# Chapter 27
# Supporting the Development of Professionalism in Surgeons in Practice: A Virtues-Based Approach to Exploring a Surgeon's Moral Agency

**Linda de Cossart CBE and Della Fish**

**Overview** The intentions of this chapter are to refresh and clarify how we might construe and facilitate the continuing development of professionalism in surgical practitioners in the twenty-first century. Firstly, we consider the current concept of professionalism in surgery and then attend to two aspects of supporting the development of professionalism in practitioners who are members of a profession that serves vulnerable fellow human beings. Secondly, we share our experience of facilitating one way of beginning those deep but very sensitive considerations about the person the professional brings to their work. We conclude that all this requires members of the profession of surgery to be willing and able to articulate what it means to them to be a member of a profession and that surgical teachers take time to become well developed educators in *the moral mode* of educational practice.

## 27.1 What Does Professionalism for a Surgeon Consist of in the Twenty-First Century?

Surgeons are members of a profession that has a long history and tradition as a professional practice and which demands of the practitioner particular qualities of character and conduct. Surgery as a profession provides a public service that seeks to offer 'a good' (in this case for surgeons the best possible health) for both the individual patient and the whole community. Belonging to a profession is more than 'being professional' which today we tend to apply to anyone who does something well or to any activity done thoroughly [1–3]. It is not about 'belonging to an interest group that seeks self-interest' [4]. Indeed, the tone of irony that lurks behind the last statement indicates disappointment at the shortfall. Professional practice for a surgeon is undoubtedly an ethical practice [5–7] and as such should be engaged in

L. de Cossart CBE (✉) · D. Fish
Ed4medprac Ltd., Cranham, Gloucestershire, UK



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by those who recognise and aspire to the unchanging principles of ethical practice because as James Drane [6] reminds us 'doctoring is through and through an ethical enterprise', and as such it is not part of the everyday activities of laymen and laywomen. Thus its practical and educational implications need deep consideration.

For some time now, professional practice in surgery (and in many other professions) has been perceived as a mere skills-based enterprise by a world that has lost its moral compass and been persuaded to adopt a technical rational view of life [5, 8–11]. We would argue that in both medicine and surgery, the technical mode of practice, while vital, is not sufficient. This is not about downgrading the importance of skills and knowledge but rather upgrading the importance of the professional's identity, personhood and humanity and their continuing flourishing throughout their professional life [7, 8, 11, 12]. Chapters 12 and 13 explore concepts around the professional identity development of surgeons and surgeon educators in greater depth.

Professionalism – for members of a profession – is about who you are, both as a person and a professional, and therefore how you conduct yourself. How you conduct yourself is more than about how you behave. Behaviour refers to your surface performance, which can be – but may not be – related to your inner beliefs and convictions. The term 'conduct' is used here to signify that visible performance is driven by inner belief about how to be and to act and about who one is as a person in life and in professional practice. Members of a profession are under scrutiny and accountable for their conduct at all times. Beyond that, however, they also recognise and accept fully that their professional practice makes demands of them that are beyond what is naturally required of those who engage in occupations other than surgery [9].

All this has profound implications for how surgeons in practice learn to become the person and the professional who can constantly aspire to the ideals of professional practice as well as to the technical accuracy and artistry of their performance in the operating theatre.

## 27.2 Aims and Intentions of This Chapter

Our aim in this chapter is to offer some provoking ideas and questions to shape and revitalise ways of thinking about and conceptualising professionalism for surgeons and ways of teaching it. Our intentions are to inspire teachers and learners in (postgraduate) surgical practice to move beyond the technical rational mode of professional practice with its emphasis on efficiency and performance and to re-engage with the moral heart of practicing medicine which is concerned with understanding the drivers of our decision-making and professional judgement (what Aristotle called *phronesis* or practical wisdom) [3, 10, 11, 13, 14]. Two of these key drivers are the person and the professional we bring to each individual patient case.

We will thus attend to two aspects of supporting the development of professionalism; firstly, we will clarify how the concept of professionalism in surgery has

developed recently. Following this we will share our experience of how this might be taught and will conclude with some principles to guide teachers and learners in surgical practice.

