Professionalism in Pathology

A Case-Based Approach as a Potential Educational Tool

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• ***Context.***—**Professionalism issues in residency training can be difficult to assess and manage. Generational or role-based differences may also exist between faculty and residents as to what constitutes unprofessional behavior and how to manage it.**

Objective.—**To examine and compare how faculty and residents would approach the same 5 case scenarios detailing various aspects of unprofessional behavior.**

Design.—**Five case scenarios highlighting various unprofessional behaviors were presented in a workshop at an annual meeting of pathology department chairs, residency program directors, and undergraduate pathology medical educators (ie, pathologists involved in medical student pathology education). The same cases were presented to a cohort of pathology residents currently in training. A standard set of responses were offered to the participants, polling results were collected electronically, and results were compared.**

Results.—**Faculty and residents were fairly consistent within their respective groups. In a subset of cases, faculty were more likely to favor working with the individual in the scenario, whereas resident respondents were more likely to favor either no response or a severe response. Generational or role-based differences were also potentially evident.**

Conclusions.—**Assessing expectations and differences around professionalism for both faculty and residents should be considered as part of any educational and management approach for professionalism. Although a level of generational differences appears to be evident in this study regarding the recognition and management of unprofessional behavior, there was also agreement in some cases. Further exploration into the discrepant responses between faculty and residents may prove useful in developing educational, assessment, and remediation resources.**

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The importance of professional and ethical behavior by physicians in training or in practice cannot be overemphasized.[1,2] This is no less true for the practice of pathology.[3–5] Unprofessional or unethical behaviors are the most common reasons for disciplinary action taken by licensing boards and professional organizations. In several studies in pathology, professional and ethical behaviors continue to be important in the practice setting, but employers have repeatedly found new hires to be deficient in this area.[5] Studies have shown that educating learners in professionalism, as well as the assessment and remediation of unprofessional behavior, is difficult at best.[6–8] Even when identified, approaches to the remediation of unprofessional behavior can be quite variable.[6–8]

In an attempt to help residency and fellowship program directors recognize and remediate unprofessional behavior, the Graduate Medical Education Committee of the College of American Pathologists (CAP) held a workshop session at the July 2015 Association of Pathology Chairs (APC), the Pathology Program Directors Section (PRODS), and the Undergraduate Medical Education Section (UMEDS) annual meeting. Following this workshop, a large cohort of residents currently in training was surveyed. This article presents the results of, and the lessons learned from, that workshop and survey.

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MATERIALS AND METHODS

This study was divided into 2 parts. Part 1 reflects the data collected from faculty at a live, interactive workshop held at a national meeting. Part 2 reflects the data collected from an online survey of residents currently in training.

Part 1: Data Collected Live at an Interactive Workshop

A subcommittee of the Graduate Medical Education Committee of the CAP developed a 2.5-hour workshop/plenary session, "Case Studies in Professionalism: An Interactive Session," for the APC, PRODS, and UMEDS July 2015 annual meeting. Five case scenarios were developed that contain elements of unprofessional behavior based on real-life experiences as well as some fictional elements to highlight certain behaviors (Appendix). Any potential identifiers were altered or deleted to protect privacy and confidentiality.

A moderator and an expert panel of 4 APC, PRODS, and UMEDS members were assembled for the session. Four invited residents were also available to provide a "resident's perspective." After each case was presented, the moderator used the Poll Everywhere (Poll Everywhere Inc, San Francisco, California) audience response system to capture responses to specific questions, encouraged general discussion from the audience (approximately 150 attendees), and directed questions to the panel and representative residents.

For each case scenario the audience was asked to use Poll Everywhere to select the most appropriate course of action from the following potential choices:

1. No immediate action but monitor
2. Meet informally to discuss, then monitor
3. Determine formal remediation plan and follow-up
4. Request fitness for duty evaluation
5. Place on probation
6. Immediately dismiss
7. Do not renew contract

Case scenario 2 also involved a medical student and thus had an additional course of action: "Refer to academic progress committee."

The discussion for each case scenario was recorded in order to capture individual comments, questions, and discussion threads.

Part 2: Data Collected From an Online Survey of Current Residents

Approximately 2 months following the July 2015 plenary session, the same 5 case scenarios (Appendix) and potential courses of action were sent by email to the 2500 resident (junior) members of the CAP. Survey Monkey (Palo Alto, California) was used to capture residents' responses and comments. Only residents currently in training were permitted to complete the survey.

