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Medical Student Professionalism: Are We Measuring the Right Behaviors? A Comparison of Professional Lapses by Students and Physicians

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Abstract

Background

Examining the relationship between unprofessional behaviors observed in medical students and those manifested by physicians is important in determining whether medical school faculty are observing and reporting behaviors relevant to medical practice.

Method

This study compares the relationship between unprofessional behaviors identified in students at our medical

school through Early Concern Notes, and behaviors for which physicians were sanctioned by our state medical board.

Results

The majority of reports in both groups were related to lapses in professional responsibility and integrity, and the specific behaviors identified in the groups were similar. A smaller number of reports in both groups were related to pursuit of excellence or personal interactions.

Conclusion

There are common features to the professional shortcomings seen in students at our medical school and practicing physicians in our state. These similarities add credibility to our faculty's observations, and reinforce the relevance of monitoring such behaviors in future physicians.

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Professional behavior is considered essential to the practice of medicine, and is increasingly emphasized in medical school curricula. However, several obstacles limit the effectiveness of professionalism education in medical training. Medical educators struggle to define and measure professionalism, which, in fact, is usually identified in terms of its absence—when unprofessional behavior is observed in trainees.¹ Instruments to assess professionalism reflect this struggle for consistency and credibility.^{2–4} There is also skepticism as to whether professionalism is a learnable skill or an inborn character trait.⁵ Student peers and teachers are often reluctant to report negative behaviors, either because they do not directly observe such behaviors, or feel personally uncomfortable with (or fear) the confrontation that arises in making such reports.^{6,7} Finally, faculty typically encounter such behaviors as isolated events, and may be hesitant to generalize about what are seen as solitary behaviors in individual students.

Our school assesses professionalism as part of students' standard academic evaluation in every medical school course. This process focuses on the small-group, problem-based learning component of courses in years 1 and 2, and clinical clerkship evaluations by faculty preceptors in years 3 and 4. Despite this emphasis, it is rare in our school that a student fails, or even receives negative comments on professional behavior, despite faculty anxiety that such behaviors occur. We were concerned that the aforementioned limitations, and perhaps others, were leading to substantial underreporting of professionalism problems in the academic evaluation of our students.

In 2000, we introduced an Early Concern Note (ECN) as a means for faculty to report professional behavior concerns they identify in students. The format of our ECNs was influenced by the American Board of Internal Medicine's Project Professionalism,⁸ and was developed based on a process described by Papadakis and colleagues.⁹ Our ECNs differ, however, in that they remain separate from the academic record, are managed confidentially through an

Associate Dean, and rely on students' voluntary acceptance of interventions individualized to the specific problem(s) identified. This structure for ECNs is designed to foster student trust in the process, and to maximize faculty comfort with reporting their concerns without stigmatizing students. Faculty are encouraged to use a very low threshold for submission of an ECN, and to report any student action that "does not feel right" to them. Our goal is to avoid the usual filtering that occurs in decisions to report professionalism concerns through the mainstream academic process.¹⁰

Our ECN is part of a school- and campus-wide initiative to heighten awareness of the importance of professional behavior as a life-long skill, and was developed with three goals. The school uses them as a mechanism to emphasize the career-long importance of professionalism, with a single instrument used through the four years of instruction. Second, the ECN allows development of a longitudinal tracking system of unprofessional behaviors, permitting trends to be identified in students who receive multiple notes, and allow intervention at a time earlier than

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would otherwise be possible. Finally, the ECN is a springboard for developing methods to assist students with professionalism deficiencies. As individual student problems and school-wide patterns of behaviors are identified, appropriate methods of intervention are developed.

The structure of our curriculum, which includes small-group, problem-based sessions in years one and two, provides substantial opportunity for faculty and student interaction early in training. Students are oriented to the purpose and use of ECNs at matriculation and at the beginning of each academic year. Faculty receive a reminder about ECN use at the beginning of each course in which they teach. Over time, the frequency of ECNs has remained fairly stable, suggesting a general culture of acceptance. Annual reports are made to the curriculum committee describing the overall issues identified through ECNs. The important next step was to demonstrate the relevance of behaviors being captured.

Previous investigations have suggested that problematic behavior in medical school is associated with subsequent disciplinary action by a state medical board.^{11,12} Other studies have demonstrated that relatively simple behaviors, such as failing to complete required course evaluations and failing to report immunization compliance were predictors of unprofessional behavior found by the school in subsequent years.¹³ Professionalism deficiencies early in medical school have also been shown to predict poor clinical performance in subsequent courses.¹⁴ To insure we were tracking behaviors that were credible to students and faculty, and relevant to the ultimate practice of medicine, we sought to understand whether there was a relationship between the unprofessional behaviors identified in students at our medical school and the behaviors for which practicing physicians were sanctioned by our state medical board. This report compares the unprofessional behaviors identified in these two groups.

