

A Lack of Consensus on Appropriate Sanctions for Lapses in Medical Professionalism: An Observational Cohort Study

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Abstract

Introduction: There has been a renewed emphasis placed on teaching and evaluating professionalism; however, little research has been done on addressing lapses when identified. In order to develop guidelines on remediation, we must first understand how learners and faculty view "unprofessional behavior." The goal of this study was to examine differences in perspective between medical students and faculty regarding appropriate consequences for lapses in medical professionalism.

Methods: An observation cohort design was utilized to survey a cross-sectional sample of medical students and Internal Medicine faculty at Baylor College of Medicine. Participants were asked to assign ordinal level sanctions to twenty-five scenarios involving first-time lapses in professionalism with optional area for open-ended text. A mixed methods analysis was conducted on data collected.

Results: 513 medical students and 37 faculty members completed the surveys. There was a significant decrease in the severity of sanctions applied between preclinical and clinical years. The faculty were more like preclinical students in their pattern of sanction assignment. Clinical students were less likely to choose "expulsion" than their preclinical counterparts but no cohort had >35% of respondents selecting expulsion.

Conclusion: Clinical students were more lenient than preclinical students and faculty in the severity of sanctions applied. There was no significant difference between preclinical students and faculty on these measures. All cohorts favored remediation suggesting that short of expulsion, there is a lack of consensus regarding appropriate consequences for lapses in professionalism.

Practice Points

- This study illustrates that there is disagreement among preclinical students, clinical students and faculty on the severity of sanction assignment for lapses in medical professionalism.
- Despite the disagreement within cohorts, there is a shift towards leniency as learners transition from preclinical to clinical students while faculty perspectives are more in line with those of preclinical students.
- We should seek to understand the environmental factors that could cause such a shift in views during medical school.
- We should continue to expand faculty and medical student professional training, and focus efforts on establishing clear policies that explicitly define inappropriate behavior and/or focus our attention on ensuring a more personalized approach to remediation.

Keywords: Professionalism

Article

Introduction

Medical schools have been tasked with teaching learners both the scientific knowledge and the core professional values needed to become "competent" physicians. Recognizing the importance of the latter, the Liaison Committee on Medical Education formally adopted professionalism as a core competency around which medical schools were to organize curricula (Liaison Committee on Medical Education Accreditation Standards). Now, as studies raise concerns regarding the moral judgment of matriculating students (Bebeau, 2002) and suggest that a deficit in one competency is associated with broader concerns for deficits in others (Dupras *et al*, 2012) there has been a renewed emphasis placed on the teaching of professionalism. In the absence of a professionalism curriculum, students fail to enhance their professional development (Bebeau and Thomas, 1994; Bebeau and Faber-Langendoen, 2014) and thus schools have incorporated new techniques to teach and evaluate professionalism (Swick *et al*, 1999; Kao *et al*, 2003; Hickson *et al*, 2007). However, relatively little research has focused on methods for responding to professionalism lapses when identified. Currently, methods for addressing lapses are determined by individual schools and as such, there is lack of consensus as to how these lapses should be managed (Hickson *et al*, 2007; Hauer *et al*, 2009; Papadakis *et al*, 2012). This is concerning given the noted variability in the definition of professionalism with a "lack of agreement on what constitutes professional and unprofessional behavior" (Hauer *et al*, 2009; Borrero *et al*, 2008; Wilkinson *et al*, 2009). One study noted that sanctions are likely to be case dependent with medical students marginally stricter than faculty on some issues while the opposite held true for others (Roff *et al*, 2011). Another noted that the prevalence of professionalism deficits increase with level of training (Guerrasio *et al*, 2014).

To advance the professionalism literature and develop guidelines on remediation, we must first better understand how learners and faculty view "unprofessional behavior" and its appropriate consequences, primarily to discover how perspectives may shift at different stages in learners' careers. The goal of this study was to examine learner and faculty views on appropriate consequences for lapses in professionalism - views we predicted would vary with level of training. We sought answers to three primary questions: was there consensus regarding sanction assignment within each cohort, how did views change with level of training, and, were there scenarios that respondents felt were not remediable thus meriting immediate expulsion?