Workshop participants and resident response frequencies were computed for each of the 5 cases. For cases 1, 3, 4, and 5, χ^2 tests of independence were also conducted to determine whether the proportion of respondents selecting each response option differed significantly between the workshop and resident samples. This type of analysis was not possible for case 2 because workshop participants and residents did not respond to the same question. Specifically, residents answered 2 questions regarding this case that allowed them to specify an appropriate course of action for both the medical student and the resident depicted in the scenario. In contrast, for case 2, workshop participants selected only one appropriate course of action that did not take each individual involved into separate consideration.

RESULTS

Part 1: Data Collected Live at an Interactive Workshop

Total responses for each case scenario during the workshop ranged from 99 to 110. The percentage responses for each course of action in each case are shown in Table 1. For case 2, responses for the medical student course of action were not separated out from the resident course of action during the plenary session, so results may have been slightly skewed compared with the resident survey participants who were presented with separate courses of action options for the resident and the medical student (especially for the "refer to academic progress committee" choice).

Table 2 highlights common threads/themes recorded by the workshop participants.

Part 2: Data Collected From an Online Survey of Current Residents

A total of 350 residents answered the first question asking for their postgraduate year (PGY) of training. Of the 350 respondents, there were 3 PGY-1 residents (0.9%), 91 PGY-2 residents (26.0%), 85 PGY-3 residents (24.3%), and 90 PGY-4 residents (23.1%) who participated. A total of 81 of 350 residents (23.1%) indicated they had completed training and were screened out of the survey. For each case scenario, residents were instructed to choose the appropriate course of action as if they were the person in the position of authority (ie, the program director) to make the decision. Case 2 was broken into 2 responses: one course of action for the resident and one for the medical student involved in the unprofessional behavior. Responses are detailed in Table 1. Table 3 highlights selected written comments made by the residents on the online survey.

Table 1 also summarizes response frequencies for both the workshop and resident samples across each of the 5 cases. The χ^2 test confirms that workshop participants and residents provided comparable responses to case 1 (χ^2 [4] = 5.05, P = .28) and case 4 (χ^2 [5] = 5.34, P = .38).

Responses to case 3 were significantly different based on respondent role (ie, workshop participant or resident), χ^2 (6) = 16.93, P = .01. Response frequencies suggest residents were more likely to take no immediate action in response to this scenario; that is, 91 of 246 residents (37%) compared with 23 of 108 workshop participants (21%). Workshop participants were more likely to meet informally to discuss the behavior; that is, 76 of 108 of workshop participants (70%) compared with 128 of 246 residents (52%).

A significant difference in the response patterns was also observed for Case 5, χ^2 (6) = 21.96, P = .001. Residents tended to take more extreme actions than did workshop participants. Only 119 of 239 residents (50%) suggested it would be sufficient to *determine a formal remediation plan and follow-up*, compared with 69 of 99 workshop participants (70%). Nearly one-quarter of the residents (52 of 239; 22%) felt the individual should be placed on probation, compared with only 6 of 99 workshop participants (6%).

DISCUSSION

Unprofessional or unethical behavior can be among the most difficult to recognize and correct during residency training. However, ensuring that trainees are competent in these areas is critical to the health of patients and the reputation of our profession. A case-based approach can help educate residents and faculty to recognize inappropriate behavior, help in defining professionalism, and help in formulating assessment tools and educational approaches to remediation.

Our study is one of the few to compare faculty and resident responses on how to approach unprofessional behavior. Cases 1 and 4 showed remarkable agreement

