"Once When I was On Call. . .," Theory versus Reality in Training for Professionalism

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Abstract

Purpose
To identify the degree to which interns' reported experiences with professional and unprofessional behavior converge and/or diverge with ideal professional behavior proposed by the physician community.

Method
Interns at Wayne State University's residency programs in internal medicine, family medicine, and transitional medicine responded to essay questions about their experience with professional and unprofessional behavior as part of a curriculum on professionalism. Responses were coded for whether they reflected each of the principles and responsibilities outlined in a major publication on physician professionalism. Content analysis included the frequencies with which the interns' essays reflected each principle or responsibility. Additionally, a thematic analysis revealed themes of professional behavior that emerged from the essays.

Results
Interns' experiences with professional and unprofessional behavior most frequently converged with ideal behavior proposed by the physician community in categories involving interpersonal interactions with patients. Interns infrequently reported experiences involving behavior related to systems or sociopolitical issues.

Conclusions
Interns' essays reflect their concern with interpersonal interactions with patients, but they are either less exposed to or less interested in describing behavior regarding systems or sociopolitical issues. This may be due to their stage of training or to the emphasis placed on interpersonal rather than systems or sociopolitical issues during training. The authors recommend future proposals of ideal professional behavior be revised periodically to reflect current experiences of practicing physicians, trainees, other health care providers and patients. Greater educational emphasis should be placed on the systems and sociopolitical environment in which trainees practice.

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Unprofessional behavior by physicians has been widely publicized, from fictional portrayals of arrogant, demeaning physicians on popular television to reports of illegal and unethical behavior contributing to medical errors[1] and skyrocketing health care costs. Unprofessional behavior may begin before or during medical training; a recent study linked problematic behavior in medical school to subsequent disciplinary actions by a state medical board.[2] The physician community has taken steps to address the issue, setting standards and delivering innovative curricula to train future physicians. Three of these are significant to the purposes of this project.

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First, although many definitions have been proposed,[3] the Medical Professionalism Project, a collaborative effort by the ABIM (American Board of Internal Medicine) Foundation, the ACP (American College of Physicians) Foundation, and the European Federation of Internal Medicine wrote a Physician Charter that has been widely adopted as the standard. Published in 2002 in both the *Annals of Internal Medicine* and the *Lancet*, the charter states:

> Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health.[4,5]

The Physician Charter then specifies three fundamental principles and ten professional responsibilities that form the contract with society (see List 1). A follow-up article published 15 months later reported that the publication had been endorsed and reproduced in several journals around the world, including the major journals for the fields of internal medicine, surgery, obstetrics–gynecology, and dentistry, and had been translated into several languages. In addition, the follow-up article reported that several hundred U.S. and international newspapers had cited the Physician Charter in related stories and 65,000 reprints had been requested from around the world.[6]

In a second major step toward addressing the issue of physicians' professionalism, the Accreditation Council on Graduate Medical Education (ACGME) declared professionalism to be one of six general competencies all physicians should possess and in 2001 began requiring that all residency programs document the teaching and assessment of their residents' professional behavior as part of the accreditation process.[7] Third, the major journals of nearly every medical specialty society have published descriptions of a range of curricula that teach and assess medical trainees in the area of professionalism.[6]

Medical educators are acutely aware that their curricula for teaching all competencies are not delivered in a vacuum.[8,9] The nature of medical training inherently exposes medical students and residents to a social, economic, and political context that may or may not reinforce the principles taught in the medical schools' labs

List 1

Three Fundamental Principles and Ten Professional Responsibilities Listed in Medical Professionalism in the New Millennium: A Physician Charter*

Fundamental principles

- Principle of primacy of patient welfare; i.e., altruism
- Principle of patient autonomy; i.e., providing honest and full explanations contributing to a patient's ability to make informed decisions about care.
- Principle of social justice; i.e., working toward a society in which there is a fair distribution of health care resources

