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Self-awareness and professionalism

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

The GP curriculum and self-awareness and professionalism

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

- Demonstrating the attitudes and behaviours expected of a good doctor
- Managing the factors that influence your performance

Maintaining an ethical approach:

- Treating others fairly and with respect, acting without discrimination
- Providing care with compassion and kindness

Communication and consultation:

- Establishing an effective partnership with patients
- Maintaining a continuing relationship with patients, carers and families

Professionalism, broadly speaking, is the knowledge, skills and attitudes expected of any given professional. It implies not only standards of technical competency, but also expectations regarding values and beliefs. Although there is no overarching definition of medical professionalism that is universally agreed upon (Birden et al., 2014), there is some evidence that professionalism can be developed through role-modelling and reflection (Birden et al., 2013). Understanding where you need to be is only part of an educational journey; you also need to understand where you are in order to be able to obtain a sense of direction.

There are potential concrete benefits to professional self-awareness as well. Given the plurality of world-view among doctors and society at large, self-awareness in the context of professionalism can offer a way of recognising, understanding and reconciling difficulties and conflicts in practice. A lack of self-awareness may lead to a failure to notice when ideals and values become compromised. It may also lead to failure to understand distress caused by external pressures to behave in ways that are inconsistent with beliefs and values (Riley, Haynes, & Field, 2007).

This article offers an approach to professional self-awareness through a set of four questions:

- What are my goals?
- What are my beliefs?
- What are my values?
- What is my condition?

I suggest that these questions could form the starting point for self-awareness, whether in a trainee's group, a mentoring session or for an appraisal. These questions are not intended to replace well-established tools for reflecting on particular experiences, only to group those aspects of 'self' which have a bearing on

professionalism. Two 'reflective tools' in circulation (see Box 1) are the 'Kolb Cycle' (Kolb, 1984) and the 'Three Whats' (Driscoll, 2007).

Box 1. The Kolb Cycle and the three 'Whats' in relation to professional self-awareness.

The Kolb Cycle (1984) and the Discroll (2007) 'three Whats' consist of three stages that follow on from each-other:

- 'Concrete experience', which corresponds to Discroll's 'What Happened?'; this leads onto . . .
- 'Abstract conceptualisation', which corresponds (very broadly) to Discroll's 'So what?'; this leads onto . . .
- 'Active experimentation', which corresponds to Discrolls, 'What should I do now?'; this will hopefully lead to new concrete experiences and further 'Whats'

The following questions clearly relate to 'abstract conceptualisation' or 'So what?', but are arguably broader than any one experience:

- What are my goals? Every profession aims to do something and do it well
- What are my beliefs? That is, about anything that relates to professional life
- What are my values? And how do they affect what we do?
- What is my condition? That is, physical and emotional; intellectual and moral

What are your goals?

What are your goals as a professional? Are they in alignment with those of society, the government, the healthcare service, your profession, or your institution/practice? Are your goals realistic and sustainable?

Consider the goals of medicine and society. In 1948, the World Health Organisation made the claim that health is a 'State of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. By this definition, few if any will achieve 'health', and doctors will fail to deliver health based on this definition. Although aspirational goals for medical science are important, goals for practitioners need to be more realistic. In turn, patients may have unrealistic expectations of what medicine can offer. By contrast, the General Medical Council (GMC) offers 'Good Medical Practice' to outline the duties of doctors (including GPs) in the UK. Patients can expect doctors to practise according to the duties enshrined in 'Good Medical Practice'. If your goals clash with the duties enshrined in 'Good Medical Practice' you may be in the wrong job.

Consider the goals of your workplace. Culturally, medicine and its allied professions have a tendency to value perfectionism and excellence in the workplace (a lot has certainly been written about it, for example, '*Irondoc*' by Mamta Gautam (2011)). Healthcare workers learn that 'good enough' is not 'excellent' and that anything less than excellent is not good enough. Induction into the medical world can distort understanding of what duty means, and instill the idea that 'going the extra mile' is normal practice. In a framework of perfectionism there is no distinction between what is required and what is beyond requirement and optional (Tessman, 2015). The NHS in the UK has allowed some room for the values-based and vocationally-driven culture to flourish, but discussion about the enlarging 'credibility gap' between rhetoric and reality in clinical care provision (Heath, 2008) leads us to acknowledge a potentially limitless need and demand for healthcare provision in the primary care setting (McKenzie-Edwards, 2017).