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Case Scenario and Potential Responses	Workshop Participants, % (No.)	Resident Survey Participants, % (No.)	Statistical Significance
Case 1: inappropriate comments by resident and lack of cultural and gender sensitivity			$P = .28$
No immediate action but monitor	0	2.0 (5/253)	
Meet informally to discuss, then monitor	75.45 (83/110)	79.1 (200/253)	
Determine formal remediation plan and follow-up	22.73 (25/110)	17.4 (44/253)	
Request Fitness for Duty evaluation	0	0.8 (2/253)	
Place on probation	1.82 (2/110)	0.8 (2/253)	
Immediately dismiss	0	0	
Do NOT renew contract	0	0	
Case 2: inappropriate use of social media by medical student and resident			ND
No immediate action but monitor	0	0.4 (1/248)	
Meet informally to discuss, then monitor	0.91 (1/110)	3.6 (9/248)	
Determine formal remediation plan and follow-up	15.45 (17/110)	27.0 (67/248)	
Request Fitness for Duty evaluation	5.45 (6/110)	6.5 (16/248)	
Place on probation	60.91 (67/110)	35.9 (89/248)	
Immediately dismiss	13.64 (15/110)	25.0 (62/248)	
Do NOT renew contract	0	1.6 (4/248)	
Refer to academic progress committee	3.64 (4/110)	25 (62/248)	
Case 3: inappropriate off-hour and work requests by a faculty member			$P = .01$
No immediate action but monitor	21.3 (23/108)	37.0 (91/246)	
Meet informally to discuss, then monitor	70.37 (76/108)	52.0 (128/246)	
Determine formal remediation plan and follow-up	5.56 (6/108)	8.5% (21/246)	
Request Fitness for Duty evaluation	2.78 (3/108)	0.4 (1/246)	
Place on probation	0	1.2 (3/246)	
Immediately dismiss	0	0.4 (1/246)	
Do NOT renew contract	0	0.4 (1/246)	
Case 4: medical disorder in a resident impairing performance			$P = .38$
No immediate action but monitor	0	0	
Meet informally to discuss, then monitor	0.94 (1/106)	2.9 (7/242)	
Determine formal remediation plan and follow-up	2.83 (3/106)	5.0 (12/242)	
Request Fitness for Duty evaluation	87.74 (93/106)	82.2 (199/242)	
Place on probation	3.77 (4/106)	6.6 (16/242)	
Immediately dismiss	0	0.8 (2/242)	
Do NOT renew contract	4.72 (5/106)	2.5 (6/242)	
Case 5: inappropriate behavior by resident toward other residents and faculty			
No immediate action but monitor	1.01 (1/99)	0	$P = .001$
Meet informally to discuss, then monitor	18.18 (18/99)	15.9 (38/239)	
Determine formal remediation plan and follow-up	69.7 (69/99)	49.8 (119/239)	
Request Fitness for Duty evaluation	3.03 (3/99)	5.9 (14/239)	
Place on probation	6.06 (6/99)	21.8 (52/239)	
Immediately dismiss	0	1.7 (4/239)	
Do NOT renew contract	2.02 (2/99)	5.0 (12/239)	

Table 1. Comparison of Course of Action Responses by Workshop Participants and Resident Survey Participants

Abbreviation: ND, not determined; this analysis was not possible for case 2 because workshop participants and residents did not respond to the same question.

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between both faculty (workshop participants) and residents in how to handle unprofessional behavior related to inappropriate comments (case 1) and a resident impaired because of a medical condition (case 4).

The responses to cases 3 and 5 demonstrated a lack of consensus between faculty and residents, showing statistically significant differences in proposed responses. Case 3 illustrated inappropriate off-hour and work requests by a faculty member, and case 5 illustrated inappropriate behaviors by a resident toward other residents and faculty. In both cases, residents tended toward a more severe approach to handling the unprofessional behavior. The responses to case 2 could not be statistically compared because the responses at the workshop were not delineated separately for the resident and the medical student involved in the case. However, the responses detailed in Table 1 seem to also suggest a more severe approach by the residents compared with the faculty.

Only a few other studies have examined the potential generational or role-based differences in defining or addressing the types of behavior that are deemed to be unprofessional. Borrero et al[9] distributed a survey of 16 vignettes depicting unprofessional behavior to faculty and to first- and second-year internal medicine residents. Survey respondents were asked to rate the severity of the infraction depicted in each vignette as "not a problem," "minor," "moderate," or "severe." Only 2 of the vignettes (depicting an "abuse of power" and a "lack of conscientiousness") demonstrated a statistically significant difference between trainees and faculty. The authors concluded that genera-

