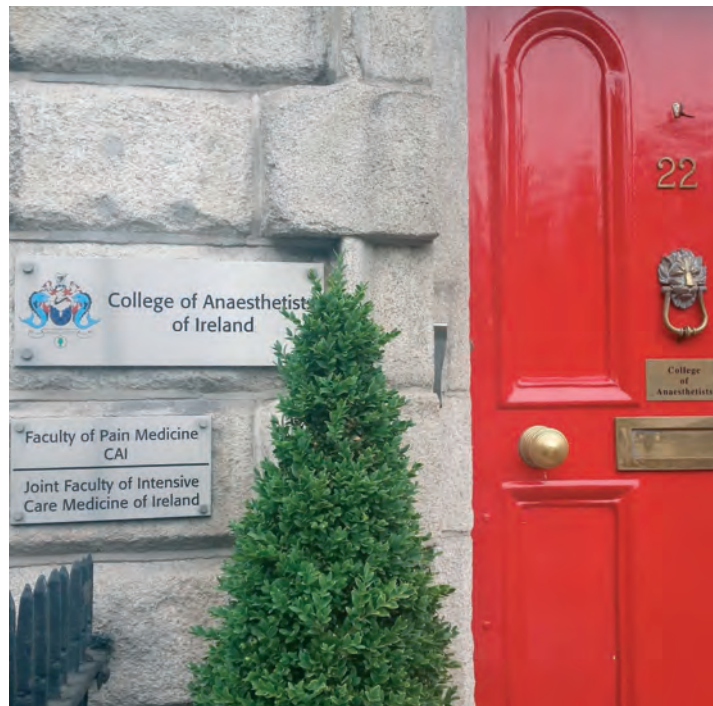




# Professionalism in Anaesthesia, Intensive Care and Pain Medicine

COLLEGE OF ANAESTHETISTS OF IRELAND, 2018



PARTNERSHIP

PRACTICE

PERFORMANCE



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# President's Foreword

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It is my pleasure to introduce the speciality specific guide to professionalism and ethics to sit alongside the Medical Council's Guide to Professional Conduct and Ethics (8<sup>th</sup> Edition).

Professionalism is the cornerstone of professional integrative practice that has its roots in a robust training and education, underpinned by current and innovative research, scrutinised by appropriate tests of knowledge and competencies to ensure the highest standards of patient safety throughout the discipline and related specialties in the operative department, intensive care unit, pain clinic, PACU and the wards.

Anaesthetists are recognised as natural team leaders, moderators and good decision makers. They work well in teams, providing support for their non-anaesthetic colleagues but can also assist each other sharing specialist knowledge and skills. We should respect other colleagues, interacting with them professionally.

Anaesthetists care for patients from the time of contemplation of surgery to their discharge home and beyond as such and may be regarded as perioperative physicians. Consultant anaesthetists make up approximately 12% of the consultant workforce in Ireland and is the largest in-hospital speciality. Anaesthetists will engage with almost 70% of patients during their clinical pathway in the hospital setting. Through anaesthesia, critical care and pain medicine, we are challenged to deal with such difficult areas as breaking bad news and end of life issues, which must be treated with due assiduousness, respect and diligence.

The doctor patient-relationship is a fundamental unit of care and interaction and it demands integrity, altruism, compassion, patience, respect, tolerance and an understanding of diversity. Excellent communication skills, including the ability to listen, and recognition of the anxious patient with the ability to allay their fears are essential.

We have a duty to preserve patient confidentiality not only undertaking not to divulge confidential information but also to ensure written information and data is kept in a secure manner.

Dealing with patients whose treatment has had an unpredicted outcome can be challenging, but must be dealt with empathically by senior, appropriately skilled anaesthetists and intensivists, embracing the tenets of open disclosure, acknowledging and apologising for adverse outcomes.

In pain medicine, discussing chronic pain issues, the ramifications of pain behaviour and therapeutic options, as well as their limitations, demands special skills.

We must be advocates for our patients, bearing in mind that some will be at both extremes of life and possess the "quietest voice" in the room. As patient advocates, it is our duty to listen, carefully and fully explain the benefits and risks of procedures.

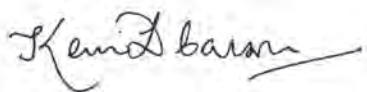
At all times, we strive to uphold and cherish the dignity of those in our charge. We aim to treat pain and suffering in all areas of practice, peri-operatively, in ICU and though the speciality of pain medicine. Symptom relief may suppress vital reflexes, but we must never set out a priori, or with the aim, to shorten or extinguish life. However, at times withdrawal of life-support, in an arena of futility, may be the appropriate therapeutic choice.

The Advanced Healthcare Directives have now been introduced into Irish law as part of the Assisted Decision Making (Capacity) Act 2015. These will provide a roadmap for patient's healthcare choices, so we can treat them in accordance with their "will and preferences"

While the apothegm of the speciality is patient safety, we also have a duty to "those who watch" – the anaesthetists and intensivists themselves. Wellness and mindfulness, self-care and that of colleagues is a fundamental principle of professionalism.

