

## Viewpoint: Learning Professionalism: A View from the Trenches

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### Abstract

The authors, medical students immersed in *learning* professionalism, observe that most of the professionalism literature misses the mark. Their views on professionalism education, although not the result of qualitative research, were gained from four years of conversations with students from a dozen medical schools, plus online student discussions, focus groups, and meetings with supervisors from five schools.

The authors propose that the chief barrier to medical professionalism education is unprofessional conduct by medical educators, which is protected by an established hierarchy of academic authority. Students feel no such protection, and the current structure of professionalism education and evaluation

does more to harm students' virtue, confidence, and ethics than is generally acknowledged.

The authors maintain that deficiencies in the learning environment, combined with the subjective nature of professionalism evaluation, can leave students feeling persecuted, unfairly judged, and genuinely and tragically confused. They recommend that administrators, medical educators, residents, and students alike must show a personal commitment to the explicit professionalism curriculum and address the hidden curriculum openly and proactively. Educators must assure transparency in the academic process, treat students respectfully, and demonstrate their own professional and ethical behavior.

Students overwhelmingly desire to become professional, proficient, and caring physicians. They seek professional instruction, good role models, and fair evaluation. Students struggle profoundly to understand the disconnect between the explicit professional values they are taught and the implicit values of the hidden curriculum. Evaluation of professionalism, when practiced in an often unprofessional learning environment, invites conflict and compromise by students that would otherwise tend naturally toward avowed professional virtues.

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**W**e wrote this essay to describe how we are learning medical professionalism as medical students, especially in the hospital environment in our clinical years. It is not a research report or a scientific article on medical students' experiences of professionalism education. Rather, it is our view from the trenches. We will describe observations and experiences, and relate a few of the many stories collected from students attending a dozen medical schools across the country. We have assembled specific narrative anecdotes over the last four years from five medical schools, using

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formal and informal focus groups, online medical student discussion groups, conversations with our peers, and meetings with our supervisors. The anecdotes that we have included here are only a small fraction of those that we could have shared, but they are representative. In our experience, they are the sort of stories shared by medical students at every social engagement and get-together. Although we collected these anecdotes unofficially and without using modern qualitative techniques, we feel that they are a sufficiently accurate snapshot of the medical student experience at a variety of institutions and for a variety of specialties, academic performance levels, and degrees of experience. We hope that future research will prove that our snapshot is less representative than we fear it is, and will also uncover solutions that we have missed to the problems presented below.

### Background

The academic study of medical professionalism is becoming very common, and there are several reviews, articles, and books on *teaching*

professionalism.<sup>1–4</sup> However, as current medical students immersed in *learning* professionalism, it is our observation that most of the current literature on this topic misses the mark. We propose that the chief barrier to medical professionalism education is unprofessional conduct by medical educators.

In practice, unprofessional conduct by faculty and residents is protected by an established hierarchy of authority.<sup>5–7</sup> We students feel no such protection, and maintain that the current structure of professionalism education does more to harm students' virtue, confidence, and ethics than is generally acknowledged.

Medical educators, like the students they teach, are forced to operate within the larger medical culture.<sup>8</sup> Rather than the consistent teaching or expert caregiving that we would wish for as the standard, providers in academic hospitals seem to operate on an ethic of crisis control.<sup>9,10</sup> As in any crisis, the environment has evolved to accept substandard professional behavior in exchange for efficiency or productivity.<sup>11,12</sup> Established

hierarchies, in turn, are not inclined to recognize and reform their own substandard behavior, and therefore the medical community tends to only theoretically support the explicit professionalism curriculum.<sup>13,14</sup> Students are the most malleable members of this community, and with the novel advent of professionalism evaluations, they are also the only players subjected to grading based on their behavior.<sup>15,16</sup>

### The Problem

A medical student expressed concern to a dean that there were no protections in place for students that are poorly evaluated for professionalism or may be wrongly accused of or disciplined for a lack of professionalism. The dean replied, “Being called unprofessional is like being called a racist. You have no way to defend yourself; the conversation is over.”

