Residents' Perspectives on Professionalism

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Abstract

Background Research defining professionalism exists, yet little is known about how residents view this important attribute for medical practice. Knowing more about residents' interpretations of professionalism and about how they value professionalism would enhance definitions and facilitate support for the development of professionalism skills and behaviors at the graduate level.

Purpose The purpose of this phenomenological study was to investigate how residents think about professionalism, how they value it, and how it plays out in their educational lives.

Methods This study uses qualitative methods, employing 5 focus groups representative of a range of disciplines. Methods include providing unstructured prompts, member checking and informant feedback to support credibility, and content analysis to discern significant patterns.

Results Content analysis supported that residents highly value professionalism and see it as a complex construct, dependent on the situation, discipline, and on personal experience. Challenges to professionalism are common in graduate medical education and a great concern for residents.

Conclusions Physician educators often discuss professionalism as an overarching concept in medicine, especially in classes during the preclinical years. Although some general principles are applicable, residents relate more deeply to aspects of professionalism that concern their own clinical practice, situation, and specialty. Implications for measurement of professional skills and for further research are included in this report.

Residents' Perspectives Regarding Professionalism

Despite the importance of professionalism and the increased attention to teaching professional behavior in medical education,[1] the medical and medical education community does not appear to have a uniform understanding of the concept of professionalism. A common interpretation of professionalism encompasses caring, empathy, and ethics, whereas the literature offers a wider range of concepts. Ginsberg et al[2] argue for skill in conflict resolution, and Epstein and Hundert[3] advance technical skills, clinical reasoning, and reflection regarding patients and community as key. Other studies support social components such as interpersonal skills, rapport, attentiveness, attitude and empathy,[4] communication skills,[5] and lifelong learning.[6]

In this context, it is important to know how professionalism is perceived by resident physicians. Knowing more about how residents think about professionalism may provide a starting point for teaching professional skills. This topic is especially important because theoretical principles of professionalism are learned predominantly during the preclinical years, before most students have chosen a specialty. However, residents' attitudes about professionalism appear to be shaped by clinical experiences later in training. In addition, although professionalism is a core competency in residency, its assessment is more likely to occur as part of residents' day-to-day work.

Residents' opinions have been examined regarding a range of topics including their work environment,[7] the effects of duty hour requirements,[8] evidence-based clinical decision making,[9] and teaching.[10] To date, how residents think about professionalism or how it plays out in their lives has not been a topic of investigation. We wanted to know how residents think about professionalism, how they define it, and what experiences they related to developing professional skills. The authors (a physician and a medical educator) thought that professionalism might be a "top-down" concept defined by general stereotypes and a literature replete with constructs including empathy, timeliness, ethics, and team play. At the same time, we were unsure how residents would define professionalism: would their descriptions echo these stereotypes, would they vary across disciplines, and how would residents think professionalism and professional behaviors are developed?

Methods

Our approach was phenomenological, geared toward exploring participants' experiences of professionalism as the

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"phenomenon of interest,"[11] and our aim was to elucidate residents' perspectives and examine variations across programs.[12] Focus groups have been used successfully in exploring issues such as bedside teaching,[13] residents' preferences for evidence-based medicine,[14] health advocacy,[15] and factors affecting career choices of family medicine graduates.[16]

Participant Selection

We conducted 5 single-specialty focus groups with residents in obstetrics and gynecology, physical medicine and rehabilitation, ophthalmology, psychiatry, and surgery. Focus groups are commonly based on homogenous populations, and participants were selected based on a purposeful sampling technique.[17] We recruited intermediate residents (postgraduate years 2 and 3) because we thought that this group would provide the most information-rich data; novice residents may focus on learning basic skills, and graduating residents transitioning to new positions may have an "inflated" view of their professionalism. We used an unstructured interview process,[17,18] starting with the question, "What are some examples of professional or unprofessional behavior that you observed during training?" We included general open-ended questions as the discussion evolved. Some of these were: "What is professionalism to you?" "What experiences have you had with professionalism?" "What components might professionalism include?" "How did you learn to be professional?" We used a member checking strategy to support credibility throughout.[19] The researchers served as interviewers. Neither was known to the residents. Focus group participation was voluntary and confidential. Written consent was obtained from participants and institutional review board approval was obtained for the project.

