Communities of practice: The value of face-to-face communications and in-person learning

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Editor's note: The following is Chapter 1 of the 2024 Alpha Omega Alpha Honor Medical Society professionalism monograph, "Medical Professioalism Best Practices: Professionalism in a relentless world." To receive a copy of this, or previous AΩA monographs, E-mail info@alphaomegaalpha.org.

Professionalism in medicine has been a core value for Alpha Omega Alpha Honor Medical Society (AΩA) since the society's founding in 1902. In fact, demonstrated professionalism is one of the primary criteria for election to membership in AΩA.

The profession of medicine is based on a covenant of trust—a contract we have with patients and society. Medical professionalism represents an interlocking foundational structure among physicians, patients, and society that determines values and responsibilities in the care of the patient.

AΩA was founded in 1902 by William Root, a medical student, who, along with a group of other students, were galled by the absence of professional values, and the lack of professionalism of their fellow medical students and faculty. They wrote, "The mission of AΩA is to encourage high ideals of thought and action in schools and medicine, and to promote the highest ideals in professional practice."[1] They established the AΩA motto as, "Be Worthy to Serve the Suffering," and they defined the mission—educational achievement, professionalism, leadership, teaching, humanism, and community service—as a way to encourage ideals of thought and action in schools of medicine, and to promote that which is the highest in professional practice. They defined the responsibilities of AΩA members—to foster the scientific and philosophical features of the medical profession; to look beyond self to the welfare of the profession and the public; to cultivate social mindedness, as well as individualistic attitudes toward responsibility; to show respect for colleagues, especially for elders and teachers; to foster research; and to always respect the noble profession of medicine and advance it in the public opinion.[1]

They went on to further explain that it is equally a duty to avoid that which is unworthy, including the commercial spirit and all practices not in the welfare of patients, the public, and the profession.[1]

A physician's commitment

The modern era of medicine has brought about incredible advances in science and technology designed to improve the care of patients and population health. At the same time, major social changes are occurring that impact society, patients, physicians, medicine, health care, and medical education. Medical professionalism continues to be a core, but challenged, value at the forefront of all these changes.

A physician's commitment to medical professionalism is one of our profession's most important tenets, and signifies our trustworthiness, accountability, and commitment to patients and society. We must address the role of changes

in society, medicine, science, medical education, and the businessification of medicine, and other aspects of the modern era with medical professionalism as a core value at the forefront of these changes. Medical professionalism underlies the basis of trust that society places in physicians.

Ongoing changes in technology, changing practice patterns, inadequate time for patients, are affecting the way care is delivered. We must be dedicated to the priority and importance of the doctor-patient relationship while addressing these challenges.

The doctor-patient relationship

The core of the doctor-patient relationship is caring and compassion, and the importance of communication. It is more than understanding the science of medicine and technology in curing disease, it is addressing the emotional and other needs that differ with each patient.

Ensuring that physicians have the needed time to provide compassionate care is being challenged by economic, political, technologic, and financial challenges that also threaten our medical professionalism.

Fundamentally, professionalism is about always doing the right thing! United States Supreme Court Justice Louis Brandeis defined a profession. He wrote, "A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge, and to some extent learning, as distinguished from their skill. A profession is an occupation which is pursued largely for others and not merely for oneself. It is an occupation in which the amount of financial return is not the accepted measure of success." [2]

In 2000, the Royal College of Physicians and Surgeons of Canada stated, "Physicians should deliver the highest quality of care with integrity, honesty, and compassion, and should be committed to the health and well-being of individuals and society through ethical practice, professionally led regulation, and high personal standards of behavior." [3]

And, in 2004, Richard and Sylvia Creuss defined medicine as, "An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served, and to society." [4]

Professional responsibilities

Throughout medical history, professional organizations have defined a set of professional responsibilities:

- Professional competence;
- Honesty with patients;
- Patient confidentiality;
- Maintaining appropriate relations with patients;
- Improving quality of care;
- Improving access to care;
- Just distribution of finite resources;
- Scientific knowledge, and
- Maintaining trust by managing conflicts of interest.

Since learning requires a clear, straightforward set of expectations combined with learning opportunities, reflection, evaluation, and feedback, the following principles may provide an important basis for medical student and physician learning:

- The care of the patient comes first;
- Do no harm;
- No lying, stealing, or cheating, nor tolerance for those who do;
- Always be true to your word;
- Commit to professional competence and lifelong learning;
- Self-reflection;
- Accepting professional and personal responsibility;
- Using knowledge and skills in the best interest of others;
- Treating everyone humanely, with benevolence, compassion, empathy and consideration;
- Caring for patients in an ethical, responsible, and respectful manner;
- Respecting patients' dignity, privacy, and confidentiality, and their right to make their own decisions about their care;
- Communicating effectively, and
- Listening, understanding, and respecting others' points of view.

