How resident unprofessional behavior is identified and managed: a program director survey

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OBJECTIVE: To determine how unprofessional behavior by residents is identified/managed within residency programs, and under what conditions concerns are communicated to potential employers.

STUDY DESIGN: A web-based survey was emailed to 241 directors of US obstetrics and gynecology residency programs.

RESULTS: 141 program directors (PDs) responded (58%). 84% of PDs indicated that problems with professionalism most commonly come to their attention through personal communication. Methods of addressing the problem included expression of expectation of improvement (95%), psychological counseling (68%), placing resident on probation (59%), and dismissal (30%). The majority of PDs felt remediation was not completely successful. All PDs are willing to communicate professionalism concerns to potential employers, but 42% provide this information only if asked.

CONCLUSION: Resident unprofessional behavior is a common problem for program directors, and remediation is challenging. PDs are willing to express concerns to potential employers, but a significant percentage indicate concerns only if asked.

Key words: ACGME competencies, medical education, professionalism, residency programs, unprofessional behavior

Medical educators are increasingly familiar with the Accreditation Council for Graduate Medical Education (ACGME) competencies, 6 areas in which residents should demonstrate competency prior to graduation. Efforts in the area of the professionalism competency initially focused on establishment of a definition, followed by creation of teaching and assessment methods. In published reviews of 20 to 30 years’ worth of professionalism research until 2002, the majority of studies evaluated a single element of professionalism, such as ethics, humanism, or multiculturalism, and were generally undertaken as a means of overall program evaluation rather than to provide formative or summative evaluation of individual students or residents.1-4 However, some review authors noted the availability of appropriate assessment tools, calling for an effort to strengthen their measurement properties.1,2 Recently, focus has shifted to utilization of specific interventions, as well as assessment tools, to evaluate medical students and residents individually across medical specialties.5-10 As Epstein notes, “Aside from the need to protect the public by denying graduation to those few trainees who are not expected to overcome their deficiencies, the outcomes of assessment should foster learning, inspire confidence in the learner, enhance the learner’s ability to self-monitor, and drive institutional self-assessment and curricular change.”11 Thus, a definition of unprofessional behavior, including methods of identification and remediation, is an important aspect of educational efforts in professionalism.

In his review of professionalism issues in ophthalmology residency programs, Lee comments, “Although it may be difficult to define professionalism, we all seem to agree with . . . 1964 Justice Potter Stewart’s definition of ‘obscene’ (ie, ‘I know it when I see it’) as a field definition for unprofessional behavior.”12 However, some have come closer to a concrete definition, despite the variety of behaviors that could qualify as “unprofessional.” In a survey of obstetrics and gynecology program directors undertaken by Fries in 2000, 99% of respondents believed there were circumstances in which clinically competent but unprofessional residents should not be graduated, citing criminal behavior, negligence of patient care, sexual harassment, chemical dependency, and lying about laboratory values as conditions warranting termination. The majority of respondents in that study felt that published professionalism guidelines would be useful, but only 35% reported giving such guidelines to residents.12 Duff proposed a list of the “Top Ten Examples of Unprofessional Behavior” that he had seen in his academic career, including dishonesty, arrogance and disrespectfulness, prejudice, abrasiveness, lack of accountability, fiscal irresponsibility, lack of sustained commitment to self-learning, lack of due diligence, personal excesses, and sexual misconduct.13 The American Board of Internal Medicine identifies 7 general areas for lack of professionalism: abuse of power, greed, arrogance, misrepresenta-
tion, impairment, lack of conscientiousness, and conflict of interest.14

This survey was undertaken to assess program directors’ current experiences with identification and remediation of resident unprofessional behavior. Competency-based teaching and assessment was in its infancy when the Fries study was done, and although medical educators have become increasingly sophisticated in their approaches in the intervening 7 years, professionalism remains one of the most challenging competencies to teach, assess, and remediate effectively.

