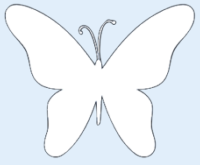
Professionalism– Clinical Ethics Teaching Session

Chapter 3

The Forgotten Text

Vivian V. Altiery De Jesús



"What does Professionalism mean?" Stopping for a second to think about it, I realized that at least I knew what "unprofessional" meant…not likely (‘¯ ◇ ¯;). My brain was confabulating to fill in the gap (:-p). If it was so hard to define professionalism, then there is a high probability that the notion of being "unprofessional" is also unknown to me. Currently, I am a 75% MD (Completed 3 out of 4 years) and had completed my third term of my bioethics master's degree. And yet I was struggling how to formulate a strong and concrete definition for professionalism\(ºoº)/.

The *Clinical Ethics Teaching* session was designed for second year medical student. A brief introduction made by two internal medicine physicians (Dr. Joseph Carrese and Dr. Zack Berger), followed by case presentation, small group discussion and then sharing the discussion with the rest of the class. No laptops, no phones…just one power point presentation and grey matter power *(^o^)*. The AAMC, LCME and Charter on Professionalism provides the definition of professionalism. However, the first activity of the day, Brainstorming, provided a more global and tangible conception of the term(¬.—). "A professional" was described as a respectful towards the patients and colleagues, competent on their assigned skill, honest, humble by knowing their limitations. At the same time, it was helpful to define unprofessional and it was described by the second-year medical students as being dishonest, engaging with physical and verbal aggression, among others.

It was concluded after the brainstorm activity that Medicine is the balance between privilege and obligation, as well as, public trust committed to self-government. If the profession's goal is to prepare trainees for unsupervised practice, then professionalism preparation is a must. The importance of wellness and resiliency were briefly discussed before starting the first case.

Case 1

A student had made 2 lumbar punctures (LP) supervised by the resident. A third patient a 68 years old man presents to the hospital with fever, nuchal rigidity and disorientation, an LP is indicated. The Resident says to the student that he cannot supervise the LP, because he is with another patient, unless it is after 4:00pm. The student's rotation ends at 4:00pm. The resident gives the option to the student of doing the LP by himself or to call the intern from the ED.

What is (are) the problem(s) with professionalism?

As medical students we have a duty to learn, but we don't have the set of skills (competency) to realize them. Also, the student may feel pressured for a good evaluation from the resident and show that he is a good team player. The other problem is that there is an obligation to the patient that needs to be correctly diagnosed and treated for a life-threatening disease. Like any other procedure LP has risks and complications. Furthermore, an error (i.e. sample contamination) could delay a more accurate treatment for the patient.

Ethically speaking: The student's duty to learn and their responsibility to achieve the professional milestone (evidenced by the evaluations) are in conflict with the principle of non-maleficence. The principle, treated as the maxim, *primum non noncore*, "obligates the individual to abstain from causing harm to others"[9]. Moreover, *professionalism* is in question also. One of the discussed requirements is to possess competency. Are two LPs enough to acquired competency? Would the benefit of having an earlier LP with a less competent trainee outweigh not having an early LP at all? These deliver us to the following questions:

What are the options? What are the tradeoffs?

One of the options is to wait after 4:00pm, assuming that the student does not have any other academic obligation (i.e. conference, test) and that the delaying of the procedure would not cause more harm (i.e. It is 3:55pm and a five minutes delay would not make a difference versus if it is 12:00pm). The tradeoff is that the student may feel like they are not helping the team or making a good impression, and the patient is waiting more time.

The second option is that the student informs that he does not feel ready to make an LP alone. The intern would be pulled up from the ED and the patient will have a sooner and more accurate diagnosis. The tradeoffs are that the student may feel like a weight on the team since he could not alleviate the workload from his superior and have distress regarding making a good impression on the team. Also, the student could

lose the learning opportunity of making his 3rd LP. An alternative option would be to ask the intern to supervise the student, but it would all depend on the workflow at the time.

The third option is that the student asks a nurse for supervision or to actually make the LP unsupervised. The tradeoff is that this goes against policies and to some extent safety. Two LPs are not enough to be competent and even if the student made 100 LPs, he still does not have medical license or have all the necessary skills to be left unsupervised by another licensed physician. The tradeoffs are patient and student's safety. This option was the least popular during the group discussion, and I agree.