## 27.3 Why Is All This Important?

At a national educational association seminar in 2016 for exploring virtues and values in being a doctor, we were struck by the passion of delegates (mostly senior medical practitioners) when we challenged their notions of how they saw their professional work. They talked of 'working on the shop floor', 'seeing patients as customers,' 'learning important things from marketing and industry' and aiming to 'deliver targets'. They all had pride in their work and wanted to do their best for patients despite the increasing hostility of the current environment. However, the language of trade, commerce and 'the market' had been unconsciously insinuated into their mindset and discourse. Only with some prompting did they consider the virtues and character needed to undertake the complex and moral job of being a doctor.

In medicine increasing regulation, both intrinsic and extrinsic, fuels the technical mindset with the laudable aim of reassuring the public about professionals' 'fitness to practice'. 'Fitness to practice', with its assumption of mastery, is inappropriate in a medical world where knowledge and understanding is always incomplete and where everyday practice can only call on best endeavours rather than the achievement of perfection.

How does all this influence teaching and learning professionalism? How should this be approached in the postgraduate surgical curriculum and how might this look with respect to real practice today? How do we balance the increasing technical mode of professionalism with the endemic ideals of the moral heart of medicine?

## 27.4 Towards Reconceptualising Professionalism and Professional Education

We argue here that education in professionalism for surgeons ought to begin with seeing the responsibilities of being a member of the profession of surgery as a major permeating theme throughout all aspects of professional development and not as an add-on extra [7]. This means taking account of the past traditions, current challenges and future trends of the current social and political environment. Further, we do not see it as merely a matter of changing the definition of professionalism or adding on a new assessment process [15, 16]. We see it as a matter of identifying and retaining certain inescapable fundamental principles (and character development) that need to shape a *doctor's* practice [2, 6, 17].

Fish and Coles [2], extrapolating from Freidson's work [17], offer the notion that membership of a profession:

- Is an occupation exercising 'good' in the service of another
- Is a specialised work in that it cannot entirely be understood by the layman
- Is not measured by financial reward alone
- Is ethically and morally based
- Has an esoteric and complex knowledge base
- Requires the capacity for and the exercise of discretion and depends upon wise professional judgement

Indeed, *being a member of the profession of surgery* goes far *beyond* complying with the standards and the codes of good practice set down in regulatory documents. It requires the doctor to be a moral agent for their own practice, with accountability for their discretionary judgements as practitioners [4, 11, 13]. The importance of this most crucial ability has been echoed by the hundreds of doctors we have taught who recognise this as a never-ending quest.

The Keogh report in 2013 highlighted that young doctors in the UK are undervalued and receive inadequate supervision and support, particularly when dealing with complex issues [18]. But despite the claim Pringle makes that '[doctors] have a strong internal sense of appropriate and good behaviours, based on a robust set of inbuilt values and virtues', we argue that these capacities need to be explicitly appreciated, nurtured and strengthened throughout professional life [19].

Engaging in *the moral mode of educational practice* requires the postgraduate teacher to put their learner's growth as a person and a professional at the centre of the teaching transaction, so that the learning is worthwhile and the teaching encourages the learner's flourishing as exemplified in their maturing capability, confidence and effectiveness as a practitioner [3, 5, 20]. This requires recognising the learner's own humanity as well as developing their clinical expertise. We argue that this means attending to their *being, knowing, thinking, doing and becoming* a better doctor [5, 13]. Developing professionalism is therefore far more than role modelling, which leaves implicit the conduct modelled. It requires intentional and explicit teaching to foster learning.

Educating surgeons for all this demands a rigorous approach to help them to understand themselves, their values and what specific virtues they have, in order to nurture, develop and enrich their role as a doctor and surgeon [18]. It would seem reasonable therefore to claim that these themes should permeate the whole postgraduate surgical curriculum, and beyond, because they influence and will always influence the very heart of a surgeon's actions. Currently the curriculum does not explicitly require this to be attended to. Further, teachers are not aware of how to recognise in their own practice and develop in others' an awareness and understanding of *phronesis* and how and why it goes beyond technical and procedural ability [1, 5]. This starts with knowing yourself and having the language to discuss these matters with all learners.