Data Aggregation

An audiotape was made of the focus group sessions, from which verbatim transcripts were obtained. The researchers then analyzed the content of the transcribed data[11] to discern major and minor themes and patterns based on significant statements and quotes. Both investigators developed independent coding schemes and discussed these to enrich interpretations. The physician investigator on the team cited major trends within and across specialties, and the educator investigator supported these and also gleaned subtle variations from the more traditional interpretations found in the literature.

Results and Discussion

Beliefs

Two major trends emerged. First, residents across specialties clearly articulated an in-depth understanding of professionalism and expressed their high regard for the construct. A second general theme involved concern about situations and events that present challenges to professionalism. In response to the question, "What is professionalism to you?" none of the participants advanced a specific definition. Instead, residents listed traits of professional behavior, such as positive attitude, respect for patients, respect for confidentiality, respect for others, promptness, and thoughtfulness. Interestingly, one resident suggested that knowing limitations and proficiency were key: "I think one component is knowing your limitations and level of confidence—if you are not good at what you do there is no way that you're going to be professional." Another resident took a more relationship-oriented approach: "If you never let them [patients] voice their opinions or problems and you just tell them what you are thinking all the time, it's unprofessional."

All 5 groups focused on the doctor-patient relationship as the most important application of professionalism. Relating to the patient and treating the patient with respect were common themes. One resident said, "When it comes to patient interaction, just good listening and trying to convey to the patient that you understand their fears…and that we're here to get you through whatever is happening." Other themes included spending time with patients to explain medical treatment, talking with family as well as patients, and empathy.

A second concept that emerged was challenges to professionalism during residency. The 2 most common themes were interactions with nurses and interactions with other clinicians overnight and on call. Residents perceived interactions with nurses as a challenge to professionalism; an example involved the conflict between an inexperienced resident "in charge" of more experienced nursing staff or questions from nonphysician colleagues. One resident noted, "It's because at 3 in the morning when you're trying to sleep and you get woke[n] up for what you consider to be a truly stupid question, it's not stupid to them because they are asking you but for whatever reason it could have waited or it was just not appropriate…it's hard to be professional at that point in the morning." Call issues also centered around unprofessional behavior of consulting physicians, either in "dumping" patients on the consulting service or inappropriate requests from the consulting service. One group elaborated on this by citing pressures in training that push residents away from professional behavior, such as time constraints and cost-driven medicine. Finally, residents tended to separate professionalism from ethics noting that physicians they think of as "professional" have exhibited "unethical" behavior, and vice versa. A resident observed, "I had this great professional pediatrician. About 2 months after I rotated off his service he was arrested for stealing medication from his own clinic!"

Behaviors

Residents reported that managing emotions is part of professionalism. Dealing with an angry patient might demand important professional skills. One resident

reported, ''If someone is getting upset with you, [don't feed] into that, but rather [say], 'What I hear you saying is,' or, 'I understand that you are upset here and I want to address that.'" Reflective listening and defusing emotion were reported as critical to professional skills. Another resident suggested taking a reflective approach to communication early in practice: ''Well if you don't practice (active listening) up front, it won't be part of your practice later on…you need to be conscious of what you're saying and how it affects your patients. If it is not something that you care about when you are first learning, how do you make it something that you care about later on?'' The shared emphasis was on taking a reflective stance and on developing the associated communication skills.

Residents also reported that a part of professionalism and professional development is adapting professional behavior to the situation. Values and beliefs serve as a basis for behavior, but adjusting behavior for different situations may be a key in developing professional skills and ''expertise.''

Boundaries, Situations, and Applications

Another set of themes reflected the situational or contextual nature of professional behavior. Several residents mentioned maintaining distance as a key to professionalism. This theme is not well articulated in the literature. In sharing perceptions regarding an exemplary attending, one resident said, ''…although he maintains very congenial relationships with his patients, you can always tell that there is a professional barrier, he doesn't exactly get overly friendly…you can tell that there is an air when he walks in the room.'' Although the history of medical care has been characterized by distance, cool posture, and scientific objectivism, helping residents to achieve a flexible line involving both the content and effect of their communication may be important.

