Self-awareness and professionalism

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Professionalism is a key component of good General Practice and self-awareness is a key component of professionalism. Being self-aware means understanding your own fitness to practice medicine as a GP. It is a critical skill for e-portfolio reflections and appraisals because it is a critical skill for good practice. In this article I will offer an approach to professional self-awareness through a set of four questions: What are my goals? What are my beliefs? What are my values? What is my condition?

The GP curriculum and self-awareness and professionalism

Core statement 1: Being a GP requires you to know yourself and relate to others in the following ways:

Fitness to practise

Demonstrating the attitudes and behaviours expected of a good doctor

Managing the factors that influence your performance

Maintaining an ethical approach

Treating others fairly and with respect, acting without discrimination

Providing care with compassion and kindness

Communication and consultation

Establishing an effective partnership with patients

Maintaining a continuing relationship with patients, carers and families

Professionalism, broadly speaking, is the knowledge, skills and attitudes expected of any given professional. It implies not only standards of technical competency, but also expectations regarding values and beliefs. While there is no overarching definition of medical professionalism that is universally agreed upon (Birden et al 2014), there is some evidence that professionalism can be developed through role modelling and reflection (Birden et al 2013). Self-awareness and reflection have been identified as a core element of professionalism. Understanding where you need to be is only part of an educational journey – you need to understand where you are in order to get a sense of direction. There are potential concrete benefits to professional self-awareness as well. Given the

plurality of world-view among doctors and society at large, self-awareness in the context of professionalism can offer a way of recognising, understanding and reconciling difficulties and conflicts in practice. A lack of self-awareness may lead to a failure to notice when ideals and values become compromised. It may also lead to failure to understand distress caused by external pressures to behave in ways that are inconsistent with beliefs and values (Riley). In this article I will offer an approach to professional self-awareness through a set of four questions: What are my goals? What are my beliefs? What are my values? What is my condition? I suggest that these questions could form the basis for reflection, whether this be in a trainee's group, a mentoring session or for an appraisal.

What are your goals?

What are your goals as a professional? Are they in alignment to those of society, the government, the healthcare service, your profession, or your institution/practice? This may not always be possible, which is why the General Medical Council offers 'Good Medical Practice' to outline the duties of doctors (including GPs). One goal for doctors is to practise according to the duties enshrined in good medical practice. Consider the goals of medicine however. In 1948, the World Health Organisation made the claim that health is a 'State of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.' By this definition, few if any might achieve 'health.'

Are your goals realistic or sustainable? Culturally medicine and its allied professions have a tendency to value perfectionism and excellence in the workplace. Health care workers learn that good enough is not excellent and that anything less than excellent is not good enough. Induction into the medical world can distort understanding of what duty means and instil the idea that 'going the extra mile' is normal practice. In a perfectionist framework there is no distinction between what is required and what is beyond requirement and optional. The National Health Service (NHS) in the UK has allowed some room for the values-based and vocationally-driven culture to flourish but discussion about the enlarging 'credibility gap' between rhetoric and reality in clinical care provision leads us to acknowledge the potentially limitless need and demand for healthcare provision in the primary care setting (McKenzie-Edwards 2017).

Consider what informs your goals. Are they set by you or by others? Beliefs may be important – for example beliefs about life and death, the effectiveness of western medicine, and the value of the NHS. Values may be important – and goals may hinge on how we define good: is saving lives or treating pain better? And acronyms such as SMART (Specific, measurable, achievable and time-limited applied) to our goals take account of the fact that we are human – we have to take stock of our human condition if goals are not to be unrealistic. Finally, how fit -broadly speaking- are you to pursue your goals and what is the effect of not being able to fulfil them when this happens?

What are your beliefs?

All doctors in the UK have a professional obligation not to allow their own values and beliefs to prejudice their work. 'Beliefs' are usually interpreted as religious beliefs. However, there are other relevant beliefs that influence people. These include scientific beliefs health beliefs and political

beliefs. Whilst these kinds of beliefs have the potential to be based on some form of evidential truth, the history of science and politics teaches us that it is not quite so simple.

