Understanding Unprofessionalism in Residents

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While all residents are expected to meet medical professionalism standards, there is a general lack of consensus regarding how to define, teach, assess, and remediate residents with behaviors demonstrating a lack of professionalism.[1–8] Thus, it is not surprising that addressing unprofessionalism is among the most difficult challenges facing medical educators. While more literature exists on approaches to unprofessionalism among medical students than residents, the underlying issues are likely to be similar, and studies often address the 2 groups together.[1,2,5]

In order to understand unprofessionalism, I believe it is instructional to ask what it takes for a resident to be professional. Three prerequisites must be in place. First, the resident needs to understand what is expected of a professional in the given situation. Second, the resident must be willing to accept these professional expectations. Third, the resident must be capable of adhering to the professional expectations. If any of these prerequisites are absent, the resident may be at risk for a lapse in professionalism.

An Approach to Unprofessionalism

When a resident has a lapse in professionalism, asking 3 key questions, each tied to the prerequisites, will allow an efficient, thorough assessment of root causes (BOX).

Does the Resident Understand Professional Expectations?

It is easy to assume that residents know how to be professional. In reality, failure to understand professional expectations is a common cause for what educators identify as unprofessionalism.[9] While some professional behaviors, such as honesty and reliability, may be present before graduate medical education begins, the broader understanding of the professional identity of a physician must be developed.[10] Residents evolve an identity as a professional over time and, ideally, internalize the values of physician culture through direct teaching, role modeling, coaching, and feedback.[8]

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The Accreditation Council for Graduate Medical Education makes this point explicitly by identifying subcompetencies and milestones within the core competency of professionalism.[11] Medical learners are expected to develop their professional identity as they progress through medical school and residency.[2,12,13] Just as residents cannot be expected to master clinical knowledge at an early point in their career, junior residents cannot be expected to be fully proficient in professional behaviors. Jauregui et al[14] found differences in perceptions of professionalism values between junior and senior emergency medicine residents and hypothesized that these differences were due to residency training.

Is the Resident Willing to Comply With Professional Expectations?

Based on the limited existing literature and on personal experience, I believe it is rare for a resident to simply refuse to be professional. Residents who have admitted to personal professionalism lapses cite factors such as lack of training, system issues, and the behavior of others as contributors. These residents did sometimes rationalize away their lapses by viewing them as minor issues, but they did not report an overall lack of desire to be professional.[15] Ainsworth and Szauter[16] found that less than 10% of medical students with noted professionalism lapses did not acknowledge them and accept responsibility.

Exploring the resident's willingness to work toward complying with professional expectations is a critical step. Occasionally, there will be residents who do not wish to attempt remediation. This could be because they have a fundamental disagreement with stated expectations or because they are unwilling to put in the effort to complete the process of professional identity formation. In instances when a resident truly is not willing to remediate, it is prudent to move toward dismissal.

Is the Resident Able to Comply With Professional Expectations?

A resident who understands expectations of professionalism and desires to meet those expectations can still fail to do so for many reasons. These reasons can be intrinsic to the resident, system problems, or even educator problems.[17,18] All of these factors can act as

BOX Three Questions to Ask When a Resident Has a Lapse in Professionalism

1. Does the resident understand professional expectations?
2. Is the resident willing to comply with professional expectations?
3. Is the resident able to comply with professional expectations?

stressors, distractors, and barriers for a resident. More than 1 such factor may be present for any given resident. These factors contribute to unprofessionalism by shifting the resident's priority away from meeting the expectations for professionalism.

Of the factors contributing to a resident's inability to comply with professional standards, a large proportion relate directly to the resident. Among these, mental health is the single most cited contributing factor.[17,19] Dyrbye et al[20] found that medical students suffering from burnout were nearly twice as likely to self-report engaging in at least 1 unprofessional behavior. Substance abuse was the most frequently reported contributor to unprofessional behavior by clerkship directors in 1 survey.[21] In addition to mental health concerns, factors intrinsic to the resident include physical health, financial stressors, marital strife, fatigue, lack of social support, learning disorders, attention-deficit disorder, and personality disorders.[17,19]

Beyond the resident, system issues can challenge a struggling resident to meet expected standards. Examples of system issues include inadequate supervision, overwhelming workloads, unclear expectations, and a lack of timely feedback.[17] When viewed from a learner's perspective, system issues and a lack of adequate education are among the top contributing factors cited as contributing to unprofessionalism.[15]

In addition, the actions of other individuals in the learning environment can create resident stress and hinder adherence to professional standards. Examples of behaviors by others include poor role modeling, bullying, racial microaggressions, and sexual harassment.[22] Educators bring their own biases, life stressors, and expectations to every learning situation, which can negatively affect residents.[17,19]

Implications for Remediation

Existing models for remediation largely describe escalating levels of unprofessionalism and corresponding escalating corrective measures.[22] These models do not focus on understanding contributing factors beyond the resident.[23] While there is no standardized remediation process,[2,23–26] determining complete answers to the aforementioned 3 questions may structure the creation of a plan and increase the chances of success. Thus, faculty must attempt to minimize or remove other distractors and barriers to progress while the resident focuses on meeting expectations. To make these expectations clear, remediation should start with an educational component.

Education on Expectations

Without a shared understanding of expectations, no remediation plan is likely to succeed. Delineating expectations was the most frequently listed feature of remediation plans in a survey of obstetrics and gynecology program directors.[27] A remediation task force convened by the Council of Emergency Medicine Residency Directors created a list of remediation methods for frequently encountered lapses in professionalism. Over half of the task force's remediation recommendations were educational in nature.[11] Al-Eraky[28] has provided 12 tips for teaching professionalism that cover the context, teacher, curriculum, and networking.

Removing Barriers and Addressing the Educational Environment

Medical educators can maximize the chances of a successful remediation by removing barriers and creating an educational environment that allows the resident to meet expectations. The specific issues that need to be addressed will be highly individualized to the resident. Wilkinson et al[29] suggested that self-assessment is a key component of this process. Remediation strategies with supporting evidence include reductions in clinical workload, changes in scheduled rotations, changes in supervisors, and leaves of absence to address personal issues.[17,18] Such changes must be balanced with the necessity of having the resident demonstrate the ability to perform and meet standards of professionalism under a broad range of circumstances. However, there may also be curricular, infrastructure, or personnel issues that need to be addressed. It must be acknowledged that some barriers will not be directly within an educator's sphere of influence.[2,30]

Treating Underlying Mental Health Disorders

Special attention must be paid to ensure that addictions, affective disorders, and other mental health disorders are being addressed. A study of psychiatry clerkship directors found that medical students exhibiting unprofessional behavior were referred for mental health evaluation in more than three-fourths of cases.[21] Mental health evaluations

were the most commonly reported remediation strategy in a study of US and Canadian medical schools in 2012–2013.[31] Similarly, in a review of 25 years of resident training records at 1 program, psychiatric counseling was the most commonly implemented strategy associated with successful remediation.[32]

Failure to Remediate

Remediation may fail despite explicit education, a resident's willingness to meet expectations, and honest attempts to remove barriers and provide a nurturing educational environment.[33] If a resident continues to be unprofessional despite a thorough exploration of underlying issues, followed by sincere attempts to address those issues, preparation for dismissal is appropriate.[17,22]

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