—Fourth-year medical student

An exam asked a student how he would respond to an intoxicated attending. The institution lacks both whistleblower protection and a student abuse policy; the student answered that there was no one to turn to in these cases, and that he was too afraid to report. He failed the exam for lack of professionalism.

—Second-year medical student

In his clerkship evaluation, a student complained that canceling over half of the clinical lectures was unprofessional. A year later, this confidential evaluation was cited as evidence of “unprofessional expectations.”

—Third-year medical student

A student felt that she was sexually harassed by an attending. After agreeing that the attending’s conduct was at least unprofessional, the clerkship director discouraged her from filing a grievance because it would hurt her chances of securing a residency. In return, she was assured that the incident would be kept confidential and the attending would no longer work with students. Her confidentiality then was breeched and the attending continues to mentor students.

—Third-year medical student

The typical, explicit professionalism curriculum places the patient at the center of an ethical framework consisting of the virtues of altruism, respect, honor, integrity, excellence, and accountability.<sup>17</sup> Many of our attendings, educators, and colleagues exemplify this standard. However, there is a commonly acknowledged implicit, or “hidden,” professionalism curriculum that is

defined by the learning environment in which it takes place. That environment, as the setting for the hidden curriculum, encourages the learning of an opposing set of values.<sup>18,19</sup>

In Coulehan’s<sup>20</sup> view, the hidden curriculum places the academic hierarchy—not the patient—at the center of medical education. In this arrangement, students witness many unprofessional acts by medical educators for which the educators are not held accountable.<sup>21</sup> Students watch as “professional” physicians “free beds,” “dump” patients, and “block” admits for reasons that have nothing to do with altruism.<sup>22</sup> Students hear medical educators make derisive comments about patients’ weight, ethnicity, or diseases.<sup>23</sup> These problems have been described in the literature, and efforts have been made to solve them.<sup>24–26</sup> Unfortunately, our discussions with our student peers make clear to us that this pattern continues. Students report that their supervisors violate patient confidentiality, disrespect other physicians and specialties, disregard hospital regulations, and even place patients at risk. They relate that patients continue to be examined, disrobed, or treated without respect for their dignity and without their consent.

It is often these same residents and faculty members who are called on to conduct the evaluation and grading of students’ professionalism. Most concerning are the instances in which the label of *unprofessional* is applied to a student who exhibits explicitly professional behavior.<sup>27</sup> It is our observation that this usually occurs when students behave in a manner that disrupts the breakneck pace of the team. Students’ professionalism has been questioned when they disagree with a team on a patient history, question the appropriateness of a consent process, report duty hours violations, make an unpopular choice of health insurance for themselves, request their own academic records, or ask for a remedy to a grading error. Our peers consistently report that they have learned that professionalism is in the eye of the beholder regardless of the written definitions.

Although there is no literature in the field, we suggest that high marks in professionalism correlate with protecting the efficiency of the academic hierarchy.

Efficient students whose actions support the unprofessional aspects of the learning environment are rarely corrected. Praise for professionalism comes when a student demonstrates promptness in response to an administrative summons, timeliness of vaccination reporting, rapid turnaround of clerkship evaluations, and general agreement with the opinions of superiors.<sup>28</sup> We believe that our peers learn that showing up on time and covering up minor mistakes is far more likely to be evaluated as “professional” than will other avowed professional values such as honesty and respect for patients.

### Praise for the Unprofessional and Punishment for the Professional

A student was asked to forge an attending’s signature on a discharge order. When she protested, stating that forgery was likely unprofessional, her supervising resident promised her an “A” in professionalism in exchange for the signature. She complied.

—Third-year medical student

A student reports to his clerkship director that he has been writing discharge summaries for his residents that he believes are fraudulent and in clear violation of school policy. She responded that “the most important professional virtue is getting along with your superiors” and suggested he continue the activity.