**Materials and Methods**

A survey addressing identification and remediation of a pattern of unprofessional behavior in residents was e-mailed twice to 241 obstetrics and gynecology program directors, along with an explanation for the study, information regarding approval of the study by the Oregon Health and Science University Institutional Review Board, and an offer to share the results. The survey consisted of 13 items, 3 of which involved demographic information such as length of time as program director and resident characteristics. The other 10 items related to means of identifying a problem resident, policies and decision-making strategies for intervention, the existence of a departmental or institutional progress board for professionalism, methods of remediation, perceived success of remediation, and willingness to communicate concerns to potential employers. Volunteers for a follow-up semi-structured phone interview were solicited; the phone interviews are currently ongoing and will not be reported here.

**Results**

One hundred forty-one of 241 surveys were completed (58%). Forty-two percent of respondents had been a program director for 5 years or more, and another 26% had held the position for 3-5 years. Interestingly, 84% of respondents noted that concerns about unprofessional behavior most typically initially come to their attention through some form of private communication, such as an e-mail or phone call, rather than through their program’s formal resident evaluation system. This communication of concern most commonly comes from a faculty member (43% of the time), followed by nurses (33%) or other residents (18%). No program director reported initially becoming aware of the problem through medical student feedback.

A slight majority of programs use policy to guide management in this area: 57% of respondents reported that their program has a written policy regarding unprofessional resident behavior, and 39% do not (4% were unsure). There is some variation regarding who decides how to proceed at this point: 46% state they decide how to manage the situation themselves, 16% present the situation to the departmental education committee, 11% consult their chair, and 10% consult another faculty member (usually the faculty advisor for that resident or an associate program director). Only 11% formally take their concerns to their DIO or GME at this point, although 73% of respondents’ institutions do provide counseling or other resources to deal with poor professionalism. Respondents were relatively evenly split on the existence of an institutional progress board designed to address professionalism, with 55% of their institutions having such a board, and 45% lacking one.

The survey asked respondents to indicate all the mechanisms they had used to address resident unprofessional behavior. The most common response was to meet with the resident and express expectation of improvement without specific assistance (95%); however, program directors have also mandated psychological counseling (68%), placed a resident on probation (59%), or required some other type of educational activity regarding professionalism (41%). Thirty percent have dismissed a resident or did not renew his or her contract because of these concerns. Only 15% reported remediation as being highly successful. The majority of respondents felt that their efforts at remediation were only somewhat successful (59%). Twenty-one percent felt remediation was not especially successful, and 3% felt it was not at all successful.

Finally, when a resident’s professionalism remained concerning but the resident graduated, only 25% would volunteer their concerns either verbally or in writing. Forty-two percent would communicate concerns only if asked. No program director stated that he or she would not indicate concerns at all. Several mentioned obtaining legal advice, and others would obtain a release of information from the resident and then answer questions truthfully, but withholding some information if the resident does not waive the right to see the recommendation. Several admitted intentionally “limiting communication” in such a case, or simply stating that the resident was “average.”

**Comment**

This survey of obstetrics and gynecology program directors was undertaken to clarify their current experiences and practices regarding identification and remediation of resident unprofessional behavior, as well as their willingness to communicate concerns in this area to potential employers. Although the study is limited due to its response rate, it still provides important information, particularly when placed in the broader context of the path of so-called “disruptive physicians” from medical school to residency to practice. In such physicians, problematic behavior seems to begin early in medical school, and unfortunately can persist through residency and into practice, where it can have devastating effects. In Papadakis’ groundbreaking 2004 study of UCSF medical school graduates disciplined by the California state medical board over a 10-year period, 95% of disciplinary actions were due to deficiencies in professionalism. UCSF-graduated physicians disciplined by the board for unprofessional behavior were twice as likely as graduates in the control group to have negative comments regarding professionalism in their medical school records. Her follow-up study of 235 graduates of 3 medical schools disciplined by 1 of 40 state medical boards over a 13-year period demonstrated similar findings. In fact, those physicians were 3 times more likely to
have demonstrated unprofessional behavior in medical school than the control physicians. The Papadakis studies support the need to identify unprofessional behavior prior to graduation from medical school, and certainly from residency training. It is especially disturbing that obstetrician-gynecologists were overrepresented in the disciplinary group in both studies, comprising 14% of the offenders, but only 4% of all UCSF graduates—second in frequency only to psychiatrists.

