On the Road to Professionalism

David H. Chestnut, M.D.

ABSTRACT

Many observers have concluded that we have a crisis of professionalism in the practice of medicine. In this essay, the author identifies and discusses personal attributes and commitments important in the development and maintenance of physician professionalism: humility, servant leadership, self-awareness, kindness, altruism, attention to personal well-being, responsibility and concern for patient safety, lifelong learning, self-regulation, and honesty and integrity. Professionalism requires character, but character alone is not enough. We need others to help and encourage us. And in turn, as physician leaders, we help shape the culture of professionalism in our practice environment. Professionalism is not something we learn once, and no physician is perfectly professional at all times, in all circumstances. Professionalism is both a commitment and a skill—a competency—that we practice over a lifetime. (ANESTHESIOLOGY 2017; XXX:00-00)

THE title for this essay was inspired by David Brooks'[1] book—*The Road to Character*. Brooks wrote about people who achieved an extraordinary depth of character—people in whom "the climb to success … surrendered to the struggle to deepen the soul."[2] He described two sets of virtues—the résumé virtues and the eulogy virtues. The résumé virtues are the achievements and "skills that you bring to the job market and … contribute to external success. The eulogy virtues are deeper … [the ones that are] talked about at your funeral … whether you [were] kind, brave, honest, or faithful, [and] what kind of relationships you formed. Most of us would say that the eulogy virtues are more important than the résumé virtues."[3] But our culture and educational systems give greater priority to the skills and strategies we need for career success than to the qualities we need to develop strong character.[3]

A study tracked how frequently words related to moral excellence and virtue appeared in books published over the course of the 20th century.[4] The authors observed a significant decline in the use of general moral terms such as *character, virtue, decency,* and *conscience*. They also found a decline in the use of virtue words such as *honesty, truthfulness, patience, kindness, humility, modesty, honor, courage,* and *sacrifice*.[4]

Meanwhile, many observers have concluded that we have a crisis of professionalism in the practice of medicine. This has not occurred because of a lack of emphasis or effort. Our accreditation and certification bodies all include professionalism as one of the six core competencies for physicians. But every definition of professionalism is somewhat subjective. Shakespeare *et al.*[5] said that "professionalism is … intangible, and competence in professionalism cannot be guaranteed … in the same way as competence in central line placement."

The American Society of Anesthesiologists (ASA) newsletter[6] posed the question: Do we know professionalism when we see it? In 2012, the American Board of Medical Specialties (ABMS)[7] defined medical professionalism as "a belief system in which group members … declare to each other and the public the shared competency standards and ethical values they promise to uphold." The ABMS then asked a group of external stakeholders to articulate their expectations regarding physician certification. The stakeholders expressed a desire for an outcomes-oriented assessment of physician performance, with an equal focus on all six competencies—including professionalism.[8] In other words, the public wants an assessment of a competency that is difficult to define.

In this essay, I affirm professionalism as a core competency that requires character and lifelong learning, commitment, and practice. And I suggest that all of us need some help and encouragement along the way.

Humility may be the single most desirable professional attribute.[9] After completing my anesthesiology residency training, I began my training in obstetrics and gynecology. I was bursting with confidence! In other words, I was arrogant and overbearing. One day my chief resident grabbed me and said, "Chestnut, the labor nurses hate you! And if you don't change, they will run you out of here!" I immediately started saying "please" and "thank you" more often. When I needed to make a clinical decision, I would often ask the nurses for advice. They taught me a lot.

Obstetric nurses are often harshly critical of young physicians.[9] But good relationships with the nurses and other

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staff are critically important. And good teamwork skills are essential, especially in crisis situations. A prominent surgeon emphasized the importance of getting to know the staff.[10] In my judgment, making an effort to learn their names is the single most helpful way to foster mutual respect and collegiality in the operating room and on the labor unit.

