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CHAPTER 1

General introduction

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Assessing professional behaviour: Overcoming teachers'
reluctance to fail students.

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Doctors' professional behaviour is a crucial component of the quality of the health care they offer. For a physician, behaving as a professional is not just a desirable condition but also a requirement for patient safety and improved outcomes [1, 2]. Papadakis's study has revealed that students' unprofessional behaviour predicts later unprofessional behaviour after graduation, once they become physicians [3, 4]. This finding has had several consequences for health-care education. Professionalism has been described as an important topic in undergraduate preclinical and clinical curricula ever since [5-7].

While medical professionalism is now widely taught and assessed in medical schools, educators still notice that some students have yet to learn how to behave professionally. Educators often find it difficult to provide professionalism feedback to their students and subsequently do not fail them, resulting in the 'failure to fail' phenomenon [8-10]. The medical education research literature on unprofessional medical student behaviour does not provide sufficient practical guidance to faculty members on how to identify and classify unprofessional behaviours, and subsequently how to guide students who behave in an unprofessional manner. Furthermore, it does not indicate when unprofessional behaviour is truly a concern versus a temporary lapse in a well-intentioned person.

Medical educators would be less prone to the failure to fail phenomenon if they knew (1) how to identify students who behave unprofessionally, (2) what guidance these students would need from them to improve their behaviour and (3) which steps to take if a student persists in displaying unprofessional behaviour. Failing students would then become an opportunity to help them become professionally behaving physicians. Doing so would not only benefit students but would also help educators and their medical schools, and ultimately – and most importantly – better serve future patients and health-care colleagues.

This thesis provides a framework for identifying, classifying and guiding students who display unprofessional behaviour in medical school. The studies, which build on existing knowledge from the medical education literature, advance research on the identification and remediation of unprofessional behaviour through offering medical educators knowledge and tools for recognising and classifying unprofessional behaviour among medical students, and then defining appropriate response strategies.

The introductory chapter of this thesis firstly provides background information on the concept and definition of medical professionalism and on the teaching and assessment of professionalism in undergraduate medical education. The focus then shifts to the practical and theoretical aspects of unprofessional medical student behaviour, thus providing a rationale for the studies that were performed. The introductory chapter ends with an overview of the research questions and studies.

What is medical professionalism?

According to the dictionary, a profession is a 'job that needs a high level of education and training' [11]. Cruess et al. have developed a more expansive description of what the term *profession* encompasses. A profession is:

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 the 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 a 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, to the profession, and to society [12].

Medicine is a profession, since it is a field of scientific knowledge in which the members have distinct social roles, a specific nomenclature and understandings, distinctive practices, distinct self-regulation and characteristic manners of behaviour [12].

In addition to knowledge and skills, values have been widely acknowledged as being essential to physicians from Hippocrates's time until today [13]. *Classical values* are virtue-based, meaning that medicine encompasses caring and compassion by a person who has developed a moral character. Around 1970 the focus of attention shifted from character to physicians' attitudes. Starting around 1980, attitudes and values have been described by the term *professionalism* [7]. While there is no universally agreed-on definition of professionalism in the context of medicine [14], all existing outlines of a physician's professional duties, from the Hippocratic oath to the Declaration of Geneva of the World Medical Association (WMA), prescribe that the doctor-patient relationship requires good practice and a focus on patient needs, medical confidentiality, social responsibility and continuing improvement [15, 16]. See Table 1.1 for the Hippocratic oath and Table 1.2 for the WMA's Declaration of Geneva.

The essence of the various definitions of medical professionalism is the necessity for physicians to adhere to high ethical and moral standards to gain the trust of their patients [17, 18]. For medical students, professionalism necessitates that they gain the trust of their peers and teachers and, if applicable in the context, (simulated) patients. Showing professional behaviour requires knowledge, skills and judgement in order to manage dilemmas that occur in specific situations. Professional identity formation is the process of acquiring such knowledge, skills and judgement qualities and then integrating those qualities into a

I swear by Apollo the Healer, by Asclepius, by Hygiea, by Panacea, and by all the gods and goddesses, making them my witnesses that I will carry out, according to my ability and judgement, this oath and this indenture.

