Professionalism Team
435

Revised by
خولة العماري & هشام الغفيلي

PROFESSIONALISM

All Summaries in One File

Team members:	Color index:	Important links:
- Nouf Altwaijri - Luluh Alzeghayer - Malak Alsharif	- Important. - Extra note.	- Correction file. - Quizzes file. - Lectures file (revised).

Lecture 1: Introduction & Key Elements

Important notes:

- Although there are common key elements in the definition of professionalism that must be fulfilled, the definition might vary depending on culture, law and community needs.
- Professional Values (Six Columns of the building) are: Excellence, Humanism, Respect, Accountability, Altruism and Integrity.
- Key bases of professionalism (Four steps of the building): Ethical and Legal Boundaries, Communication and Interpersonal Skills, Continuous Learning and Self Development, and Clinical Competence (Knowledge and Skills)

Summary:

❖ **Profession:**
Is the conduct, aims, or qualities that characterize a person in a work setting or profession

❖ **Professionalism:**
Constituting those attitude and behaviors that serve to maintain patient interest above physician self-interest.

❖ **Professionalism has three main characteristics:**
Individual , Interpersonal and Societal.

❖ **Professionalism in Medicine:**
Professionalism embodies the relationship between medicine and society as it forms the basis of patient –physician trust. It attempts to make tangible certain attitudes, behaviors, and characteristics that are desirable among the medical profession.

Why professionalism is important?

Medical professionalism sets out three principles: ethical principles, knowledge and skills & selflessness.

- Being productive.
- Effective management of relationships.
- Handling conflicts.
- Being an ambassador.
- Being mission-minded.
- Being able to know and avoid the unprofessional behavior.

❖ **Key elements Of Professionalism:**

- Excellence. - Humanism. - Respect. - Accountability. - Altruism.
- Integrity.

❖ **Bases of Professionalism:**

- Ethical and Legal Boundaries.
- Communication and Interpersonal Skills.
- Continuous Learning and Self Development.
- Clinical Competence (Knowledge and Skills).

2: Accountability, Altruism & Integrity

❖ **Discuss the meaning and the key components of Accountability.**

Definition: "…Procedures and processes by which one party justifies and takes responsibility for its activities"

Key components:

1. Responsibility
2. Self-regulation in activities
3. Standard setting for current and future members of the profession
4. Ability to resolve conflict (financial, ethical, moral, pharmaceutical etc).
5. Free acceptance of duty to serve public
6. Explain and give reasons for actions that could have caused harm to the patient, colleagues, and community

❖ **Discuss the place of accountability in professionalism.**

It comprises responsibilities to patients, patient-physician relationship, colleagues, profession, society and public.

❖ **Explain why Accountability is needed in the medical profession.**

1. Providing optimal health care services.
2. Enables continuing improvements.
3. Helps in protecting the rights of patients.
4. Resolving conflicts.
5. Building trust, and ensuring that the workplace environment is safe and healthy.
6. Reflects behavior and attitude of responsible people.

❖ **Discuss the meaning and key components of Altruism and Integrity.**

Altruism:

Definition: to put the duty and patient care ahead of your own needs.

Key components:

- Donate time to humanitarian causes.
- Help or treat patients who are poor or cannot afford the costs of the service.
- Going beyond the call of duty to help patients.
- Show selfless behavior and the willingness to serve others, particularly those in need.
- Unselfish concern for the welfare of others.
- Subordinate your own interest to the interest of others.

Integrity:

Definition: Latin adjective "integer" meaning the inner sense of "wholeness" as represented by a number of values such as honesty, trustworthy, fairness, and no favoritism. Integrity is about demonstrating that the values you hold you are applying in your day-to-day practice.

Key components:

1. Highest standards of behavior.
2. Refusal to violate one's personal professional codes.
3. Being fair, honest and truthful.
4. Keeping one's word.
5. Avoidance of relationships that allow personal gain to supersede the best interest of patients.
6. Not working in the darkness or involved in any behavior that aims at harming others or taking their rights without their knowledge.

❖ Interpret some practical examples about Accountability, Altruism and Integrity. (examples from lecture 1)

Accountability:

1) Accept responsibility.
2) Always consider confidentiality.
3) Work on resolving conflicts.
4) Avoid the business of blaming others, circumstances or how much you are busy

Altruism:

1) Put the patient first.
2) Avoid any conflict between your needs and the patients' rights.
3) Give full commitment to your patient.
4) Avoid any financial or relationship biases

Integrity:

1) Be a principle-based person.
2) Be honest, and stand by your words.
3) Be fair, & do what you say.
4) Do not abuse your position/authority.

❖ Apply knowledge learnt to case scenarios. (example)

Dr . J.A. is a known urology surgeon working in one of the Ministry of Health hospitals. One of his patients has a chronic renal failure and is recommended for a kidney transplantation. Dr .J.A. agrees to conduct the operation. Over the next four weeks he works on preparing the patient for the operation. Two days before the operation, Dr .J.As' nurse rang the family and informed them that Dr .J.A. is travelling overseas and the operation will be postponed. They will be informed about the time of the operation when he is back in two months.

What do you think about Dr. J.A. attitude? Explain your views.

He made a mistake by comprising his patient's health for his personal needs, neither informing him nor referring his case to another doctor.

What would you do differently if you were Dr. J.A.?

- Postponding the trip for a better time –if possible-.
- Informing the patient and his family of the situation beforehand.
- Arranging for the patient's procedure to be performed by another trustworthy surgeon.

Lecture3: Patients' Safety

Defining patient safety:

The reduction of risk of unnecessary harm associated with health care to an acceptable minimum. (WHO, World Alliance for Patient Safety 2009).

key dimensions of healthcare quality:

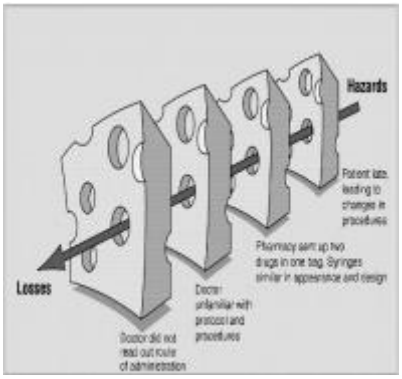
1. **Safe:** Avoiding injuries to patients.
2. **Effective:**
   Providing services based on scientific knowledge to all who could benefit and avoiding underuse and overuse. Doing the right thing for the right person at the right time.
3. **Timely:** Reducing waits for both who receive and those who give care.
4. **Family (patient) -centered:**
   Providing care that is respectful of individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.
5. **Efficient:**
   Avoiding waste, in particular waste of equipment, supplies, ideas and energy.
6. **Equal:**
   Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.

Sources of System Error:

1. **Active errors or human error:**
   Are committed by frontline staff and tend to have direct patient consequences. Example, giving the wrong medication.
2. **Latent or system errors (most often):**
   Are those errors that occur due to a set of external forces and indirect failures involving management, organizational culture, protocols/processes, transfer of knowledge, and external factors. Example: understaffed wards or inadequate equipment.

"Swiss cheese" model of accident causation:

Only when the holes in many layers momentarily line up does the trajectory of accident opportunity reach the victim causing the damage.



Culture of patient safety:

Definition:

An integrated pattern of individual and organizational behavior that continuously seeks to minimize patient harm that may result from the process of care delivery.

Approaches:

1. **Blame culture:** we look for the individual person resopnsible for the adverse incident & hold him accountable.
2. The opposite of a 'blame' culture is a **'blame-free'** culture, which is equally inappropriate. In some instances, the responsible individual should be held accountable in case of negligence or recklessness.
3. **Just Culture:** balancing the 'blame' and 'no blame' approaches. we look for the system defect such as communication & protocols, in addition to investigating the negligence or recklessness of the worker. It is the most effective approach.

The concept of Clinical incident:

A clinical incident is an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint. (deviation from standard of care and safety).