Few physicians fail because of poor intellect or lack of manual dexterity. But arrogance and pride are self-destructive. Ironically, a person who possesses true humility does not have the slightest idea that he or she is humble. A humble person recognizes that he or she is not always right and accepts criticism graciously and gratefully. A humble person acknowledges his or her mistakes and is quick to apologize when an apology is needed. A humble person does not deliberately call attention to himself or herself. Wise leaders understand this principle, but I learned it the hard way. Shortly after I became a department chair, I sent my faculty a memorandum with a list of platitudinous slogans and goals for the department. It was ostensibly intended to motivate the faculty, but some of them perceived that it was sanctimonious and self-serving. The next morning, a copy of the memorandum had been slipped under my door. On the copy was this handwritten question: "What makes you believe *any* of us care what you think?" Respect is not an entitlement. Respect must be earned.

Collins[11] concluded that the most successful leaders demonstrate "a paradoxical mix of personal humility and professional will." Such leaders "display a compelling modesty, [and] are self-effacing and understated."[11] They do not talk about themselves. Rather, they talk freely about the organization and the contributions of others. In other words, they demonstrate *servant leadership*. I have long believed that career satisfaction is greatest among anesthesiologists who embrace a commitment to servant leadership. As leaders of the perioperative medicine team, we have the unique opportunity to create a collegial and mutually supportive work environment. We can and should affirm and encourage the staff with whom we work. We can learn their names, treat them with respect, and express gratitude for their work.

Emotional intelligence and self-awareness are also vitally important. Brooks[12] said that all the people he has deeply admired "are profoundly honest about their own weaknesses."

Scemama and Hull[13] identified emotional intelligence and self-awareness as key skills in anesthesiology. They affirmed the need for good interpersonal skills in "creating emotional and empathetic connections that engender trust [and] confidence…."[13] But self-awareness is not always enough. Several years ago, I was counseling a resident who was having trouble getting along with the nurses. She said, "I am at a disadvantage in this program because all the other female residents are kind and sweet … and I am not sweet." Not everyone can be sweet. But all of us can—and should—be kind.

Few definitions of physician professionalism include *kindness* as an essential attribute. But the older I get, the more I value kindness among colleagues and staff. Sadly, a singular focus on career success often erodes a person's kindness.

I became a more unkind person during my 11 yr as a department chair. My wife first called it to my attention when she told me that I was demanding and impatient with servers in restaurants. Over time, my interactions with patients became more impersonal and mechanical. One day I prepared to perform a preanesthetic assessment on a woman who was scheduled to undergo surgery for breast cancer. Her surgeon was in the room talking with her, and so I waited outside the door. I became annoyed when 1 min stretched to 5 and then 10 min. I had other things to do. What were they talking about? But then I realized that the patient was crying, and the surgeon was listening and speaking with an extraordinary empathy that put me to shame. I learned a lesson in kindness from that surgeon.

It occurred to me that I had read very little on how we can connect with our patients before surgery. This seemed odd, given the fact that resident applicants often say that they chose anesthesiology because they want to interact with patients at times of great stress. If that is true, then why do so few of us write about it?

In recent years, I have learned a few lessons about connecting with my patients before surgery. First, I sit down, and then I confirm that I am pronouncing the patient's name correctly. I then ask, "What do you prefer to be called?" and "May I call you by that name?" I may then say, "Tell me about your name" or "What does your name mean?" I write that name on a note card, and I discipline myself to address the patient by her preferred name from that time forward. When we call a patient "dear" or "sweetie," we are being lazy at best, and disrespectful at worst. Second, I typically ask, "Where do you live?" and "Where are you from?" Everyone is from somewhere. Third, I ask the patient what he or she is looking forward to doing after he or she recovers from surgery. Fourth, I have changed the way that I complete my assessment. If I say, "Do you have any questions," that intimidates some patients, who are reluctant to admit that they have any questions. And so I now ask, "What questions do you have?" This subtle change seems to make patients more comfortable in asking their questions. Finally, I ask, "What can I do for you right now?" Many patients say, "nothing." But some patient requests have greatly enriched the interaction.