I would like to add, that besides the "end-my-world-dilemma" (AKA Performance Evaluation), there is another pressure that haunts the students "What if I harm my patient, what if I kill my patient?" These are the questions that makes your heartbeat goes faster, when you are walking down the hallway, rehearsing every word and action before arriving to your patient's room (it helps you with the compulsion, but it never works). However, there is one situation that I know that the third option becomes a necessity…when a disaster strikes.

Puerto Rico has one tertiary hospital at the capital, and it is also the home of the only public medical school in the country. After the Hurricane, we were quickly saturated…communications and electrical power were down, peripheral hospitals could not open for service or did not had the resource to keep their patients. Allocating

resources was a challenge, this included power plugs for ventilators, but also human resources were not enough. Nurses, residents, and interns were already saturated, third year and fourth year medical students had tasks that perhaps during a normal year we would not dream of having. Granted, we did not perform appendectomies or deliver babies alone*(o_O)*, but I had many experiences that made my heartbeat increase. The saturation condition lasted pretty much the whole year, but the hospital condition got better, baby steps, but better, nonetheless.

"Did you see the videos for ABGs (arterial blood gas)?"- inquired my resident, the team was working non-stop.

"Yeah." - I was not liking where the conversation was going(・ _ ・ ;). The team had patients scheduled for surgery, inpatient floor was full, internal medicine and the emergency department did not stop asking for consults.

Deep down, I knew that she could care less in that moment whether I could watch the video or not(-.-;). In fact, I did watch the blasted video around 1:00am in the morning(¬o¬), we had to report at 4:00am (optional it was open to arrive at 6:00am), no exit hour scheduled. I remembered the details of the videos and also the complex ritual (-__-) of turning on the generator plant at that hour, crossed my finger for any curse against my mother…at that hour not a lot of people were using the internet (obviously) (ʊ_ʊ)ノ and you could see all the videos that you wanted, at a snail pace(¬.¬), but still watch them.

"Take one ABG kit, and get the sample from L.X., room 16"

"What if I get it wrong?"

"You won't, and he is on nasal cannula"- and she waltzed away, going to a patient that the intensive care unit paged…. Cold bucket (ˣ.ˣ). I was still uneased, thoughts came rushing. *Yeah, he was on nasal cannula (Was that supposed to make me feel better?* (•_•) *), wonder why do we need to do an ABG… and, and, and why did I waste my time at an amphitheater, med school should be delivered by video* (¬.¬). Practically I got a good 15 seconds of rambling and ranting in my mind. However, at the same time, I had to do everything I could to help out, it felt like everything was falling apart \(ˣoˣ)/, and we needed to keep it all together…but at the same time I wanted to be cautious that my "super hero delirium" did not get out of hand (@_@)…*the road to hell is paved with good intentions*. I stood there a few seconds debating the course of action…To the Counter! \(°o°)/

I asked a nurse if she could come with me, and in less than 1 minute I gave her the case. "*A desperate third year medical student presents for her rotation 5 hours ago…"* and you can imagine the rest. Under the nurse instructions, I successfully drew the ABGs, placed them in the bag with ice, thanked the nurse (who took her time from her non-end shores) and delivered it myself to the lab(^₀⁻)/. Yeap, medical students functioned as cart, escort, or material seekers. *Can relate to 'Indiana Jones's adventures*. I did not explicitly disclose to L.X. that he was my first ABG attempt. But I did tell him that I was

a third-year medical student (that is how we are told to present ourselves), and the short coat gives it away as well. However, if he were directly to ask, I would have told him in heartbeat that he would be my first ABG… I believe we did the correct thing, the question that I ask myself now is how much does the rule bend under a crisis? (~_~)I think that medicine is a constantly weighing benefit-risk, and the circumstances play an interesting weight in the balance…

What ought to be done? Why?

The answer to this question, is simple and short. It also was my most hated and awe-striking answer during my first term at JHSPH (currently I am accustomed to it): "**it all depends**". (ﾉ°□°) I must confess, it took me **<u>two</u>** terms to understand the answer \(ˣOˣ)/. Sorry *first-term-me*, you would surely hate *third-term-me*, but this question is answered with an "it all depends" ¯_(ツ)_/¯. Medical ethics depends highly on the facts, depending on the theories or methods used to analyze the case. The same outcome could potentially be classified as right or wrong…some theories are even sensitive to the motivation behind the action. So yeah, a painful journey indeed (⌐■_■), to understand that most of the important and crucial questions in life are answered with "**it all depends**".