We are dedicated to on-going education, life-long learning, to maintain our knowledge and skills at the highest level.

As specialties of Anaesthesia, Intensive Care and Pain Medicine, we are committed to the three pillars of professionalism: partnership, practice & performance. As a College, we purport that these are continually revisited in a structured way through a specialised curriculum from medical school, through specialist training and throughout one's career as a specialist to ensure the highest professional conduct at all times.



**Prof Kevin Carson**

BSc(Hons) MB BS FFARCSI FFPMCAI FJFICMI FAMM FFSEM

*President*

*College of Anaesthetists of Ireland*





# Introduction

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The College of Anaesthetists of Ireland (CAI), and its Faculties, is committed to promoting the highest standards of professional conduct and performance amongst its fellows and trainees. It aims to deliver excellent training to future fellows, and to support consultants in maintaining and improving knowledge and skills through lifelong continuing professional development. Outlining how it expects all doctors to practice and perform, the Irish Medical Council updated its *Guide to Professional Conduct and Ethics* (8th Edition - hereafter referred to as *The Guide*) in 2016. Within it, the Medical Council has defined eight domains of good medical practice, one of which is professionalism. While there is no agreed definition of medical professionalism, most professional bodies share the view that at its core is the principle of absolute commitment to patient care. This is underpinned by a set of foundational values: clinical competence, effective communication, and an understanding of physician ethical and legal obligations.

*The Guide* contains general guidance that provides broad assistance and direction for doctors, but clearly cannot address the needs of particular specialties. In response, the CAI has produced this framework document to provide for greater detail and clarity on professionalism in respect of the practices of Anaesthesia, Intensive Care Medicine and Pain Medicine. CAI recognises that the medical landscape has changed in recent times, with greater societal and regulatory expectations in respect of medical transparency, accountability and behaviour. It also acknowledges that these expectations can sometimes pose particular challenges for anaesthetists. In order to set out some specific guidance this document will use the principles and values laid out in the Medical Council's three pillars of professionalism (Partnership, Practice and Performance), identifying areas of particular relevance to the provision of good care by doctors practicing in Anaesthesia, Intensive Care and Pain Medicine.

*“The College of Anaesthetists of Ireland (CAI), and its Faculties, is committed to promoting the highest standards of professional conduct and performance amongst its fellows and trainees.”*





# The Anaesthetist

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**A**s a professional, every doctor is expected to have expertise in the skills of their specialty, acquired through study, training and practice, and evidenced by relevant accreditation and qualifications. An anaesthetist is a qualified medical practitioner who specialises in Anaesthesia and Perioperative Medicine. Following the awarding of a basic medical degree an anaesthetist undertakes a minimum six-year specialist training programme in Anaesthesia, including Intensive Care and Pain Medicine. Training comprises a combination of theoretical learning and practical experience in clinical and non-clinical aspects of practice. Doctors who are registered on this specialist training programme are subject to close supervision, and formal assessment and examination, throughout their training. Following completion of their specialty specific training, trainees can apply for a consultant role in Anaesthesia, Intensive Care or Pain Medicine.

Anaesthetists form the largest single in-hospital medical specialty, and interact with two-thirds of all patients admitted to hospital. Anaesthetists, intensive care doctors, and pain specialists play a unique and valuable role in caring for acutely unwell patients throughout the hospital, with particular skills

that are important to all aspects of patient welfare. Whilst the perioperative anaesthetic care of the surgical patient is the core of specialty work (this includes wide variety of procedures performed by all types of surgeons, and some physicians), many anaesthetists have a wider scope of practice which may include:

- The preoperative preparation of surgical patients
- Pain relief in labour and obstetric anaesthesia
- Pre-hospital emergency care
- The resuscitation and stabilisation of patients in the Emergency Department
- Transport of acutely ill and injured patients
- Intensive care medicine
- Pain medicine including:
  - *The relief of post-operative pain*
  - *Acute pain medicine and the management of acute teams*
  - *Chronic and cancer pain management*



# The Intensivist

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An intensivist, the majority of whom in Ireland are also anaesthetists, is the doctor responsible for the care of the critically ill patient in the acute hospital setting. The intensivist leads the multi-disciplinary team of doctors, nurses and allied health professionals in the care of the critically ill patients admitted under their care to the Intensive Care Unit. They also provide a consultation service for their colleagues throughout the hospital and in the Emergency Department.

They provide complex therapies to these patients. Honest and open communication with patients and their families is an essential component of their competencies. They must also be cognisant of limits of therapy and end of life care of their patients. Their practice also encompasses the issue of organ donation in cases where brain death has occurred, where empathy and sensitivity are essential.

# The Pain Medicine Specialist

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Consultants in pain medicine, the majority of whom are also anaesthetists, function in the traditional consultant led model. Consultants in Pain Medicine have their own outpatients, theatre operating lists and admission rights. Consultants in Pain Medicine diagnose, manage and follow up patients with chronic painful conditions as well as caring for those at the end of their lives, frequently in conjunction with oncology and palliative care services.