Professional responsibilities

- Commitment to professional competence; i.e., lifelong learning of medical knowledge and clinical and team skills
- Commitment to honesty with patients; i.e., assuring that patients are completely and honestly informed before and after treatment, including the disclosure of errors
- Commitment to patient confidentiality; i.e., applying safeguards to the disclosure of patient information
- Commitment to maintaining appropriate relations with patients; i.e., avoiding the exploitation of patients for sexual advantage, personal financial gain, or any other private purpose
- Commitment to improving the quality of care; i.e., working collaboratively to create systems contributing to continuous quality improvement in health care
- Commitment to improving access to care; i.e., reducing barriers to equitable health care based on education, laws, geography and social discrimination
- Commitment to a just distribution of finite resources; i.e., providing health care based on wise and cost-effective management of limited resources
- Commitment to scientific knowledge; i.e., upholding current scientific standards and promoting the creation and appropriate use of new knowledge
- Commitment to maintaining trust by managing conflicts of interest; i.e., compromising professional responsibilities by pursuing private or personal gain
- Commitment to professional responsibilities; i.e., working collaboratively and treating one another with respect

* A collaborative effort by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine, the Charter was simultaneously published in the *Annals of Internal Medicine* and the *Lancet* in 2002.[4,5]

and classrooms. Outside of the classroom, trainees face the vagaries and complexities of patient care and interactions with colleagues, faculty, and myriad other health care professionals. Therefore, the challenge to physicians and medical educators is to set standards, teach, and assess professional behavior in a way that converges with and builds upon trainees' daily experiences rather than contradicts them.

Although many publications have set standards and described strategies for teaching and assessing professional behavior,[3,4,10,11] few have reported the daily experience of trainees. Surveys of medical students and residents reveal they frequently encounter challenges to professional behavior in the hospital setting.[8,12–15] Baldwin et al.,[13] reporting the results of a survey of 571 second-year residents describing their observations of unethical and unprofessional behavior during their first postgraduate year, found that nearly half reported personally observing falsification of patients' records by others and others taking credit for their work. Nearly two-thirds witnessed mistreatment of patients and colleagues working while impaired. Over a fourth of the residents reported being required to do something that was immoral, unethical, or personally unacceptable. Kasman et al.[14] described emotions triggered by experiences during medical training in hospital settings, arguing that these responses affect professional behavior. Rosenbaum et al.[15] interviewed internal medicine residents about their experiences with ethical and professional behavior and classified the responses into five broad categories: concern over telling the truth, respecting patients' wishes, preventing harm, managing the limits of one's competence, and addressing performance by others that is perceived to be inappropriate. In focus groups with medical students, Ginsburg et al.[8] noted the gap between articulated principles of professionalism and students' observations of lapses in professional behavior. As these reports demonstrate, a significant gap exists between the ideal standards set forth by the physician community and the daily practices observed and experienced by physicians-in-training.

To teach and assess professional behavior, some residency program directors at Wayne State University require first-year residents (interns) to read a variety of published definitions of ideal professional behavior and respond in writing to three essay questions regarding their experience with professional and unprofessional behavior. In reading the essay responses, we were struck by the discrepancy between the definitions the interns were required to read and the experiences they described in their essays. This inconsistency motivated us to conduct a systematic exploration of the gap between the ideal and the real with regard to physicians' professional behavior. In this report, we answer two research questions:

> Research Question 1: To what extent do the interns' reported experiences with professional and unprofessional behavior *converge and/or diverge* with the categories of professional behavior considered by the physician community to be ideal?
>
> Research Question 2: How do the interns' reported experiences *extend* these categories of professional behavior?