An important question left unanswered by the Papadakis study is the value of remediation, since her study did not examine whether remediation could reduce the association between professionalism concerns in medical school and subsequent disciplinary action from state medical boards. Our results indicate that remediation programs are felt by obstetrics-gynecology program directors to be only partially successful at best.

Duff states unequivocally that “the single most effective method of teaching professionalism is modeling of appropriate behavior by faculty members.” When we teach, in addition to the knowledge and skills we intend to convey, we also transmit a vast array of behaviors, beliefs, and attitudes we never intended to share, or even recognized we were imparting—the so-called “hidden curriculum.” Faculty members who speak of patients or colleagues in derogatory terms, refuse to take responsibility, or throw surgical instruments are teaching students and resident observers that such behavior is acceptable. Duff proposes a policy of zero tolerance for unprofessional behavior for both residents and faculty, in which every significant departure from acceptable norms is called to account, and egregious violations are grounds for dismissal from school and employment, with suspension or revocation of licensure. It is interesting that, despite much effort and attention paid to development of ever-bigger and presumably better evaluation tools, most program directors in this study were first made aware of a problem through personal communication. Opportunity lies in this reality. All constructive criticism is best given in the moment. Faculty members should be trained to give immediate feedback to any resident demonstrating unprofessional behavior, language, or attitudes. They should also strive to eliminate such negatives from their own repertoire, so that residents will receive a clear, consistent message of the unacceptability of such behavior.

Nevertheless, it is important to recognize that trainees and physicians in all training and practice settings at times display unprofessional behaviors, including those designated as role models. Goldstein refers to this concept as “continuous professionalism improvement,” similar to continuous quality improvement. It is essential that professionalism be seen as a work in progress at any institution, stemming from the recognition that the best physicians can be fatigued or stressed at times. Students, residents, faculty, and administrators should work together to create an institutional culture in which reflection, acknowledgment of mistakes, and recommitment to the highest standards of professionalism is a goal to which all aspire throughout their careers. It may be that one of the positive outcomes of resident duty hours’ restrictions will be to decrease fatigue and sleeplessness of residents, thereby decreasing frequency of unprofessional behavior due to stress.

Finally, it should be noted that in this study, program directors varied widely regarding their willingness to communicate concerns regarding professionalism to future employers. Poor documentation may lead to hesitation to act, and fear of legal reprisals was mentioned by several as a deterrent to complete disclosure. However, Irby and Milam have pointed out that, when due process is followed, program directors can expect the courts to appreciate the importance of upholding professional and academic standards. When due process has been served, the courts have repeatedly upheld dismissal decisions made by higher-education faculty. In situations where the concern was not serious enough to dismiss the resident, disclosure can be supported by documentation and should be reported truthfully. However, it is hoped that serious professionalism issues would be dealt with during medical school and residency with stringent performance standards, direct feedback, and dismissal if necessary. If program directors accept the responsibility to act when required, they would not be placed in the uncomfortable position of providing a recommendation for someone about whom they have doubts.

The Papadakis studies cover a period before the current increased emphasis on professionalism in medical school was present. However, the evidence of unprofessional behavior, presumably obtained by personal observation or communication, was recorded. If, with increased focus on professionalism, we succeed in identifying more lapses in this area, and agree that remediation of those lapses is only somewhat or not very successful, yet dismiss few residents, and don’t tell prospective employers about our concerns, the problem of unprofessional behavior in the workplace will not change.