Medications used to treat chronic painful conditions need to be carefully monitored and most medications have significant side effect profiles. Thus much of pain medicine treatment is theatre based interventional techniques which requires a specific skill set.

There are also recognized complications and the potential for permanent disability after neurodestructive techniques which focus attention on the decision to perform these techniques and the core issue of *patient consent*. This demands *effective communication* skills both with the patient and their families.

*Patient advocacy* is a core part of the Consultant in Pain Medicine's function. The Faculty of Pain Medicine has established links with patient advocacy groups such as

Chronic Pain Ireland and the Irish Patients Association.

*Research and education* is a crucial part of Pain Medicine as there is a growing understanding of the mechanisms of pain chronicity in vivo and a number of new immune based therapies about to enter clinical use.

The Consultant in Pain Medicine must demonstrate a high degree of partnership and collaboration to allow them to work with other medical and surgical specialties and healthcare professionals. They must also have specific communication skills to achieve consent from patients and surgical skills to perform complex interventions such as rhizotomy and neuromodulatory techniques as well as compassion for patients when cure is unlikely.

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*“The Consultant in Pain Medicine must demonstrate a high degree of partnership and collaboration to allow them to work with other medical and surgical specialties and healthcare professionals.”*

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# The Anaesthetic Department

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Anaesthesia is different to most hospital specialities in that it does not operate with an independent clinical unit lead by a consultant as its fundamental component. Instead, the majority of anaesthetists practice within a department, which essentially functions as an anaesthetic team. In most cases a designated head of anaesthesia services will be responsible for co-ordinating the activities in which the department is engaged, and usually serve as a focal point for communication with other clinical teams, and the organisation's administrative service. In some instances, the department will have a clinical director with defined bureaucratic responsibilities. While it is incumbent upon the individual anaesthetist to perform and behave according to professional standards, how a department is structured, and the atmosphere that pervades it, are particularly influential determinants of an anaesthetist's conduct.

In medical practice, effective team working reduces medical error and increases patient safety, and also leads to improved staff outcomes by reducing stress and improving job satisfaction. The culture of an individual anaesthetic department creates a set of (generally unacknowledged) rules, beliefs and attitudes that governs that department's perception of professionalism. This impacts upon how anaesthetists see their role within the hospital, and regard their obligations in respect of learning, teaching, and delivering a service. The departmental culture influences how its members interact and communicate with each other, with trainees, with other clinical teams, and with patients, and is a central factor in determining patient safety and outcomes. A department that fosters collegiality, civility and collective functioning, and overtly values training, reflective practice and good patient outcomes will thrive and maintain high-quality care. The converse results in a corrosive atmosphere that leads to low morale, diminished motivation, decreased job satisfaction, and disengagement by consultants and trainees. Professionalism in anaesthesia demands that individual practitioners strive to cultivate and promote a cohesive and effective departmental team.

An environment in which all team members are shown respect and courtesy is likely to have particular benefits.

- Firstly, it allows for better communication, particularly between trainees and consultants. A steeply hierarchical relationship leads to hesitancy in communication, with the possibility of insufficient information transfer and a consequent increased risk of error, adverse event and patient harm. Flattening the hierarchy allows all team members to have the confidence to speak up, and verbalise uncertainties.
- Secondly, anaesthetists are more likely to come forward and discuss mistakes, near misses and adverse outcomes in a supportive culture that regards such events as

occasions for departmental learning. The aim should be to encourage all members to participate in a compassionate, no-blame manner focused on harm reduction and the improvement of patient safety.

- Thirdly, a culture of respect encourages openness, and allows members of an anaesthetic department to have challenging discussions. Diversity of opinion and dissensus can be healthy, and critical analyses of performance and goals are drivers of success. Civility in discourse encourages both the delivery and acceptance of feedback as a mechanism of effective learning. In a respectful environment, feedback will be more frequent, specific, focused on behaviours rather than personalities, and more likely to be beneficial.
- Fourthly, departmental culture is a key determinant of whether individuals will be able to come forward and to seek help when needed. Like many doctors, anaesthetists have higher than average rates of mental health and substance abuse problems. Physical health issues may also impact upon an anaesthetist's capacity to perform complex technical tasks. Historically, there has been a tendency for departments to tacitly ignore such problems, and for individuals to mask them. A highly functioning department will encourage its members to seek help when needed, and be supportive of anaesthetists in difficulty. It is part of the professional duty of all doctors to acknowledge any health issues that impair their performance, and to seek appropriate advice and treatment. When an anaesthetist discloses health issues to the department, they should be treated compassionately and non-judgmentally, and the information considered confidential. If an anaesthetist appears to have impaired judgement or performance, and refuses to acknowledge this, it must be remembered that patient welfare remains the overriding consideration. Members of the department should consult with the relevant institutional structures and follow appropriate guidance.
- Finally, a department with a positive supportive culture will challenge, and be intolerant of unprofessional behaviours: of rudeness, discrimination, bullying or harassment. Acceptance of these behaviours creates a dysfunctional environment that negatively impacts on departmental performance and is particularly harmful to those on the receiving end. CAI regards bullying, discrimination and harassment to be completely unacceptable, and expects anaesthetic departments to foster an environment free of these behaviours.

