Professionalism – how and what?

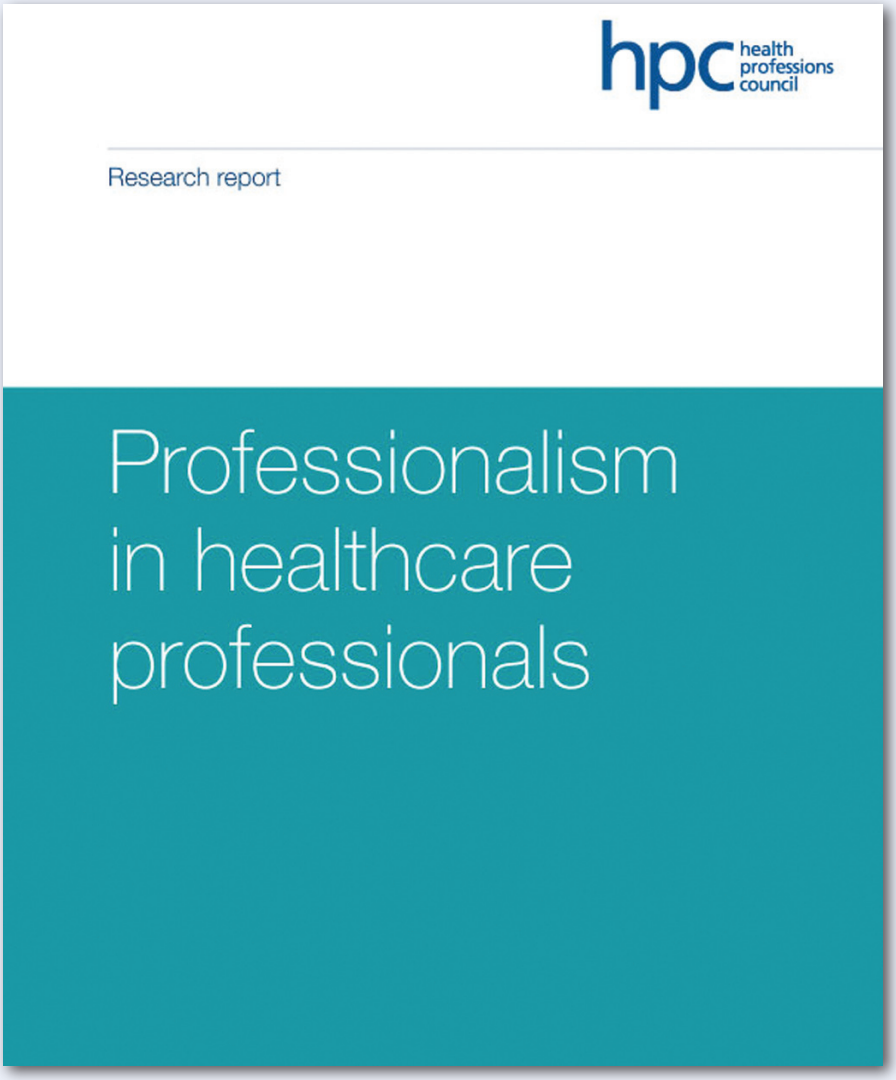
What does professionalism mean for ODPs? Jonathan Hauxwell offers a summary and commentary on a Health Professions Council research report on the subject

Keywords – Professionalism; HPC; attitudes; role models; expectations.

Ask a group of students what it means to act like, or to be 'professional' and they will respond with comments such as: *'do your job well', 'never let your feelings show', 'maintain a tidy appearance'* and so on. The national curriculum for ODPs (AODP, 2006) defines content related to being a professional for educators that includes: team work, communication and confidentiality – categories closely related to the tenets of statutory regulation that were to follow on soon after. Evidence is needed to validate that this is how professionalism is viewed and defined; little is written on the topic that is relevant to regulated healthcare professions (Arnold, 2002; Cruess and Cruess, 2006; Stern, 2006). To this end, the Health Professions Council (HPC) commissioned the University of Durham to undertake a study that explores aspects of professional practice, which was published in 2011 as *Professionalism in Healthcare Professionals* (HPC, 2011).