Method

Permission for this study was obtained from our Institutional Review Board and School of Medicine Curriculum Research Committee. For this study, we reviewed all ECNs submitted since the program's

inception (August 2000) through November 2005. The ECN allows faculty to report behaviors in three categories: (1) professional responsibility/integrity, such as failure to reliably fulfill duties; (2) pursuit of excellence/insight, such as actively seeking the minimally acceptable level of performance; and (3) personal interactions, such as inability to establish appropriate working relationships with patients or co-workers. These categories were derived from the work of Papadakis,⁹ and modified based on focus-group discussions with faculty and students concerning the professional challenges they found most difficult. These sessions resulted in a list of 16 behaviors of importance, subcategorized by a steering committee into the three final categories. We calculated and analyzed the type and frequency of reported student professionalism problems in each of these categories. Our ECN differs from reporting formats used at other schools in that the same format and categories of behavior are used throughout the four-year curriculum.¹⁵ Because student activities in years three and four differ substantially from years one and two, with substantially less classroom-based instruction and greater patient contact, we also analyzed the pattern of ECN submission in these two subgroups of students.

To obtain a measure of problematic physician behavior, we accessed information from our state medical board's public database of disciplinary actions against licensed physicians. We reviewed records from this database for 2004 and 2005. The reason for each disciplinary action was recorded and sorted by the authors into one of the three themes used for ECN classification. We then compared the percentage of reports and specific behaviors in each category for the students and physicians.

Results

One hundred three ECNs, representing 110 behaviors were submitted on 90 students during the study period. The state medical board reported 667 disciplinary actions on 631 physicians in 2004 and 2005. Of these, 95 sanctions (14.2%) were directly related to substandard clinical care with an adverse patient outcome, and 56 reports (8.4%) provided insufficient information to classify for this study. We report on the

remaining 516 disciplinary sanctions, which were based on unprofessional behavior.

As shown in Table 1, the most frequent ECNs related to students' professional responsibility and integrity. Although the most frequent concerns were of failure to attend a required activity, or failure to meet a specific responsibility, other examples were more complex. These included instances of students who knowingly overstated their capabilities or their role in patient care, such as introducing themselves as "doctor" or providing patients advice beyond their authority. Other reports involved students' abuse of privileges, such as hoarding group resources for their exclusive use, and unauthorized access to medical records. Of the 516 state medical board disciplinary reports, the dominant source of concern (77.1% of actions) also dealt with issues corresponding to professional responsibility or integrity. For physicians, these violations included failure to meet licensing or medical documentation requirements, and abuse of privileges unique to physicians, such as nontherapeutic prescribing and boundary violations.

Substantially fewer reports were seen for both students and physicians in the other two ECN categories (pursuit of excellence/insight, and personal interactions). The most frequent examples in both categories were similar across the two groups, including impairment and ineffective relationships toward those with whom they interacted.

The types of student behaviors reported during their early and late phases of medical school training were similar. Forty-four (40%) ECNs were submitted on students in their first two years of school, while 66 (60%) were submitted on students in their final two years. Category 1 reports (professional responsibility/integrity) were the dominant source of concern in both groups, though more so for third and fourth-year students (82% of ECNs compared to 59% of ECNs for early students). The number of ECNs submitted by departments with clinical clerkships varied substantially, with two-thirds of that subtotal originating from one department.

Table 1

Comparison of Early Concern Notes (ECNs) and State Medical Board Disciplinary Actions

	<i>n</i>	ECN category 1 professional responsibility/ integrity (%)	ECN category 2 pursuit of excellence/ insight (%)	ECN category 3 personal interactions (%)
Early concern note behaviors	110	80(72.7)	15(13.6)	15(13.6)
Year 1 and Year 2 students	44	26(59)	9(20)	9(20)
Year 3 and Year 4 students	66	54(82)	6(9)	6(9)
List of ECN prompt statements for each category (additional actions may be reported as "other")		<ul style="list-style-type: none"> • Failure to fulfill responsibilities reliably • Misrepresents or falsifies actions/information • Fails to accept responsibility for actions • Fails to respect patient confidentiality • Abuses student privileges 	<ul style="list-style-type: none"> • Inadequate personal commitment to patients • Resistant or defensive in accepting criticism • Unaware of limits • Accepts/seek minimally acceptable level of performance • Impairment 	<ul style="list-style-type: none"> • Inadequate rapport with patients/families • Does not function /interact appropriately within groups • Insensitive to needs, feelings of others • Uses disrespectful language • Arrogant or abusive during stress • Fails to maintain professional appearance and attire
State Medical Board disciplinary actions	516	398 (77.1)	103 (20.0)	15 (2.9)
Examples		<ul style="list-style-type: none"> • Failure to maintain medical records • Failure to renew license/complete CME • Improper delegation or supervision • Abuses physician privileges 	<ul style="list-style-type: none"> • Deviation from standard of care without adverse patient outcome • Impairment 	<ul style="list-style-type: none"> • Poor function with healthcare providers • Arrogant/abusive with patients

