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REVIEW

Challenges to professionalism and ethics in perioperative clinical practice

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Abstract

Perioperative medicine can pose myriad challenges to professionalism and ethical practice. Medicine is a science, but definite end points, and predictable results and outcomes do not consistently occur. There is the potential for error during all steps of a patient's assessment and treatment. Examination findings, laboratory investigations, diagnosis, plans for and outcomes of surgery and long-term outcomes can all be uncertain and/or not meet expectations. Factors including pressures in the workplace, conflicts, ego, prescribed guidelines and pathways, the need to achieve healthcare targets, desire for autonomy and need to maintain multidisciplinary involvement in patient care can lead to an environment in which it is challenging for professionalism and ethics to thrive.

Key words: Medical ethics; Moral distress; Organisational support; Perioperative environment; Professionalism in medicine; Surgical attire; WHO checklist

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Professionalism: what does it mean?

Professionalism is a characteristic by which professionals demonstrate and practice their quality, skills, competence and duty efficiently and ethically to satisfactorily manage a given situation or circumstance. Gawande (2011) wrote: 'all learned occupations have a definition of professionalism, a code of conduct. It is where they spell out their ideals and duties. The codes are sometimes stated, sometimes just understood but they all have at least three common elements. First, is an expectation of selflessness, second is an expectation of skill and third is an expectation of trustworthiness.'

Collaboration with other professionals may require the individual to reduce their autonomy in the interest of team working. Expert professionals know when adhering to a guideline might not be the best option and how to get the best results for the patient. Maintaining professionalism and practising ethically can be a formidable task in the NHS.

The Health and Care Professions Council (2014) report focuses on seven key aspects of professional practice: doctor as healer, patient partner, team worker, manager and leader, learner and teacher, advocate and innovator. It discusses the key attributes of the doctor that are applicable to the wider professional team: creates, commits, demonstrates, develops, exercises judgement and innovates. Reflective learning should be added to this list.

Informing and consenting

Providing adequate information is essential to obtain valid consent. Patients differ in their understanding, circumstances and wishes, hence there is not one perfect method for obtaining consent that suits every patient. Some might need additional support, eg an interpreter, repeated explanation or time to think. Making decisions and giving consent require partnership between the healthcare professional and the patient (General Medical Council, 2020).

Capacity to consent is a sensitive, often uncertain issue, which is governed by the Mental Capacity Act 2018. The following example is worth considering.

An 89-year-old obese woman had Alzheimer's disease and other medical comorbidities. She had complained of abdominal swelling and discomfort, so an ultrasound scan was performed. This was not definitive, so a computed tomography scan was undertaken that

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detected a 20 cm ovarian cyst, which was thought to be benign. Her serum CA125 level was normal. A final diagnosis would require histological examination. Although there was a small chance of this being cancerous, the clinical circumstances and quality of life must be considered. The patient had complete memory loss, was confused, disoriented, could not hold any meaningful conversation and lacked capacity to consent, so a formal assessment of mental capacity was unnecessary. She did not have an independent mental capacity advocate to facilitate a decision. Given her lack of capacity, the question was whether to operate and what the benefit of an operation might be. Would she survive anaesthesia and surgery? What if the diagnosis is cancer? Would she withstand adjuvant treatment if necessary? In these circumstances, a multidisciplinary team approach becomes necessary. After multidisciplinary team discussion, her fully informed husband and daughter declined the offer of any surgical procedure. The anaesthetist and gynaecologist both agreed that it was in the best interest of this woman not to proceed with surgery (General Medical Council, 2020).

In emergency situations, patients undergo surgery in good faith, putting their trust in the doctor's actions. These situations are often not conducive to the patient being able to think clearly, discuss, consider and then make a judgement, yet patients consent to be operated upon. A signature on paper does not necessarily make a consent valid – the patient's understanding of the situation, their previously expressed intentions and wishes, and often their body language are all important in such circumstances. The patient's trust confers immense accountability and responsibility on the surgeon. In return surgeons must use their ethical and professional values and skills to uphold the patient's trust in their ability.