Types:

1. **Adverse Events:**
   a) Sentinel events:
   A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk of Serious injury specifically includeing loss of limb or function. Example: Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
   b) Never Events:
   Events that should never happen while in a hospital, and can be prevented in most cases. Example: Infant discharged to the wrong person.
   c) Adverse drug reaction:
   A response to a drug which is noxious and unintended, and which occurs at normal doses.
2. **Near miss:**
   Is any situations that did not cause harm to patients (that did not reach the patient) , but could have done.

Seven levels of safety:

1. **Patient factors:**
   Such as personality, language and psychological problems may also be important as they can influence communication with staff.
2. **Task factors:** The design of the task, the availability and utility of protocols ….
3. **Individual factors:** Include the knowledge, skills and experience of each member of staff
4. **Team factors:**
   The way an individual practices, and their impact on the patient, is influenced by other members of the team and the way they communicate and support each other.
5. **Working conditions:**
   These include the physical environment, availability of equipment and supplies and the light, heat, interruptions and distractions that staff endure.

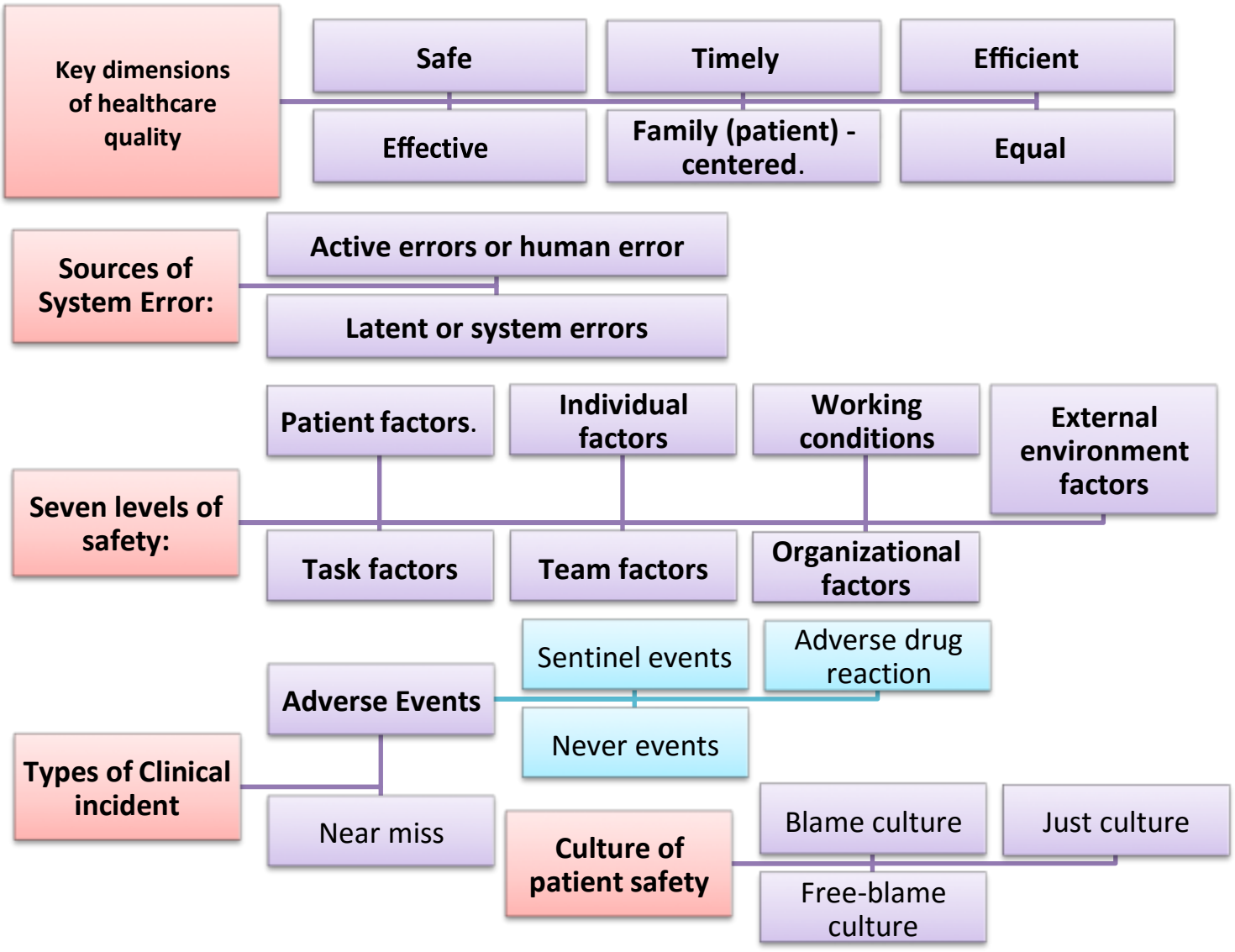
6. **Organizational factors:**
   The team is influenced in turn by management actions and by decisions made at a higher level in the organization.
7. **External environment factors:**
   The organization itself is affected by financial constraints, external regulatory bodies and the broader economic and political climate.

ROP-Patient Safety Goals:

- Adverse reporting
- Client verification
- Medication reconciliation
- Dangerous abbreviations
- Safe injection practices
- Safe surgical practices
- Preventive maintenance program

Recommended actions:

- Pharmacists / Technicians should CHECK carefully the label of each medication they prepare.
- DOUBLE CHECKING.
- Look-Alike medications should be stored separately with proper labeling or change the brand the hospital purchases of either drugs if possible
- Label all syringes. Be suspicious of unlabeled syringes & Never use them unless you have drawn the medication up yourself.
- Communication.



Lecture 4: Human Factors & Patient Safety

❖ **Define and describe the Human Factors and its relation to patient safety**

Definition: Human factors can be defined as anything that affects an individual's performance, which influence behavior at work in a way which can affect health and safety. They involve aspects:

1. **The job**. This includes matching the job to the physical and the mental strengths and limitations of people. Including nature of the job and the workload.
2. **The individual**. Including: Competency, Skills (changeable), Personality, attitude(fixed), Risk perception, Sleep deprivation. all influenceing behavior.
3. **The organization/environmental.** Including: Work patterns, The culture of the workplace, resources Communications, Leadership and so on.

❖ **Recognize the importance of applying human factors in healthcare**

- To prevent Medical Errors.
- Understand why healthcare staff make errors.
- Identify 'systems factors' that threaten patient safety.
- To prevent occupational accidents and ill health.

❖ **Differentiate between the different types of Medical Errors.**

Medical Errors: Failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

Causes of Medical Errors:

1- Healthcare Complexity	○ Complicated technologies ○ Prolonged hospital stay. ○ Multidisciplinary approach	○ Drugs interaction. ○ Intensive care
2- System and Process Design	○ Inadequate communication ○ Unclear lines of authority	
3- Environmental factors.	○ Over crowded services ○ Unsafe care provision areas	○ Areas poorly designed for safe monitoring
4- Infrastructure failure.	○ Lack of documentation process	○ Lack of continuous improvement process
5- Human Factors and Ergonomics	○ Tired/fatigue/sleep less ○ lack of skilled workers. ○ Lack of training.	○ Hungry ○ Angry/ Emotions ○ Late/ lazy

Sources of System Error: (recall lecture 3-patient safety)