Forty-six of our respondents provided contact information for a semi-structured phone interview in which we are exploring the specifics of their experiences with individual residents, their plans for remediation, the outcome of remediation, and their overall feelings about how well or poorly the situation was managed, with lessons learned. A survey of medical school student affairs deans is also planned that will examine their willingness to communicate professionalism concerns to residency programs in the Dean’s letter. The data gathered in these ways will hopefully shed additional light on the challenging problem of remediation of unprofessional behavior at all levels of training. As we become increasingly aware of the critical nature of early identification and remediation of unprofessional behavior, with dismissal of those who cannot meet a minimum standard, it is hoped that medical school, clerkship, and residency administrators will use the evidence-based recommendations generated as a source of support in performing this difficult part of their jobs.
REFERENCES

DISCUSSION
Gainer Pillsbury, MD. Last year at this program in Sun Valley, ID, Dr Larry Veltman presented a paper titled, “Disruptive behavior in obstetrics: A hidden threat to patient safety.” Dr Veltman reported that disruptive behavior occurred in 61% of the labor and delivery units surveyed, and this behavior happened daily or weekly 50% of the time. Nurses, midwives, and other physicians demonstrated this behavior on occasion, but obstetrician/gynecologists were the most frequent offenders.

When we speak of disruptive physicians, we are referring to those who exhibit a pattern of repeated abusive or intimidating behavior. Isolated events which are often precipitated by stressful or annoying circumstances are not the problem. A simple apology usually resolves these issues.

Persistent disruptive behavior negatively affects communication and team dynamics and often leads to staff dissatisfaction and adverse events. Given the growing concerns about accountability for providing high-quality outcomes, patient safety, and workforce shortages many hospitals are taking aggressive action to curb disruptive behavior. A recent appellate court decision in California upheld a hospital’s right to bar a medical staff member from the hospital premises because of disruptive behavior. In her paper, Dr Adams refers to the study by Papadakis, which found that physicians who were disciplined by state medical/licensing boards were 3 times as likely to have displayed unprofessional behavior in medical school than were control students.

Dr Adams’ paper expands the research on this subject and describes the outcome of a web-based survey of 241 directors of US obstetrics and gynecology residency programs. Fifty-eight percent of the program directors responded and all of them had had to deal with the unprofessional behavior of a resident.

There was an inconsistent policy about how to deal with these problems, and while 59% felt their efforts were somewhat successful, 24% reported that their efforts were not. Presumably, most of these individuals completed their programs and were certified as being competent and trustworthy medical practitioners.

What is disturbing to me as a hospital medical executive is that efforts to control unprofessional behavior in medical school and residency programs are often ineffective. Equally disturbing is the fact that only 25% of program directors would volunteer their concerns about the graduate either verbally or in writing, and 42% would communicate concerns only if asked.

While this might seem to serve the resident’s best interests, in fact it often does not. Medical staff coordinators are becoming more suspicious about less than glowing reports from residency program directors. It is frequently like pulling teeth to get accurate information on this subject. Until it is resolved, the new graduate’s application to a medical staff is incomplete and the applicant cannot practice in the hospital until the matter is cleared up.

I congratulate Dr Adams for presenting this information to us, and I urge all program directors to establish written policies establishing a Code of Conduct that residents must agree to at the beginning of their training. Standards need to be applied equally to everyone and expectations articulated. All incidents of inappropriate behavior should be documented and managed by straightforward dialogue and an organizational insistence on accountability. This policy should extend to the faculty as well and academic advancement should depend in part at least on effective role modeling. Behavior is significantly affected by example and the faculty should teach and demonstrate professional behavior with the same rigor as they do surgical skills.

As difficult as it is, if a resident continues to perform at a level that is below an acceptable standard, and if multiple opportunities to correct that behavior fail to resolve the problem, the resident should be
terminated from the training program. These residents are not helped by being retained in a discipline for which they ultimately will not succeed. The legal concerns about doing so are not as great as many believe, and leaving the problem for some future time not only puts patients at risk, but may result in lengthy, bitter, and expensive disciplinary actions by hospital medical staffs and/or state medical boards. It is far better to identify these irremediable problems sooner when it can be determined that the resident’s time and energy would be better spent elsewhere.\(^4\)

Obstetrics-gynecology program directors’ experience with remediation of unprofessional residents is mixed, and some hesitate to communicate concerns to potential employers.

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REFERENCES