Angelos (2014) believes that obtaining informed consent for surgery is very different from informed consent in other areas in medical care. The patient's willingness to undergo an operation indicates the high level of trust that they place in surgeons. Christian et al (2008) explain that the patient demands accountability, trustworthiness, ethical standards and altruism from the clinician. In return, the professional can exercise autonomy and self-regulation.

Clinical judgement and decision making

To highlight issues around clinical judgement and decision making, consider the case of a young women with symptoms of abdomino-pelvic pain, which she believed was a result of endometriosis. She expected to have a laparoscopy to diagnose and treat endometriosis because she has been trying to conceive for almost a year and one of her friends had told her that endometriosis interferes with fertility. She did not report any dyspareunia and a recent ultrasound scan of her pelvis was normal. In clinic she declined an examination because she was menstruating. She also declined a follow-up appointment, despite explaining the need for examination. Given that her pain could have many causes, an examination is essential before approving a laparoscopic procedure, so her request for laparoscopy was declined.

In these situations, professionals might seek solace in the four principles of medical ethics (Beauchamp and Childress, 2013): autonomy, beneficence, non-maleficence and justice. Potential conflicts between these principles cause a dilemma for clinicians. By not persuading the patient to submit to a gynaecological examination and in not being forced into enlisting her for a surgical operation, autonomy for both the doctor and patient is upheld. As a laparoscopy could be risky, this also underpins non-maleficence. Not adding another patient to the waiting list gives justice for all those on the waiting list from the perspective of utilitarianism (valuing the greatest good for the greatest number of people).

When professional principles come into conflict with each other, the clinician must decide which principle should take precedence, whereas decision making about moral issues in healthcare may require that clinicians detach their emotions from the decision.

Preoperative period

Ward round

Patients are usually admitted for major surgery in the morning of their operation, which leaves little time to make a final judgement about proceeding to surgery in patients who

have been on the waiting list for a long time. The patient should be reviewed that morning to ensure that the previous decision to operate is still justified.

An operation may be cancelled on the morning because of a lack of inpatient beds. It would be natural for the professional to feel dejected, frustrated and helpless: 'moral distress'. Jameton (1984) defined moral distress as a phenomenon in which one knows the right action but is prevented from taking it as a result of institutional or organisational constraints. Moral distress is not the same as an ethical dilemma where one recognises that a problem exists, and that there are two or more ethically justifiable but often mutually opposing solutions to that problem.

Moral distress is a conflict between the patient's autonomy and utilitarian aspect. Professionals need to agree the best way forward with other staff involved, and demonstrate situational judgement appropriate for a given scenario so that an appropriate decision can be taken. Professionalism and ethical values cannot be upheld and propagated single handedly. Employers, regulators and managers have an important role to play in supporting professionalism and enabling it to flourish and develop. A supportive environment needs to be provided in which professionals feel valued; this should include management support and the recognition of other professions (Health and Care Professions Council, 2014).

The World Health Organization checklist: a simple tool to get things right

Gawande (2011) recommended using a checklist before any operation and the 2-minute World Health Organization checklist is a simple starting point. This can be built upon to create specialised checklists, for example for elective or emergency caesarean sections, or instrumental vaginal birth. However, some practitioners feel that the use of checklists has gone too far, hindering the smooth and efficient running of an operating list. Some sibling checklists have been created; while these can be beneficial, it is important to ensure that questions are not repeated for no purpose at multiple points during the patient's admission and journey from ward to operating theatre. To be an expert professional for patients, surgeons need to be able to decide when to follow their own judgement and when to follow a set pathway.

Take the example of a woman needing an operation for a 10 cm dermoid cyst in one of her ovaries. It is not uncommon to face concerns about laterality during a preoperative World Health Organization checklist. On ultrasound it may be difficult to decide the exact side of origin of an ovarian cyst and this often remains unknown until laparotomy is performed. If this is discussed during the World Health Organization checklist in front of the patient, this could affect the patient's trust in the ability of the professionals. However, a true professional must understand that mutual performance monitoring is a way of identifying lapses in order to enable supportive actions to be taken by team members. Team orientation is the willingness to accept others' ideas and perspectives into account and align team goals to what is best for the patient and more important than individual goals (Weller et al, 2014). Mistakes happen as evident from a case of the wrong fallopian tube being removed (Paduano, 2019) but the case of an ovary with a clearly identifiable 10 cm cyst is likely to be different.