If I were placed in the same situations and the resident told me that after 4:00pm she could supervise me, and it was 3:50pm and a 10 minutes delay would not pose a risk, it is most likely (almost 99.9%) that I would have waited for the supervision(*ₒ*).

Who would reject the opportunity to gain the experience of their first ABGs? \(ˣoˣ)/ On the other hand, if the same scenario repeated itself, I would, again, walk to my haven…To the Counter!

Case 2

A 73 y/o white male presents to the ED due to a COPD exacerbation. Twenty-four hours after admission, the team visit the patient during rounds. The patient informs the attending physician that he does not want a -pejorative racial insult- as his doctor (the resident) and points to a medical student (unknown to him) as his preference.

What is (are) the problem(s) with professionalism?

Here is a big issue, a patient that is refusing treatment due to racism. Definitely, a crack in the physician-patient relationship has been made. Furthermore, the physician has the upper hand, the patient is ill and vulnerable. At the same time, physicians are humans who deserve the application of the ethical principles as well, like for example, respect for persons (—.—). The question is how to deliver optimal care when the patient is rebuffing treatment due to discriminatory behavior. How to deliver optimal care when physician may feel threatened?

My third year Psychiatric (Psych) Clerkship consisted of 1-week conference and 3-weeks on the field. Even though it was my last clerkship, I felt equally lost in the inpatient ward. And this is interesting, sure you may see a depressed or sad patient from now and then, but for some reason there is a separation between body health and

mental health (@_@). An example is how some believe that to assess a patient's capacity we need a psychiatrist to do it, even [for some physicians] the capacity context is foreign with medicine. Nonetheless, at the end of the rotation I felt more confident in dealing with mental health diseases especially suicidal, bipolar, depressive, and schizophrenic patients. Also, it gave me insight of the seriousness and reality of mental health disease.

Returning to the main point of our case problem, a resident was teaching us the Safety 101 during the first week. One safety technique evoked an open-mouthed, stupefied reaction: The Biting-Maneuver *(o_O). I surely hope it was not expected on my log, right* (¬ o¬)*?*

"If a patient bit you, you cannot pull because you will tear your skin." True, very logical, I was nodding inside my head. And then what? \ (ˣOˣ)/ Do we Jackie-Chan-poke their eyes, it works with shark apparently? (o_O) I just pictured myself in a supermarket or a park, and someone bit me out of nowhere…a ninja-anime-scene played in my head(⌐■_■), surely it would be less graceful than what I picture. Her voice returned me to the small classroom.

"You have to move around to where the patient is moving, until someone close by gives him the "triplet" (Haldol, lorazepam, and a benztropine or diphenhydramine). That is when I realized what I was wearing…my short white coat, yeap as Uncle Ben

said to Peter "With powers comes responsibility" (or something on those lines (¬.¬)). People were more concerned, me turning into a *Wall-E*, and nobody told me about biting-maneuver risk…*Where do I place this on my CV* (¬_¬)?

After my first brain was fatigued, it was time for the second brain (the one with reasons to kick in)[g]. They are vulnerable patients, they came searching for help… (and I surely did not sign up to be bitten(¬o¬)), however, those are the risks of the profession and we are free to quit at any moment. The question is how should we act? How can we protect ourselves? (@_@)Physicians (and students) are humans, we have emotions, bad days, etc. A healthy working environment avoids emotional and moral burnout, and avoiding burnout increases the chances of a better service to the overall patient population. Definitely, these issues must be addressed but in a very orderly manner, we are not in the kickboxing field (although sometimes it may look like it (¬_¬)).

Yet, this is very different, unlike my previous experience, this new patient population has their mental health compromised. *This is an example of the innocent separation between mental and body health. This was not a thought I had transitioning from Pediatrics to Surgery. However, I have a hunch of why this distinction is important…* Most of the patient population during Psych rotation have their capacity and autonomy

[g] During my first term we discussed Dr. Daniel Kanheman thesis (found in his book *Thinking, Fast and Slow*) between two mode of though: The fast brain (System 1) which is driven by instinct and emotions and the slow brain (System 2) which is the rational and logical.

restricted and/or compromised. Therefore, issues such has decision making, patient's best interest, honoring patient's values could be more challenging than in other professions. Furthermore, the chances of treating patients with the "expected" inhibitions (aggression against others and themselves, sexual constraint) and unbalanced intense emotions (fear, sadness, confidence) are higher than in any other specialty.

