession to respond to these pressures and even more importantly to make explicit the professional standards which protect the safety of patients and enable the delivery of excellence.

Ideally, institutional values would enhance a learning culture and minimise the potential clashes between either personal or professional values. A learning culture is only possible if a critical mass of the more permanent anaesthetic staff is sufficiently committed to the educational process. Each member must engage in aspects of both formal and informal educational activities, such as the delivery of an induction programme or conducting Workplace Based Assessments, or listening to any concerns raised by junior staff or offering time to teach an under-developed skill.

Key thoughts

The difficulties inherent in maintaining or improving the professionalism of junior staff and creating a positive learning culture are varied and wide reaching. However, success breeds success. The quality of teaching, support and feedback, and the time spent on training activities, will be indicative of the strength and depth of positive behaviours created and therefore observed and will exhibit themselves in the choices made by these individuals.

Evidence of progression

Basic level

- Watch a video clip of your favourite TV medical drama, with a colleague, for example (ER 2009). Now discuss the positive and less-positive behaviours and values you have witnessed. What are the challenges to, and temptations away from the good behaviours?

Intermediate level

- Prospectively identify some key stages (induction, emergence etc) during a theatre list. Ask a colleague to observe your behaviour, rather than your clinical skills during these, and then feedback on your 'professionalism'. Ask them to use the reverse side of the A-CEX WPBA (RCoA 2010) or the ANTS system (Fletcher 2003), as a framework during the feedback session.

Higher level

- Design and run a 30-minute interactive workshop on 'Professionalism in the workplace'. Highlight key areas for the group to focus on and identify questions that will promote active discussion.

Further reading

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RCoA 2010 Syllabus Key

TM_BK_01 Knows that patient safety is paramount in all aspects of medical education.

TM_BK_02 Knows their roles and responsibilities as a trainee in the context of clinical governance and patient safety.

TM_BK_08 Knows how to engage in e-learning.

TM_BS_02 Seeks appropriate levels of supervision for themselves when undertaking activities in which they are not fully competent.

TM_BS_03 Demonstrates safe practice in patient management when teaching and supervising others.

TM_BS_09 Keeps a reflective portfolio of learning and clinical practice.

TM_BS_10 Appropriately solicits and receives feedback from others regarding their own clinical knowledge, skills and behaviour.

TM_BS_11 Demonstrates the ability to reflect and analyse constructive feedback from others regarding their own clinical knowledge, skills and behaviour.

TM_BS_13 In discharging educational duties acts to maintain the dignity and safety of patients at all times.

TM_BS_14 Demonstrates how to use information technology to keep up-to-date.

TM_BS_16 Uses on line e-assessment tools.

TM_IK_01 Knows how to design and implement a personal learning plan for an educational activity related to their own learning.

TM_IK_04 Knows that personal and team performance is affected by non-technical skills and knowledge.

TM_IK_08 Knows the value of inter-professional learning in their own development and in the development other professional roles.

TM_IK_10 Lists the basic concepts and role of human factors and team-based training including crisis resource management in ensuring patient safety.

TM_IK_11 Knows the value of inter-professional learning.

TM_IS_06 Engages with and contributes to inter-professional learning opportunities.

TM_IS_08 Performs self-critical reviews of their own educational practice (workplace based teaching, tutorials, simulation training or lectures).

TM_IS_09 Participates in human factors and patient safety training.

TM_HK_02 Knows the importance of always ensuring safe supervision of learners and takes wide responsibility for this including checking the safety of any teaching being undertaken by trainee anaesthetists within their clinical arena.

TM_HK_04 Understands how to use a wide range of educational methods to provide effective clinical learning opportunities, such as: opportunistic workplace-based training, lectures, part- and whole-task simulator training, full immersion high fidelity simulation, audio-visual feedback and behavioural debriefing.

TM_HK_11 Explains the importance of their own behaviour as a role model for more junior trainees.

TM_HK_12 Recognises the importance of personal development as a role model to guide trainees in aspects of good professional behaviour.

TM_HK_14 Knows how to provide a level of clinical supervision appropriate to the competence and experience of the trainee.

TM_HS_01 Teaches trainees and others in a variety of settings to maximise knowledge, effective communication and practical skills; and to improve patient care.

TM_HS_03 Shows consideration for learners including their emotional, physical and psychological well being with their development needs; acts to endure equality of opportunity for students, trainees, staff and professional colleagues.

TM_HS_08 Engages in simulator-based learning.

TM_HS_09 Assists in simulator-based teaching.

TM_HS_17 Assesses the quality of teaching both classroom and workplace-based and records this in their reflective portfolio.

TM_HS_19 Maintains honesty and objectivity during appraisal and assessment.

TM_HS_20 Provides appropriate career support, or refers trainee to an alternative effective source of career information.

TM_HS_22 Participates in strategies aimed at improving patient education e.g. talking at support group meetings.

TM_HS_24 Demonstrates a willingness to advance own educational capability through continuous learning.

TM_HS_26 Balances the needs of service delivery with education.

TM_HS_25 Acts to enhance and improve educational provision through evaluation of own practice.