To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else.

I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein.

Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I break it and forswear myself, may the opposite befall me.

Table 1.1 The Hippocratic oath (translation by James Loeb)

developing professional identity. Thus, unprofessional behaviour may be a sign of a student's need for guidance in this process of professional identity formation.

Many definitions exist for *profession*, *professionalism* and associated terms. The definition of medical professionalism we believe is most applicable for this thesis is by Van Luijk, who argues that professionalism means 'having medical knowledge and skills acquired through extensive study, training and experience, being able to apply this within the rules that have been drafted by the medical profession itself, the medical organisations and the government, in which one can be held accountable for actions by all parties involved. This needs to be placed within the cultural context and time frame in which the term is used' [17]. Because the value of professionalism is difficult to measure in an individual, the medical education field has introduced the term *professional behaviour* for assessment purposes [19]. Professional behaviour is the practical, relevant aspect of professionalism, through which a learner's professionalism becomes observable [7, 20-22]. When we only look at behaviour, however,

As a member of the medical profession:

I solemnly pledge to dedicate my life to the service of humanity;

The health and well-being of my patient will be my first consideration;

I will respect the autonomy and dignity of my patient;

I will maintain the utmost respect for human life;

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I will respect the secrets that are confided in me, even after the patient has died;

I will practice my profession with conscience and dignity and in accordance with good medical practice;

I will foster the honour and noble traditions of the medical profession;

I will give to my teachers, colleagues, and students the respect and gratitude that is their due;

I will share my medical knowledge for the benefit of the patient and the advancement of health care;

I will attend to my own health, well-being and abilities in order to provide care of the highest standard;

I will not use my medical knowledge to violate human rights and civil liberties even under threat;

I make these promises solemnly, freely, and upon my honour.

Table 1.2 The World Medical Association's Declaration of Geneva: the Physician's Pledge [15]

becoming a physician is not always clearly a developmental process, influenced by time and context. As a result, those in the field have recently shifted their attention to *professional identity formation*, which acknowledges the developmental process of becoming a physician [23-27]. Irby states that each of these discourses on professionalism, whether classical values, professional behaviour or professional identity formation, has its own purpose, as well as pros and cons, in daily practice [28]. Professionalism and professional behaviour may be thought of as two sides of the same coin [29]; using the same figure of speech, professional identity formation might be thought of as representing the third side of the coin. All three – professionalism, professional behaviour and professional identity formation – are intrinsically connected [28, 30].

Apart from the nomenclature of professionalism, professional behaviour and professional identity formation, the term *profession* originated from (and in part paralleled) the discourse as well. As Cruess's definition of a profession indicates (see Glossary of definitions and terms, p. 213), a profession has a 'social contract' with society, which means that the profession and its members have privileges, but they also have duties to the public [31, 32]. The social

contract between physicians and the public demands that members of the profession itself prevent potential breaches and act on obvious unprofessional behaviour. Regulations from governments or external institutes are also required to ultimately protect the safety of the public. The balance between external and internal regulations can cause tensions between the medical profession and its regulatory bodies regarding the autonomy of the profession [33]. Too much external regulation threatens the autonomy of physicians. If the medical profession values its autonomy, then it should ensure that the profession's self-regulation is effective.

The importance of self-regulation in medicine implies that educators must prepare students for a future role in which they, as members of the medical profession, will be held responsible, not only for their own professional behaviour but also for the trustworthiness of the medical profession as a whole. Reasons for medical claims and healthcare complaints are often based on physicians' unprofessional behaviour [34, 35]. Papadakis's finding that unprofessional behaviour during medical training is predictive of unprofessional behaviour as a physician makes clear that having a permissive approach towards unprofessionalism in undergraduate education is not acceptable [4].