Social responsibilities

In addition, there are common social responsibilities and advocacy:

- Commit to, and advocate for, high quality care and improved access to care for all;

- Eliminate conflicts of interest—business, financial, organizational;
- Work collaboratively;
- Ensure responsible management of resources, and
- Advocate for the medically underserved.

Dr. Frances W. Peabody wrote, "One of the essential qualities of the clinician is to be interested in humanity, for the secret of the care of the patient is in caring for the patient." [5]

Physicians must put patients first and subordinate their own interests. They must adhere to high ethical and moral standards based on the Golden Rule - treat others as you would have them do (treat) to you.

Everyone has a unique personal identity that was acquired from early childhood and is formed based on gender, genes, race, ethnicity, family and social experiences, education, communities, language, physical and mental capability, and experiences. Everyone is unique with their own personal identity. For different reasons, and with a unique personal identity, many have aspired to be a physician, with curiosity, grit, perseverance, capability, education, medical school, residency, etc. Over a seven, or more, year period of medical school and post-medical school training and experiences, physicians understand and speak the languages of medicine, science, and health care. They have the professional knowledge and experience to be a physician. They have medicine's community of practice, caring for and serving patients and society. They accepted the ethical, moral, and virtuous responsibilities of being in this community of practice as a physician.

Much of what physicians do is dependent on excellent communication, using language and professional knowledge and skills. The power of language creates a version of reality and serves to help make sense of things. Reality is shaped by a subjective view of what happens, which is shaped in language. Truth seeking requires we be maximally mindful of the biases that language and reasoning introduce. Human reasoning and language evolved as a social tool. Language's greatest flaw is that it allows us to say some things that aren't true. When we talk, our words create our versions of reality, whether social or physical.

When I was a new faculty internist at the University of Chicago, I was the head of a new general internal medicine academic division, and also clinical services on the wards and in the clinics. One busy afternoon I looked at my schedule and was somewhat upset because I had been overbooked. At that time, new patient visits were one hour, and follow up visits were 30 minutes.

When I got to the clinic there was a middle-aged woman screaming and ranting and raving about how bad our clinic was, and about her multiple medical problems for which she hadn't been able to get the care she needed. I asked the clinic nurse about the screaming woman, and she replied "She is your first new patient this afternoon, doctor." I thought "oh no," but went in and introduced myself and asked her to tell me about why she was there to see me. I listened attentively and continued taking her history. She continued to shout and rage intermittently, seemingly unrelated to my questions or her symptoms. I asked the nurse to join us for my examination and to change her into an exam gown. I did a thorough examination, listened to her, and found no abnormalities or evidence of disease or injuries. I had her redress and sat with her to explain that I knew she was suffering and feeling angry and bad. I told her that her physical exam was normal. I asked about her family issues, job, and stress, but she said those were not the reason she was angry and suffering.

I was uncertain of the diagnosis, so I explained to the patient that I was sending her to the laboratory to have blood drawn for some screening tests that might explain or guide us in taking care of her.

I wrote her a prescription—I don't remember what I prescribed—and told her to stop at the pharmacy and have the prescription filled, and to follow the instructions on the label. I then scheduled her for a follow-up appointment.

Several months later, I was walking through the hospital lobby and saw her standing in a line for something. I walked up to her, reintroduced myself, and asked how she was doing. She said she was much better. She also told me she didn't have the tests done, and had canceled her follow-up appointment.

I then asked her about how the medicine I prescribed had been. She told me it had given her great relief from her illnesses. I asked her if she needed any refills since it had been quite awhile. She opened her purse explaining that she still had the medication I prescribed.

She then showed me the actual written prescription with my signature, which hadn't been filled.

My hypothesis is this was a therapeutic outcome from caring and interpersonal communication. It represents an n=1, case study in the value of taking the time for face-to-face communication.

Communication

Face-to-face communication continues to be the most meaningful mode of human communication, and

represents the gold standard for which other forms of communication are evaluated.

Effective communication skills include verbal communication, active listening, personal connection, trust, compassion, presentation skills, nonverbal communication cues, cultural awareness, learning, education, caring, intimacy, humility, patience, respect, gratitude, emotional support, sympathy, and forming a connection. The human factor is the essence of clinical care, as well as teaching, learning, and life.

Communication can make all the difference when it comes to feeling supported, establishing trust, evaluating judgment, and engaging with others. I understand that heavy workloads, complex and difficult work processes, and disorganized and stressful environment often create barriers. However, effective doctor-patient communication is a central clinical function in building a therapeutic relationship, which is the heart and art of medicine.