But then again, what can we as physician do to provide safety, not only to the patient, but also to the working staff? Acquiring the Biting-Maneuver ~~technique~~ *awareness*[h] is an example of how physician mitigate the risk of the profession: through training and protocols. There is an effort to foresee the risks, and also provide a solution, such as the Biting-Maneuver-Technique. However, bigotry, which is a potential threat, was not discussed much (I don't recall (@o@)). It could be due that culturally there is a resistance to thinking that there is bigotry at all in the island. I recall that during one of my Social Science courses when doing my bachelor's degree, there was sometimes resistance to acknowledge, that like any other place in the world, Puerto Rico was not exempt of prejudice(ˣ.ˣ). Obviously, Case 2 manifested during the wards, but more important was the response.

What are the options? What are the tradeoffs?

[h] I am proud that I avoided any biting-accident, but I am not comfortable saying that I have the technique mastered…and I don't think it would be ethical to implement a practical component at Med-School…Can't imagine "Mortal-Biting!!! Fight!" (Those who had played *Mortal Kombat* understand this reference).

Interestingly, there were mixed reviews. Some argued that nothing must be said at the moment, others that the attending physician should confront the patient, and others asked regarding the patient's mental status. Doing nothing would promote this type of behavior in future occasion, and with nearby patients that may be observing the situation. Furthermore, it would create discomfort on the team. I remember an article written by Jennifer Adaeze Okwerekwuthis in 2016[6]. It arrived in my email under one of my medical association newsletters. Adaeze explains how a patient referred to her as "colored girl", and how she felt when the attending physician did not address it with patient or privately with her[6]. A sense of abandonment can be perceived during Adaeze's narrative.

The other option offered (and I agree with this one) is to address the situation at the moment. Surely, there are array of methods to do this(ᵘ.ᵘ). We wouldn't endorse (nor expect) that the physician responded to the bigotry, like they would to a "honking-car" while changing from a slow lane to a high-speed lane, during their late teens (very colorful scenario) (¬.—). Instead, a boundary of respect should be placed. The options include the intern's reply right away, the senior immediate reply (fellow, senior resident, attending), intern report to the superior, the attending address the matter at a later time, etc.

I think that the intern should not answer right away if they don't feel comfortable. However, I do believe that they should observe how the superior addresses the

situation, with the goal to acquire the competency in such situation (crossing our fingers that the superior does not respond with the "honking-car" approach).

We [the second-year medical students and I] were curious of what is the average outcome when a patient is confronted…and it is pretty much diversified. Some asks for forgiveness and refrain from racist behavior at the hospital, others say a half-heartedly "sorry" and continue with their behavior, others couldn't care less. Depending on the severity of the case, the hospital may administratively discharge the patient. This conversation made my mind travel back in time.

I was in charge (ᗧ(ò_óˇ)Ↄ) ("pull-up version in charge") with a charming elderly man, he had a valve replacement, and the team was trying to anticoagulant him. Yet his diabetes was keeping the heparin on his skin. We were worried about clotting and potential stroke. My task was to have the daily progress note (。◕‿◕。) (AKA history and checking his heart sound) …it sounded different, a little bit mechanic (or perhaps it was my imagination playing games) . MS3s tend to have awful auditory skills(>>.<<), we hear things that are not there, and do not hear the things that are there; truly fascinating phenomena (@o@).

A few hours later, we did the morning rounds with the cardiology fellow. When we entered, the patient's first words were "Finally, a 'jincho' (which means a "white" person in Puerto Rico) (º.º). The room fell completely silent… The complexity of race is beyond my imagination and even elicits fascination… Puerto Ricans have their own

racial system: Coffee with milk skin color, light honey chocolate skin color (and so on) but the winner is the coffee with peroxide skin color classification (O_O). Don't have any reference of how any of those actually should look like, and I don't plan in a near future mixing peroxide with coffee (◔̯◔). In fact, I regret inquiring more, about how in the world, the individual reached that classification (=_=). Now it gets more complicated… After "successfully" classifying the skin color against the type of coffee bean and the soy-milk grade, plus the factorial's ratios of *milk:peroxide:coffee*; then the afflicted souls can start with the hair, nose and lip classification (•_•).