Table 2. Common Themes From the Workshop
• Before determining a specific course of action, it should be assessed whether or not the unprofessional behavior is an isolated incident or a pervasive behavior. • Document the event(s) and the retention of files. ○ A "note to file" or a "focused letter of concern" can be an informal way to document an isolated breach in professionalism. These one-time notes can then be shredded after the resident successfully graduates from the program. ○ Caution is required as to how documents are labeled in residents' files, because state medical licensing boards are increasingly asking for detailed information. ○ No clear guidelines on how long to maintain resident evaluations. • Contact the Designated Institutional Official (DIO) and legal office earlier rather than later. • Faculty/attendings are role models for both professional and unprofessional behavior. • However unprofessional behavior is dealt with, perceived consistency is important. • Unprofessional behavior is an opportunity for all residents to learn from the experience. • Empathy and cultural sensitivity are important tools for the remediation of professionalism issues. • The DIO and legal office need to be involved early when there are professionalism issues related to medical or mental concerns. • Definitions and policies for remediation, probation, fitness for duty, etc, should be as clear as possible. • Institutional policies for fitness for duty can be variable. • Professionalism education in residency is important. • Unprofessional behavior in both residents and faculty is too often ignored or "swept under the rug" rather than addressed.

tional differences do not seem to play a significant role in teaching professionalism to residents.[9]

A study by Hultman and Wagner[10] examined aspects of professionalism as viewed by graduating medical students versus surgery residents, fellows, and faculty. In one part of the survey, participants were asked to rank 30 clinical scenarios of unprofessional behavior on a 5-point Likert scale (from the most unprofessional behavior to the least egregious behavior). Their results showed agreement between both groups on the top 11 scenarios constituting the most unprofessional behaviors, but there were some minor differences because there was rank-order agreement for only 2 of the 11 cases. The authors concluded that both groups had similar attitudes about professionalism and as to what constitutes the worst behaviors, and that educational efforts, particularly through modeling and mentoring, could be improved.[10] Another study demonstrated that perceptions of some aspects related to professionalism varied with educational level and age.[11]

The argument has been made that rather than looking at absolute differences in age as a surrogate for generational differences, what truly lies at the heart of the matter is the transformative process that occurs through the life stages of medical student, resident, fellow, and practicing physician, and that this explains differences in attitudes about professionalism.[12,13] Professional identity, which encompasses professional values and behavior, is developed gradually and continuously through the various life stages, adapting and changing over time.[14]

For others, professionalism is more than a checklist of desirable behaviors, and is more attuned to a comprehensive "belief system" about how we (physicians practicing

Table 3. Selected Written Comments From the Residents' Online Survey
• "We need less authoritarian training. . ." • "Professionalism training during residency is an important topic. . ." • "What can we do to address unprofessional conduct among faculty and staff?" • "The social media scenario is the most frequent one I've encountered. . .Another one that comes up a lot in my program is faculty members gossiping about residents, in particular perceived incompetence or bad behavior by residents, in front of other residents." • "Most residents in my program feel that faculty members are not modeling professional behavior. . ." • "Professionalism is a learned behavior in which faculty and mentors are role models. Unfortunately not all faculty model professionalism, and sometimes these individuals get away with inappropriate behavior. . ." • "I appreciate that attention is being paid to professionalism—it's so important, yet I see unprofessional behavior quite frequently from both residents and attendings." • "Professionalism is extremely important. . .and there is definitely a need for guidance and leadership in this area. I don't think it's fair to expect medical students to wake up and start residency one day and automatically BE professionals—guidelines must be emphasized and appropriate/inappropriate behaviors need to be discussed and addressed so that residents will know how to act appropriately in the workplace."

pathology) ensure that our members are worthy of the public's trust and how we hold each other accountable.[15] In this context, despite changes within and outside of the practice of medicine, physician organizations and groups act as "moral agents" by repeatedly and consistently reinforcing their mission and providing guidance in carefully crafted ethics and professionalism statements, policies, and position papers that set their moral tone.[16] Values, desirable behaviors, professional identity transformation, and a belief system are each important parts that make up the whole, and make it imperative that the process of teaching and role modeling professionalism and ethics to our trainees be approached as a multidimensional competency requiring multiple skills as well as robust faculty mentoring.[1] To paraphrase Steinberg, we must treat "professionalism as a verb, as action-ethics," and, through the best mentoring model we are capable of, "mirror back to the trainee" the ideals of our profession.[13] The desire for, and importance of, mentoring and role modeling by faculty was reinforced by several comments from both the workshop participants and the residents' online survey (Tables 2 and 3).