# The Intensive Care Unit

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Intensive Care Medicine is an area where the majority of consultants in Ireland currently come from a background in anaesthesia. However, in line with international practice an increasing number of trainees from other disciplines are entering this career path. The principles outlined above pertain to all practitioners. The Intensive Care Unit is reliant on strong leadership and team work. It can be an area of high stress due to the complexity of patients presenting for admission, resource constraints and the need for staff to deal with difficult decisions in a vulnerable patient population. Intensive Care doctors must work with all specialties in the hospital and good communication and listening skills are essential. The three pillars of professionalism outlined below are essential to safe practice in Intensive Care Medicine.

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*“The Intensive Care Unit is reliant on strong leadership and team work. It can be an area of high stress due to the complexity of patients presenting for admission, resource constraints and the need for staff to deal with difficult decisions in a vulnerable patient population.”*

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# The Pain Medicine Team

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The Pain Medicine team is led by the Consultant in pain medicine and includes nurses trained and credentialed in Pain Medicine at the CNM or CNS level with clinical psychologists and physiotherapists as the core team members. Doctors training in pain medicine work in hospitals recognised for training in pain medicine alongside other healthcare professionals in training who are part of the Pain Medicine team. There is a close working relationship with other specialties including rheumatology, neurology, orthopaedic surgery, spine surgery, oncology and palliative care. A strong link exists between the general practice specialists and Pain Medicine. The three pillars of professionalism outlined are essential to safe practice in Pain Medicine.

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*“Doctors training in pain medicine work in hospitals recognised for training in pain medicine alongside other healthcare professionals in training who are part of the Pain Medicine team.”*

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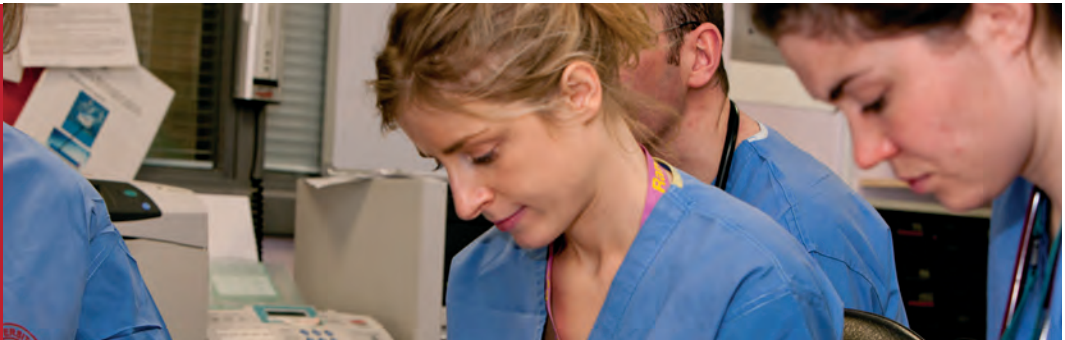
## PARTNERSHIP



## PRACTICE



## PERFORMANCE



# The Three Pillars of Professionalism: PARTNERSHIP, PRACTICE AND PERFORMANCE

Professionalism in anaesthesia, intensive care and pain medicine is essential to the wellbeing of patients. An anaesthetist, intensivist or pain medicine specialist who performs effectively as part of a clinical team can make a significant difference to the patient's experience in terms of preoperative anxiety, post-operative pain, recovery from surgery and survival of life threatening emergencies and critical illness. The Medical Council deploys the Pillars of Professionalism as a schematic to indicate ways in which the application of particular principles and values underpin good care. These principles and values are identified under three headings – Partnership, Practice and Performance.

# 1. Partnership

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Good care depends on doctors working in collaboration with patients, and other professionals. The Medical Council identify partnership as relying on:

## 1. Trust

(a) It is generally stated that the relationship between patients and doctors lies at the heart of medical practice, and that trust is a fundamental element of this relationship. Patients are more likely to trust their doctor if they perceive them to be competent, caring, honest and fair. Yet, in any relationship trust takes time to develop. In contrast to physicians or surgeons, who usually have a long-term relationship with patients, anaesthetists frequently have a very short period of time within which to interact, provide information, and establish a relationship with the patient. Contemporary health service delivery entails increasing numbers of day of surgery admissions, and so in many instances the anaesthetist may not meet the patient until shortly before the procedure. Thus, there is a challenge for anaesthetists in meeting their regulatory and legal obligations within a complex and pressured environment that often prioritises efficiency over other concerns.

It is here that the College of Anaesthetists (and individual departments) has a significant role to play, as it creates the conditions that allow the public to trust in the speciality of anaesthesia prior to any meeting between individual patient and anaesthetist. Such public confidence is sustained through

- rigorous training and assessment standards assuring competence
- a clear statement of professional values
- public engagement including the visible provision of relevant information aimed at advising and reassuring patients

However, this does not obviate the need for the individual anaesthetist to engage professionally and sympathetically with the patient, provide meaningful information, answer questions, and reassure where possible.