—Third-year medical student

During a case conference, a student questioned the appropriateness of performing a rectal exam, and stated that the rectal exam may sometimes be used as a form of student and patient abuse. The student later received an evaluation noting that question was “inappropriate” and indicated an “unprofessional resistance to learning.”

—Third-year medical student

Students have reported an excess of work hours to the clerkship director. The response was, “The professional student would just do the work and not complain.”

—Third-year medical student

We suggest that, without objective standards, medical educators are more likely to evaluate appearance, formality, and conformity as “professional” than the virtues of honor, altruism, and responsibility. Students say that they function within a system where power and personality are more important than patients or than explicitly “professional” behavior. Most students whom we have

talked to or heard about seem to adopt an implicit set of rules that place hospital etiquette, adherence to academic hierarchy, and subservience to authority above patient-centered virtues. Our observations show that students become “professional” and “ethical” chameleons because it is the only way to navigate the minefield of an unprofessional medical school or hospital culture.

Long before they begin medical school, students learn that grades and evaluations are supremely important to future opportunities. They are also intimately familiar with the fact that the *best* answer on a test may not be the *right* answer—it all depends on who asked the question.<sup>27,29</sup> In the grading and evaluation of professionalism, students are caught between a familiar rock and a known hard place—but the negotiations are newly paradoxical.

In negotiating this power differential, our colleagues say that high marks in “professionalism” are best obtained by students who *compromise* formal professional ethics, are *flexible* with their ideals, or, at best, can be *diplomatic* while following their personal ethical standards. This is hardly what we would hope for as the outcome to medical education’s professionalism directive.

### Negotiating a Power Differential

A student observes what she believed to be a sexual assault on an anesthetized minor. After reporting this incident to the proper administrative authority, this faculty member agreed that the witnessed action was likely unprofessional, unethical, and may have been illegal. She was instructed to keep quiet in order to protect her professional career.

—Third-year medical student

A student was told by a clerkship director, “All you have to do is fall asleep once during a lecture, and that’s enough for me to fail you from the clerkship for being unprofessional.”

—Third-year medical student

A student was brought before a disciplinary committee for receiving a failing grade in professionalism in a clerkship. As suggested, he brought an advocate to the meeting, and was later criticized by a committee member for the “unprofessional arrogance” of bringing an advocate to the meeting.

—Third-year medical student

An attending, working in the acute oncology ward with immunosuppressed

patients, instructed students that it was unprofessional to take sick days “unless you are comatose.”

—Third-year medical student

A student discovered an arithmetic error in his evaluation, resulting in a failing grade. He requested to have the transcript altered to reflect his performance. After originally standing by their erroneous arithmetic, the grade was changed. However, he was later criticized for “unprofessional assertiveness” by the office that had made the error.

—Second-year medical student

A student was evaluated for professionalism as having “difficulty collecting an accurate and thorough history,” and as “misrepresenting labs” because she once reported a lab value as pending instead of uncollected. Though the clerkship director agreed that the evaluating residents had been reckless and damaging in their assessment, she refused to change the evaluation.

—Third-year medical student

Many medical students feel they are victims of unprofessional behavior by educators.<sup>30</sup> In addition to obvious cases of malignant pimping (i.e., interrogation intended to humiliate), belittlement, and shame,<sup>31</sup> students are targeted according to gender or ethnicity.<sup>32,33</sup> Sexual harassment of students remains commonplace.<sup>34,35</sup> Students yield to the team’s deception of patients, colleagues, and superiors.<sup>36</sup> Students share stories of how they are unfairly asked to mislead patients, sign fraudulent documents, ignore duty hours guidelines, and disregard hospital and academic regulations. Although many of these behaviors have been long documented in the literature, we maintain that they remain pervasive, and the institutional evaluation of student professionalism in this environment simply adds insult to injury.

It is our observation that, at best, students understand that they are participants in a chaotic system in which staying afloat is the priority and courtesy and respect are luxuries seldom afforded by their educators. At worst, students learn they are rewarded for mimicking the unprofessional behavior of their educators.<sup>37</sup> Students are genuinely confused as to what constitutes professional behavior.