A doctor's communication and interpersonal skills are critical to facilitating accurate diagnosis, providing counsel, facilitating therapeutic instructions, and establishing a caring and trusting relationship with patients.

Recommendations to communicate well, even in complex cases and challenging settings, include:

- Be attentive and listen completely and attentively to build rapport and trust, and have meaningful discussions about diagnosis and treatment.
- Always start with an open question giving the person time to talk about what is most important to them.
- Maintain a sense of curiosity about your patient by asking yourself questions like—"I wonder what is going on with this person and their life? Why they are saying it in this way?
- Periodically summarize what the patient is saying and ask the patient if you have correctly understood the key points . Demonstrate that you are listening and care.
- Invite the patient in complex situations to have family or peers with them who may be able to help them to reflect on the issues and explore the options.
- Use simple and concise language without talking down to the patient and recognize that non-verbal communication often conveys a sense of caring and empathy.
- Be mindful of all that may be going on in the patient's life which may affect how you manage their care.
- Involve other medical personnel and nurses to help answer questions when needed

  Use the right tone and positive non-verbal communication to convey a sense of warmth and empathy to the patient.
- Work to be aware of your patient's situation, and how other issues may be affecting them.
- Be aware of cognitive and non-cognitive biases, acknowledge them if needed, and do not let them affect how you care and communicate with patients so they feel comfortable sharing deeply personal and other issues pertinent to their care.
- Find ways to support your communication with tools and analogies for better understanding.
- Try to keep shared decision-making in mind.
- Be an active listener to evaluate if you need to ask more. Make sure the patient has understood your question or message. Communicate to help decrease anxiety and stress.
- Adopt a freedom to speak out communication style for patients to share ideas with you. Show that you are prepared to listen, and willing to learn.
- Keep accurate records, and frequently share your notes with the patient.

Communicating well with others also brings joy to the workplace, and in personal relationships. I remember seeing and caring for patients in the clinic and gathering in the conference room to complete the patient's chart—we didn't have electronic health records back then.

I would join my colleagues, medical students, residents, and nurses before, between, and after patient visits. If I had made a terrific observation or diagnosis I would share my case with the team. If I had a difficult case, and not sure what to do, I would present the case and discuss it with others for advice and counsel. Sometimes, we would commiserate about the system, or other personal problems. Sometimes, we would plan an outing, family event, or social gathering. This was my community of practice.

Unfortunately, we seem to have lost our joy in being a part of a physicians' community of practice. This may be because limited time and other priorities have limited our abilities, or we haven't worked hard enough to understand and create a social and professional organization within our work communities.

Much of what we refer to as burnout and lack of resilience stems from the inadequate response from our professional communities to challenge and overcome detrimental effects.

We no longer have strong communities of practice.

This is detrimental to medicine, health care, our profession, and us as doctors, educators, and human beings.

Communities of practice

To form a community of practice, identify two or more colleagues to meet with and get to know them personally and professionally, and to develop a professional and social relationship. Set up a meeting with them. Learn about them and from them, who are they. What shared passions do you have in common? Do you find joy when interacting with these people?

As a member of a community of practice you can engage in joint activities wherein you can, and will, learn how to improve programs, share best practices, and discuss areas of growth, development, and innovation. These are colleagues with whom you can commiserate without judgment.

Once working together well, communities of practice can always add more members. A community of practice will develop a shared repertoire of resources, including experiences, stories, tools, ways of addressing problems and dealing with difficult issues, and overcoming barriers.

A community of practice is a cohesive and functioning group. It can address unique and important issues within an organization and/or community, and can provide an outlet for social opportunities.

Successful and effective communities of practice include:

- Understanding, evaluating, and sharing unique and important issues in a workplace/organization/community.
- Recruiting and sustaining a diverse team of academic, clinical, professional, policy, and other participants.
- Providing regular forums to identify, translate, and disseminate information.
- Identifying the best strategies and processes for understanding and tackling diverse important challenges.
- Developing an ongoing evaluation of strategies in influencing target audiences.
- Incorporating other points of views and needs.
- Serving unique needs of members of the community of practice

To form a community of practice:

- Identify members;
- Convene and develop agreements about purpose, common goals, expectations, outcomes, and ongoing participation;
- Develop commitments to the community of practice;
- Build relationships and share personal and professional narratives;
- Determine the initial and ongoing projects, needs, and opportunities;
- Understand why, what, how, who, and when questions for the community of practice;
- Identify strategies for ongoing communication and dissemination of information, and
- Schedule professional, social, and other events for members and families to get to know one another and develop professional relationships and camaraderie.

You can develop a useful community of practice with your colleagues, and you must do it. Most important of all, find joy, and celebrate with your community of practice!

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