(b) Trust between anaesthetists and their colleagues is also essential for good professional practice. Integrity, mutual respect, effective communication and shared aims are important ingredients in delivering good patient care.



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## Intensive Care and Pain Medicine

The principles outlined above equally apply to doctors practising in Intensive Care and Pain Medicine, where the element of continuity of care over a longer period of time comes into play and more often than not a professional relationship with the patient's family members and advocates. Intensivists and Pain Medicine consultants must frequently interact with a wider range of other specialists and healthcare workers, so mutual respect, trust and effective communication are essential.

## 2. Working Together

- Anaesthetists, intensivists and pain medicine consultants work in a multidisciplinary environment and interact with a variety of healthcare specialties. Developing, and being a part of, a highly-functioning clinical team is an important part of professional identity, and is essential to the optimisation of patient outcomes. Patients expect this (not unreasonably), and generally anticipate that the healthcare team providing their operative, or intensive, treatment will collaborate to deliver safe and effective care.
- However, teamwork is complicated, and the healthcare professionals with whom anaesthetists and intensivists engage may have a plurality of knowledge, skills, experiences, attitudes and views. Disagreements occasionally arise, both about patient-centred matters and organisational issues.
- Resolution of divergences of opinion are best achieved through respectful dialogue that is focused on facts rather than emotion. Anaesthetists and intensivists are frequently well placed to have an objective perspective of matters relating to the care of individual patients, and indeed may have a particular role in safeguarding patients' welfare.<sup>1</sup> Any disagreement should be resolved with patient outcome, wellbeing and safety as the primary objectives.

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## 3. Good Communication

Effective communication is central to patient choice, autonomy, safety and outcome. It is also the key tool doctors have in order to protect themselves from future complaints. Excellence at communication is a core element of medical professionalism.

### (a) Anaesthetist-patient communication:

- Listen to patients.
- Provide honest and relevant information.
- Explain and advise on choice of technique where pertinent.
- Seek questions from patients, and respond to them in a comprehensive and comprehensible manner.
- Clearly document all of the discussion.

### (b) Anaesthetist-operating theatre team communication:

How communication takes place between healthcare personnel in the theatre environment is a key factor in a number of functions:

- Building and maintenance of team relationships and structures.
- Co-ordination of team tasks and performance.
- Exchange of important clinical information.

Effective communication between theatre staff is critical to the delivery of high-quality outcomes, especially in a complex setting. Conversely, communication deficiencies can lead to inadvertent error, and the risk of patient morbidity or mortality.

### (c) Anaesthetist-anaesthetist communication:

- Within the operating theatre or the intensive care unit, handover of patients from one anaesthetist to another is a common occurrence.
- Handover marks the transfer of clinical and legal responsibility for the patient from one professional to the other.
- The anaesthetist handing over should effectively transmit all relevant knowledge of the patient's perioperative care, and plans in respect of ongoing or future care, to the receiving anaesthetist.

Communication issues for intensivists and pain medicine specialists can be broadly divided into

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<sup>1</sup> See *The Lourdes Hospital Inquiry: Report of Judge Maureen Harding-Clark* (2006) pp336-7

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**(a) Intensivist to Intensive Care Nurse/ Pain Medicine Specialist to Pain Medicine CNM/CNS**

The intensive care nurse is a highly skilled member of the team and is providing one on one care to their patient and regular communications to the family. Their importance in the intensive care team cannot be overstated. The intensivist must give clear instruction, verbal and written on the care plan for the patient. The intensivist should also seek the input of the nursing staff to their decision making in care of the patient.

**(b) Intensivist/ Pain Medicine Specialist to Primary Team**

The intensivist / pain medicine specialist must communicate with the primary team on a regular basis. This avoids misunderstandings and reduces the potential for conflict. If a referral is deemed not for admission to intensive care this should be communicated to the team and documented in the medical record, with any recommendations on future care or review. In Pain Medicine, good communication between the primary care team and the hospital based doctor regarding diagnosis, treatment and medication management in particular is essential.

**(c) Intensivist/ Pain Medicine Specialist to Multi-disciplinary Team**

The complex nature of intensive care is such that input from many health care professionals is required to enable a successful outcome for the patient – for example radiology, laboratory medicine, microbiology, pharmacy, allied health professionals, psychological medicine and many other medical specialties. The intensivist must co-ordinate the care of the patient and communicate with all of these healthcare providers, ensuring safe, evidence based care always in the patient's best interest, even if that involves with-holding or withdrawing therapies.

The Pain Medicine team is led by the Consultant in pain medicine and includes nurses trained and credentialed in Pain Medicine at the CNM or CNS level with clinical psychologists and MSK physiotherapists as the core team members. Doctors training in pain medicine work in hospitals recognised for training in pain medicine alongside other healthcare professionals in training who are part of the Pain Medicine team. There is a close working relationship with other specialties including rheumatology, neurology, orthopaedic surgery, spine surgery, oncology and palliative care. Good communication is essential.