In our various communications with colleagues at our own and other

institutions, we identify the following patterns:

- The system encourages professionalism and at the same time asks for its evaluation by unprofessional supervisors. Thus, subjective evaluations are useless.
- Feedback is rarely seen as accurate and is almost never constructive. Instead, students receive lists of innocent mistakes or descriptions of behaviors that have failed to grease the wheels of the ward team.
- Students learn how to avoid trouble, rather than how to exemplify the virtues of professionals.

The unprofessional behavior endured by students transcends the clinical arena and furthers the impossibility of learning by example or of genuine remediation. We have observed that our lectures are canceled without notice, appointments are forgotten, and meetings rarely start on time. Other medical students report that their educators frequently fail to return pages and feel free to ignore emails. Clinical evaluations take many months to be returned and often refer to the wrong student. Students’ evaluations often contain factual errors, are applied haphazardly, inaccurately, and with little attention to detail. Test grades are lost, delayed, or misinterpreted. Academic policies are forgotten, misremembered, or disregarded depending on the individuals involved. Confidentiality of evaluations by students is promised but not upheld. Academic leadership, deans, and faculty are in a constant state of turmoil and turnover. When we ask students to relate their experiences with professionalism, the problems stated above are ones that come up repeatedly. Studies of such experiences are scarce.

Many students believe that the academic process is infused with opacity, duplicity, and politics. This is the impossible venue in which a student might seek to rectify an unfair evaluation or an accusation of unprofessionalism, and it is small wonder that we students feel more victimized by the professionalism curricula than enhanced.

### Solutions

An introspective look at an institution’s learning environment is necessary before

implementing a professionalism curriculum. A handful of institutions have done this to some apparent benefit; among them are the Indiana University School of Medicine,<sup>24</sup> the University of Washington School of Medicine,<sup>25</sup> and the University of Texas Medical School Branch at Galveston.<sup>26</sup> The following solutions that we propose are familiar, and many have been suggested previously.<sup>38–40</sup> It is our feeling that this return-to-fundamentals approach is the key to the real success of professionalism education.

- Attempts to reduce student abuse must take precedence over efforts toward evaluation of medical students' professionalism. Professionalism education should involve consistent education, clear standards, and fair assessment. Students who are having difficulty with attaining and demonstrating professional virtues should face rational consequences, educational remediation, and reorientation toward success.
- Role models are of central importance to the success of professionalism education.<sup>41–44</sup> Medical educators must lead by example, and professionalism education and evaluation must be top down, starting with the most senior physicians, administrators, and staff. Definitions of professionalism must be cogent and clear, and evaluations should be objective and based on such definitions. Subjective and narrative evaluation of students' professionalism ought not to be performed except when there are trained evaluators and when past experience has proved that there will be constructive feedback.
- Medical educators should hold themselves accountable for the unprofessional behavior within the medical education system.<sup>45</sup> The schoolyard dynamic of medical students trained by residents deserves consistent and intensive supervision. Hospital ethics committees ought to be encouraged to move beyond the traditional scope of areas such as death and dying and into the realm of professionalism of health care teams. There should be a zero-tolerance policy for unprofessional behavior by anyone in a teaching role.
- Faculty, residents, staff, and students alike need to show a personal

commitment to the explicit curriculum, and address the hidden curriculum openly and proactively. They must assure transparency in the academic process, treat students respectfully, and demonstrate their own professional and ethical behavior.

### The Ongoing Dilemma

Students overwhelmingly desire to become professional, proficient, and caring physicians. They believe in the professional virtues of altruism, honesty, integrity, dutifulness, honor, excellence, respect for others, and accountability. They desire professional instruction, good role models, and fair evaluation. Students struggle profoundly to understand the disconnect between the explicit professional values they are taught and the implicit values of the hidden curriculum. In this struggle, the evaluation of professionalism as it is practiced in an often unprofessional learning environment invites conflict and compromise by students that would otherwise tend naturally toward avowed professional virtues.

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