Consider what informs your goals. Are they set by you or by others? Beliefs may be important, for example, beliefs about life and death, the effectiveness of Western medicine, and the value of the NHS. Values may be important, and goals may hinge on how we define good: is saving lives or treating pain better? Using acronyms such as SMART (Specific, Measurable, Acheievable, Realistic and Time-limited) can help us select acheivable goals and keep track of how we are doing. We have to take stock of our human condition if goals are to be realistic. Finally, how fit, broadly speaking, are you to pursue your goals, and what is the effect of not being able to fulfil them?

What are your beliefs?

All doctors in the UK have a professional obligation not to allow their own values and beliefs to prejudice their work. The GMC offers extensive guidance for UK doctors on not allowing doctors' values and beliefs to prejudice their work (GMC, 2013). 'Beliefs' are usually interpreted as religious beliefs. However, there are other relevant beliefs that influence people. These include scientific beliefs, health beliefs and political beliefs. Although these kinds of beliefs may be based on some form of evidential truth, the history of science and politics teaches us that the influences can be more complicated.

What are your religious beliefs? What do the beliefs that you hold imply? For example, if you believe that human life is sacred from the point of conception, then it is wrong to act in a way which ends the life of an embryo or foetus. If you have no religious beliefs, how do you reconcile this with the religious beliefs of colleagues and patients when they impact on a particular aspect of work? Savulescu (2006) argues that doctors should have no right of conscientious objection to

evidence-based treatments that the state has agreed to provide. However, GPs in the UK are legally permitted to conscientiously object to participation in specified treatments, such as termination of pregnancy, unless this will put the patient at risk of significant harm.

What are your beliefs about science? If you believe that only evidence-based treatments should be provided to patients – do you evaluate your own evidence or rely on others? Links (2006) argues in a *BMJ* article that doctors' use of medical knowledge bears many similarities to the reading of religious texts. We take our evidence-based knowledge summaries and textbooks on faith. Beliefs about science may also give rise to conscientious objection. Do your beliefs about evidence-based medicine mean that you object to providing NHS treatments with poor evidence of benefit? Do the same beliefs mean that you refuse to be complicit in private treatment by complementary and alternative practitioners?

What are your beliefs about health? A surprising lack of thought is given to the idea that the question: 'What is good health?' depends upon the answer to the question: 'What is health?' (Misselbrook, 2016; Owens, 2012). A basic exploration of what we mean by health can be useful. For example, some healthcare interventions may restore physical function or correct a biochemical anomaly, but not contribute to meaningful health for a patient. Other treatments might be arguably mutilating or physically harmful, but enable better overall health.

Political beliefs might include a belief in the power of competition to motivate good practice, or a belief that only UK citizens have a right to NHS treatment, free at the point of use. Do you have any political beliefs? How might they affect your practice? And how should your understanding of general practice influence your political beliefs and engagement with national and local politics? In his James Mackenzie lecture to the RCGP Martin Marshall has suggested that: 'General practice has a long track record of crying foul and then simply carrying on delivering the goods' when unwelcome changes to practice are instigated by politicians (Marshall, 2009).

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

What are your values?

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

Virtue ethics are often attributed to the ancient Greek philosopher Aristotle, virtue ethics are popular with healthcare educators because virtue ethicists ask the question: 'How should I live?' rather than: 'What should I do?' This idea gives rise to the characteristics of a healthcare professional such as honesty, trustworthiness, compassion and diligence. Aristotle argued that virtues were a balance of extremes. Thus, courage was at a perfect point between recklessness and cowardice. How might you use this idea to describe compassion? This is especially pertinent in the NHS today. Following the Mid Staffordshire healthcare scandal in the UK, there has been much public discussion on what compassion means in healthcare and whether it is possible in pressured healthcare settings (Charlton, 2015; Hordern, 2013; Smajdor, 2013).

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

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

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

Consider whether you intuitively favour any of the above approaches, or appear to favour some or all of them. Educational materials may offer a toolkit of ethical

approaches (Gillies, 2009). Dilemmas are sometimes the result of a conflict between different ways of deciding what is good. For example, sometimes following the rules will result in harm and sometimes we are tempted to break rules in the name of kindness (a virtue) or beneficence.

What is your condition?

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

What is your physical condition?

