**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 quantitative 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.

**Background**

The academic study of medical professionalism is becoming very common, and there are several reviews, articles, and books on teaching professionalism. 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. 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. 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. As in any crisis, the environment has evolved to accept substandard professional behavior in exchange for efficiency or productivity.
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.\textsuperscript{13,14} 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.\textsuperscript{15,16}

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 would no longer work with students. In return, she was promised an “A” in professionalism in exchange for the signature. She complied.

—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

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 professionalism or 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. 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. In addition to obvious cases of malignant pimping (i.e., interrogation intended to humiliate), belittlement, and shame, students are targeted according to gender or ethnicity. Sexual harassment of students remains commonplace. Students yield to the team’s deception of patients, colleagues, and superiors. 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. 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,24 the University of Washington School of Medicine,25 and the University of Texas Medical School Branch at Galveston.26 The following solutions that we propose are familiar, and many have been suggested previously.38–40 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.41–44 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.45 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.

References