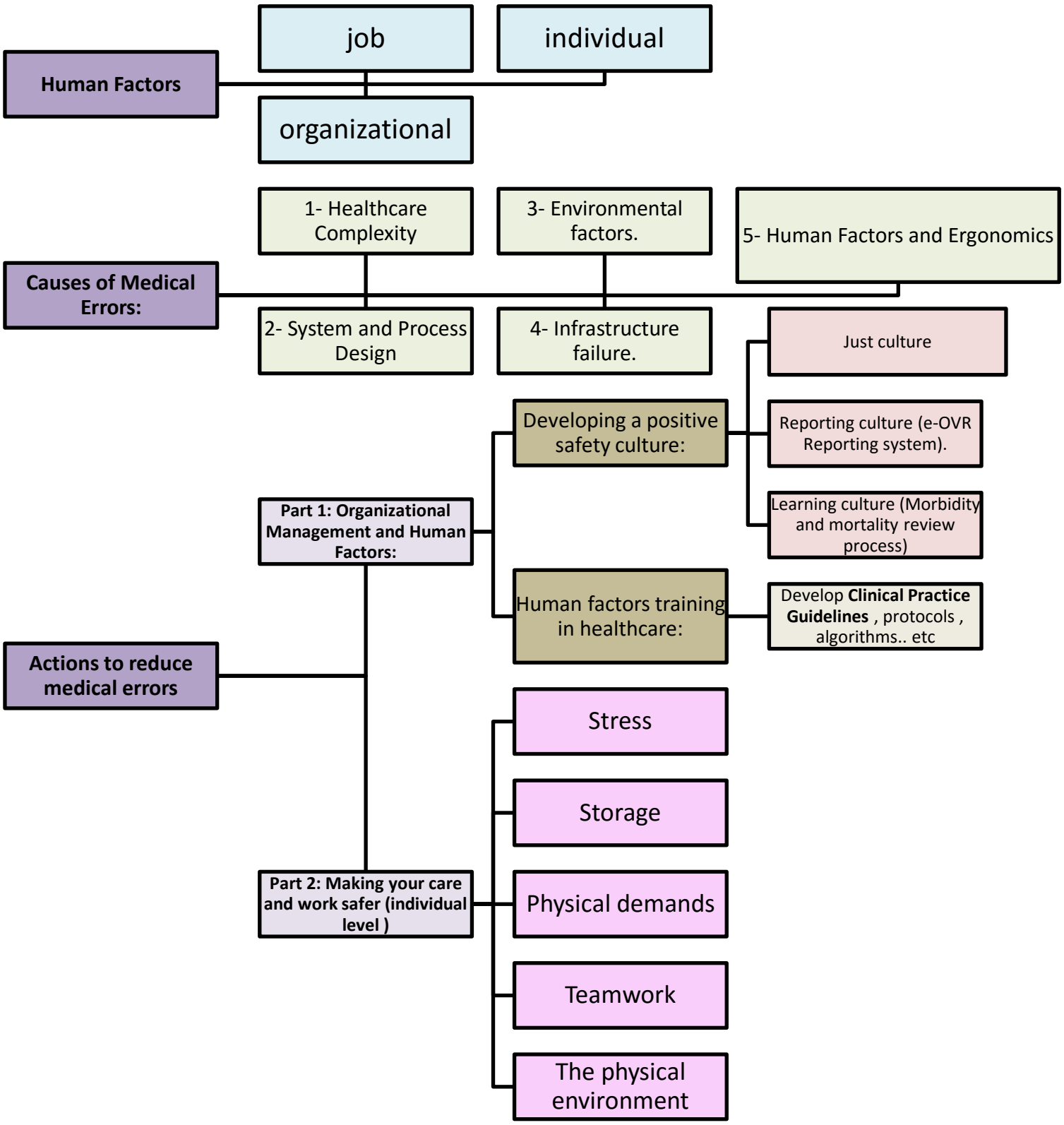
1. **Active errors or human error:**
   Are committed by frontline staff and tend to have direct patient consequences. Example, giving the wrong medication.
2. **Latent or system errors (most often):**
   Are those errors that occur due to a set of external forces and indirect failures involving management, organizational culture, protocols/processes, transfer of knowledge, and external factors. Example : understaffed wards or inadequate equipment.

❖ Describe several specific Actions to reduce medical errors as related to Humans Factors

1. **Part 1: Organizational Management and Human Factors:**
   - Developing a positive safety culture:
     - Just culture
     - Reporting culture (e-OVR Reporting system). See below
     - Learning culture(Morbidity and mortality review process)
   - Human factors training in healthcare:
     - Develop **Clinical Practice Guidelines** , protocols , algorithms.. etc
2. **Part 2: Making your care and work safer (individual level)**
   - Stress
   - Storage
   - Physical demands
   - Teamwork
   - The physical environment

❖ OVR (Occurrence Variance Reporting) or IR(Incident Reporting):

- **Occurrence:** An Occurrence is defined as any event or circumstance that deviates from established standards of care & safety.
- **OVR:** an internal form/system used to document the details of the occurrence/event and the investigation of an occurrence and the corrective actions taken.


Human Factors
job
individual
organizational
Causes of Medical Errors:
1- Healthcare Complexity
3- Environmental factors.
5- Human Factors and Ergonomics
2- System and Process Design
4- Infrastructure failure.
Actions to reduce medical errors
Part 1: Organizational Management and Human Factors:
Developing a positive safety culture:
Just culture
Reporting culture (e-OVR Reporting system).
Learning culture (Morbidity and mortality review process)
Human factors training in healthcare:
Develop Clinical Practice Guidelines , protocols , algorithms.. etc
Part 2: Making your care and work safer (individual level)
Stress
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Physical demands
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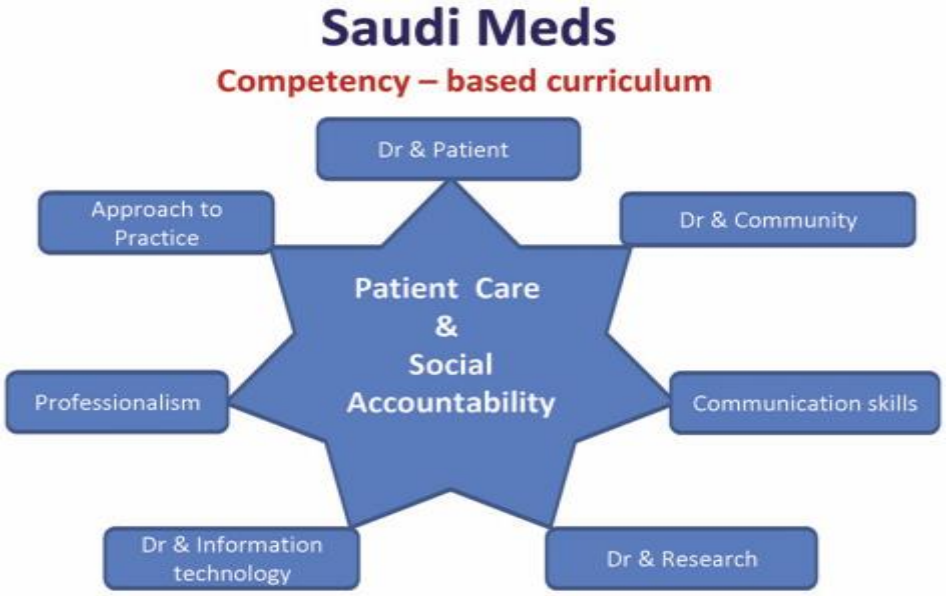
The physical environment

Lecture 5: Continuous Professional Development

KSU Medical College Outcomes:

- Communication and consultation skills.
- Clinical care.
- Health promotion and disease prevention.
- The family and community context of healthcare.
- Personal professional development (CPD).
- Use of technology and information gathering.
- Attitudes, ethics and professionalism.
- Research.