Altogether, these questions add only 2 or 3 min to the preanesthetic assessment, but they foster the human connection and add joy to my clinical practice. As others have said, "It is more important to know the person with a disease than to know what disease a person has."*

Another important quality is *altruism*, which may be defined as unselfish concern for the welfare of others. Altruism results in behavior that supercedes self-interest, without any expectation of reward. And in some cases, concern for the welfare of another person may involve a risk or cost to ourselves.

* Variations of this statement have been attributed to both Hippocrates and Sir William Osler, but a primary source for this information has not been located.

Kearney[14] surveyed anesthesiology educators in Canada to identify desirable professional qualities for anesthesiologists. She was surprised that the respondents did not give high priority to altruism.

On a recent flight, I heard that familiar announcement, "If there is a doctor on the plane, please notify one of the flight attendants." I helped resuscitate a man who appeared to be almost dead. A kind nurse helped me. We did nothing extraordinary. Perhaps the most important thing we did was place him supine, which restored his cerebral perfusion pressure and allowed him to complain of chest pain. We maintained the airway and administered oxygen, aspirin, and nitroglycerin. At my request, the pilot made an emergency landing, and thankfully this man did well. Like many physicians, I have provided this kind of assistance on several occasions.

So I was surprised to read that a medical professional volunteered to assist in only 20% of in-flight medical emergencies in 2005.[15] Do some physicians not respond because of insecurity, fear of litigation, or a desire to avoid inconvenience?

Some 15 yr ago, I was attending a medical meeting in Chicago. A group of tattoo artists was holding a meeting at our hotel. In those days, tattoos were not as common as they are today. Some of my physician colleagues made fun of the tattoo artists, who seemed to have a tattoo on every piece of exposed flesh. I did not say anything, but I admit that I had some unkind and judgmental thoughts. That evening, one of my friends asked, "Did you hear what happened outside the hotel this afternoon?" He told me that a man had suffered a cardiac arrest and collapsed—face forward on the sidewalk. His teeth were broken, and his mouth was covered with blood. Several prominent physicians were standing nearby. One physician offered to call for help. A second started chest compressions. But the other physicians stood frozen like statues. No one volunteered to clear and maintain the blood-covered airway, until one of the tattoo artists stepped out of the crowd and said, "I will do it." As scripture says, "People look at the outward appearance, but the LORD looks at the heart."*

Maintenance of a good heart requires nourishment of the soul. When discussing *physician well-being*, we often emphasize a healthy diet, exercise, adequate sleep, and avoiding substance abuse. But personal well-being requires much more than that. A highly respected medical school dean wrote a remarkably candid essay on his own experience.[16] He wrote, "I first met my soul in childhood bedtime stories….[I learned that] good character arose from faith, hope, and love – achieved through prudence, justice, courage, and temperance….[But] during medical school, I devalued these lessons….I judged them to be unworthy of study or reflection and superfluous to my professional development….As my…[career advanced], my humanity languished. I became work focused, self-centered, prideful, jealous, angry, [and] resentful….I hit a deep…emotional and spiritual bottom…[as a result of] my neglected soul."[16]

Osler[17] said "Engrossed … in professional cares, … you may find, too late, with hearts given away, that there is no place in your habit-stricken souls for those gentler influences which make life worth living."

Duffy[16] concluded that in teaching professionalism, we should include "the care of the doctor's soul." He suggested that we "practice social displays of gratitude … [and] humility … for the healing miracles that come through our work together."[16] We need to say thank-you more often.