What are your religious beliefs? What do the beliefs which you hold imply? For example if you believe that human life is sacred from the point of conception then it is wrong to act in a way which ends the life of an embryo or foetus. Similarly if you have no religious beliefs, how do you reconcile this with the religious beliefs of colleagues and patients when they impact any aspect of work? Savulescu (2006) argues that doctors should have no right of conscientious objection to evidence-based treatments that the state has agreed to provide. The law allows British GPs to conscientiously object to participation in specified treatments such as termination of pregnancy unless this will put the mother at risk of significant harm.

What are your beliefs about science? If you believe that only evidence-based treatments should be provided to patients – do you evaluate your own evidence or rely on others? Links (2006) argues in a BMJ article that doctors use of medical knowledge bear many similarities to the reading of religious texts. Does your conscientious endorsement of evidence based medicine mean that you object to provide NHS treatments with worse evidence of benefit, or that you refuse to be complicit in private treatment by complementary and alternative practitioners?

What are your beliefs about health? A surprising lack of thought is given to the idea that the question, 'What is good health?' depends upon the answer to the question, 'What is health?' (Misselbrook 2016) Philosophical accounts of health include those which relate to functional and statistical normality (implying that worse than normal is unhealthy and better than normal is enhanced), and those relating to human flourishing (whilst more holistic these can also be unhelpfully open-ended) (Owens 2012). Regardless, a basic exploration of what we mean by health can be useful. An argument for this is that some healthcare interventions may restore physical function or correct a biochemical anomaly but not contribute to meaningful health for a patient, whilst others might be arguably mutilating or physically harmful but enable better overall health. Political beliefs might include a belief in the power of competition to motivate good practice, or a belief that only UK citizens have a right to NHS treatment, free at the point of use. Do you have any political beliefs? How might they affect your practise?

However, given that they may be expected to influence patient's decisions, it is doubtful that GPs operate in a state of neutrality. The ability and duty of the GP to influence patients is remarked upon by Neighbour (2007) in his 'Inner Consultation' – he refers to this as an 'apostolic function'. The reflective GP must decide how far they will allow their values to influence the patient, and how far they will allow their patients' values and choices to influence their actions. Intuitively clinicians should attempt to influence and persuade patients to accept healthcare goods and avoid harms. However they also ought also to decide to what degree they should display their espoused values and beliefs, and acknowledge any particular source of moral values that the patient would consider to represent a conflict of interests. A declaration of beliefs may undermine that ability to persuade.

What are your values?

In other words how do you assign 'good' and 'bad'? There are many approaches to this that are formalised as 'ethics.' The main approaches are virtue ethics, consequentialism, deontology (duty), and contractarianism. These are briefly summarised here – consider whether you identify with any of them. If not, how do you decide whether an action is good or not? Virtue ethics are often attributed

to the ancient Greek philosopher Aristotle, virtue ethics are popular with healthcare educators because virtue ethicists ask the question, 'How should I live?' rather than what 'What should I do?' This idea gives rise to the characteristics of a healthcare professional such as honesty, trustworthiness, compassion and diligence. Aristotle argued that virtues were a balance of extremes – courage was at a perfect point between recklessness and cowardice. Following a number of healthcare scandals in the UK, there has been an expansion on what compassion means in healthcare and whether it is possible in pressured healthcare settings (Hordern, Smajdor 2013).

Duty-based ethics based on two key ideas, that ethical duties should apply at all times, and that we should treat people always as ends in themselves and never purely as a means to an end. This means doing something because it is the right thing to do, rather than because we want to for some reason, for example, making money. Arguably many medical codes of ethics are deontological.

Utilitarianism is the idea of maximising good and minimising harm. The problem is how to quantify these, and what to consider a 'good' or a 'harm'. Quality adjusted life years (QALYs) are one way that the health benefits of treatments are quantified in the UK. The idea of maximising good is present in public health initiatives such as cancer screening, the collection of healthcare data and incentives for treating chronic diseases in primary care.