Definition of competence:

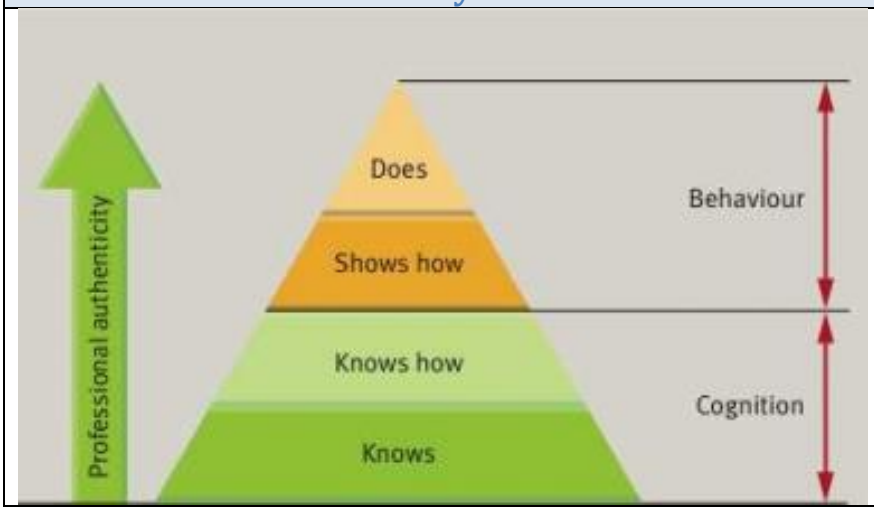
" The **ability** to **perform** a **specific task** in a manner that **yields desirable outcomes**", Competence develops over time and is nurtured by reflection on experience.

Different Aspects of Competence:

Knowledge, ***Skills*** & ***Abilities***

Skills	Abilities
Skill is the capacity to perform specific actions. It is a combination of knowledge and strategies.	The performance, *power or* ***capacity*** *to* ***do something*** *or* act physically, mentally, legally, morally, etc.
Acquired	**Innate**
What you have learned to do	What you can actually do!

Levels of competence:

Miller's Pyramid[1]	Bloom's Taxonomy[2]
	

How is competence acquired?

Through **Continuous Professional Development (CPD)** :

- *pre-service education* (students) - *in-service training* (interns, residents)
- *work experience*

What is CPD?

The conscious updating of professional knowledge and the improvement of professional competence throughout a person's working life. It is a commitment to being professional, keeping up to date and continuously seeking to improve. CPD differs from formal learning in that there are no learning curricula nor examinations, where motivation to learning comes from the necessity to improve practice.

Why CPD?

Ostensible[3] reason: Requirement by the governing bodies of the profession.

Cardinal[4] reasons:

- Half-life of what we learn is very short.
- If we do not update, we will practice obsolete medicine.
- There is a high chance that patients will not get optimal care.
- We all are helping others/dealing with patients.

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[1] Psychologist *Miller's Pyramid*/Prism of Clinical Competence (*1990*) ... George Miller proposed a framework for assessing levels of clinical competence back in *1990*.

[2] Bloom's Taxonomy was created in 1956 under the leadership of educational psychologist Dr Benjamin Bloom in order to promote higher forms of thinking in education such as analyzing and evaluating, rather than just remembering facts (rote learning).

[3] Superficial

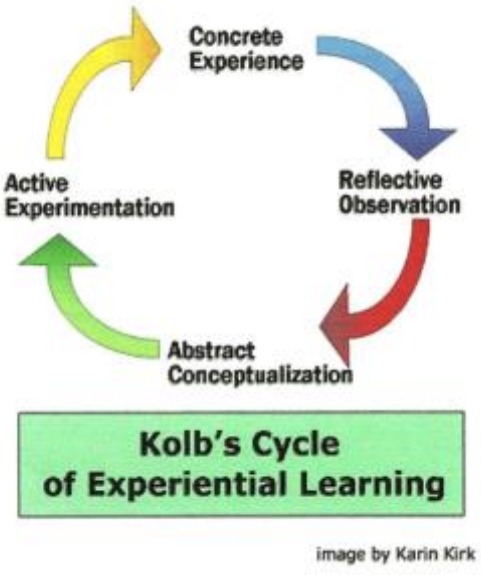
[4] Main

How can we achieve CPD?

- **Lecture programs** - **Conferences** - **Workshops** - **CME[5] courses**
- **Currently, Reflective Practice/Learning is the most favoured.**

What is the Reflective Learning?

Reflection relates to a complex and deliberate process of thinking about and interpreting experience, in order to learn from it. It is the systematic revisiting of a learned experience with a view to learning from it.
Reflective log is a cyclical process presented by Kolb's cycle.



A scenario:
A 55 year old man came to clinic with complaint of low back pain (LBP). You have examined his back which was ok. His height was 160 cm, and weight is 100 kg. You would like to manage this patient's LBP contributed due to his excess body weight.

1. **Learning concrete experience: What is the learning event?**
   This obese person who needed to reduce weight.
2. **Reflective observation:What did I learn?**
   Learned how the patient's activities have been affected by obesity.
3. **Abstract conceptualisation: What do I have to learn more?**
   Did not know the advice that should be given to the patient with a given BMI.
   Are there guidelines for interpreting BMI?
4. **Active experimentation: How can I learn it?**
   Refer a book/article. Talk to the dietician.
5. **Evidence for further learning or change of practice:**
   BMI was accurately interpreted. Patient was advised about the dietary/lifestyle changes and referred to an obesity clinic. References of books referred.

Constraints on Development:

- Time - Budgets - Life Cycle Issues - Motivation - Lack of Trust and Real Leadership

[5] *continuing medical education*

Lecture 6: The Concept of Communication Skills in Medicine

Communication definition:

- The act by which information is shared.
- It is the process by which we relate and interact with other people.
- It includes listening & understanding with passion & respect as well as expressing views & ideas and passing information to others in a clear manner.

Communication theory: Communication is a learned skill based on **3 pillars**:

- Accuracy - Efficiency - Supportiveness

Types of communication:

Verbal (mainly focuses on questioning)	**Non verbal**
• **Open (broad) –** gives control to respondent, allows disclosure. • **Open (focused) –** gives control to respondent within a given area, encourages disclosure of feelings. • **Closed –** control is with interviewer, checks information. • **Leading –** control with interviewer, suggests desired response.	• Listening (active and passive) • Silence • Touch • Hand gestures • Eye contact • Posture • Facial expression

Effective communication

Effective communication is the ***key to success in professional career, and*** **is the** ***basis of mutual understanding*** **& trust.** Doctors cannot practice medicine without effective communication skills, as patients are humans with sensitive needs

Importance of communication in medicine:

- Increases job & patient satisfaction and health outcomes
- Reduces the risk of complaint and litigation
- Ensures good working relationship
- Increases patients understanding of illness & management
- Improves patients compliance with treatment
- Reduce medico-legal problems
- Reduce uncertainty
- Poor communication **causes** ***a lot of misunderstanding*** **& hinders work & productivity.**

What is required from the doctors

Towards the <u>patients</u>	***Towards your <u>colleagues</u>***
• Listen to patients and respond to their concerns and preferences. • Give patients information in way they can understand • Taking patient's views into consideration when assessing their condition • Respond to patients questions , keep them informed & share information . • You must make sure, wherever practical, that arrangements are made to meet patient's language and communication needs. • You must be considerate to relatives, carers and partners in providing information and support	• Communicate effectively with colleagues within and outside the team • Make sure your colleagues understand your role and responsibilities in the team and who is responsible for each aspect of patient care • You must treat your colleagues fairly and with respect

Where to apply our Communication skills?

- The medical interview is the usual communication encounter between the doctor and the patient
- It can be classified according to the purpose of the interview into 4 types:
  1. History taking. 2. Consultations. 3. Obtaining informed Consent.

Principles of effective communication:

- Planning
- Interaction rather than a direct transmission
- Flexibility in relation to different individuals and contexts.
- Ability to handle emotional outbreaks

Communication skills: Some techniques:

- **PRACTICE**- fluent dialogue with patient
- **USE**- silence effectively, allowing patient enough time to express thoughts or feelings
- **ENCOURAGE**- patients with your supportive words
- **UTILIZE** - non-verbal communication

Listening vs Hearing:

Hearing	Listening
A passive activity; no effort	- Attention - Active involvement, - Full understanding - Takes time and effort

Barriers to effective communication:

- Personal attitudes. - Ignorance. - Human failings (tiredness, stress)
- Language - Poor time management - Strenuous working environment

Lecture 7: Understanding And Learning From Errors And Managing Clinical Risks

- **Medical error: important**
  An error is a failure to carry out a planned action as intended. or the use of a wrong plan to achieve an aim. Example: Retained surgical instruments
- **Violations:** are errors caused by deliberate deviation by an individual from an accepted protocol or standard of care.