Discussion

Most physician sanctions by our state medical board are a result of professional behavior violations, with only a minority of actions directly related to substandard clinical care with adverse patient outcome. For both medical students and practicing physicians, the most problematic behaviors were in the category of fulfilling basic professional responsibilities and integrity. This may be explained, in part, by the high expectations and responsibilities placed upon students and physicians in their

respective environments, and the resulting opportunities for professionalism lapses. Although some differences were seen in the actual behaviors of students and physicians, these differences are due, at least in part, to different levels of authority and opportunity. For example, both students and physicians have their respective paperwork/documentation responsibilities, but only physicians are in a position to misapply prescribing authority. For those problems that are not inherently role-specific, however,

such as impairment or inadequate communication skills, the parallel between groups was dramatic.

We were surprised that professional responsibility and integrity was an even greater source of concern for third and fourth-year students (82% of ECNs) than for first and second-year students (59% of ECNs). We had hypothesized that greater emphasis on patient-based activity in years 3 and 4, with more stress and patient responsibility, might have led to a greater proportion of concerns about students' personal interactions. Although it may be gratifying to see that such concerns rarely arose, it is troubling that issues of integrity persisted throughout all four years of the curriculum.

Our study has similarities to, and differences from other published reports comparing student and physician professionalism lapses. Our findings are similar to the retrospective study of Teherani and coauthors, who identified three domains of unprofessional behavior among a cohort of medical students that were associated with subsequent disciplinary action by their state medical board: (1) poor reliability and responsibility; (2) lack of self-improvement and adaptability; and (3) poor initiative and motivation.¹⁶ The authors used negative and questionable comments abstracted from the students' academic file. Our study differs in that it utilizes reports (ECNs) independent from the academic record, and does so for currently enrolled students in comparison to physicians currently in practice. Attempts to attribute significance to similarities between ECNs and state medical board disciplinary actions presumes that ECN categories are appropriate measures of unprofessional behavior. Although no gold standard for documenting such behavior exists, the striking parallels seen in this study, even in preclinical students, reinforce the appropriateness of the categories used.

We emphasize the confidential nature of ECNs, and faculty are encouraged to have a low threshold for submission. Despite this encouragement, as well as our widespread efforts to educate faculty about ECNs, and a campus culture that emphasizes professional behavior, it is possible that many student behaviors of concern to faculty remain unreported. The variation in ECN reporting

frequency we observed between clinical departments, for example, suggests that the penetration of ECNs into the culture of the clinical teaching environment is uneven. One clinical department, in fact, has never submitted an ECN. Whether this lack of reporting represents better professional behavior by students in this department, faculty failure to sufficiently observe students, failure to recognize certain behavior as unprofessional, or failure to report known unprofessional behavior is unknown. Although ECNs may represent only a portion of actual unprofessional behavior in our students, state medical board disciplinary actions similarly represent only the most serious violations that justified official sanctions.

The common behavioral themes identified in this study and others represent steps toward a consensus of the boundaries of professional behavior as it relates to the practice of medicine, and how behaviors identified in medical students represent “teachable moments” for their professional development. Our results present the opportunity to reinforce the relevance of professionalism for students, and to dispel misconceptions that behavior in medical school is irrelevant to future practice. Our results suggest that some shortcomings identified in our students (e.g., failure to complete a required activity, or arrogant/abusive behavior) were identical to the problems encountered by sanctioned physicians, while other behaviors (e.g., impairment or abuse of role-specific privileges) have

identifiable parallels between the groups. Although medical student behaviors may provide only a partial insight into future difficulties, they represent opportunities for intervention while students remain in a relatively supervised setting. Previous reports have demonstrated that the ability of medical school behaviors to predict subsequent disciplinary actions is far from perfect, but offers greater promise than traditional academic measures.^{11,12} The parallels seen between problematic behavior in our students and physician behavior will serve to reinforce our efforts to teach, monitor, and remediate professionalism issues we identify.

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