**(d) Intensivist/ Pain Medicine Specialist to Patient**

Two-way communication with a critically ill patient in the intensive care setting may be difficult, but every effort to communicate with the patient who is often undergoing difficult treatments in an alien and challenging environment. Even heavily sedated patients can hear and recall conversations, so conversation at the bedside should always be respectful of this. In Pain Medicine there can be recognised complication to treatment and the potential for permanent disability after neurodestructive techniques which focus attention on the decision to perform these techniques and the core issue of patient consent. This demands effective communication skills both with the patient and their families.

**(e) Intensivist/ Pain Medicine Specialist to Family and Patient Advocates**

More often than not the intensivist is communicating with the patient's family, next of kin or advocate, to keep them informed of the patient's condition and planned treatments. Admissions to the intensive care are often emergent and it may not be clear whether the patient has indicated with whom information may be shared. The intensivist must respect the sometimes difficult balance between the patient's right to confidentiality and the need to communicate to others on critical issues while in intensive care.

Patient advocacy is a core part of the Consultant in Pain Medicine's function. The Faculty of Pain Medicine has established links with patient advocacy groups such as Chronic Pain Ireland and the Irish Patients Association.

## 4. Advocacy

- Anaesthetists, Intensivists and Pain medicine consultants have an obligation to advocate for the patients to whom they provide care. In the case of intensive care or pain management, this may include advocating for specific treatments for a particular patient who is disadvantaged by the absence of the relevant treatment.
- Advocating for patients also entails raising concerns where either the environment or staffing levels place patient safety at risk.

## 2. Practice

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This describes the behaviour and values that support good care. It relies on putting the interests and well-being of patients first. The main elements of good practice are:

### 1. Caring when treating patients

- Patients should be treated as individuals, and the anaesthetic plan must take into account the will and preferences of the particular patient.<sup>2</sup>
- The operating theatre is a complex technological environment that is understandably focused on the efficient performance of procedures. Within this busy space it is possible for staff to become inadvertently neglectful of the needs of anxious and vulnerable awake patients. It is important to remember that the patient is more than the subject of the next operation, and care should be taken to be as attentive as possible to their very human stresses.
- Patient-centred care also entails respect for a patients' dignity and modesty. Patients' bodies are often exposed within the operating theatre, and healthcare professionals (including anaesthetists, intensivists and pain medicine specialists) should ensure that this exposure is only to the degree, and for as long, as is medically necessary.
- Issues of dignity, modesty and confidentiality extend to the recovery or post-anaesthesia care unit (PACU) and intensive care units. The PACU usually contains many patients who can witness the treatment of another patient.
- Anaesthetists should be cognisant of their obligations to act professionally within this environment.

### 2. Promoting Patient Safety

Advancing patient safety is an important element of anaesthesia and intensive care medicine training and practice. Because of this, anaesthetists and intensivists are often invited to play a central role in hospital safety and quality initiatives.

- In practice, there is sometimes a gap in respect of patient safety between what represents an ideal situation and what it is possible to deliver in particular circumstances. The goal of anaesthetists and intensivists should be to reduce this gap by aiming to reliably deliver best practice

care. Efforts to improve anaesthesia safety and safety in critical care involve identifying and analysing the human or structural factors that lead to such safety deficits, and devising strategies to address these. Anaesthetists and intensivists may have to take a lead role in communicating with, and engagement of, the other members of the multidisciplinary team in this process. The successful implementation of effective safety procedures can have far-reaching consequences for patient care.

- Medical errors are unfortunately inevitable in complex healthcare systems. These can result from personal, personnel, institutional and organisational factors. There are a number of published strategies aimed at minimising the occurrence of mistakes that departments, and individual anaesthetists and intensivists, can employ in practice. Anaesthetists, intensivists and pain medicine specialists should be familiar with the evidence-based patient-safety literature.
- Risk management can also present a challenge for anaesthetists, particularly where a proposed procedure poses significant and identifiable hazards to the patient. In this instance it is important that the patient, and the multidisciplinary team, understand the risks involved so that choices are informed, and plans can be put in place to minimise and manage any adverse outcomes.
- Should a mistake or adverse event occur, the organisational culture of the anaesthetic department should make practitioners feel safe to report their error, with subsequent analysis aimed at improving safety rather than blaming individuals.
- When a significant adverse event does occur, doctors have a duty to communicate with the affected patient (and/or the patient's family in some circumstances) in an open and honest manner. The discussion should contain an acknowledgment and explanation of the event, and the doctor should apologise, where appropriate. This is a sympathetic expression of regret for what has happened to the patient, and does not constitute an admission of liability or fault, nor is it admissible in legal proceedings.<sup>3</sup>
- Anaesthetists, intensivists and pain medicine specialists who are under investigation in respect of an adverse event should be supported by their colleagues. Being the subject of an investigatory or disciplinary process is an emotionally and psychologically challenging situation, the harm of which can be significantly mitigated through collegiality.

<sup>2</sup> This includes cases where a patient's capacity may be in doubt. The *Assisted Decision Making Act*, 2015 has replaced the 'best interests' paradigm with the 'will and preferences' of the patient. This is in order to ensure respect for the wishes and choices of all individuals, whenever possible.

<sup>3</sup> *Civil Liability (Amendment) Act* 2017, s10.