- **A clinical incident:** Is a deviation from standard of care and safety. Examples: Medication errors.

- **Near miss:** Is any situations that did not cause harm to patients (that did not reach the patient), but could have done.

- **Types of medical erorrs: important**

Diagnostic	Treatment	Preventive	Other
▪ Error or delay in diagnosis(in the case of the diabetic patient may lead to blindness or glaucoma) ▪ Use of outmoded tests or therapy	▪ Error in the performance of an operation, procedure, or test (inserting a breathing tube into a patient's esophagus). ▪ Error in the dose or method of using a drug.	▪ Failure to provide prophylactic treatment. ▪ Inadequate monitoring or follow-up of treatment (no order for anticoagulant post major orthopedic procedure may lead to PE).	▪ Failure of communication ▪ Equipment failure

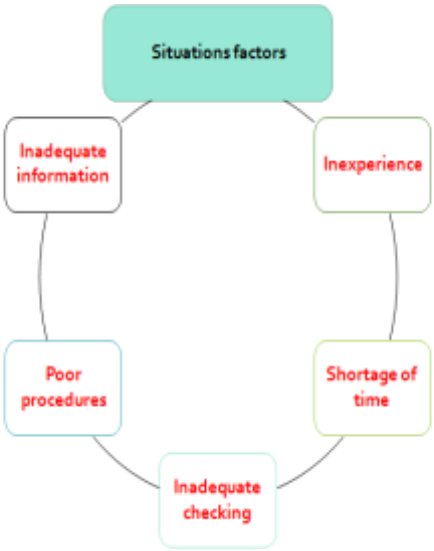
Ways to learn from errors:

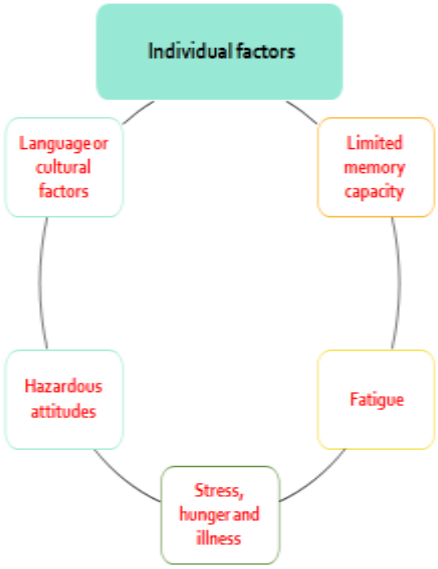
1- incident reporting: Incident reporting and monitoring involve collecting and analyzing information about any event that could have harmed or did harm a patient in a clinical setting or health-care organization.

2- Root Cause Analysis(RCA):

- Is a highly structured systemic approach to incident analysis.
- RCA focuses on the system, not the individual.

Factors Associated with an Increased Risk of Error:





- **Hazard:** is any activity, situation or, substance that potential to cause harm, including ill health, injury, loss of product and/or damage to plant and property.
- **Risk:** is the probability that harm (illness or injury) will actually occur.

What is clinical risks?

Is the chance of an adverse outcome resulting from: clinical investigation, treatment or patient care.
Clinical risk management: Organizational effort to identify, assess, control and evaluate the risk to reduce harm to patient, visitors and staff and protect the organization from financial loss.

Activities Commonly Used to Manage Clinical Risk: (Important, try to understand the definitions)

1- Incident reporting:

- **An incident:** as an event or circumstance that could have or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage.
- **Incident monitoring:** refers to mechanisms for identifying, processing, analyzing and reporting incidents with a view to preventing their reoccurrence

  The key to an effective reporting system is for staff to routinely report incidents and near misses.

2- Sentinel Event:

Is an unexpected occurrence involving death or serious physical or psychological injury ex: operating on the wrong side or wrong patient.

e.g. surgery on the wrong patient or body site, incompatible blood transfusion.

3- Patient complain:

A complaint: is defined as an expression of dissatisfaction by a patient, family member or carer with the provided health care.

Fitness-to-practice requirements: (important)

- Accountability.
- Competency of healthcare professionals.
- Are they practicing beyond their level of experience and skill? Are they unwell, suffering from stress or illness.

Credentialing	Registration (licensure)	Accreditation
The process of assessing and conferring approval on a person's suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual's license, education, training, experience, and competence.	▪ Registration of health-care practitioners with a government authority, to protect the health and safety of the public through mechanisms designed to ensure that health practitioners are fit to practice. ▪ E.g. Saudi Commission for Health Specialties ▪ Proper registration is an important part of the credentialing and accreditation processes	▪ Is a formal process to ensure delivery of safe, high-quality health care based on standards and processes devised and developed by health-care professionals for health-care services. ▪ National Accreditation Program: CBAHI ▪ International Accreditation Program: Joint commission (US), Accreditation Canada(Canada).

Lecture 8: Being an Effective Team Player

❖ What is a team?

A team is a group of two or more individuals (have limited lifespan of membership) WHO:

- Interact dynamically.
- Have a common goal/objective/mission.
- Have been assigned for specific tasks.
- Possess specialized and complementary skill.

❖ Why teamwork is an essential element of patient safety?

The importance of effective teams in health care is increasing due to factors such as :

- The increased incidence of complexity and specialization of care. For Example :
  - ✓ a pregnant woman with diabetes who develops a pulmonary embolus.
  - ✓ The health-care team might include nurses, a midwife, an obstetrician, an endocrinologist and a respiratory physician, as well as the patient.
- Increasing co-morbidities.
- Increasing incidence chronic disease.
- Global workforce shortages.
- Initiatives for safe working hours.

Teams found in health care:

Core teams:

Consist of team leaders and members who are directly involved in caring for the patient.

Include direct care providers such as nurses, pharmacists, doctors, dentists, assistants and, of course, the patient.

Coordinating teams:

- Is the group responsible for day-to-day operational management, coordination functions and resource management for core teams.
- Nurses often fill such coordinating

Contingency teams :

Contingency teams are formed for emergent or specific events (e.g. cardiac arrest teams disaster response teams, rapid response teams).

Ancillary services :

teams consist of individuals who provide direct, task-specific, time-limited care to patients or support services that facilitate patient care. Such as cleaners staff.

Support services :

teams consist of individuals who provide indirect, task-specific services in a health-care facility. Such as Transportation team, security team

Administration :

includes the executive leadership of a unit or facility and has 24- hour accountability for the overall function and management of the organization.

❖ Stages of team development :

1- Forming Stage :

- Initial stage when the team is formed and the members are coming together for the first time.
- A best candidate should be selected to form a dynamic team , but a flexibility should be adopted in selection process.
- The skills of the members should match the team task and goals.
- Voluntary team membership seems to work best when given as a choice.

2- Storming Stage :

- Each member tend to rely on his/her own experience.
- Resistance to work together openly.
- Hesitate to express new ideas and opinions.
- Interpersonal disagreement and conflicts.
- Personal goals rather than team goal.

3- Norming Stage :

- Start to know each other.
- Start to accept each others ideas and opinions.
- Understand the strengths and weaknesses of the team.
- Members become friendly to each other.
- Work together to overcome personal disagreement.
- Share responsibilities and help each other.

4- Performing Stage:

- Member are satisfied with the team progress.
- Members are capable to deal with any task based on their strength and weaknesses.
- Work together to achieve the team goals.

❖ How to move from storming to norming stage ?

- Team members should be introduce to each other in more details.
- Responsibilities must be assigned accordingly.
- Clear communication.
- Social activities.
- Role should be in rotation.
- Everyone should be treated equally.

❖ Characteristics of successful teams

1. Effective leadership :

Teams require effective leadership that set and maintain structures, manage conflict, listen to members and trust and support members. Effective leadership is a key characteristic of an effective team.