The study was an attempt to increase understanding of what professionalism means by focusing on students and educators from three HPC-regulated groups: podiatrists, occupational therapists and paramedics. Within these groupings, 112 participants were asked about their perceptions of what professionalism was and how it – and the lack of it – can be identified.

This paper seeks to utilise some of the report's content and contextualise the study for operating department practice by summarising and commenting on the content that is relevant to education and clinical practice in the ODP field. Operating department practitioners (ODPs) are regulated by the HPC and are expected to conform to the council's general and also profession-specific codes of conduct (HPC, 2008a; 2008b). While the Department of Health does not classify ODPs as allied health professionals (AHPs) like the other groups regulated by the HPC (except for the instance of the framework document *Modernising Allied Health Professions* (DH, 2008), it is appropriate that we look at research that relates to AHPs and examine its conclusions with regard to where we find ourselves as educators and clinical practitioners. It is also appropriate for ODPs in the context of the Big Conversation. This was inaugurated by the chief health professions' officer Karen Middleton, and exorts AHPs to re-examine their values and attitudes on professionalism (DH, 2012). The Big Conversation is an initiative to promote an internal professional dialogue about what professionalism means. ODPs should engage in this process for a number of reasons: disciplinary data on the HPC website includes ODP cases, so we must take heed of the messages these give,



and taking part in such a reflexive internal dialogue is itself a measure of maturity and professionalism in a discipline.

Educators (both clinical and university-based) are identified in the research study as role models as much as qualified practitioners in the workplace are (HPC, 2011). However, the examples discussed have clear implications for patient and colleague interactions, so there is an across-the-board responsibility being mooted for our profession. I am an ODP educator, so this has influenced the interpretation and contextualisation of the HPC report.

Individual values

In summary the study shows that professionalism is founded by individual values, but is more largely defined by where individuals work, how well they are supported by their organisations, what others expect and the actual specifics of the patient contact. Codes of conduct seem to be a baseline rather than a specification. Professionalism is a function of *situation* as much as of defined behaviours – *'where' as much as 'what'*.

Some of the qualities of a professional were identified as inherent in an individual before they joined their chosen field, characteristics such as empathy and caring were noted, but that role-modelling was also important to determine what action or behaviour fits what context.

The supporting role of employers was emphasised too, in providing an environment where feeling valued is perceived as normal, and management support and recognition by other professions is a given. 'Newer' professions, of which ODP is one in terms of statutory registration (but was not part of the project), may find it harder to gain such support and recognition.

I have chosen to pursue the ODP-related contextualisation of the HPC report by drawing on the raw data from focus groups quoted in an appendix of the report and selecting data that raises issues judged to be relevant to the (student and qualified) ODP role and situation.

Talking about patients

Extract 1: *'I mean sometimes it's just an MDT [multidisciplinary team] meeting because we have big personal meetings but the patients aren't there... because the patients aren't there I think sometimes the professionals forget and sometimes it's terminology, how they described patients and they think it's safe because it's a team that they know quite well but then they forget that they might have students in and new people who have come in, you know and sometimes after a meeting we have to say, "Oh that's just how they are", when actually they shouldn't be saying it in the first place… you know it's a sentence about a patient which is quite derogatory like about their size or something which isn't really relevant to anything and that can be a quite public meeting sometimes as well' (Focus Group 8, occupational therapy placement educator).*

In Extract 1 there are issues that can be seen to apply to the ODP educator, student and qualified contexts. Clearly they centre on inappropriate comments that are derogatory and may be abusive of persons not present. Is there ever a time when referring to patients, students or colleagues in derogatory terms is appropriate? This 'locker-room' behaviour, if we match it against HPC standards, can be seen to be never appropriate. HPC standard 1 b.1 says: *'be able to work, where appropriate, in partnership with other professionals, support staff, service users and their relatives and carers'* (HPC, 2008a: p6). This is qualified this by the addition of: *'– understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team.'*