Sensitivity to context and/or tailoring communication to context is another dimension of professionalism that is not extensively addressed in the literature. One resident, who was elated to have identified her patient's disease, was dumbfounded when the patient burst into tears on hearing the diagnosis because a friend had just died from this condition. Another commented, ''…the level of professionalism changes as you know the individual you are interacting with…you may say something to a colleague that a patient, if he heard, would consider unprofessional, but having a sense of camaraderie in the clinics makes you a better professional, and in a better position to do your job.'' A third asserted, ''…there is a friendly attitude when you are joking around with your colleagues, even though it may be unprofessional at the time, it makes for a better working relationship.'' Clearly, residents are aware of guidelines for professionalism, but skill in reading situations and thoughtful adaption of the ''rules'' appears to facilitate collaboration and community.

Professionalism in the Disciplines

The focus groups found variations in interpretations of professionalism across disciplines. Although most discussed the intimacy of the doctor-patient relationship, specialty groups related this intimacy to unique features of their clinical specialty. Obstetrics and gynecology residents linked the relationship to women's and sexual health issues; ophthalmology residents related it to the critical importance of maintaining eyesight; surgery residents cited the life-and-death nature of their practice; and psychiatry residents discussed the delicate nature of mental health and the need for balance in treating patients.

The groups spent significant time discussing aspects of professionalism unique to their specialty. Ophthalmology residents mentioned the elective nature of many ophthalmologic procedures, which made establishing patient rapport important to ensure patients would return. Physical medicine residents discussed the specialized team structure of their service and the need to collaborate with other disciplines. Unique themes in psychiatry include the stigma of mental health issues as it impacts professional practice. A resident observed, ''They (other specialties) don't see individuals with psychiatric illness as real patients—they are more a problem that they have to deal with to get to their 'real' patients and that is pretty unprofessional.'' Surgery residents suggested that knowing one's limitations is critical because ''if you are not good at what you do (surgery) then there's no way that you will be professional.'' Surgery residents also suggested that immediacy of the specialty was a powerful influence on professionalism: ''You have to be able to communicate with families and patients about the severity and about how you think things could be and then reflect on your empathy towards them.''

Conclusions

The focus groups elucidated residents' understandings of professionalism along 3 dimensions: beliefs, behaviors, and context. Residents have a personal understanding of professionalism; they readily provided examples, cited common threats, and discussed the construct in terms of social/interpersonal and specialty context. The data also suggested that residents first view professionalism as a multifaceted and highly valued construct. Second, they focus on professionalism as relational or part of patient-centered care; and third, they fairly frequently experience concern with situations they perceive as threats to professionalism. Residents also view professionalism as contextual, dependent on the situation and the discipline, and may be more concerned with the question, ''What makes a good surgeon?'' than with, ''What makes a good doctor?'' Participants interpreted the nature of the doctor-patient relationship in terms of specialty-specific aspects of

clinical practice, such as life and death or sensitive aspects of sexual or mental health history.

Suggestions for Teaching, Learning, and Assessment

Physician educators often discuss professionalism as an overarching concept. In medical school, professionalism usually is taught in ''introduction to clinical medicine'' classes during the preclinical years, most commonly as a general concept divorced of specialty-specific content. Providing support for the development of professional skills at the graduate level should include consideration of the specific aims and demands of the clinical specialty. Learners writing about or engaging in small-group discussion of events in their specialty may promote insight and reflection.

Professionalism is a complex construct, making measurement challenging. Quantitative measures, scales, and checklists often isolate discrete behaviors and miss important dimensions, or are too general to be meaningful (eg, maintains appropriate behavior with patients and families). Although a behavioral measure of professionalism with quantitative data is an appropriate strategy, it is also important to include qualitative information to capture the larger picture. Having respondents write about or explain rationale for ratings is critical, as is providing opportunity for general comments and/or qualitative data.