2. Effective communication :

- Strategies can assist team members in sharing information accurately :

  SBAR : Situation , Background , Assessment and Recommendation.

- Call-out: is a strategy to communicate important or critical information to inform all team members simultaneously during emergent situations. Such as CPR announcement.
- Check-back/read-back. E.g. : drugs check.

3. Common purpose:

Team members generate a common and clearly defined purpose that includes collective interests and demonstrates shared ownership.

4. Measurable goals:

Teams set goals that are measurable and focused on the team's task.

5. Good cohesion:

Have a unique and identifiable team spirit and commitment and have greater longevity as team members want to continue working together.

6. Mutual respect:

Effective teams have members who respect each others talents and beliefs, in addition to their professional contributions.

❖ Challenges to effective teamwork:

Changing roles : In many health-care environments there is considerable change and overlap in the roles played by different health-care professionals.
Changing settings: The nature of health care is changing in many ways, including increased delivery of care for chronic conditions in community care settings and the transfer of many surgical procedures to outpatient centers.
Health-care hierarchies: Health care is strongly hierarchical in nature, which can be counterproductive to well functioning and effective teams where all members' views should be considered.
Individualistic nature of health care: Many health-care professions, such as nursing, dentistry and medicine, are based on the autonomous one-to-one relationship between the provider and patient.

Lecture 9: Concept of Community Services

❖ Definition of Community:

- Community is a **group** of interacting people, living in some proximity (i.e., in space, time,
  or relationship).
- Community usually refers to a social unit larger than a household that **shares common values and has social cohesion**.

❖ Community service:

✓ Defined as donated service or activity that is performed by someone or a group of people for the benefit of the public or its institutions.
✓ Basically anything which benefits the society in any way can be considered as a community service project or activity.
✓ Performed by volunteers who are not paid for their time.
✓ Some people associate community service with ***punishment***, since it is often offered to small-time offenders as an alternative to fines or jail time. However, community service
can also be ***altruistic***, and it is a vital part of many small communities.

Examples of Community Service:

- Visiting and spending time with lonely elderly.
- Tutoring needy students in their studies for free.
- Helping out at organizations such as libraries.

Why to carry out community service?

- Benefits the community
- The volunteers in the activities also gain a sense of accomplishment
- Better social communication skills
- Exposure to new peoples and cultures
- Overall improved mental health.

❖ Physicians role in the community is not limited to those within the hospital and clinical care, but extends to:

- Public Health
- Prevention of illnesses
- Educational roles
- Setting policies
- International Aid
- Assurance of competence
- Improving health care access
- Fund raising, which may not apply locally since health care services are provided by the governments. Funds may be raised to help those individuals who cannot afford to purchase medications or medical equipment.

❖ Health depends not only on medical care but also on other factors including:

- Individual behavior
- Psychological and environmental factors.
- Genetic makeup
- Social and economic conditions

❖ Health Stakeholders1 are:

- Health care providers
- Community organizations
- Schools
- Public health agencies
- Government agencies
- Social services organizations

10 Essential services of stackholders:

Monitor heahth status	Diagnose and investigate health problems
Inform, educate, and empower people	Mobilize community partnerships
Develop policies and plans	Enforce laws and regulations
Link people to needed health services	Assure a competent workforce
Evaluate quality	Research

❖ Public health :

The science and practice of preventing diseases and promoting health in populations .

- It depends largely on epidemiology.
- Largely performed by governmental organizations.

Objectives of public health:

- To control communicable diseases.
- Response to national disasters.
- Safety of water and food supply.

Educational role of public health: Educating the public about:
Causes of illness, Preventive measures, Predisposing factors and Changes in lifestyle.

❖ International community services. Done through:

1- **General organizations:** They provide: Clean water supplies, Clothing and Education.

2- **Medical organization :**

Medical teams provide: Medical care, Medications, Immunizations, Medical supplies, Teach communities about nutrition and preventive measures, Training of local health care providers.

3- **Governments:**

Provide aid to other countries during time of need. May include sending: Medical professionals, Medical equipments and Medications.

❖ The concept of Volunteering :

- Volunteering is generally considered an **altruistic** activity, intended to improve human **quality of life.**
- Volunteering can be daily, for hours, weekly or when needed.
- It can be done through: money, donations, work effort, or relations.

Why do people volunteer?

- For their own skill development.
- To solve problems when needed
- Get benefit of spare time.
- To make contacts for possible
- To help others and earn respect and favor.
- A variety of other reasons…

Types of volunteering:

- Skill–based volunteering. e.g. special skills required.
- Micro & virtual volunteering. e.g. off-site tasks done by internet
- Environmental volunteering. e.g. Protecting animals…
- Emergency volunteering. e.g. During natural disasters…
- School volunteering. e.g. Additional teaching for students.
- Community volunteering. e.g. for orphanages, mosques, etc…
- International work/camps. e.g. Environmental conservation, rural developments.

❖ Doctors are to be committed to:

- **Working in partnership with members of the other health care teams.**
- Integrity.
- Compassion.
- Altruism.
- Excellence.
- Continuous improvement.

Lecture 10: Professionalism Through Mentoring

❖ The concept of Mentoring.

- "It is a professional relationship built within an organization that is intended to target and focus the training of individuals"
- Effective mentorship is crucial to career success in academic medicine.

❖ The roles of Mentor and Mentee.

	Mentor	Mentee
Who?	• Teacher • Rolemodel • Advisor • Friend	• Student • Learner **Protégé** (male), a **protégée** (female), Nowadays **MENTEE** (both)
should be…	• Available • Socialable • Approachable	• Strategic "WHAT & WHY" • Tactical "HOW"

	Mentor	Mentee
Should do/have…	• Address their educational needs. • Identify their strengths and weaknesses. • Explore options with their mentee. • Provide Motivation. • Encourage Reflection & **Provide Feedback**. • Act as a challenger: **The ability to challenge** the mentee in a non- threatening way. • **Have the desire** to help: should be willing to spend time helping someone else, and remain positive throughout. **What is achieved by a Mentor?** • ↑ Satisfaction • ↑ Personal development • ↑ Experience Contribution	1. **Respect:** Mutual respect is the starting and sustaining aspect of a successful mentoring relationship. Professional and personal appreciation of one another is core to enhancing learning. 2. **Responsiveness:** Your willingness to learn from your mentor and your mentor's willingness to respond to your learning needs are important for successful collaboration. 3. **Accountability:** Once you and your mentor establish mutually held goals and expectations, keeping your agreements strengthens trust and helps maintain a positive relationship. 4. **Motivation** to continue developing and growing and **listen actively** • **Most importantly, consider:** Students are obliged to recognize the multiple demands on a mentor's time.

❖ What is to be expected from good Mentoring?

- Mentoring flourishes behavioral, motivational and career outcomes
- It is an effective way of helping people to progress in their careers.

❖ Professionalism through Mentoring.

Professional Excellence: individual, interpersonal, and societal.

The nature of a mentoring relationship varies with the level of students and Mentor "One size doesn't fit all":

- Different human relationships
- Different learning needs
- Different styles of mentoring

❖ Characteristics of GOOD mentoring:

1. Establish an open communication system with reciprocal feedback
2. Set standards, goals, and expectations
3. Establish trust
4. Care for and enjoy each other
5. Allow mistakes
6. Participate willingly
7. Demonstrate flexibility
8. Consider constraints to mentoring
9. Learn from others
10. Work on common tasks
11. Be open and comfortable

Lecture 11: Professionalism in cultural context

❖ Cultural Influences on Medical Professionalism:

Characteristics of Professionalism:

Competency, Responsibility, Attitude and Conduct on the job.

❖ Attitudes Central To Medical Professionalism In Cultural Context:

- Humility. • Empathy. • Respect. • Sensitivity. • Curiosity.
- Awareness of all outside influences including cultural on patients health.