Methods

Survey Development

A draft survey instrument of professionalism lapses was developed using a combination of scenarios documented in the literature (Roff *et al*, 2011; Guerrasio *et al*, 2014; Roff and Dherwani, 2011) and lapses reported to the Baylor College of Medicine (BCM) professionalism committee. For each lapse, respondents were asked to assign one of five sanctions as the most appropriate for a first-time offense with no limiting psychosocial circumstance. Optional area for open-ended text responses regarding sanction choice was included with each item. The draft survey tool was reviewed and approved by the BCM Institutional Review Board (protocol H-30830). The instrument underwent trial testing for clarity and quality assurance using samples of the target cohorts, including thirty-five medical students and five Internal Medicine faculty members. These key informants provided feedback on the survey's format and wording. Items and sanctions that generated confusion were either removed or re-written. The final survey utilized is shown in Table 1. It included twenty-five items; each item was answered using ordinal-level response options (i.e. sanctions).

Table 1. Survey Items and Sanctions

The following scenarios have been reported to the medical education administration. Please select the most appropriate sanction that should apply for a *first time offense with no limiting psychosocial circumstances*.

Sanctions

0. None
1. Verbal Warning
2. Written Warning in File
3. Probation with Required Remediation
4. Expulsion

Questions

1. A patient speaks a language in which the medical student is not fluent. Without the use of a translator, the medical student conducts the initial patient history and physical.
2. After being told by the chief resident that he/she needs to practice his/her technical skills, the medical student is seen taking suture materials from the wards for personal use.
3. A medical student offers an excuse known to be false in order to postpone taking an exam.
4. A medical student arrives at work in clothing that does not meet institutional dress code.
5. After hosting a New Year's Eve party the previous night, a medical student arrives at work smelling of alcohol. He/she tells a fellow medical student that he/she is "hung over."
6. A medical student offers to sell Ritalin to a fellow student who is worried because he/she has been having a hard time studying for the USMLE Step 1 exam.
7. A medical student uses a family connection with a faculty member to improve his/her grade.
8. A patient presents to the ER with a facial laceration. After an introduction to procedures workshop, the student begins to suture the wound without providing analgesia for the procedure despite the patient expressing pain.
9. During an elective in a foreign county, a medical student undertakes unsupervised elective procedures beyond his/her level of training.
10. A medical student is caught cheating on an exam.
11. A medical student is very derogatory in expressing his/her dissatisfaction with the medical profession in front of residents and patients.
12. A medical student asks a classmate to sign him/her in for classes that he/she does not attend.
13. A medical student records information in a patient's chart that he/she did not personally elicit through history and physical examination.
14. A medical student starts dating a former patient no longer under his/her care.
15. A medical student accepts a pair of designer shoes as a gift from a patient presenting for post-op follow up.
16. A medical student is seen smoking marijuana outside the hospital.
17. A medical student posts a derogatory comment on Facebook about an unnamed 300lb patient with syphilis presenting to labor and delivery.
18. During a clinical rotation, a medical student starts dating a resident who will be evaluating him/her.
19. During a medical evaluation, a medical student makes demeaning comments to the patient.
20. A medical student checks his/her personal email and sends texts during rounds.
21. A medical student makes derogatory remarks about a body donated for anatomy dissection.
22. A medical student makes derogatory comments about an attending on Twitter. The attending physician's name IS explicitly mentioned.
23. A medical student posts an x-ray of a patient with a beer bottle in his rectum on Facebook. The patient's name IS NOT explicitly mentioned.
24. A medical student feeds questions from his/her exam to a question bank for use by future classes.
25. A medical student and resident are performing a pre-op exam on a homeless patient with basal cell carcinoma. As they are leaving the patient's room, the student turns and says to the resident, "why don't we just cut up her face and send her to the zoo." It is not clear if the patient heard the remark.

Data Collection

An observational cohort design was utilized to take a cross-sectional sample of two cohorts: medical students and Internal Medicine faculty between August 2012 and May 2013. Students were subdivided into four groups: first-year (MS1), second-year (MS2), third-year (MS3) and fourth-year (MS4) students. MS1s were surveyed after having completed one semester of the basic science curriculum with clinical exposure limited to preceptorships, MS2s were surveyed after having completed three semesters of the basic science curriculum with clinical exposure limited to preceptorships, MS3s were surveyed after having completed one year of clerkships, and MS4s were surveyed after having completed all clerkships and a mandatory sub-internship. Clinician educators in the Department of Internal Medicine who were on service during the last two weeks of March were also recruited to complete the survey. Faculty participants represented approximately 50% of the full time clinician educators in the Department of Medicine at Baylor's affiliated public hospitals (see Table 2 for sample sizes). Surveys were anonymous and participation was optional. No incentives were offered.