Responsibility, accountability, and concern for patient safety are also essential components of physician professionalism. But on my second day of residency training, one of my patients almost suffered a catastrophic outcome. I nearly killed a young man because of a lack of knowledge, poor judgment, lack of vigilance, and inadequate supervision. My staff had performed an axillary block on a healthy young man undergoing hand surgery. As he placed ampules of fentanyl and diazepam in my hand, my staff told me, "Keep him quiet with some of this." I did not see him again. Sometime later, another provider arrived to give me a lunch break. I remember his exact words: "Looks a little blue doesn't he, Chestnut?" If he had not arrived at that moment or soon thereafter, my patient likely would have died.

In his Fred Hehre lecture, Santos[18] described a maternal death that resulted from inadequate supervision of a junior resident in his department early in his career. When Alan discussed this case with his department chair, the chair replied, "Think about it, Alan. It probably costs one life to train one resident." All of us would like to think that we are doing better. But not long ago, an anesthesiology resident from a premier department told me that on her first day of training, she was left alone with a patient undergoing prolonged surgery in the prone position.

It is not surprising that the rate of medical errors increases when faculty are less than frequently involved in resident supervision.[19] And in some recent cases of unintentional subarachnoid block during administration of labor epidural analgesia, resuscitation was delayed and maternal death occurred because airway equipment was not immediately available.[20]

We take great pride in the recognition that anesthesiology received in the seminal report on patient safety published by the Institute of Medicine (Washington, D.C.).[21] In his Rovenstine lecture, Pronovost[22] said, "We have undoubtedly made progress…. But the reported numbers likely overestimate how much we have improved because it is difficult to measure safety…. We still have much work to do."

I want to discuss the importance of *lifelong learning* by reviewing my own experience with litigation for a complication of anesthesia. Thankfully I have had this experience only once.

The patient was a 77-yr-old woman scheduled for abdominal hysterectomy. Mask ventilation was easy, but intubation was unexpectedly difficult. At laryngoscopy, an experienced provider had a grade 3 view of the glottis. With difficulty

* Holy Bible, 1 Samuel 16:7.

she advanced a styletted endotracheal tube, and we immediately recognized esophageal intubation. We then intubated the trachea with the aid of a bougie. Initial postanesthesia recovery was uneventful. But on postoperative day 3, her planned discharge was delayed by unexplained fever. Several days later, dysphagia led to the diagnosis of esophageal perforation, and she was taken to the operating room for exploration and drainage of a mediastinal abscess. Three more times she returned to the operating room. Finally, she was discharged home well on postoperative day 36, and thankfully she suffered no sequelae.

I saw this patient every day for 5 weeks. I played an active role in her care. I had a good relationship with her and her husband. A month after discharge, they visited me in my office. But 728 days after the initial surgery, I received a late night e-mail from our corporate counsel, in which she asked, "David, did you know you have been sued?" Physicians who have been sued know what this felt like. It was embarrassing. It was a blow to my self-esteem and self-confidence. And I had recurrent feelings of guilt.

Outside consultants agreed that the anesthetic management included no violation of the standard of care. But I thought we might have some vulnerability because of the delayed diagnosis of esophageal perforation. We went through the initial phases of discovery. We obtained the anesthetic record from previous surgery at another hospital, which also described an unexpected difficult intubation. The plaintiffs then gave their depositions, and I gave mine. Three days later the plaintiffs' counsel suggested that we engage the services of a mediator. The mediation was both fascinating and successful, and the plaintiffs dropped their lawsuit.

I learned some important lessons from this experience. First, how did my apology during the mediation differ from my previous apologies? I said, "I am sorry that this happened. I am sorry that you suffered as a result of this event." And then I said what I would do differently in the future. Second, this experience was another lesson in humility. I had been an anesthesiologist for 20 yr. I thought I was an expert in airway management. But my understanding of airway injuries and their sequelae was not what it should have been.