The World Health Organization checklist must be carried out by the same team members who do the preoperative ward round and will be doing the operation, otherwise errors can occur between the checklist being completed and the surgical procedure.

Attire and dress code

A study by the Health and Care Professions Council (2014) found that participants' interpretation of professionalism encompassed many aspects of behaviour, communication and appearance, including uniform. It is important to distinguish between professionalism and professional identity. Wilson et al (2013) explained that professional identity is what an individual thinks of him or herself, whereas professionalism involves practising as and demonstrating the behaviour of a professional. The attire or uniform worn by clinicians helps develop professional identity and makes them more recognisable to patients and their family. Joseph and Alex (1972) stated that to a non-uniform wearing outsider, the

uniform stresses difference and separation and acts as a flag to signify that he or she is not part of the uniformed group. The Welsh Assembly Government (2010) explained that wearing a uniform shows off a recognisable identity that helps to promote public trust and confidence.

When a doctor is working, they should dress according to the occasion. Sometimes a doctor may need to attend a ward or clinic straight from the operating theatre, so will still be in scrubs. This should not be seen as unprofessional.

The surgical operation

Gawande (2003) observed that doctors drug people, stab them with needles, introduce catheters and tubes, add blood and salt to their body, alter their bodily biology and physics, render them unconscious and open up their bodies with apparent certainty. They do so out of an abiding confidence in the knowledge of their subject, although the stakes are high. Despite their expertise, professionals experience anxieties and doubts, make mis-steps, and experience failures as well as the successes, adverse events and near misses.

Here the case of a trainee wanting to operate is pertinent. The risks of an operation quoted to patients do not encompass the surgical learning curve which will invariably carry increased risk (Johnson and Rogers, 2012). It is often only in retrospect that a surgeon will realise that they have passed the steep portion of the learning curve. This is the ethical challenge. To estimate the higher risk during the learning curve is difficult and to disclose that is controversial and problematic. Angelos (2013) feels that one expectation of taking consent is to adequately inform the patient of one's experience with a surgical procedure. The reality is that the potential risks of a trainee surgeon operating remain at best impossible to know and at worst not even mentioned. This is not ethical but may be the reality and is how newly qualified surgeons learn. Recalling non-maleficence, one will see how this situation can be a potential source of moral distress. This is the practicality that most teachers have to cope with. To not allow a trainee doctor to operate is to not allow skills to be learned and practised.

Benbassat (2014) stated that insensitive and inconsiderate behaviour of trainers towards patients is perceived by trainees as a negative trait for role models. However, when a supervising surgeon takes over from a trainee during a difficult operation it should be seen as practice of non-maleficence rather than an unkind gesture, and trainees should remember that the supervisor is being sensitive to the patient's need and demonstrating reasoning skills in doing the best for the patient.

Performing an unplanned and unexpected procedure in the best interest of the patient is not unethical, for example, the need to insert a ureteric stent intraoperatively to safeguard the ureters in a complex operation. According to the General Medical Council (2020), in situations where a patient lacks capacity the clinician must consider which options provide overall clinical benefit for the patient. If the patient is under anaesthesia, one can proceed without consent, provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition. Such unplanned procedures need organisation and cooperation of all those involved and recognition that operating time will be prolonged. The General Medical Council (2016) recommends that good teamwork makes for good outcomes. Effective teams reduce mortality and morbidity and increase patient satisfaction (General Medical Council, 2016).

In an operation that is prolonged as a result of difficulties or complications with the procedure, scrub teams may change over in the middle of the operation because their shift is over. Such change in personnel may be risky. Ideally, operating team members should be the same throughout the surgical procedure unless comfort breaks are needed during prolonged procedures. In these moments, within the four walls of the operating room 'altruism' should be invoked – a professional behaviour while looking after the patient's best interests. With its sense of service, selflessness and self-sacrifice, altruism is often thought to be an integral trait of ideal medical professionalism. Devotion and dedication to the welfare of the public differentiates the average craftsman from a true professional (Cruess and Cruess, 1997; Harris, 2018). For altruism to be upheld time and effort needs to be recognised, supported by the organisation and managers.