❖ Cultural Context:

1. Focusing On Knowledge:

1. It is important for a medical student or post graduate trainee to **learn** about the surrounding community in which he/she practices or trains. e.g. Socio economic status, patterns of housing nutritional habits, healing practices and disease incidence and prevalence.
2. The knowledge taught has specific evidence-based **impact** on health care delivery. e.g. How Ramadan fasting affects Muslims who are diabetic.

3. Focusing On Skills:

It is crucial to understand health **beliefs** of those who come from different cultures or have different health care experiences.

❖ Medical Professionalism "Three fundamental principles":

1.Patient welfare.	2. Patient autonomy	3. Social justice
1. Professional competence. 2. Honesty with patients – integrity. 3. Patient confidentiality. 4. Caring attitude. 5. Scientific knowledge. 6. Maintaining trust. 7. Setting and maintaining professional standards.		1. A just distribution of resources. 2. Managing conflict of interest. 3. Improving quality and access to care. 4. Respect for colleagues

❖ Cultural Influences:

While providing professional care physician must not impose his / her view on a patient's:

- Life style, culture, beliefs & race. • Sex, age/sexuality. • Social status/economic worth.
  - Physicians must be prepared to explain and justify his / her actions and decisions.
  - Culture is directly related to health promotion, disease prevention, early detection, access to health care, trust and compliance
  - **Confidentiality:** Confidentiality concept may not be the same in the East as in the West. However its principles are applicable in most settings.

❖ Patient-Physician Relationship- 4 possible consultation models:

1. Paternalistic model physician as a parent/ imam	• Physicians are in the best position to judge what is best for their patients. • Culturally applicable in Chinese culture.
2. Deliberative model physician as a mentor	• The physician mentor's grip on decision making is **more relaxed** than the physician / parent model but autonomy-conscious patients find it unsatisfactory. • Culturally this is an option for some of the patients in Eastern countries
3. Informative engineering model physicians as technicians	• Physicians only provide value **neutral** medical information and leaving patients to make decisions independently based on personal values (total patient autonomy) • Culturally applicable To certain sections of the West
4. Interpretive/ collegial model physicians as friends or counsellors	• Physician's medical facts and patients personal values contribute to **balanced (shared) medical decision making**. • Culturally popular in the West, Increasingly accepted in the East.

❖ Special Cultural Issues In Professional Care In Different Parts Of The World:

- Insistence on eye contact?
- Uncovering of face in some females.
- Undressing of female patients?
- Sharing of confidential information with spouses, relatives?
- History taking of female adults from parents or husbands?
- Giving information to patients in a way they can understand.
- Accepting gifts or other inducements:
  - ✓ You should not ask for or accept any material rewards, except those of insignificant value from representatives of pharmaceutical companies.
  - ✓ Help with conferences and educational activities may be acceptable.
- Physicians must not exploit patient's vulnerability or lack of medical knowledge.
- **Research :**
  - ✓ Research should not be contrary to the patient's interest.
  - ✓ Research protocol should be approved by a research ethics committee. This committee may be non existent in many settings.
  - ✓ Your conduct in the research must not be influenced by payments or gifts.
  - ✓ Record your research results truthfully.

❖ Professionalism in Different Cultural Contexts:

1. **CRASH:**
   - Cultural Competency • Respect. • Assess. • Sensitivity/ Self Awareness. • Humility.

2. **PEARLS:**

Partnership:	Working with the patient to accomplish a shared outcome
Empathy:	Recognizing and comprehending another's feelings or experience
Analogy:	Being willing to acknowledge or express regret for contributing to a patient's discomfort, distress, or ill feelings
Respect:	Non-judgmental acceptance of each patient as a unique individual; treating others as you would have them treat you.
Legitimization:	Accepting patient's feelings or reactions regardless of whether or not you agree with those perceptions.
Support:	Expressing willingness to care and be helpful to the patient however you can

Lecture 12: Professional & Unprofessional Behavior

❖ Proffessionalism:

- Attributes and behaviors that serve to maintain patient interests above physician self-interest. E.g. Honesty/integrity – Openness – Reliability – Responsibility - Respect – Presence - Compassion/empathy – Competence ….
- It is the unconditional caring of the patient, putting others before self.
- IT IS NOT WHAT WE DO BUT HOW WE DO IT THAT DEFINES MEDCIAL PROFESSIONALISM

❖ Define unprofessional behavior:

Unprofessionalism is not pertaining to the characteristic of a profession. As:

- Increased workplace difficulties
- Decreased morale in other staff
- Decline in patient care
- Do not have to wait until patient dies to determine that medical care suffered.

❖ Categories of unproffessional behavior

1. **Illegal or Criminal acts:**
   A physician may be disciplined and lose his medical license based solely on the fact that he was convicted for a crime or offense.
2. **Immoral acts:**
   "Immoral" acts generally fall into the limited category of sexual activity with individuals that may be patients.
3. **Business related acts:**
   These acts are related to the operation of the business, not the quality of the care . e.g. Obtaining a license to practice medicine by bribery, fraud or misrepresentation.

4. **Acts that violate acceptable medical practices (Negligent practices)**
   - Failure to maintain records of a patient, relating to diagnosis, treatment and care
   - Altering medical records
   - Failure to make medical records available for inspection
   - Medical errors:
     - Harmful medical errors.
     - Near miss medical errors: An event that under slightly different circumstances could have been an accident, either because the error was detected and corrected in time or because the patient was just lucky.
     - **Actions to be taken in case of medical errors:**
       - Reporting it to the health care system. Report both types and labelling a near miss medical error as "near miss ME"
       - Disclosing it to the patient involved.
     - **Common types of medical errors**
       - **Surgery-related errors**
       - **Medication-related errors,** such as
         - Wrong prescription / dosage, Inadequate instructions to patient.
       - **Body-fluid-related errors,** such as:
         - Blood transfusion administered too quickly, which resulted in congestive heart failure and death.
         - Transfusion of contaminated blood.
       - **Diagnostic errors** such as:
         - Misdiagnosis, leading to an incorrect choice of therapy.
         - Failure to order necessary diagnostic test.
         - Misinterpretation of test results
         - Failure to act on abnormal results.
       - **Equipment failure** such as:
         - Defibrillators with dead batteries.
         - Intravenous pumps whose valves are easily dislodged, which cause increased doses of medication over too short a period.
     - **Why do we need to disclose medical errors?**
       - Promote public trust.
       - Prevent further harm to a patient and to other patients.
       - Respect personal autonomy.
       - Support principle of justice.
       - Improve the safety of medical practice.
       - Be able to trust the physicians and the system.

         Non-disclosure of errors undermines efforts to improve the safety of medical practice, and blocks efforts to identify the faults and weaknesses in the health care processes and procedures.

- **Legal obligations** includes having an efficient system for disclosures of our own medical mistakes and those of higher authorities, as well as having written policies and procedures that fully support patients and their rights.
- **What do we disclose to patients?**
  - Full disclosures of all the errors that result in harm
  - What has happened and why.
  - How the problem occurred.
  - Implications.
  - How to prevent it happening again.
- **Practical Disclosure Approach**
  - Disclosure should be at the right time and setting, when the patient is medically stable enough to absorb the information.
  - A physician should take the lead in disclosing errors to patients and their families
  - They should avoid being defensive or evasive, but rather explain what happened in an objective and narrative way
  - Avoid reacting to the response that such disclosure might generate.
  - A proper acknowledgement and empathy accompanied by apology may be appreciated by the patient. Thus it may strengthen, rather than undermine, the physician-patient relationship.
  - Support should be provided.