Teaching professionalism in medical school

Professionalism is generally not thought of as an innate trait but as a quality that can be learned and must be taught [32, 36, 37]. Becoming a professional is a process that starts in medical school and continues during further training and practice as a physician. To be retained, professionalism must be made practical and applicable in the medical undergraduate curriculum [14]. The professionalism outcomes of an undergraduate programme that will stimulate students' professional development include interpersonal skills, understanding of roles, capacity for teamwork, cultural competence, collegiality, respect for patients and colleagues, and ethical conduct [7, 20, 38].

To achieve these professionalism outcomes in medical school, the teaching of professionalism must comprise different aspects. First, the cognitive base of professionalism has to be taught. This means that the expected competences of a physician should be made clear to incoming students [7, 39]. These expectations must be apparent in the institute – not only to students but also to faculty [40]. Then, by practicing in the learning environment as well as in authentic situations, and subsequently reflecting on their experiences, students will be stimulated to develop their professionalism skills and values [21].

The formal medical curriculum ideally includes all the teaching of professionalism in an integrated way [40, 41]. Teaching is mainly explicit at the onset of the curriculum, in the form of a transfer of the experiences of others who speak about values, truths and meaning [36].

This teaching informs students about the expectations and provides them with the necessary cognitive base of professionalism. During the course of the curriculum, teaching becomes more implicit through role modeling [42]. Practicing can take place both in small-group sessions and in practical sessions. Alongside this in-school practice, medical schools should create opportunities to practice in an authentic environment with physicians and patients alike. Early practical experiences in hospitals or community-based health-care facilities can also offer students the possibility of learning from subjectively experienced primary events that they experience in person [43]. Performing in authentic situations will contribute to the student becoming a professional physician [44]. Students are thus taught that professionalism is not only a matter of what they do but also of how they do it; they learn that becoming a professional is a process [41].

Besides the formal curriculum, the informal curriculum is influential for teaching and learning in medical school. In fact, most of the teaching and learning of professionalism in medical schools takes place informally, through what Hafferty describes as the ‘hidden curriculum’ [45]. The informal messages of educators and other role models, positive or negative, influence students and will have an impact on their professional development. What educators perceive as normal, students will adopt as normal, too. An informal curriculum is not always consistent with a formal curriculum, which can be either negative or positive.

Assessing professionalism in medical school

Professionalism can be assessed, among other methods, through observing behaviours in clinical or teaching settings [41, 46]. Assessing professional behaviour in medical school serves an individual, institutional and societal purpose [38, 47]. The individual purpose is examined through formative assessment, which refers to assessment *for* learning, i.e. feedback provided to the student mid-course that should highlight steps for improvement and enable the learner to learn. Summative assessment, which is the assessment *of* learning (i.e. the evaluation and formal judgement at the end of the course), confirms that a student has achieved the required goal. Summative assessment thus serves another goal in addition to formative assessment: it aims to ensure quality. In a few rare cases, remediation or even disciplinary action will be needed to ensure this quality and to show accountability to society. The third purpose of assessment is to acknowledge that not only individual factors influence a student’s professional behaviour; institutional culture also plays a role. The use of assessment can reveal the contextual causes of unprofessionalism that may indicate gaps in the institutional system. An additional institutional goal of assessment is thus to search for any gaps in the system, which will then need to be sent back to curriculum developers [21].

Types of instruments that are recommended for assessment of professionalism, both

formatively and summatively, are rating forms, OSCE's (*Observed Structured Clinical Observations*), moral reasoning assessments, and behavioural assessments. Early and often evaluating a student's professionalism based on performance in context can create a reliable picture by incorporating information using different methods, by different assessors, in different settings [48].