Method

Study participants and instruments

After receiving approval from the institutional review board at our university, we informed all interns from the residency programs in internal medicine, transitional medicine, and family medicine who began training in July of 2002 or 2003 ($n = 137$) that we planned to examine their essay responses (with identities concealed) as part of this study, and we provided them with the opportunity to decline to participate. Interns from these programs were chosen because they are regularly required by their program directors to complete an online professionalism module as part of their general competencies curriculum. This online curriculum consists of reading a series of definitions and standards for ideal professional behavior,[11] the web site of the American Board of Internal Medicine,[16] and the Physician Charter,[4] and then submitting essay responses to three questions:

> Essay Question 1: Of the various definitions of professionalism you reviewed in this module, what single attribute is most critical to your own personal definition of professionalism? Briefly explain why.
>
> Essay Question 2: Reflecting back on your medical education to date, briefly describe a situation you observed that demonstrates the ideal of professional behavior of a physician. What aspects

of the situation most clearly illustrate professionalism? Explain.

Essay Question 3: Reflecting back on your medical education to date, briefly describe a situation that you observed that demonstrates unprofessional behavior. What aspects of the situation most clearly illustrate unprofessional behavior? Explain.

For the purposes of this project, we analyzed responses to Essay Questions 2 and 3 because we felt that these questions would reveal the interns' perspectives on their experiences. We did not analyze Essay Question 1 because we felt that the responses would too closely mirror the required readings rather than yield information about the interns' perspectives.

Coding and analysis

Research Question 1. To answer Research Question 1, we created a codebook and conducted a content analysis[17] of the trainees' responses to Essay Questions 2 and 3 based on the 13 categories (three Fundamental Principles and ten Professional Responsibilities) described and defined by the Physician Charter.[4] The 13 categories, along with simple descriptions, are listed in Table 1. (Note that the codebook interpreted the word "patient" to indicate patients and their families or other representatives.)

Two authors (SE and SB) were trained to code whether each essay reflected each category of professional behavior. An intern's response to Essay Question 2 was coded positively on one or more categories if the response described an incident in which a physician exhibited a behavior that reflected that area of professionalism; conversely, an intern's response to Essay Question 3 was coded positively if the response described an incident in which the physician violated that area of professionalism. If the intern did not describe a specific incident or described an incident that did not involve a physician, the response was coded as Not Answered.

Research Question 2. To answer Research Question 2, we used a thematic analytical approach in which we read all responses to Essay Questions 2 and 3 repeatedly, searching for themes. Once identified, we assigned each theme a code.

Results

Of 137 interns asked to participate, all agreed. Three responses had been submitted incorrectly or had been deleted from the online module, leaving 134 responses. For Essay Question 2, 11 of the 134 responses were coded as Not Answered, resulting in a total sample of 123; for Essay Question 3, 13 responses were Not Answered, for a total sample of 121.

Research Question 1

The coders coded ten essay responses that were not included in the sample as pilot data. Intercoder reliability was calculated using a Cohen's kappa coefficient, with a mean result of .85 for Pilot Essay Question 2 and .97 for Pilot Essay Question 3 (>.75 indicates excellent agreement beyond chance[16]). Having reached an acceptable level of reliability with the pilot data, coding continued with the final data. One coder (SB) coded all responses, while the second (SE) coded every fifth essay (i.e., 20% of the responses). The mean reliability results for responses were .9 for Essay Question 2 and .93 for Essay Question 3. The frequency with which the interns' essay responses reflected each of the

Table 1

Frequencies at Which Internal Medicine, Family Medicine, and Transitional Medicine Interns' Responses to Two Essay Questions Reflected Professional Behaviors Listed in the Physician Charter, Wayne State University, 2002–2003*