Residents in this study focused on the doctor-patient relationship as the primary expression of professionalism. Even though this is an important aspect, it is not the entire concept, and teaching could focus on expanding learners' views of different aspects of professionalism beyond the doctor-patient relationship. Physician educators may be able to optimize teaching opportunities by starting with the doctor-patient relationship as familiar ground and broadening the discussion to other areas. Secondary concepts of collegial professionalism (such as interactions during consults and patient transfers/handoffs) and interactions with other disciplines, such as nursing, emerged in our discussions and could be the logical curricular topics. Physician educators also may be able to more successfully engage trainees on the topic of professionalism by tailoring the discussion to the specifics of their own clinical care.

Limitations of this study include its small sample size and the focus on a single institution and 5 specialties, which limits the ability to generalize the data. Further research should include investigating interpretations of professionalism in other medical disciplines, examining medical students' interpretations and comparing them to those of residents, and looking for developmental changes in professionalism across the medical education trajectory.

References

1 Steinert Y, Cruess S, Cruess R, Snell L. Faculty development for teaching and evaluating professionalism: from programme design to curriculum change. *Med Educ*. 2005;39(2):127–136.

2 Ginsberg S, Regehr G, Hatala R, et al. Context, conflict, and resolution: a new conceptual framework for evaluating professionalism. *Acad Med*. 2000;75(10):S6–S11.

3 Epstein R, Hundert E. Defining and assessing professional competence. *JAMA*. 2002;287:226–235.

4 van Zanten M, Boulet J, Norcini J, McKinley D. Using a standardized patient assessment to measure professional attributes. *Med Educ*. 2005;39(1):20–29.

5 Hobgood CD, Riviello RJ, Jouriles N, Hamilton G. Assessment of communication and interpersonal skills. *Acad Emerg Med*. 2002;9(11):1257–1269.

6 Hojat M, Veloski J, Nasca T, Erdmann J, Gonella J. Assessing physicians' orientations toward lifelong learning. *J Gen Intern Med*. 2006;21(9):931–936.

7 Avan BI, Raza SA, Khokhar S, et al. Residents' perceptions of work environment during their postgraduate medical training in Pakistan. *J Postgrad Med*. 2006;52(1):17–18.

8 Irini JL, Mello MM, Ashley SW, Whang EE, Zinner MJ, Breen E. Surgical residents' perceptions of the effects of the ACGME duty hours requirements one year after implementation. *Surgery*. 2006;138(2):246–253.

9 Montori VM, Tabini CC, Ebbert, JO. A qualitative assessment of 1st year medical residents perceptions of evidence-based medicine. *Teach Learn Med*. 2002;14(2):114–118.

10 Lempp H, Seale C. The hidden curriculum in undergraduate medical education qualitative study of medical students' perceptions of teaching. *BMJ*. 2004;329,770–773.

11 Cresswell JW. *Qualitative Inquiry and Research Design*. London, England: Sage Publications; 2007.

12 Krueger RA, Casey MA. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, CA: Sage Publications; 2000.

13 Williams KN, Ramani S, Fraser B, Orlander JD. Improving bedside teaching: findings form a focus group study of learners. *Acad Med*. 2008;83(3):257–264.

14 Akl EA, Maroun N, Neagoe G, Guyatt G, Schuemann HJ. EBM use and practitioner models for graduate medical education: what do residents prefer? *Med Teach*. 2006;2(2):192–194.

15 Verma S, Flynn L, Seguin R. Faculty's and residents' perceptions of teaching and evaluating the role of health advocate: a study at one Canadian university. *Acad Med*. 2005;80(1):103–108.

16 Lu DJ, Hakes J, Bai M, Tolhurst H, Dickinson JA. Rural intentions: factors affecting the career choices of family medicine graduates. *Can Fam Phys*. 2008;54(7):1016–1027.

17 Patton MQ. *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage Publications; 2002.

18 Lincoln YS, Guba EG. *Naturalistic Inquiry* London, England: Sage Publications; 1985.

19 Guba EG, Lincoln YS. *Fourth Generation Evaluation*. London, England: Sage Publications; 1989.