Although numerous researchers have theoretically described methods for assessing professional behaviour, assessing professional behaviour has still proven to be difficult for medical educators [49]. The literature suggests that educators often do not fail students even after they have displayed unprofessional behaviour [8, 50]. Many observations, especially observations of unprofessionalism, appear to go undocumented [51]. This *failure to fail* phenomenon was initially characterised in nursing education as a teacher's dilemma [9, 10]. The dilemma is not difficult to understand: by giving a student a negative grade, the educator admits to having failed to teach, motivate or create a learning environment in an effective manner for a particular student. By unjustly giving a student a positive grade, however, the teacher fails to ensure the quality of future patient care. More recently described reasons for the reluctance to fail are a lack of conceptual clarity about expectations, concern for the subjectivity of one's judgement, fear of harming a student's reputation, lack of appropriate faculty development, and uncertainty about the remediation process and its outcomes [8, 52-54]. Educators' reluctance to fail is unfortunate, because when underperforming students are not identified, they cannot be offered assistance to help them improve their performance [7].

'Failure to fail' is unfortunate for two reasons: (1) the student involved does not receive help to improve and (2) because the powerful 'hidden curriculum' noted above signals to all other students that it is not worth their effort to act upon unprofessional behaviour [55]. We can conclude that, although professional behaviour is important for future physicians, acknowledging students' unprofessional behaviour in medical schools is problematic. Educators would be more willing to report professionalism lapses if policies regarding the management of professionalism lapses and the effects it has on the learner were clearer to them [52].

Unprofessional behaviour among medical students

Because schools pay attention to the teaching and assessing of professionalism, medical educators will inevitably be confronted with students who do not measure up to the school's expectations for professionalism. The literature is not clear on how common unprofessional behaviour actually is among medical students. Percentages indicating professional behaviour lapses range from 3% to 20% of all students [4, 56-62]. These differences may be attributed to the differences in defining unprofessional behaviour, differences in reporting methods

(self-reported versus solicited), differences in assessment (limited to critical incident reports versus a scheme of scheduled assessments), the culture of the institute and possibly other reasons. Some speak of unprofessional behaviour as an 'iceberg' phenomenon, in which only the top of the iceberg is visible [21].

How do medical educators define unprofessional student behaviour? Unprofessional behaviour of physicians may be described as instances in which physicians fail to gain the trust of their patients or colleagues [17, 18]. Building on the definitions introduced earlier, unprofessional student behaviour could be described as failing to gain the trust of students' educators or peers and, if applicable in the context, their patients. While professionalism and professional behaviour have been described extensively in the literature, what actually constitutes unprofessional behaviour among medical students has yet to be investigated [14, 63, 64]. No agreed-on vocabulary exists to talk about medical students' professional behaviour lapses. When educators fail a student because of unprofessional behaviour, they often fail to provide sufficient qualitative information about the breaches [8, 64]. The language we use to make sense of the world directs both our perceptions and our actions [65, 66]. Educators thus need guidance on what to detect and how to describe what they detect.

The nature of professional behaviour lapses has been reported by several researchers. Three domains of unprofessional medical student behaviours that relate to later disciplinary action once these students have become practicing physicians include (1) *poor reliability and responsibility*, (2) *lack of self-improvement* and (3) *poor initiative and motivation* [67]. One study's categorisation of unprofessional behaviours during exam situations related these domains to impaired relationships with patients [68]. Other authors describe the nature of professional behaviour lapses by focusing on the egregiousness of the behaviours [69], on attributions for behaviours [70], on underlying problems [71], on predictors of poor academic outcomes [72], and on students' demographic characteristics as risk factors for professional misconduct [73, 74]. In these studies, the unprofessional behaviours are mostly approached as isolated events. It would be interesting to investigate if any further important determinants or patterns of unprofessional behaviour could be identified. This could help to detect students who need remedial teaching and support.

Unprofessional behaviour might occur for various reasons. The triggers are often a combination of individual influences, such as deficits in cognition, skills and attitude [68, 69], and contextual influences such as procedures, culture, situational factors or organisational policies [21, 70-72]. Unfortunately, trainees may not recognise these triggers in time [73]. Most of the time, people with good intentions temporarily lack the skills or attitudes they need to manage the professionalism challenge they face, or they may fail to realise that their adopted style is unprofessional [20]. How can we discriminate those temporarily lapses from persistent professionalism problems?