## 27.5 Exploring a Surgeon's Moral Agency and Professionalism in Practice: An Illustration of a Virtues-Based Approach

Working together for 16 years, as a surgeon with 40 years of experience and a teacher educator with more than 30 years of experience in teacher education and postgraduate medical education, we have explored, written about and taught on these matters in real clinical practice since 2005.

Our most recent blended learning series *Medical Supervision Matters* is aimed at the worthwhile education of supervisors in postgraduate medical education (PGME) in the UK and contains the permeating themes *teaching as a practice in its own right, the moral mode of practice, epistemology and ontology, the importance of reflection, and the importance of being, knowing, doing, thinking and becoming* [9, 21–23]. Table 27.1 shows the themes specifically relevant to preparing supervisors to explore and develop with supervisees the virtues endemic to professional practice. An evaluation of this programme reported that teachers were now more likely to focus on the professional development and well-being of learners, having completed the programme [24]. Evaluations of similar programmes we have designed and taught have found similar evidence [25, 26].

The process leading up to our specific example involved teachers/supervisors working through an initial set of learning materials (Booklet One) [9] to explore their own thinking and understanding about matters ontological and the distinctions between values and virtues [27]. This was achieved through distance learning materials and a face-to-face day session. Part of this included sharing together the results of their work with a junior doctor in charting and exploring what qualities of

**Table 27.1** Curriculum themes for teaching virtues and values in PGME

| |
|---|
| *Booklet one: starting with myself as a doctor and supervisor* [9] |
| 1. What as a person do I bring to my supervision of doctors? |
| 2. What is required of me as a clinician who supervises doctors? |
| 3. How do I construe the nature of clinical practice and why does it matter? |
| 4. How do I see virtues, values, character education and professionalism? |
| 5. How do I view the nature and status of medical knowledge? |
| 6. How do I see patients and the relative priorities of patient care and supervision? |
| 7. Review: How do I now see supervision? |
| *Booklet two: practical dilemmas about supervision and teaching* [21] |
| 1. How does and how should clinical supervision work in practice for doctors? |
| 2. What is teaching, what is education and how would I characterise good teaching? |
| 3. How, in the moral mode of practice, should I engage in teaching my supervisee? |
| 4. What do I see as the basis of my authority and my agency as a supervisor? |
| 5. How can I cultivate character, virtue and moral reasoning in my supervisee? |
| 6. What is education theory and what do I need to know about it as a supervisor? |
| 7. What do I need to understand about the role of language in supervision? |
| 8. How should I prepare, as a teacher, and what is involved in the appreciation of my practice? |

character they each brought to a shared clinical case. Montgomery argues that '[case narrative] is the principal means of thinking and remembering – of *knowing* – in medicine' and rigorously exploring clinical judgement [11]. We strongly support this approach because real cases from practice are the source of key learning opportunities.

The similar and differing ideas about the case that teacher/supervisor and junior doctor each brought to their discussion proved a highly enlightening experience for both and is one useful starting point for introducing and making explicit the thinking needed and the language used in developing professionalism as well as the virtues and wise judgement of surgical practice.

Further distance learning and a second face-to-face teaching day introduced what we call *The Moral Reasoning Pathway.* Table 27.2 provides an exemplar framework for exploring the qualities of character demanded in a second clinical

**Table 27.2** An excerpt from, and example of, how to explore the virtues and moral reasoning endemic to a real clinical case