Contractarianism is the idea that without laws life would be solitary, poor, nasty, brutish and short. So society developed rights and duties, and a system of laws to protect these. Contractarian ideas apply to patients (whose rights depend upon what society has agreed in terms of equitable care) and healthcare professionals (who have employment and citizenship rights in addition to duties).

Consider whether you intuitively favour any of the above approaches, or appear to favour some or all of them. Educational materials may offer a toolkit of ethical approaches (Gillies 2009). Dilemmas are sometimes the result of a conflict between different ways of deciding what is good. For example, sometimes following the rules will result in harm or sometimes we are tempted to break rules in the name of kindness (a virtue) or beneficence.

What is your condition?

Dicker (2007) outlines a reasonable (and often repeated) argument that the public have a right 'not to consult a doctor who is not fit to fulfil the ordinary duties of a doctor'. Fitness to practice comprises sufficient health, sufficient competence and an appropriate set of attitudes to work. This then leads to some further questions: What is your physical condition (including your emotional state)? What is your intellectual condition (including knowledge and skills)? What is your moral condition (are you practising with integrity)?

What is your physical condition?

The Medical Protection Society advise (2016): “Always be mindful of how human factors can affect your performance. Remember the ‘HALT’ mnemonic (hungry, angry, late, tired); where possible anticipate these and take action to mitigate their impact. Where they are unexpected then be prepared to seek the opinion of your colleagues or bring patients back at the earliest opportunity to fully address their needs.” A variety of online self-help resources for the general public replace ‘late’ with ‘lonely.’ Physical condition includes your emotional state. Not engaging with emotions, Kerasidou and Horn argue (2016), has a negative effect on doctors, increasing stress and anxiety and predisposing them to emotional burnout and mental suffering. It also prevents doctors from caring from their patients effectively and appropriately.

What is your intellectual condition?

Keep your knowledge up to date. Have strategies to manage what you do not know. Have strategies to admit what you do not know. GPs are a paradox – they complete a specialist training course but are by definition, generalists. Dicker (2011) warns us that we are all a little bit specialist in that we gravitate towards those bits of learning we like to do. Dermatologically interested GPs learn more than they need to know about skin diseases and will sign up for dermatology updates too. GPs versed in medical ethics go to more medical ethics conferences. There is a potential to neglect real learning needs because it is perhaps easier or more enjoyable to do more of what we are good at than to challenge the margins of generalist expertise. Identification of learning needs requires courage and humility – to admit that there is a patient unmet need or a doctor’s educational need. The uncertainty which characterises many general practice consultations is a rich source of potential educational needs.

What is your moral condition?

This is distinct from the question, “What are your values?” Jameton first coined the term moral distress to capture the inability of nurses to act on what they believe is the right thing to do because of institutional constraints (Jameton 1984). Jameton’s definition has been widely used in nursing and health care and emphasizes institutional and external constraints on the ability of nurses to practice ethically. Since then, the phenomenon has been further described in a variety of healthcare disciplines. Moral distress has been clarified as distress as a result of internal (personal) or external (institutional) factors preventing someone from acting in accordance with their core values. This is distinguished from psychological distress, which does not cause a violation of personal values, for example when working harder and rationing time during colleague sickness absence. The term ‘moral residue’ is used to discuss a feeling of distress experienced some time after personal values have been compromised (Epstein and Hamric 2009).

Key points

- Self-awareness is a critical skill for professionalism and good practice, and honest appraisal is the cornerstone of good medical practice.
- Self-awareness can be explored through the questions: What are my goals, what are my beliefs, what are my values, and what is my condition?
- Understanding the difference between values and beliefs can help identify which disagreements are easily resolved and which are not
- Self-awareness must take place in the context of relation to others
- Moral distress results from the inability to act consistently with beliefs and values

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