Responding to observed unprofessional behaviour is not always easy. The lack of clarity about how to remediate a student's behaviour once the student has been given an unsatisfactory evaluation is an additional problem for medical educators [75]. Practical knowledge has become available, but evidence from the medical education literature is not yet clear [76]. Without clear directions from research evidence, the proper guidance of such students takes a toll on the resources, time and effort of medical schools and their faculties.

Some of the stakeholders who are involved in managing medical student unprofessionalism include basic science educators, clinician educators, deans, directors, members of progress committees and educators involved in educational management, as well as peer students and patients. These stakeholders all have their own perspectives and goals in preventing and handling unprofessionalism. Elucidating these perspectives might help to understand the personal, contextual and institutional factors that might contribute to unprofessional student behaviour and to determine the challenges to unprofessional behaviour that each stakeholder faces.

Theories used in this thesis

The two theoretical frameworks that are used for the conceptual understanding of the work in this thesis are the *communities of practice* framework and the *expectancy-value-cost* model of motivation.

Communities of practice framework

The process of learning professionalism can be theorised by Wenger's *communities of practice* framework. 'Communities of practice' are groups of people who share a concern or passion for something they do, and they learn to do it better during the course of regular interactions [66]. According to this concept, learning takes precedence in interactions with others. In the case of medical schools, these 'others' include medical/clinician educators, peer students and patients. Students, being newcomers in the community of practice, are allowed to function at the periphery of the community; the teaching and learning of how to become a professional both take place through social interactions with others, whose ultimate aim is to incorporate the newcomer into the core of the community by moving him gradually from the periphery to the centre [66].

Expectancy-value-cost model of motivation

The use of the *expectancy-value-cost* model of motivation, an update of Eccles's expectancy-value model, can help to understand educators' and students' choices in how and why they

should respond to any professional behaviour lapses they observe among students and faculty [77]. According to this model, a person's motivation to engage or not engage in a certain task is based on the balance of the *expectancy* of being successful in that task ('Can I do it?'), the perceived *value* of engaging in the task ('Do I want to do it?') and the *costs* of engaging in the task ('What barriers might prevent me from doing it?'). The model divides *value* into three qualities: the first is intrinsic value, which reflects the enjoyment an individual experiences from engaging in the task for its own sake; the second is extrinsic value, which reflects the usefulness of engaging in the task for achieving another end, e.g. complying to ethical values of socializing agents such as peers or educators; the third is attainment value, which reflects individual identity factors such as relatedness, competence and esteem [77].

Methods for researching unprofessional behaviour

Certain aspects of unprofessional behaviour may be researched quantitatively, such as how many students display such behaviour, how often this occurs and what relationships exist between determinants, but qualitative research methods should also be used. Such methods can help to understand people's personal experiences and why unprofessional behaviours occur in the complex setting of medical education [78]. The combination of qualitative and quantitative methods can offer important insights into the problems described in this introduction.

The epistemological belief systems, or paradigms, that underpin qualitative and quantitative methods differ. Quantitative research is based on the *positivist* belief that there is one value-free, objective truth that can be discovered using methods that are usually applied in the natural sciences. Qualitative research, in contrast, uses paradigms that allow for other viewpoints. The common view in the *post-positivist* paradigm is that the truth is never entirely objective. In the *constructivist* paradigm, researchers believe that there is no single overarching truth but that the truth is in a constant state of revision. Constructivist researchers clarify the perspectives about reality of those who are involved in the phenomenon under consideration; they then construct knowledge during interactions with these people [79].