Surgical innovation and professional autonomy

There will be no progress in the art and science of clinical management without innovation. To innovate in health care is to take independent decisions about the care of a patient, so the patient benefits from the motivation of the surgeon to innovate. Angelos (2014) believes that the level of flexibility that surgeons have in the operating room is critical to surgical innovation and progress.

Although new equipment is tested and validated, it may be expensive and its use not appropriate, given the limited resources of the NHS. However, a surgeon may believe that using the new equipment would make an operation easier and safer. This is an example of an ethical dilemma between ethics-in-theory and ethics-in-practice – the benefits of using the new equipment (theory) vs the excess cost of the equipment that might draw funds away from other areas (practice). In such situations the answer may not be found in the four principles approach of Beauchamp and Childress (2013). These principles do not close the gap between the real world and the ideal world, although they might narrow the gap between ethics-in-practice and ethics-in-theory (Martin, 2019). The answer often lies within the surgeon who can decide about the benefits of innovation, such as using new equipment or implementing a new method of operation.

Emergency operations

Consider the case of a young patient who is undergoing a laparoscopy. She has an unruptured ectopic pregnancy in one fallopian tube and the other tube appears swollen, tortuous, blocked and visibly damaged, presumably as a result of previous pelvic inflammation. Not removing the tube with the ectopic pregnancy but restricting surgery to salpingotomy risks recurrence of ectopic pregnancy. Not doing anything and treating her postoperatively with systemic methotrexate risks rupture of a tubal pregnancy in future. In this case, the chances of future pregnancy may be higher following treatment with salpingotomy than with salpingectomy (National Institute for Health and Care Excellence, 2019). Here the risk of not removing the fallopian tube is worth taking.

Reflection in action underpinned by up-to-date evidence is a key characteristic of professionalism and ethical practice. Schon's (1983) concepts of reflection-in-action come into play when professionals connect with their feelings, emotions and previous experiences to attend to a challenge. Here, the expert surgeon must take a decision in view of what they see and believe is in the best interest of the patient.

Postoperative care

The majority of patient complaints result from failures in communication, yet most of these failures are unintentional (Abdelrahman and Abdelmageed, 2017). Appreciation of each other's role, mutual respect, shared decision making, trust and closed-loop communication are essential for effective and holistic care.

The anaesthetic recovery nurse, the ward staff and doctors, and the night shift workers have no way of knowing the operative details unless there is a good handover. The third part of the World Health Organization checklist is the 'sign-out', which can be completed hastily as, after a prolonged and taxing surgical operation, the team might feel relieved to relinquish responsibility to another team. Weller et al (2014) argued that verbal dexterity should equal the surgeon's procedural dexterity and factual knowledge as it improves information sharing. Handover of care is of better quality when a structured handover tool is used, for example under the heading of 'situation', 'background', 'assessment' and 'recommendation'.

Postoperative care is best carried out by the surgeon who performed the operation, as they are best placed to explain the operative findings, the procedure, any modifications or unusual steps and any complications. The Care Quality Commission (2021) stated that professionals should provide compassionate and reasonable support, giving truthful information and apology where it is due. Healthcare providers should promote a culture that encourages candour, openness and honesty at all levels. This should be an essential part of safety without which organisational and personal learning would not occur. The surgeon's responsibility goes beyond inpatient care and should encompass proper discharge planning, prescription advice and organisation of follow-up care.

Key points

- Perioperative medical practice poses unique challenges to professionalism and ethics.
- Sharing information and mutual respect are important influences on team working.
- Professional autonomy, surgical training and innovation can make professionalism and ethics vulnerable.
- Emergence, sustenance or inhibition of medical professionalism and ethical medical practice is strongly influenced by organisational and management structures.

Conclusions

Modern clinical practice threatens to increase the gap between what professionals are trained to do and the requirements in reality. Work pressures along with concerns around professional identity and vocational ideals can lead some to doubt their choice of profession. Motivation arises from how one views oneself in an occupational role, the sense of achievement and values that arise from it. Barriers to developing these attributes include lack of time and support for skill development, and the structures and systems that undermine principles such as teamwork, clinical leadership, learning from error and advocating for patient welfare. Emergence or inhibition of professionalism is influenced by organisational and management structures.

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Conflicts of interest

The author declares that there are no conflicts of interest.

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