The Medical Protection Society (2016) advises:

> Always be mindful of how human factors can affect your performance. Remember the 'HALT' mnemonic (hungry, angry, late, tired); where possible anticipate these factors and take action to mitigate their impact. Where they are unexpected then be prepared to seek the opinion of your colleagues or bring patients back at the earliest opportunity to fully address their needs.

The point here is that adverse 'human factors' are often unanticipated or unexpected. A variety of online self-help resources for the general public replace 'late' with 'lonely'. A feeling of loneliness or disconnection can be profoundly distressing; not only is there no-one who can help but no one who can act as a witness. Samuel Shem, author of '*The House of God*', the classic novel about life as a newly qualified doctor, has since talked of the 'healing power of good connection' (Martin, 2016).

Whether you see your emotional state as continuous with physical symptoms, like hunger and tiredness, or separately, these also are part of your condition. Clinical encounters are emotionally-charged situations, but we are expected to display professional detachment so that emotions do not compromise our usefulness. Not engaging with emotions, Kerasidou and Horn (2016) argue, has a negative effect on doctors, increasing stress and anxiety and predisposing them to emotional burnout and mental suffering. It also prevents doctors from caring for their patients effectively and appropriately. A balanced approach is clearly needed.

What is your intellectual condition?

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

What is your moral condition?

This is distinct from the question: 'What are your values?' Jameton first coined the term moral distress to capture the inability of nurses to act on what they believed to be the right thing to do because of institutional constraints (Jameton, 1984). Jameton's definition has been widely used in nursing and healthcare and emphasises institutional and external constraints on the ability of nurses to practice ethically. Since then, the phenomenon has been further described in a variety of healthcare disciplines. Moral distress has been clarified as distress as a consequence of internal (personal) or external (institutional) factors preventing someone from acting in accordance with their core values. This is distinguished from psychological distress, which does not cause a violation of personal values, for example, when working harder and rationing time during a colleague's sickness absence. The term 'moral residue' is used to discuss a feeling of distress experienced some time after personal values have been compromised (Epstein and Hamric, 2009). If you are suffering from moral distress a re-evaluation of your goals, beliefs, values and condition may be warranted. One outcome of such an evaluation may be the realisation that the sources of moral distress are irreconcilable or external; it may not be you that needs to change but your job. Are you in the right job and are you in the right profession? Sometimes the question needs to be asked, and this is not easy, especially as a career involves considerable financial and physical investment. By the time someone asks the question they may have financial debts to pay and family depending on their income.

Conclusions

Self-awareness and professionalism are important for good medical practice and critical to the completion of ePortfolio reflections and appraisals. Fitness to practice comprises sufficient health, sufficient competence and an appropriate set of attitudes to work, to influence patients

and share decision-making. Considering the four questions is an approach to developing the self-awareness that is integral to professionalism.