Methods used in this thesis

The studies in this thesis describe attempts to understand the complexity of unprofessional medical student behaviour by investigating the experiences of the people who are involved in handling such behaviour. The aim of this thesis is to build a detailed picture of unprofessional behaviour among medical students, based on the literature and on the researchers' interactions with representative samples of various stakeholders. These stakeholders shared

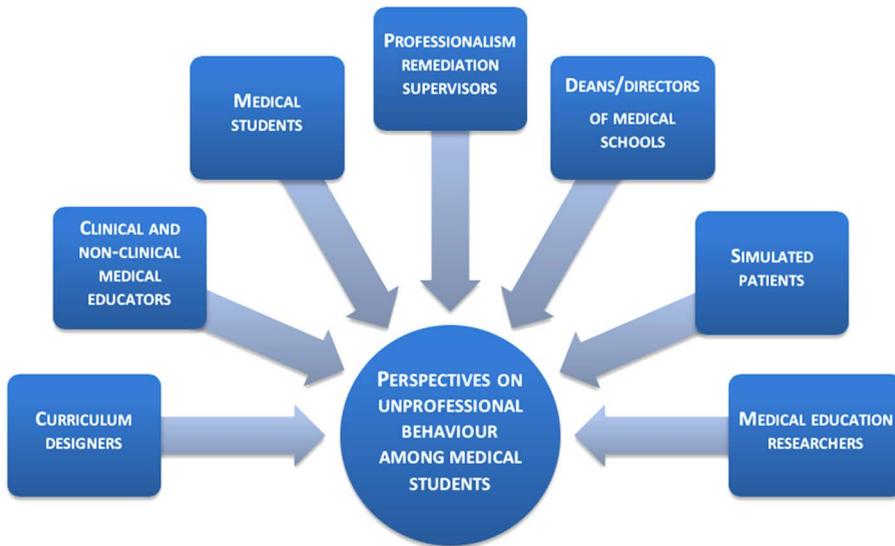


Figure 1.1 Stakeholders’ perspectives on unprofessional behaviour among medical students

their perspectives and personal experiences with identifying, classifying and responding to unprofessional behaviour among medical students. The thesis provides a framework for attending to unprofessional medical student behaviour in order to offer medical educators the support and tools they need to recognise, classify and remediate such behaviour.

Main research questions of the thesis

The three main questions to be explained in this thesis are as follows.

First, *how can medical educators identify unprofessional behaviour?* **Chapter 2** describes an illustrative case example of a system of professional behaviour assessments in a medical curriculum. Which aspects educators could take into account to identify students’ unprofessional behaviour is addressed in **chapter 3**.

Second, *how can medical educators classify unprofessional behaviour?* **Chapters 4 and 5** describe two studies that reveal patterns of unprofessional behaviour among medical students.

Third, *how should stakeholders respond to unprofessional behaviour?* **Chapters 6, 7 and 8** describe the opinions and experiences of medical educators as well as of other stakeholders, such as peer students and simulated patients. These chapters examine the various stakeholders’ responses and strategies when confronted with medical students’ unprofessional behaviours.

Specific research questions

Several specific research questions flow from the three main questions, as follows.

1. *How were teaching, training and the assessment of professional behaviour designed and implemented at VUmc School of Medical Sciences Amsterdam?* This question is addressed in a descriptive way in **chapter 2**.
2. *Which descriptors are used for unprofessional medical student behaviours within medical education research papers?* **Chapter 3** addresses this research question through a systematic review study of the medical education literature.
3. *Which patterns of behaviour can be distinguished among students who behave unprofessionally in medical school?* **Chapter 4** presents an investigation of this research question through an empirical study using latent class analysis.
4. *How can the profiles model (as described in **chapter 4**) be refined to make the model usable for medical educators in different contexts?* **Chapter 5** describes the investigation of this research question through an empirical study using a triangulation of the nominal group technique and thematic analysis.
5. *Which strategy of remediation can be determined based on the final profiles model?* **Chapter 6** describes this research question, which is investigated through an empirical study in which a grounded theory approach has been applied.
6. *How do medical students respond to unprofessional behaviour of peers and faculty?* This research question, described in **chapter 7**, is addressed through an empirical study using a thematic analysis of interviews with students.
7. *What perspectives do simulated patients have on the teaching of responding to unprofessional behaviour in medical school?* **Chapter 8**, a perspective paper, addresses this question based on data from interviews with simulated patients.
8. *What can medical educators do to define, classify and respond to unprofessional behaviour?* In **chapter 9**, this question is addressed based on the performed studies, the literature and the authors' personal experiences.

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