Standard 1 b.3 adds: *'be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relatives and carers'* (HPC, 2008a: p6). If the changing room or the coffee room are considered an appropriate location for this behaviour then consider Standard 3 *'You must keep high standards of personal conduct, as well as professional conduct. You should be aware that poor conduct outside of your professional life may still affect someone's confidence in you and your profession'* (HPC, 2008b: p9) The required behaviour should be clear – any conversation about a patient, student or colleague should be of a neutral, professional tenor. This is both enshrined in standards for the qualified registrant and, since 2009, guidelines for the student ODP:

- *'You should be aware that conduct outside of your programme may affect whether or not you are allowed to complete your programme or register with us.*
- '*You should be polite with service users, your colleagues and the programme team*' (HPC, 2009: p9).

Social media

In terms of indirect remarks made that are derogatory, the use of social media in communicating about the same three groups must fall within these regulations. Extract 2 is relevant to this.

Extract 2: *'When I was at university Facebook was sort of flagged up as a big no-no when we were on placements, we were told we weren't allowed to even mention we're on placement… there had been some incidents in the past where people had sort of mentioned educators or said or complained about what a horrible time they were having and it just obviously the message that gives for the people it comes across as very unprofessional…'* (FG13, occupational therapy placement educator).

Remarks about others on such a medium can be traceable, and even without the use of names, can be matched to particular individuals, be they educators, as above, patients or colleagues. As a result, higher education institutions (HEIs) and NHS trusts are now becoming more prescriptive about how social media are used.

Politeness

The study makes a point about how learners use role models, both good and bad, to make judgements about what professional practice is. Qualified practitioners who are mentors are more exposed to this behaviour (Hauxwell, 2010); they spend more time than any other person in the student's educational process. The report also raises the issue of adopting the unprofessional habits of others as a result of compliance/acceptance with them.

If students hear corridor conversations that are derogatory, or they see or experience behaviour in the classroom or workplace that is poor then they may either think it is the norm and therefore acceptable, or they judge that it is not the norm and not acceptable. The key thing for the professional in all contexts is to render this judgement unnecessary by eliminating unacceptable personal behaviour completely.

Politeness is a key to treating others, and being treated equally as the extract below shows:

Extract 3: *'Coming in late, you know habitually being late, not just the one occasion where it's been difficult […] and it's the taking responsibility for that lateness so it's ok somebody being late, really sorry I'm late, well you don't even get sorry you were late, "I'm late", "Why were you late?", "Oh it was because*

of somebody else", it's that sort of thing, it's everybody else's fault, it's never me' (FG6, occupational therapy classroom educator).

The impoliteness is clear, but if one pursues the role-model theme one might surmise that if the educator in Extract 3 does not make it a maxim to apologise for any example of his or her own lateness, then the mould is set for the student. The patient and colleague contexts are obvious transferences here.

Extract 4: *'Talking in class when, and quite clearly it's inappropriate to be talking about whatever it is they are talking about you know, whispery, jokey, messing around, not talking about what we are supposed to be talking about, you know, not showing the insight that they're there for a reason, that's one thing'* (FG6, occupational therapy classroom educator).

For the classroom example given in Extract 4 the inappropriateness is clear; one can turn this on its head again and ask does the educator deals with this in a way that does not insult or abuse the perpetrators? It is a classroom behaviour that can be controlled professionally.

Inappropriate behaviour

The world is not a perfect place to live or work in – students can observe and occasionally become involved in disagreements in the workplace that are conducted unprofessionally. An opportunistic mentor can use incidents where the student is an observer as a valuable learning experience by asking: *'Did you understand what took place there? Was the behaviour appropriate? If not, why?'*

Students themselves can be the focus of general criticism centred on their course of education and its seeming over-complexity and over-academic nature – the criticism itself is not the issue, it is when and how it is delivered. More specifically it must be the ability to put one's personal values to one side if they are not congruent with the values of the profession.