A review of airway injury acknowledged that prompt diagnosis of esophageal perforation may be difficult.[23] But sometimes we don't know what we don't know. When I last took the American Board of Anesthesiology (ABA; Raleigh, North Carolina) Maintenance of Certification exam 7 yr ago, I studied for it. I was surprised at what I had forgotten, and I was stunned at what I did not know. Ongoing self-assessment and lifelong learning are hallmarks of medical professionalism.

Finally, my case helped me understand the stress that accompanies a bad outcome and the litigation that follows. Eichhorn[24] summarized another anesthesiologist's description of his experience as a second victim: "The 'wall of silence' … takes a huge toll on the involved caregivers. He was not supported … by his colleagues…. He had no way to express and deal with his feelings…. No one … considered the enormous impact it had on him."[24]

A survey[25] of the impact of perioperative catastrophes on anesthesiologists revealed that 84% of respondents had been involved in at least one unanticipated patient death or serious patient injury during their career. More than 70% experienced guilt and anxiety. Some 88% required time to recover emotionally, and 19% said that they had never fully recovered.[25] Martin and Roy[26] said that if vigilance and confidence are reduced as a consequence of depression or acute posttraumatic stress disorder, "then patients subsequently anesthetized by the affected anesthesiologist may become third victims." All of us likely have at least one colleague who needs our support today.

Any definition of professionalism should include *self-regulation*. Candidly, we have not done this very well. In a survey,[27] among physicians who had direct personal knowledge of an impaired or incompetent colleague during the previous 3 yr, 45% had not reported that physician to relevant authorities. Too often we have regarded a medical school diploma as a lifetime entitlement. And we struggle to assess ongoing competence and fitness for clinical practice, especially in those of us who are aging.

An important example of collective professional self-regulation is our specialty's response to physician involvement in execution by lethal injection. The lethal injection protocol was described by an anesthesiologist in 1977.[28] Until recently, the protocol typically involved the sequential injection of a barbiturate, pancuronium, and potassium. Lethal injection is now used by all states with the death penalty.

The public debate over the use of medicine to perform execution began early. Denno[28] wrote that "the law turned to medicine to rescue the death penalty." The potential for physician involvement became quickly apparent. Early opposition was voiced by the American Medical Association (Chicago, Illinois). But in 2001, 41% of surveyed physicians said that they would be willing to participate in executions,[29] and Gawande[30] wrote about his conversations with several physicians who have done so.

Why would states ask physicians to participate in lethal injection? In brief, not just anyone can do it. It is often difficult to obtain intravenous access in the condemned. Even preparation and administration of the drugs is challenging. In recent years, federal courts have issued orders requiring the participation of an anesthesiologist in the lethal injection.

Imagine reading the following news report of an execution: "After multiple attempts, the prison staff were unable to obtain intravenous access. A board-certified anesthesiologist was summoned to the execution chamber. Using sterile technique and sonographic guidance, the anesthesiologist skillfully placed a central venous catheter. He then reassured the condemned that he would remain at his side until he was comfortably … and safely … dead."

Not long ago, many of our patients asked, "Are you going to give me the drug that killed Michael Jackson?" Do we

want our patients to ask if we are going to give the same drugs that another anesthesiologist gave during an execution? Leaders of our specialty wisely concluded that anesthesiologist participation in lethal injection would undermine, erode, and perhaps destroy our patients' confidence in physician anesthesiologists. In 2006, the ASA House of Delegates approved this statement: "Capital punishment in any form is not the practice of medicine…. ASA strongly discourages participation by anesthesiologists in executions."[31]

But voluntary professional societies have a limited ability to enforce ethical guidelines. So the ABA added the following statement to its professional standing policy: "An anesthesiologist should not participate in an execution by lethal injection and … violation of this policy is inconsistent with the professional standing criteria required for ABA certification…. ABA certificates may be revoked if the ABA determines that a diplomate participates in an execution by lethal injection."[32]