Professional behavior	Essay question asking respondent to describe experience in which: MD exhibits this behavior (no. = 123) Frequency (%)	Essay question asking respondent to describe experience in which: MD violates this behavior (no. = 121) Frequency (%)
Three fundamental principles		
Principle of primacy of patient welfare	105 (.85)	79 (.65)
Principle of patient autonomy	33 (.27)	16 (.13)
Principle of social justice	7 (.06)	4 (.03)
Ten professional responsibilities		
Commitment to professional competence	10 (.08)	17 (.14)
Commitment to honesty with patients	2 (.02)	5 (.04)
Commitment to patient confidentiality	6 (.05)	5 (.04)
Commitment to maintaining appropriate relations with patients	1 (.01)	0 (0)
Commitment to improving quality of care	1 (.01)	0 (0)
Commitment to improving access to care	2 (.02)	2 (.02)
Commitment to a just distribution of finite resources	2 (.02)	3 (.02)
Commitment to scientific knowledge	1 (.01)	2 (.02)
Commitment to maintaining trust by managing conflicts of interest	1 (.01)	3 (.02)
Commitment to professional responsibilities	11 (.09)	42 (.35)

* The Physician Charter was a collaborative effort by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine, simultaneously published in the *Annals of Internal Medicine* and the *Lancet* in 2002.[4,5]

13 categories of professional and unprofessional behavior is reported in Table 1.

Research Question 2

Table 2 includes the themes of professional and unprofessional behavior that were identified from the interns' essay responses, with frequencies of response. As we had done for the coding in Research Question 1, one coder (SB) coded all responses, while the second (SE) coded every fifth response (20%). Intercoder reliability was calculated using a Cohen's kappa, resulting in a perfect intercoder reliability score of 1.000 for both Essay Questions 2 and 3. See Table 1 for the frequency with which each theme occurred.

Discussion

We analyzed the written essay responses of interns regarding their experiences with professional and unprofessional behavior in relation to the Physician Charter on medical professionalism.[4] Results of this analysis demonstrate little convergence between the categories of ideal professional behavior proposed by the Physician Charter and the interns' reported experiences during their medical training. Only one of the Physician Charter's 13 categories was frequently reflected in the interns' experiences: the principle of the primacy of patient welfare (i.e., altruism in the physician–patient relationship). In a content analysis of the interns' essays, 85% of the essays written by interns described incidences of altruism, and 65% described violations of this principle. A thematic analysis of the same essays, which allowed common themes to emerge naturally, demonstrated the same phenomenon, identifying issues in the physician–patient relationship. The following two essays illustrate the interns' varying experiences:

> As a fourth-year student doing outpatient medicine, I was seeing a patient who happened to mention brake problems with her car. The attending then arranged for a car repair shop to have a look at her car while she was being seen at his office. The aspect of this situation that went above and beyond professionalism was that the physician took valuable time out of his busy day to make sure his patient wouldn't be in danger while driving. He placed his patient's interests before his own. (Intern 1)

> It was during my surgery rotation—a patient of mine needed an ng tube put in—myself and my senior resident attempted to put the tube down her—she fought and resisted, so we did not force it on her. Our attending got very angry that we did not put the tube down her. He stormed into her room and (I am not joking) forced and shoved it down her throat. She was screaming and yelling, "No, stop, please, I beg you." Our attending continued to ram it down her throat. After what felt like forever, the attending gave up and threw the ng tube on the floor and stormed off. That to me is the ideal definition of unprofessional behavior. (Intern 2)

Although the interns' essay responses overwhelmingly endorsed the fundamental principle of the primacy of patient welfare, and to a somewhat lesser extent other issues related to individual patients and members of the health care team, they nearly ignored the Physician Charter's principles related to larger social, political, or economic issues, such as social justice, quality of care, access to care, just distribution of resources, or the development and application of scientific knowledge.