| Column I: virtues identified | Column II: the outline of the clinical case | Column III: dilemmas in moral reasoning in this case |
|---|---|---|
| Respect for others and the system | At the 8 am handover on a Saturday morning, I (an SpR year 3) received a case of a young adult who had been admitted at 3am drunk and smelling of urine with a laceration on his arm. The arm had been sutured but the youth had been surly and uncommunicative. He had received antibiotics and a tetanus injection. He was deemed likely to be ready for discharge later | Respect for patient |
| | | Critique of handover diagnosis |
| Honesty | | Enforcing zero-tolerance policy |
| Integrity | | A drunk or a human being? |
| Uprightness | I began the ward round on the acute admissions ward. I was nearing the bed of the young man when a nurse approached and said that his mother was outside and wanted a word before she saw her son. The boy had obviously heard this and nodded his consent to me that I should see her | Moral responsibility to patient |
| Commitment | | Being non-judgemental |
| Respect | | |
| Compassion | I left the ward with the nurse and headed for the visitor's room. The nurse filled in more of his story saying that he had been found slumped in an alley way in the town and had been rather rude. He had been warned of the zero-tolerance policy with respect to abuse of staff. I entered the visitor's room ahead of the nurse | Patient confidentiality |
| Fairness | | Following protocols or not |
| Non-judgemental | | |
| Curiosity | A woman in her mid-40s was sitting on the couch and was crying. She was being comforted by a man who I assumed was her husband. She stood up as we entered | Being cognisant of the wider circumstances |
| Kindness | She thanked us for seeing her and asked anxiously if he was *ok.* I confirmed that he did not have any serious injury and would be fine | Being caring or expedient |

The moral reasoning pathway for a patient case [9]

case and the moral dilemmas it created for the doctor. The use of this second clinical case entailed the supervisor and supervisee completing column one independently of each other. The supervisor also completed column three, identifying the moral dilemmas faced during this case. Then, during a planned professional conversation together lasting about 45 min, they shared and critiqued their varying results in column one and explored the moral issues identified by the supervisor in column three. This extended the understanding of *phronesis* related to this case. A written reflection created after the meeting by the junior doctor, on the learning stimulated by this event, served as hard evidence of what was achieved. Later versions of this activity put greater responsibility on the learner, requiring the supervisee/junior doctor to both fill in column three before the meeting. This whole process is suitable for cases from all areas of surgical practice (clinic, ward and operating theatre) and can be adapted to respect the level of experience of the surgeon.

Those we have worked with have found that their learners engaged enthusiastically with the exercise, shared a much deeper and more meaningful discussion than expected about professional matters and showed remarkable thoughtfulness. The flourishing of the learner was also evident in their new confidence and interest in their work. It also engaged each in a more meaningful and collaborative educational partnership between teacher and learner and broadened their shared language and understanding of why these things are important.

## 27.6 Conclusions

### *27.6.1 The Educational Principles for Teaching Professionalism Including Character Development and the Virtues Development of Character*

In concluding this chapter, we summarise the principles offered.

These are that:

- Surgical practice is a moral enterprise.
- Surgeons are members of a profession with a long and valuable tradition.
- Teaching professionalism needs well-prepared teachers who understand ontology and *phronesis* and can make their own judgements explicit.
- Teaching professional capacities and characteristics is an *intentional* activity and should not be left to chance.
- The moral mode of education and of professional practice can enable the young to flourish in a sustainable way.
- Learning these matters is possible with teachers who have set out and shared with learners their well-considered and worthwhile educational intentions for their work together.

All this requires both that members of the profession of surgery are willing and able to articulate what it means to them to be a member of a profession and also that surgical teachers take time to become well-developed educators in the moral mode of practice.