The ABA did not take a stand for or against the morality of capital punishment. But the ABA policy represents an endorsement of historic physician professionalism. I was not surprised that some anesthesiologists disagreed with the ABA decision. But I *was* surprised by the argument that the ABA had overstepped its authority. Some anesthesiologists said that the ABA should limit its jurisdiction to an assessment of competence. But professionalism is one of the six core competencies for physicians. Others argued that the ASA—not the ABA—should oversee and enforce standards of professionalism. But Van Norman and Jackson[33] said that "enforcing ethical norms … presents unique challenges to an organization such as ASA, which has no certification or regulatory function." And expulsion from the society would likely have little or no impact on practice or behavior. The ABMS requires each of its 24 member boards to assess professionalism. Self-regulation is a hallmark of medical professionalism.

The importance of *honesty and integrity* may seem self-evident. But one of the most vexing contemporary issues for physician certification boards is the protection of examination security and the prevention and detection of cheating on certification exams.

In 2010, the American Board of Internal Medicine (Philadelphia, Pennsylvania) disciplined 139 physicians who had systematically provided copyrighted test questions to an exam preparation course. Two years later, CNN reported, "For years, doctors … taking … exams to become board certified … have cheated by memorizing test questions [and] creating sophisticated banks of [recall questions] … meticulously compiled by … residents … [from] some of the most prestigious programs in the United States."[34] It is well known that this kind of activity is widespread. CNN[34] published comments from program directors and trainees. Some program directors did not think this activity was a problem. Some physicians acknowledged their dishonesty, but they said they needed to know the questions—in advance—in order to pass the exam. Others accused the certification boards of laziness by not asking all new questions each year. But certification boards recycle between 20 and 50% of test questions from one year to the next, because those questions serve as *anchor questions* that help maintain psychometric validity. Certification exams are not perfect assessment tools, but these news reports did not foster public trust in physician honesty and integrity.

Our specialty has had its own share of bad press. The cover of one of our premier journals was recently entitled, "Misconduct."[35] And recent studies have observed a high frequency of misrepresentation of research and publication activity, as well as plagiarism in personal statements, by applicants for residency training.[36,37]

Unprofessional behavior during training is predictive of future disciplinary action by state medical boards.[38] Perhaps it is a short step from application and examination fraud to fraud in patient care. One physician was sentenced to 45 yr in prison for giving unneeded or excessive chemotherapy to more than 500 patients.[39] He acknowledged that he had misused his talent because of power and greed.

I have a friend who is a retired medical school basic science professor. For many years, he would pose a question to first-year medical students, only 6 weeks after they had started medical school. He would ask, "How many of you have already identified a classmate to whom you would never refer a patient?" Invariably most of the students would raise their hand. Why do medical students so quickly identify classmates to whom they would not refer a patient? I suggest that it is not because the students are unimpressed with their classmates' manual dexterity or knowledge of the Krebs cycle.

I often ask resident applicants this question: "If you could change anything about the medical school admissions process, what would you change?" No one has ever told me that greater emphasis should be placed on grades and test scores. Uniformly the applicants say that greater attention should be given to character, integrity, interpersonal skills, and altruism.

But these qualities are often subverted by the so-called "hidden curriculum" in medical education and the practice of medicine itself.[40] The hidden curriculum includes the cynical attitudes and unprofessional behaviors to which trainees are exposed in the clinical setting, often contradicting and undermining the lofty ideals of medical professionalism. And it likely contributes to the hardening of the heart that often occurs during and after medical training.[41]

Many of us were troubled by a recent news story of an anesthesiologist who mocked a patient while he was sedated.[42] But I suspect that some of our discomfort occurred because at some time in our training or practice, many of us have made a disparaging comment about a patient's weight, personal hygiene, or social history. Or perhaps we have heard a colleague make unkind comments, and we were guilty of silence. As one of my colleagues said, "This kind of thing happens much more often than we want to admit."