The attention paid to individual patient care rather than larger systemic issues may be due to several factors. First, it may be possible that professional and unprofessional behavior related to the health care system in society did not occur in the experiences of this group of interns. This, however, seems unlikely in light of recent reports by the Institute of Medicine on medical errors and disparities in health care.[1,18] Another possible reason for the relatively few illustrations of larger systemic issues may be that our methodology (i.e., an open-ended questionnaire requiring essay responses describing one example of professional and one example of unprofessional behavior) may have limited the number and therefore the types of professional behaviors identified. However, given the opportunity to choose only one example of each, the interns' responses overwhelmingly reflected the category of altruism in the patient–physician relationship. Other authors, using focus groups[8] or the more positivist methodology of multiple-choice-question surveys,[12–15] discovered strikingly similar results. We believe the group of interns in this study is captivated by issues related to interpersonal interactions with patients and other members of the health care team and is less sensitive to systems issues as a reflection of their developmental stage of training. They are acutely aware of the role of the health care provider in relation to the patient and to other individuals, and at a later stage may (or may not) become more aware of the system in which they

Table 2

Themes and Frequencies of Professional and Unprofessional Behaviors Identified from Internal Medicine, Family Medicine, and Transitional Medicine Interns' Responses to Essay Questions on Professionalism, Wayne State University, 2002–2003*

Behavior	Frequency (%)
Professional behavior	
Going beyond the call of duty; e.g., calling an insurance company to help a patient have a treatment covered	38 (.31)
Managing difficult interpersonal interactions effectively; e.g., dealing with a flirtatious patient	76 (.62)
Treating stigmatized patients; e.g., drug addicts, with respect and compassion	7 (.06)
Being an outstanding teacher	2 (.02)
Unprofessional behavior	
Working while impaired; e.g., under the influence of alcohol	2 (.02)
Managing difficult interpersonal interactions ineffectively; e.g., giving end-of-life information in a cruel manner	71 (.59)
Refusing compassionate or respectful care to stigmatized patients; e.g., making drug addicts wait longer for treatment	3 (.02)
Compromising patient care for self-interest; e.g., delegating work inappropriately	33 (.27)
Incompetence; e.g., having a weak medical knowledge base	12 (.10)

* A total of 123 interns responded to an essay question describing physicians' exhibiting the behavior and 121 responded to an essay question describing physicians' not exhibiting the behavior.

practice medicine. Additionally, we believe that interns are particularly sensitive to interpersonal interactions as a result of the training they received up until the point of responding to the questionnaire. Although this group of interns attended medical schools in a variety of locations throughout the United States, and in fact throughout the world (as was reflected in many of their essay responses), medical training typically focuses on the biomedical and to some extent, on the physician–patient interactions, rather than on the health care system. This factor may be altered by new requirements by the accrediting bodies of medical schools and residency training programs that require that medical trainees learn principles of systems-based practice as part of their general competencies curriculum.[7]

The results of this research lead us to suggest that future proposals of physicians' professional behavior be accompanied by cases that represent the experiences of medical trainees, such as those that comprise the data for this project. For example, the principle of the "commitment to honesty with patients" as an abstract principle might be accompanied by a general case or by one that is appropriate to a particular institution or medical specialty, such as the following:

> As a fourth-year medical student, I rotated through pulmonology. One Friday night at 6 pm, the attending performed a "terminal wean," (i.e., turned the ventilator off). The attending walked into the room, explained and asked the family to explain back to him what was going to happen, and then proceeded to ask each person individually their thoughts and wishes. After having done all this, he and the family members hugged, and watched, not sadly mind you, the attending turn the vent off. No tears were shed then.

Further, we suggest that practicing physicians, other health care professionals, and most important, patients, be encouraged to contribute to such consensus statements.

This study was unique in that it explored trainees' perceptions of both professional and unprofessional behavior, allowing their perceptions to define the concept. Findings from this study suggest that medical training should not only emphasize professionalism in interpersonal interactions, but also in relation to the social, economic, and political systems in which health care is delivered. Additionally, results from this study suggest that future proposals of ideal professional behavior should encompass the experiences of a greater variety of participants in the health care system. In this way, the physician community will develop a consensus definition of ideal professionalism in physicians for the benefit of not only medical trainees but also for all health care professionals, patients, and families.

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