### 3. Self-Care

- Anaesthesia, Intensive Care and Pain Medicine can be challenging professions, with a variety of stressors that may impact upon the mental and physical health of the practitioner. Several, such as lacking control over one's working environment, and operating to the schedule of others (which may lead to irregular and unpredictable breaks and overtime hours) can have an insidious impact upon mental wellbeing.
- The role of the anaesthetist, which can vary from long periods of watchfulness punctuated by precise, technically demanding procedures, to occasional crisis situations, is itself both fulfilling and taxing. The fear of "getting something wrong" and harming the patient is a very real worry for many anaesthetists, as mistakes in anaesthesia may have significant adverse consequences. This concern is augmented by the perception of the current regulatory framework as being excessively intrusive and punitive.
- The intensivist and pain medicine specialist has many of the concerns outlined above and is also faced with complex decisions on a daily basis in an environment of resource constraints. They may also have to contend with unrealistic expectations of families in hopeless situations, engendered by popular culture. There may also be conflicting medical opinions to work through.

- Thus, there is a real need for doctors to mind their physical and mental health. This is both for their own wellbeing, and so that they are able to care for patients effectively. There are many routes to achieving this that are beyond the scope of this document, but doctors should seek independent advice, treatment or counselling if their health is threatened or affected. It is particularly important that professionals recognise times of especially high stress (e.g. examinations, critical incidents, personal relationship issues, etc..) and ensure sufficient support from others. Doctors are entitled to good care and support from their colleagues and employers when they suffer ill-health.

### 4. Practice Management

While much of anaesthetic practice is focused upon technical skills, non-technical aspects have become increasingly important elements of anaesthesia care, in particular verbal or written communication. While the same tenets apply to critical care the importance of the non-technical skills comes to the fore in dealing with the patient, families and the multi-disciplinary teams often for prolonged periods of time. Regular formal updates for the patient, where feasible, and their families, are essential in this complex environment.

- Handover to another anaesthetist or healthcare professional should transmit all relevant data in a structured manner that protects the patient from potential harms that may be caused through information omission.
- The anaesthetic sheet is both a contemporaneous record of perioperative events, and a clinical account that may be useful to other clinicians. This may be during that particular hospital stay, but it will certainly be of utility to the next anaesthetist to meet the patient. As such, the anaesthetic record should provide an accurate, comprehensive, legible and intelligible report of the patient's course before, during and after anaesthesia. Such records, including the core medical record, are also the single most useful tool that a doctor can deploy in his/her defence in the event of a subsequent complaint.
- Anaesthetists, intensivists and pain medicine specialists should endeavour to ensure that structural practice issues, such as the organisation of rotas and cover arrangements, are fairly and transparently arranged, and support good patient care.
- Where institutional or organisational impediments to appropriate cover threaten safe patient care, anaesthetists, intensivists and pain medicine specialists should raise their concerns at the relevant administrative level. It is prudent to retain documentation of all such exchanges.

## 5. Confidentiality

Patient confidentiality is one of the fundamental tenets of medical ethics, and its observance is essential to public trust in the profession. The occasions when confidentiality can legitimately be breached are covered in *The Guide* (pp25-7).

- The use of patient information is currently covered by Ireland's *Data Protection Act*, which will be replaced in May 2018 by the *European General Data Protection Regulation*.
- Doctors who retain patient information for logbook, research or other clinical purposes should be aware of their data protection responsibilities under the new regulations.
- Specifically, anaesthetists, intensivists and pain medicine specialists should only retain and process patient information where it is essential to do so. Data should preferentially be stored within the healthcare environment from which it has been acquired. Any stored data must be protected. If on a device moved outside of the relevant institution, it must be protected in a manner such that if the device storing the data is lost or stolen, the data will be inaccessible to others.

- Many doctors now share clinical data via social media platforms. This should only be for legitimate clinical, educational or approved research purposes. Doctors should be conscious of the security limitations of these platforms, and appropriately anonymise clinical information.
- Any identifiable patient data shared with non-treating clinicians requires patient consent.

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*“Patient confidentiality is one of the fundamental tenets of medical ethics, and its observance is essential to public trust in the profession.”*

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## 6. Integrity & Conflict of Interest

Integrity is generally held to refer to clinician honesty and truthfulness.

- However, values such as dependability, punctuality, attention to executing tasks and delivering high quality care, shared problem solving, and helping a colleague, are all implicit elements of professional integrity.
- Integrity also entails non-discrimination. Patients should be treated according to medical need. The private insurance or public status of a patient should have no impact upon the anaesthetic care that a patient receives.
- Research misconduct has been a serious problem in medicine, and has harmed the lives and possibly caused the deaths of patients. Anaesthetists, intensivists and pain medicine specialists who engage in research should commit to the highest standards of integrity in carrying out their work. The European Code of Conduct for Research Integrity specifies a number of basic principles that underpin good practice in research. These include honesty, reliability and objectivity in describing research goals, intentions, methods, and findings, and in the communication of outcomes. Research integrity includes the:
  - Conception and carrying out of research in accordance with ethical norms.
  - Avoidance of data fabrication, manipulation, substitution or hiding.
  - Avoidance of plagiarism.
  - Avoidance of guest authorship.