Key points

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

References and further information

- Birden, H., Glass, N., Wilson, I., Harrison, M., Usherwood, T., & Nass, D. (2013). Teaching professionalism in medical education:A Best Evidence Medical Education (BEME) systematic review. BEME guide mo. 25. *Medical Teacher*, *35*(7), e1252–e1266. doi: 10.3109/0142159X.2013.789132
- Birden, H., Glass, N., Wilson, I., Harrison, M., Usherwood, T., & Nass, D. (2014). Defining professionalism in medical education: A systematic review. *Medical Teacher*, *36*(1), 47–61. doi: 10.3109/0142159X.2014.850154
- Charlton, R. (Ed.). (2015). *Compassion continuity and caring in the NHS*. London, UK: RCGP
- Dicker, A. (2007). Should doctors observe a moral duty to care for themselves?. Bowman D., & Spicer J. (eds) (2007). *Primary care ethics*. Oxford, UK: Radcliffe Publishing, pp.137–147
- Dicker, A. (2011). Professional development. Hutt P., & Park S. (eds) (2011). *A career companion to becoming a GP*. Abingdon, UK: Radcliffe Press, pp.103–111
- Driscoll, J. J. (2007). Supported reflective learning: The essence of clinical supervision? In *Practising clinical supervision: A reflective approach for healthcare professionals, second edition*. London: Bailliere Tindall, pp.27–50
- Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *The Journal of Clinical Ethics*, *20*(4), 330–342
- Gautam, M. (2011). Irondoc: Practical stress management tools for physicians, second edition. Ottawa, Canada: Partner Publishing
- Gillies, J. (2009). Ethics in primary care: Theory and practice. *InnovAIT*, *2*(3), 183–190. doi: 10.1093/innovait/inn189
- GMC. (2013). Personal beliefs and medical practice. Retrieved from www.gmc-uk.org/guidance/ethical_guidance/21171.asp
- Heath, I. (2008). *Matters of life and death: Key writings*. Oxford, UK: Radcliffe Publishing, p.94
- Hordern, J. (2013). What's wrong with 'compassion'? Towards a political, philosophical and theological context. *Clinical Ethics*, *8*(4), 91–97. doi: 10.1177/1477750913502613
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice Hall
- Kerasidou, A., & Horn, R. (2016). Making space for empathy: Supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics*, *17*, 8. doi: 10.1186/s12910-016-0091-7
- Kolb, D. (1984). Experiential learning: Experience as the source of learning and development. Upper Saddle River, NJ: Prentice-Hall
- Links, M. (2006). Analogies between reading of medical and religious texts. *BMJ, 333*, 1068–1070
- Marshall, M. (2009). Practice, politics and possibilities. *British Journal of General Practice*, *59*(565), e273–e282. doi: 10.3399/bjgp09X420266
- Martin, A. (2016). The Royal Society of Medicine open section's medical humanities conference: Physician resilience and compassionate practice. *London Journal of Primary Care*, *8*(1), 10–11. doi: 10.1080/17571472.2015.1135652
- McKenzie-Edwards, E. (2017). Professional self care in primary care practice – An ethical puzzle. Papanikitas A., & Spicer J. (eds) (2017). *A handbook of primary care ethics*. Abingdon, UK: CRC Press
- Medical Protection Society. (2016). Skipping over the details. Retrieved from www.medicalprotection.org/uk/resources/case-reports/case-reports/uk-skipping-over-the-details
- Misselbrook, D. (2016). Aristotle, Hume and the goals of medicine. *Journal of Evaluation in Clinical Practice*, *22*(4), 544–549. doi: 10.1111/jep.12371
- Neighbour, R. (2007). Checkpoint 3 (Handover): Communication skills. In *The inner consultation, second edition* (pp.176–201). Oxford, UK: Radcliffe Publishing
- Owens, J. (2012). Creating a patient-led NHS: Some ethical and epistemological challenges. *London Journal of Primary Care* (*Abingdon*), *4*(2), 138–143
- RCGP. Core statement 1: Being a GP. Retrieved from www.rcgp.org.uk/training-exams/gp-curriculum-overview/online-curriculum/1-being-a-gp.aspx
- Riley, B., Haynes, J., & Field, S. (2007). Essential feature 2 - attitudinal aspects. In *The condensed curriculum guide for GP training and the new MRCGP* (pp. 114–115). London, UK: RCGP
- Savulescu, J. (2006). Conscientious objection in medicine. *BMJ*, *332*(7536), 294–297. doi: 10.1136/bmj.332.7536.294

- Smajdor, A. (2013). Reification and compassion in medicine: A tale of two systems. *Clinical Ethics*, *8*(4), 111–118. doi: 10.1177/1477750913502620
- Tessman, L. (2015). *Moral failure: On the impossible demands of morality*. Oxford, UK: Oxford University Press, pp.221–252

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AKT question relating to ethical issues in genetic medicine

Single Best Answer

The General Medical Council (GMC) offers professional guidance on the disclosure of information to the relatives of patients with genetic conditions without the patients' consent. Which statement best incorporates this advice?

Which SNGLE option is MOST appropriate? Select ONE option only.

A. 'Even if you feel the at-risk relative could have inherited a genetic condition, you must not disclose this information if the patient specifically forbids you from doing so'
B. 'If a patient refuses consent to disclosure [to at-risk relatives], you will need to balance your duty to make the care of your patient your first concern against your duty to help protect the other person from serious harm'
C. 'If the at-risk relative is your patient as well, you can disclose genetic information without the patient's consent because you have a duty of care towards the at-risk relative too'
D. 'If you are aware that the at-risk relative could have inherited a genetic condition, you have a duty to tell them regardless of the patient's wishes'
E. 'The patient does not have any legal standing in disclosure of genetic information and consent can be overruled by a clinician for the safety of the at-risk relative'

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