5. Plagiarism:

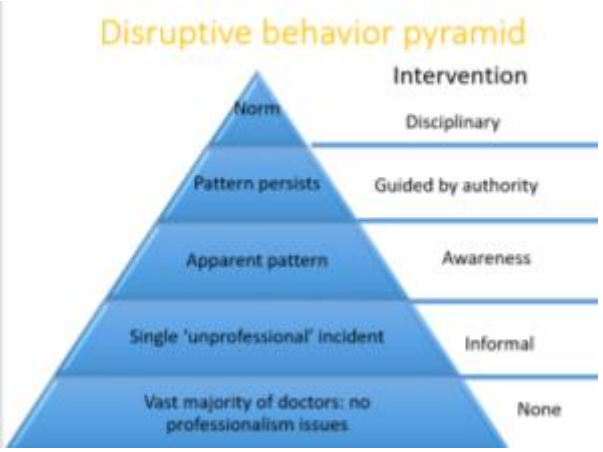
Is an unethical, dishonest act whereby an individual uses the work of another, commit literacy theft, or present work as an original idea without crediting the source or stating that it is derived from an existing source.

Plagirism has 6 types:

1. Direct copying:	Copying someone else's work using the exact words and putting it as your own. This is the most common type of plagiarism.
2. Word switching:	Putting someone else's writing as your own by changing words without showing that you are using someone else's ideas.
3. Working with others:	• Copying all or part of another student's writin. • Sharing an assignmen. • Group work on individual assignment. • Writing in Arabic and asking some else to translate your work. Group assignments, discussions, and getting advice on sources of information are **acceptable**.
4. Concealing sources:	Hiding the sources of your work and not revealing them. This includes: • Putting someone else's ideas on your words without referring to them. • Using a reference more than one time, but only pointing it out once.
5. Buying assignments:	Buying an assignment is the worst kind of plagiarism and may have serious consequences.
6. Self plagiarism:	Re-using all or part of an assignment or a project that you have used before without making it clear is considered as plagiarism.

❖ Unprofessional physician

- **Impaired:**
  Impairment means more than making incorrect diagnosis. It means:
  1. Avoidance of patients and their psychological needs
  2. Dehumanized care
  3. Inappropriate treatment
- **Dishonest**
- **Greedy**
- **Abuses power**
- **Lacks interpersonal skills**
- **Conflict of interest**
- **Self-serving**
- **Disruptive behavior:**



Include repeated episodes of:	**Early warning signs:**
• Sexual harassment • Racial or ethnic slurs • Intimidation and abusive language • Persistent lateness in responding to calls at work	• Late or incomplete charting • Delayed or no responses to call or pagers • Abusive treatment of staff • Unkempt appearance and dress • Inability to accept criticism • Gender or Religious bias

- The eyes and ears of patients, visitors and healthcare team members are considered to be the most effective **surveillance tools for detecting unprofessional behavior.**
- Formalizing a response needs cost and time.

Lecture 13: Breaking Bad News

❖ Bad News in Medicine:

It is Information that produces a negative alteration to a person's expectation about their present and future could be deemed Bad News

- Your Bad News may not be my Bad News.
- Bad News doesn't have to be fatal

❖ Examples of bad news in medicine may include:

• Traumatic Death. • Death after chronic illness.
• Diagnosis of uniformly fatal chronic illness e.g. Cystic fibrosis.
• Diagnosis of cancer. • Diagnosis of permanent disability or birth defect.

To some patients or to their families "Bad News" may also include:

• Unexpected admission to ICU. • Long bone fracture. • H1N1 influenza.
• Need for surgery e.g. Hernia or Appendicitis

Breaking Bad News "Options"		
Nondisclosure	Full Disclosure	Individualized Disclosure
	Give all information. As soon as it is known	Tailors amount and timing of information. Negotiation between doctor and patient. As soon as it is known

❖ "Bad News" Consensus (general agreement):

- Ensure Privacy and Adequate Time.
- Encourage Patients to Express Feelings.
- Discuss all the available Treatment Options.
- Provide Information Simply and Honestly.
- Arrange Review.
- Document Information Given.
- Provide Information About Support Services.

Basic Principles		
When to be informed?	Where to be informed?	Support persons present
As soon as information is clearly known. Don't pass on unsure information too soon.	Private setting. In person.	Both parents. Other support people, family, friends, hospital support.

❖ Challenges: It is a difficult task because:

- It is frequent and stressful.
- The truth is unpleasant and will upset the patients
- Most patients want to know the truth.
- We are anxious and fear negative evaluation.

❖ What Not to Do?

- Don't Break bad news over the phone.
- Don't Leave patient in suspense.
- Don't Tell patient if he or she doesn't want to know.
- Don't Give excessive information as this causes confusion.
- Don't Avoid the patient.
- Don't Lie to the patient.
- Don't Interrupt excessively.
- Don't Be judgmental
- Don't Use jargon
- Don't Give a definite time span (just say "days to weeks" or "months to years" etc.
- Don't Pretend treatment is working if it isn't.
- Don't Say "Nothing can be done".
- Do not say "I know how you feel". Instead "I think I can understand how you must be feeling."

❖ "Breaking Bad News" in the Emergency Department: It is a difficult task because;

- Families do not have time to prepare for the bad news.
- Practitioners do not have a prior relation with patient or family.
- A stressful situation for practitioners.

❖ Death Notifications In The Emergency Department:

BE READY FOR:

- Reactions are varied and Culturally determined.
- Very rarely yet chances of hostile reaction towards the staff.
- Initial reaction of eruption of grief.

WHAT TO DO?

Physician should stay in room with family

- As a resource.
- As a silent presence.
- Remind family members (especially other children) that it was not their fault.

✓ Follow the GRIEV-ING Protocol:

G: Gather	Gather the family
R: Resources	call for support to assist the family
I: Identify	Identify yourself, identify the deceased patient by name and the knowledge to be disclosed to the family.
E: Educate	Educate family about the event that occurred for their deceased in the emergency
V: Verify	Verify that their family member has died (dead).
- (Space)	Give the family personal space and time for emotional moment and absorb the information.
I : Inquire:	ask if there are any questions, answer them all.
N: Nuts and bolts:	Nuts and bolts; inquire about organ donation and other issues as applicable.

G: Give	Give them your card or contact information. Offer to answer any question that may arise later

❖ How should Bad News be delivered?

1- Getting started (getting the setting right).
2- What does the patient know?
3- How much does the patient want to know?
4- Providing information.
5- Responding to patient and family feelings.
6- Planning and follow up.

The 6 Step Protocol		The spikes protocol:
1-Prepare Yourself	• Review the patient's history and know about possible management. • Practice the interview for possible questions and answers. • Relatives can be present, but , follow the patient's wish.	S= "setting"
2-Prepare Your Setting	• Arrange to meet in a quiet room. • Make sure that you are not going to be disturbed. • If recently examined allow him/her to dress before the interview.	P= "perception"
3-Prepare Your Patient.	Try first to focus on : • What do they know already? • What do they want to know? • Some patients do not want details. • Always build up gradually.	I= "invitation"
4-Delivering the News	• Use simple language, listen, follow verbal and non-verbal cues. • Be at level of understanding and vocabulary of the patient. • Avoid excessive bluntness, it may leave the patient isolated . • Set the tone. e.g. "I am afraid I have some bad news" • Give the information in small chunks. • Avoid using hopelessness terms. • Be truthful, gentle and courteous. • Offer hope. • Emphasize the positive. • Allow questions.	K= "knowledge"
5- Response to reaction	• Acknowledge the emotions experienced by the patient and if a patient is silent use open questions, e.g. "How are you feeling now?" • Allow the patient and family time to express their emotions and let the patient know you understand and acknowledge their emotions. • Don't leave the patient confused. • Provide a clear care plan with treatment options. • Identify support systems; involve relatives and friends. • Offer to meet and talk to the family if not present. • Make written materials available. • Summarise.	E= "empathizing and exploring"
6- Care Plan	**After the Interview: Always Follow Up and:** • Make a clear record of the interview, the terms used, the options discussed and the future plan offered. • Inform all other people looking after the patient what you have done. (Parents + Attendants + Nursing staff). • Do arrange if it is needed to have a number of meetings. • Follow up the patient. • Always DOCUMENT every step taken to notify the patient of the bad news.	S= "strategy and summary"