In conclusion, although a certain degree of generational or role-based differences was potentially evident in the recognition and proposed management of some unprofessional behaviors, there was also some agreement across generations and levels of experience in some of the case scenarios presented here. Professional behaviors can be taught and learned, and are vitally important in the professional identity of physicians.[1,17] Assessment of expectations and differences around professionalism for both faculty and residents should be considered as part of any educational and management approaches for teaching professionalism. Faculty development on teaching, assessing, and role modeling/mentoring are critical components for any residency education directed toward professionalism.

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APPENDIX. Professionalism Case Scenarios Used in This Study

Case Scenario 1

In the apheresis unit, a senior pathology resident, a junior pathology resident, and a fourth-year medical student are evaluating a new patient for plasma exchange. The senior resident asks the medical student how to calculate the patient's total plasma volume and the amount of replacement fluids that will be needed during the procedure. When the student makes an arithmetic error in his calculations, the senior resident says, "I thought Asians are supposed to be good with numbers." The senior resident laughs and, as he walks away, tells the junior resident to go over the calculations with the student. Later that morning the junior resident (who is female) tells the senior that she thought he was a little tough on the medical student and that making that off-hand comment was inappropriate. The senior resident chuckles and quips, "Hey, I was just joking, don't get your panties in a wad." The junior resident relates this incident to the program director.

Case Scenario 2

Mr D is a fourth-year medical student on an elective pathology rotation and is planning a career in pathology. Dr E is a PGY-3 resident on his third straight month of autopsy rotation and is supervising Mr D on an autopsy on a 4-month-old baby who died as a result of multiple congenital abnormalities. Before the autopsy they are both joking around, and they both take multiple pictures of the baby with their cell phones and later post them on Facebook, along with derogatory and insensitive comments about the baby, attendings in the hospital, and the department. Several other residents see the photos and also post comments.

Case Scenario 3

Dr J is a PGY-3 pathology resident and has gotten to know a number of the faculty, not only during normal work hours, but also during off-hours at departmental functions (eg, picnics, softball and volleyball games, etc). One of the faculty members has recently developed a rapport with Dr J and asked him to come over on a Saturday and help with some minor repairs and painting projects. He would be paid for his help. This particular faculty person has also been known to ask female residents to babysit his two small children on weekend nights.

Case Scenario 4

During the PGY-2 year of pathology residency, Dr B experienced the new onset of a seizure disorder that obligated him to interrupt his training and to complete the year doing research. No pathology was discovered to account for his seizures, and he was placed on antiseizure medication. However, once back in residency he continued to experience problems. He tended to act out when challenged and became angry in work settings. His medications disturbed his sleep to the point that he was frequently late for duty, and there was a question about his being able to read enough to stay on top of expected learning. He was unable to drive a car, and so was dependent upon his wife for transportation. Most concerning, he was observed by many attendings to blank out at work, and had a witnessed fall on a stairway. Unsatisfactory evaluations began to accumulate. At the urging of his primary care physician, Dr B voluntarily sought psychiatric evaluation. He was placed on additional medication for a presumptive diagnosis of moderate to severe depression, but he stopped taking it because it made him tired and his thinking "foggy." During duty hours, faculty and residents continued to notice subpar performance, dozing during conferences, poor attendance at required conferences, and confrontational interactions with his peers. On two occasions in recent weeks he could not be reached while on-call.

Case Scenario 5

Dr C is a PGY-2 pathology resident whose evaluations have generally been good, but a few concerns have been raised about her interactions with others, particularly with her fellow residents who are international medical graduates. Residents have raised their concerns with you that Dr C has also called in sick on several occasions, often on busy rotations and at the very last minute, forcing other residents to pick up her duties for the day or two or three that she is gone. When she returns, she rarely acknowledges the effort made by her peers. In addition, residents have noticed her condescending and sometimes belligerent attitude toward certain residents and not infrequently toward laboratory technologists and clerical staff. One incident related by the chief resident concerned Dr C's "personal space issues" with a fellow openly gay female resident in the resident's room that would have resulted in a physical altercation had another resident not intervened. One resident who has tried to reach out to her related that Dr C told her that "It is none of your business; this is who I am." None of the residents want to work with her. In deeper conversations with the faculty you also learn that there is a general feeling that Dr C has an "attitude," that she can be "difficult" to work with, and that she has been known to "walk out" during sign-out with at least one IMG attending because the cases were "boring."

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