Expectations of others

Professional identity alone can be seen as an endower of professionalism. The study points to a piece of commonly cited medical literature (Swick, 2000) that endows some elements of professionalism to the virtues of just being a doctor, rather than it being grounded in practice. Anecdotally some student ODPs have reported that their new status brings an expectation of 'medical' nous by others, and some find this a burden. The message is in Standard 13: *'You must justify the trust that other people place in you by acting with honesty and integrity at all times. You must not get involved in any behaviour or activity which is likely to damage the public's confidence in you or your profession'* (HPC, 2008b: p14).

Implied virtue is a nebulous concept that is best replaced by something more concrete. The implication is that members of the public, or of a student's or practitioner's family, may see them in a new light and expect opinions and actions that are clearly outside of their scope.

Conclusion

The study's admitted limitations are that its focus group-dominated methodology cannot guarantee to gather every participant's opinion. However, the researchers did try to mitigate this by the use of *Post-it* note records of all views, and hence minority opinions. The use of some one-to-one interviews might have enriched the data.

There are more studies in this series, the HPC promises further investigations into 'different aspects of the regulatory and professional landscape'. A study based on putting the questions and issues of this study to qualified practitioners would provide some interesting continuity on what role models demonstrate, and what professionalism is and how it manifests itself.

Jonathan Hauxwell is senior lecturer, operating department practice, School of Human and Health Sciences, University of Huddersfield

References

Association of Operating Department Practitioners (2006) *Curriculum Document*. Wilmslow: AODP.

Arnold L. (2002) Assessing professional behavior: yesterday, today, and tomorrow. *Adac Med;* **77:** 502-515.

Cruess RL, Cruess SR (2006) Teaching professionalism: general principles. *Medical Teacher;* **28:** 205-208.

Department of Health (2008) *Modernising Allied Health Professions: a competence-based career framework.* London: DH. tinyurl.com/DH-modernising-AHP

Department of Health (2012) *Have you had the big conversation yet?* (Karen Middleton, Chief Health Professions' Officer) London: DH. tinyurl.com/DH-conversation accessed June 2012

Hauxwell J (2010) Learning in theatre: a critical commentary from experience. *Technic: The Journal of Operating Department Practice*; **1:** 4.

Health Professions Council (2008a) *Standards of Proficiency for Operating Department Practitioners.* London: HPC. tinyurl.com/HPC-standards-ODP

Health Professions Council (2008b) *Standards of Conduct, Performance and Ethics.* London: HPC. tinyurl.com/HPC-conduct

Health Professions Council (2009) *Guidance on Conduct and Ethics for Students*. London: HPC. tinyurl.com/HPC-student-ethics

Health Professions Council (2011) *Professionalism in Healthcare Professionals*. London: HPC. tinyurl.com/HPC-professionalism

Stern DT. (2006) (ed.) *Measuring Medical Professionalism*. Oxford: Oxford University Press.

Swick HM. (2000) Toward a normative definition of medical professionalism. Acad Med; **75(6):** 612-616.

What on earth? Gowers' Haemoglobinometer, invented 1875

Invented by William Gowers, an eminent neurologist, paediatrician, researcher and artist, the Haemoglobinometer was an instrument used for the measurement of haemoglobin and red cells. Similar to the earlier Haemocytometer, the Haemoglobinometer contained a free-standing comparator with a slot for one comparator tube, graduated from 0–100mm³, two glass pipettes calibrated for 20mm³, two mouth-pieces, two lengths of rubber tubing, a coloured slide, and a reagent receptacle (missing from this set). In use, a 20mm³ sample of blood sample would be mixed with water in the graduated tube to a total volume of 100mm³. A 10mm³ (1%) sample was aspirated to provide the measured volume; the water caused the blood

cells to burst, which released the haemoglobin. The mixture was again diluted until it matched the density of the picrocarmine standard slide. The concentration of haemoglobin could then be obtained by calculating the cells against the slide.

Reference

Welsh Museum of Health and Medicine: www.wmhm.org.uk/gowershaemoglobi.html