## References


1. Fish, D., & de Cossart, L. (2007). *Developing the wise doctor*. London: Royal Society of Medicine Press.
2. Fish, D., & Coles, C. (Eds.). (1998). *Developing professional judgement in health care: Learning through the critical appreciation of practice*. Oxford: Butterworth Heinemann.
3. Carr, D. (2000). *Professionalism and ethics in teaching*. London: Routledge.
4. Hilborne, N. (2015) Jackson: 'Professional negligence' could disappear as attitudes to professionals change. *Legal Futures* (Online). Available at: http://www.legalfutures.co.uk/latest-news/jackson-professional-negligence-could-disappear-as-attitudes-change. Accessed 7 Oct 2016.
5. Fish, D. (2012). *Refocusing postgraduate medical education: From the technical to the moral mode of practice*. Cranham: Aneumi Publications.
6. Drane, J. F. (1995). *Becoming a good doctor: The place of virtues and character in medical ethics* (2nd ed.). Kansas: Sheed and Ward.
7. The Jubilee Centre for Character and Virtues' statement on character, virtue and practical wisdom in the professions. http://www.jubileecentre.ac.uk/userfiles/jubileecentre/pdf/Statement_Character_Virtue_Practical_Wisdom_Professional_Practice.pdf. Accessed 15 Oct 2015.
8. Blond, P., Antonacopoulou, E., & Pabst, A. (2015). *In professions we trust: Fostering virtuous practitioners in teaching, law and medicine*. London: ResPublica Available via: http://www.respublica.org.uk/wp-content/uploads/2015/02/In-Professions-We-Trust.pdf.
9. Fish, D. (2015). *Starting with myself as doctor and a supervisor. Booklet 1 of Medical Supervision Matters*. Cranham: Aneumi Publications.
10. Cruess, R. L., Cruess, S. R., & Steinert, Y. (2010). *Teaching medical professionalism*. Cambridge: Cambridge University Press.
11. Montgomery, K. (2006). *How doctors think: Clinical judgment and the practice of medicine*. Oxford: Oxford University Press.
12. Gelhaus, P. (2012). The desired moral attitude of the physician: 1 empathy. *Medical Healthcare and Philosophy, 15*(2), 103–113. https://doi.org/10.1007//s11019-011-9366-4 Published 14 December 2012.
13. de Cossart, L., & Fish, D. (2005). *Cultivating a thinking surgeon: New perspectives on clinical teaching, learning and assessment*. Shrewsbury: TfN Publications.
14. Eraut, M., & du Bouley, B. (2000). *Developing the attributes of medical professional judgement and competence: A review of the literature* (Cognitive Sciences Research Paper 518). University of Sussex, 2000. Online version. Sections 3.1 and 3.2 reprinted on CD as part of Module 1 of the Human Face of Medicine. London: BMJ Publishing Group.
15. Canter, R. (2016, January). The new professionalism. *98*(1), 10–13.
16. Non-technical skills for surgeons (NOTSS). http://www.notss.org/. Accessed 13 Oct 2016.
17. Freidson, E. (2001). *Professionalism, the third logic*. Chicago: University of Chicago Press.
18. Keogh, B. (2013). *The Keogh review*. NHS England. http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf. Accessed 15 Oct 2016.
19. Arthur, J., Kristjansson, K., Thimas, H., Kotzee, B., Ignatowicz, A., & Qui, T. (2015). Virtuous medical practice: Research report Birmingham University Jubilee Centre. www.jubileecentre.ac.uk/userfiles/jubileecentre/pdf/Research%20Reports/Virtuous_Medical_Practice.pdf. Accessed 13 Oct 2016.

20. Hansen, D. (2001). *Exploring the moral heart of teaching: Towards a teacher's creed*. London: Teachers College Press.
21. Fish, D., de Cossart, L., & Wright, T. (2015). *Practical dilemmas about supervision and teaching. Booklet 2 of Medical Supervision Matters*. Cranham: Aneumi Publications.
22. Fish, D., de Cossart, L., & Wright, T. (2015). *Practical dilemmas about the learner and learning. Booklet 3 of Medical Supervision Matters*. Cranham: Aneumi Publications.
23. Fish, D., de Cossart, L., & Wright, T. (2015). *Practical dilemmas about assessment and evaluation. Booklet 4 of Medical Supervision Matters*. Cranham: Aneumi Publications.
24. Brown, J., Leadbetter, P., & Clabburn, O. (2016). Evaluation at East Lancashire Hospitals Trust (ELHT) of the impact of the project: 'Supervision Matters: Clinical Supervision for Quality Medical Care'.
25. Thomé, R. (2012). *Educational practice development: An evaluation (An exploration of the impact on participants and their shared organisation of a postgraduate certificate in education for postgraduate medical practice 2010–2011)*. Cranham: Aneumi Publications.
26. Thomé, R. (2013). *Educational practice development: An evaluation of the second year 2011–12 (An exploration of the impact on participants and their shared organization of year two of the postgraduate masters in education for postgraduate medical practice)*. Cranham: Aneumi Publications.
27. Annas, J. (2011). *Intelligent virtue*. Oxford: Oxford University Press.