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A reflection on professionalism

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"We are what we repeatedly do. Excellence, then, is not an act, but a habit." -Aristotle

Recently I bumped into a colleague while he was performing a pre-anaesthetic consult in the dumpling bar at the children's hospital where we both work. He was sitting on the floor with a small child who clearly had complex health issues – small stature, a small jaw, abnormal ears and a hearing aid – and chatting to her parents while they ate their lunch. 'Nice,' I found myself thinking, '…but perhaps the slightest bit unprofessional?'

What then does it mean to be unprofessional, or indeed professional? In this edition of the journal, Lockman and colleagues describe desirable aspects of professional behaviour in paediatric anaesthetists from the perspective of proceduralists, nurses, parents and anaesthetists themselves, including domains such as patient ownership, communication, humour, attire and informality (1). They demonstrate that although professionalism has few absolutes, all groups encouraged the paediatric anaesthetist to empathize with the parents and become the surrogate guardian of the patient for the duration of the procedure. But does taking on this responsibility give the paediatric anaesthetist licence to conduct consultations on the floor over lunch?

The notion of a profession stems from the craft guilds of the Middle Ages, which sought to limit the practice of a craft to appropriately trained craftsmen (at that time almost exclusively men). Their training might remind many medical professionals of their own journey: aspiring craftsmen would first serve a lengthy, unpaid apprenticeship to a master of the craft, and then work for other masters for a modest salary as a journeyman. While a journeyman, he would prepare his finest work - his 'master-piece' - that would sufficiently impress the masters of his craft that they would admit him to their ranks. Once a master himself, he received a generous income by community standards, was accorded considerable social status and was permitted to take on and train his own apprentices. Similar systems were adopted by practitioners of law, architecture, medicine and many other disciplines, and led to the development both of academic institutions that train students and of professional colleges that in many countries oversee the training (2).

The analogy between guilds and current day professions runs deeper. Guilds not only protected consumers by ensuring that the products or services delivered by their members were of a consistently high quality, but typically also demanded that their members behave in a manner worthy of their respected role in society and contribute to society in ways beyond the application of their craft, including taking responsibility for those in difficult circumstances (3). A current day profession might be defined as a disciplined group of individuals who adhere to ethical standards and demonstrate expertise derived from a high level of research, education and training. Central to the concept of professionalism is the notion that society

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can trust professionals to practice at or above a certain standard, and exercise their knowledge and skills in the interest of others (4).

Are our expectations that medical practitioners be ethical and trustworthy different from our expectations of other professions? We implicitly trust emergency services workers, air traffic controllers, customs agents and meat inspectors to act in our best interests, but unlike other professions, we often interact with the medical profession when we are scared and vulnerable. These dynamics are amplified at the induction of anaesthesia; rarely is the moment of trust as evident as when an anaesthetist administers their patient a drug that causes cessation of breathing. Engendering trust is central to anaesthesia practice, and professional behaviour in anaesthesia necessitates being worthy of that trust – not treating patients while affected by alcohol, deprived of sleep, preoccupied, unprepared, or otherwise unable to recognize a situation in which we should pause and get assistance before we start.

The professional behaviour expected of paediatric anaesthetists seems to have another layer. How often has a parent left the room after induction with a final desperate request for us to look after their child? As well as expertly engaging with and treating the child, we clearly need to convince the parents that for the duration of surgery we will act as their surrogate parent and care for their child in a broader sense. As Lockman and colleagues have demonstrated, few parents doubt that we are well trained and will do the right thing (1), even though in paediatric anaesthesia, the right thing to do is often far from certain and might not always be the safest. I might accept, for example, that all patients are safer if they have an intravenous cannula inserted before induction, yet decide that in some circumstances an inhalational induction provides improved quality with negligible decrease in safety. My equally expert colleague in the next room might have the opposite view, but what we have in common is that we have each asked parents to trust us with their child. As we aspire to become masters of the craft of paediatric anaesthesia, perhaps we should make it our habit to embrace flexibility and share decision-making with parents and carers, while demonstrating certainty that we are interested in and will care for their child to the best of our ability.

I asked my colleague about the consult. He was to be that child's anaesthetist for major surgery, scheduled for several weeks hence. The family had come to clinic, but he had known in advance that he would not be available, and so had done part of the consult by email in advance. The main goal of the consultation was to meet in person, talk over any outstanding issues and gain their trust.

'You know what the mum said to me?' confided my friend. 'She said that I was the most professional anaesthetist that little Abbie has ever had. She said that most of the others had just met them in pre-op hold, warned how dangerous her airway management was going to be and then whisked her away. She said that most of them didn't realize that she needed to

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trust the anaesthetist not only to manage the airway, but also to take on the responsibility to look after her child for the duration of the surgery.'

Aristotle couldn't have said it better.

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