# 3. Performance

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This describes the behaviours and processes that provide the foundation for good care. *Performance* depends on:

## 1. Competence

- Doctors develop competence through training under supervision, when they acquire clinical, technical and non-technical knowledge, skills and behaviours.
- Professional competence also involves acquiring new skills and maintaining established ones across a professional lifetime. A key element of this is the continued participation in targeted education. Since 2011, doctors are legally obliged to maintain their professional competence by enrolling in an appropriate professional competence scheme. The CAI operates a scheme (on behalf of the Medical Council) which supports a formal process of lifelong learning for anaesthetists that is centred on professional practice, patient safety and the quality of patient care. Continuing education allows doctors to base their practice on up-to-date evidence (as far as it is available), and understand the limits of their knowledge and capabilities.
- Participation in the Professional Competence Scheme helps registered anaesthetists, intensivists and pain medicine specialists demonstrate that they are fulfilling their statutory duty, and reassure the public of their ongoing commitment to professional excellence.

## 2. Reflective Practice:

Reflection is considered an essential component of lifelong self-learning.

- Reflecting on issues such as performance, teamwork and professional values is important in improving standards of care. Although traditionally thought of as an individual, personal process, small group sessions reflecting on individual and team functioning are also valuable.
- *Reflection on action* is the commonest form of reflective practice and involves an analysis of the experiences, actions, interactions and emotions related to a particular event. This in-depth examination considers individual and team performance across a range of parameters, and can stimulate new, or reinforce existing, practices. The process can assist in the recognition of areas of practice where further training might be of benefit, where there are institutional or organisational deficits that need to be remedied, and where quality improvement initiatives may improve patient care.



- Reflective practice is also of value in considering a variety of personal or non-technical issues such as ethical, communication or interpersonal challenges. It is important to recognise the benefits of reflecting upon things that went well, in addition to negative events.

## 3. Teaching and Training

These are clearly essential to the ongoing education of all doctors, and necessary for the provision of good care into the future.

- All anaesthetists should be willing to provide formal or informal teaching to those who are junior to them, or to other groups of healthcare professionals or students who may have an interest in anaesthesia.
- An effective educational process and supervision of clinical experience allows trainees to learn to provide good patient care in a safe environment.

## 4. Acting as Role Models

The most important determinants of a doctor's professional identity come not from what they are taught through didactic teaching, but from how they see those who act as their trainers, supervisors and mentors behaving. Thus, while a formal anaesthetic curriculum can attempt to inculcate various important values and attributes, professionalism is more effectively transmitted through the attitudes and conduct of other doctors. Anaesthetists, intensivists and pain medicine consultants thus act as role models for their peers, trainees, medical students and other healthcare professionals, and should be aware of the impact of their behaviour.



# FINAL THOUGHTS

This document is not exhaustive and only touches upon some of the aspects of professionalism that are pertinent to anaesthesia, intensive care and pain medicine. Trainees, fellows and other interested parties are encouraged to read and critically review it in light of contemporary anaesthetic practice. One purpose of this guide is to stimulate and promote reflection, so that practitioners might identify particular personal needs for professional development and education. A second is to encourage peer groups or departments to consider how they might develop standardised or consistent approaches to professional issues. A third is to foster the concept of teamwork, and the value that may be derived from enhancing relationships within and across departments, specialties and professions. Finally, it is hoped that the document will serve as a framework through which doctors can understand the regulatory requirements and social expectations of their role.



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# Acknowledgements

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The College of Anaesthetists of Ireland would like to recognise the contribution of Council and all of our fellows to the debate on Professionalism. In particular, we would like to thank:

- Professor Kevin Carson, President
- Dr Anne Hennessy, Vice President & Chairperson Examinations Committee
- Dr Brian Kinirons, Honorary Secretary
- Dr Kevin Clarkson, Honorary Treasurer
- Professor Donal Buggy, Chairperson Professional Development Committee
- Professor Gerry Fitzpatrick, Chairperson Quality and Safety Advisory Committee
- Professor David Honan, Chairperson, PCS committee
- Dr Brian O'Brien, Chairperson Training Committee
- Dr Rory Page, Hospital Accreditation
- Dr Miriam Langdon, Chairperson Communications and IT Committee
- Dr Pádraig Sheeran, Deputy Chairperson, Examinations Committee
- Dr Ehtesham Khan, Chairperson National Clinical Programme of Anaesthesia & IMGTI Cultural Liaison
- Dr Calathur Nanda Kumar, Alumni Forum
- Dr Jeanne Moriarty, Dean of JFICMI
- Professor Connail Mc Crory, Dean of Faculty of Pain Medicine
- Dr Kevin Bailey, Convener Irish Standing Committee, AAGBI
- Dr Camillus Power, Interim Director of Training
- Mr Martin Mc Cormack, Chief Executive Officer
- Ms Margaret Jenkinson, Chief Operations Officer.

In addition, we would like to recognise the particular contribution of Professor Barry Lyons, Professional Development Committee Member who drafted the initial document.

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