Definitely, this shows the inner complexity of race/ethnicity classification in the island; even though when asked at first, virtually everyone denies any type of prejudice*(o_O)*. I believe that is why they added the *Puerto Rican* classification in the census or when people simply identified themselves as "satos" (Spanish for mixed breed", whatever that means. Now I feel in the *Harry Potter*-verse, pure-wizards against muggles…the compulsion to place people inside boxes…taxonomy is a bliss[i] (¬ o¬).

Anyway, I digressed, the point was that the patient made a racist comment, and there were plenty of people in the room that were…well, just Puerto Rican *\(OoO)/*. After a few seconds in the deafening silence, the fellow addressed him:

[i] My undergraduate major was on Cellular Molecular Biology, however, few classes (aka General Biology, Ecology, Zoology and Evolution) required the taxonomical knowledge, from Domain to Specie. I wonder if that is mirror images of what we attempt in our daily life. Supermarkets, department stores, and so on.

"But what is that expression Don H.? Everyone here is a doctor, what does skin color have to do?" His face turned different shades of red, he remained silent.

"Let me check your heart."- said the fellow reaching his stethoscope.

I felt sorry for him, here he was at a high risk of dying or at best, become a crippled due to a foreseeable stroke. Instead of worrying of how to get better or formulating an advanced directive or making a will… here he was with an imaginary color-shade card classifying healthcare professionals. I felt very sorry…perhaps in two minutes, or in a few hours his brain function could be compromised…It already happened to one of my patients a few weeks early in another ward, but that case is a discussion for later. Looking back, I don't know if what I felt was compassion or borderline pity(*^*). Was there even a difference between the two? \(o_O)/ Is pity an excessive vice for compassion? In medical school they talk about empathy, compassion, even sympathy…but pity is not mentioned in the bundle. It is not expected from us.

Well, first of all, pity is not considered a moral virtue, it is merely a distressful reaction to another's distress[7]. Although we sometimes use compassion and pity interchangeably; (and even consider pity as Hren's description), they had different meaning for Aristotle. Compassion (*eleos)* describes the pain felt toward those that underserved the bad fortune; whereas, pity is reserved for those that deserve the bad fortune[8]. Regardless of which definition, pity is utterly useless for the medical

profession(ᵘ.ᵘ). Feeling merely distressful is not going to help the situation at all. Deciding whether a patient deserved it or not is even out of the question[j]…

I glanced at my residents, they had stern look, the famous physician-poker face, devoid of emotions. I glanced back at the patient, his face was getting his normal coloration, but his expression showed realization and desperation. The cardiology fellow visited him one time during the day, but the "*No-jincho*" team were his main contact point, and he just insulted them and was not praised by the fellow…I think that he felt alone and vulnerable.

He was our last patient; we went to the room to discuss and make some notes. We did not talk about the event. Back then, I felt there was nothing to talk about (=_=) ; the issue was already addressed. I also felt that, more important was to find a way of how to deliver the heparin to his circulation, before we had a crippled patient in a matter of hours. I think that the fellow's brief and stern intervention allowed the team to function without incident among colleagues or any other patient during my short inpatient week at the cardiac unit. However, after this teaching session, I think that there should have been a debriefing among team members. It would have made the fellow's intervention more official, and something that did not happened due to chance.

[j] This will be explored in more detail in Chapter 11: Opioids

It would have been a teaching opportunity for everyone in how to address cases of bigotry, because surely and unfortunately, this wouldn't be the last time (— —').

What ought to be done? Why?

The conclusion was that definitely the attending must address the situation (or the one with higher rank present) because (1) the higher rank is supposed to have more experience in how to handle these type of cases, (2) it is a learning opportunity for the new trainees to observe the dynamic and how to correctly approach the problem, and (3) it keeps a healthy working environment, avoiding strains between colleagues and other patients.

References

6. Okwerekwu JA. The patient called me “colored girl.” the senior doctor training me said nothing. *Stat.April*. 2016;11.

7. Hren J. The problem of pity: Misguided mercy & dante's infernal purgation. *Touchstone: A Journal of Mere Christianity*. 2019;32(2):38-42.

8. Kristjánsson K. Pity: A mitigated defence. *Canadian Journal of Philosophy*. 2014;44(3):343-364.

9. Beauchamp TL, Childress JF. *Principles of biomedical ethics.* 7th ed. New York: Oxford University Press; 2013:459.