Lucey and Souba[43] said that "breaches of professionalism occur at every medical center every day." And lapses of professionalism are common, even among highly motivated physicians of good character, especially in complex, stressful situations.[43]

Many observers have concluded that we have a crisis of professionalism in the practice of medicine. In recent years, we have witnessed a surge in the number of publications on medical professionalism. But it is easier to create codes of professionalism than to change the behavior of individual physicians, and it is unclear whether these statements on professionalism have had a positive impact on the practice of medicine.

As stated previously, the ABMS[7] defined medical professionalism as a "belief system." A belief in what? Kinghorn *et al.*[44] wrote, "The various professionalism statements are intended to be consensus statements, acceptable to … diverse physicians, and … explicit acknowledgement of grounding moral narratives … would likely compromise the ability … to describe a consensus."[44] But herein lies the dilemma: "There is no common consensus or morality intrinsic to modern medical practice in which the professional virtues can be firmly cultivated and grounded…. The professional virtues … bloom and grow most fruitfully in the context of the … specific grounding traditions that originated and sustain them."[44] Separated from those traditions, professionalism statements appear arbitrary and burdensome. Separated from any grounding moral narrative, a statement on professionalism becomes just another set of rules. We may read and process these statements in our head, but they do not warm and soften the heart. Codes and rules do not inspire us to be better doctors … and to be better people.

So this begs the question: in a culture that values fame and success more than service and sacrifice, how do we make a physician be good? Hunter[45] concluded that a supportive sociocultural environment is needed for character and virtue to flourish. He said that character requires "a conviction of … truth … abiding … within consciousness and life, [and] reinforced by habits institutionalized within a moral community."[45]

Brooks[46] wrote, "We all need people to tell us when we are wrong, to advise us on how to do right, and to encourage, support … and inspire us along the way." I suggest that all of us need help maintaining our moral compass, especially as we balance competing priorities and try to make sound judgments and decisions in the complex, stressful situations that we encounter in modern medical practice. Kinghorn *et al.*[44] encouraged young physicians to participate in "communities of virtue that will allow the professional virtues to be cultivated from within rather than imposed arbitrarily from without." Personally I believe that the most solid basis for medical professionalism results from a belief in—and accountability to—someone infinitely greater than ourselves.

But personal character and piety are not sufficient. Lesser *et al.*[47] said that professionalism is more than "an innate character trait or virtue," and that professionalism requires development of "sophisticated competencies that can and must be taught and refined over a lifetime of practice…. Consistently exhibiting professionalism is a practiced skill."[47] Professionalism requires lifelong learning and practice.

Some time ago, I saw one of my professional mentors for the first time in several years. I asked him, "Do you still practice?" Of course, I was asking whether he was still active clinically. But he said, "I no longer need to practice. I already know how to do it." Well … I have not yet arrived at the consistently high level of professionalism to which I aspire. I still need to practice professionalism. I am still on the road to professionalism.

In this essay, I have shared some personal reflections on professionalism in anesthesiology. I have identified attributes that I consider important: humility, servant leadership, self-awareness, kindness, altruism, attention to personal well-being, responsibility and concern for patient safety, lifelong learning, self-regulation, and honesty and integrity. Professionalism requires character, but character alone is not enough. We need others to help and encourage us. And in turn, as physician leaders, we help shape the culture of professionalism in our practice environment.

Professionalism is *not* something we learn once, and no physician is perfectly professional at all times, in all circumstances. Professionalism is both a commitment and a skill—a competency—that we practice over a lifetime.

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Correspondence

Address correspondence to Dr. Chestnut: Department of Anesthesiology, Obstetric Anesthesia, VUH 4202, Vanderbilt University Medical Center, 1211 Medical Center Drive, Nashville, Tennessee 37232. david.h.chestnut@vanderbilt.edu. Information on purchasing reprints may be found at www.anesthesiology.org or on the masthead page at the beginning of this issue. Anesthesiology's articles are made freely accessible to all readers, for personal use only, 6 months from the cover date of the issue.

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