Table 2. Study Sample Characteristics

	<i>Respondents*</i> (N = 550)	<i>Female[†]</i> (N = 249)
Medical Students	513 (69)	242 (47)
Year 1	182 (96)	92 (51)
Year 2	133 (80)	59 (44)
Year 3	100 (57)	46 (46)
Year 4	98 (52)	45 (46)
Faculty	37 (93)	7 (19)

* Data are presented as number (percentage of total participants)

[†] Data are presented as number (percentage per participant category)

Measures

Discussions with key informants during survey development revealed that many students made a distinction between sanctions with no or short-term consequences (no sanction, verbal warning) and sanctions with long-term repercussions, i.e. those that could result in a permanent record of the lapse (written warning, probation, expulsion). We thus dichotomized responses into short-term (assigned score of 0) and long-term (assigned score of 1) to analyze the distribution of responses. Two indicators of "overall sanctions" were created. First, the dichotomized responses were summed for each respondent (range 0-25). Second, an average of the dichotomized responses from all 25 items was calculated (range 0-1).

Preliminary analysis of the responses revealed no statistically significant difference between first-year and second-year students or between third-year and fourth-year students. Consequently, the student cohorts were collapsed into preclinical (MS1, MS2) and clinical (MS3, MS4) cohorts.

Analysis

The primary analysis involved testing for differences in sanctions assigned. Both overall and item-level sanction assignments were examined. For individual items, many of which were positively skewed, the chi-square test was utilized to examine distribution of responses among preclinical and clinical students and among students and faculty. Each of the overall sanctions (sum and average) met the assumptions for parametric testing and comparisons on these measures were conducted using ANOVA, followed by post-hoc analyses. To guard against type 1 error, we utilized a Bonferroni correction (Bland and Altman, 1995) and set alpha at 0.001. Sensitivity testing for group comparisons included non-parametric analyses using the

Wilcoxon-Mann-Whitney test. All analyses were carried out with SPSS 20.0 (IBM SPSS Statistics for Windows, 2011).

For items that generated significant differences between cohorts, the open-ended text responses were compiled for thematic analysis using direct coding of the comments within each cohort. Using the constant comparative method (Glaser, 1965) two reviewers (BK, LS) independently analyzed comment data for explanations regarding sanction assignment. Consensus was reached through discussion.

Results

Sample Characteristics

Of the 744 medical students enrolled, 513 (69%) completed the survey. Of the 40 faculty members who were approached, 37 (93%) completed the survey. Study sample characteristics are shown in Table 2.

*Table 3. Percentage of Medical Students and Faculty Choosing "Long-Term" Sanctions for Each Dichotomized Item (Short Term vs. Long Term)**

Question	Medical Students			Faculty	Sig ‡
	N	Preclinical	Clinical		
Q1. Takes history without use of translator		2.9	1.6	2.7	ns
Q2. Takes suture materials		16.5	2.1	18.9	<.001
Q3. Fake excuse to postpone exam		80.0	74.1	86.5	ns
Q4. Clothing does not meet dress code		3.5	4.2	8.1	ns
Q5. Smells of alcohol and "hung over"		63.2	56.6	78.4	.04
Q6. Offers to sell Ritalin		88.6	83.1	100.0	.01
Q7. Uses family connection to improve grade		86.3	74.6	58.3	<.001
Q8. Sutures a laceration without analgesia		69.6	38.6	59.5	<.001
Q9. Unsupervised procedures beyond training		63.7	47.3	67.6	.001
Q10. Cheating on exam		99.4	95.2	97.3	ns
Q11. Derogatory comments about medical profession		38.5	31.2	24.3	ns
Q12. Asks classmates to sign him/her in		36.5	34.9	70.3	<.001
Q13. Records information in chart not personally elicited		44.9	22.2	51.4	<.001
Q14. Dates a former patient		15.4	19.8	13.5	ns
Q15. Accepts shoes as gift from patient		25.3	27.3	13.5	ns
Q16. Smoking marijuana outside hospital		81.2	78.3	75.7	ns
Q17. Derogatory comment about patient on Facebook		63.2	53.7	81.1	.004
Q18. Dates resident evaluator		41.3	23.9	24.3	<.001
Q19. Makes demeaning comments to patient		59.7	61.9	56.8	ns
Q20. Checks personal email/text during rounds		5.1	2.1	13.5	.009
Q21. Derogatory remarks about body donated for dissection		12.4	10.6	21.6	ns
Q22. Derogatory comments on twitter about a named MD		76.1	67.7	70.3	ns
Q23. Posts x-ray of unnamed patient on Facebook		72.6	47.9	78.4	<.001
Q24. Feeds questions to question bank for future students		55.0	70.2	75.7	.001
Q25. "Zoo" remark about homeless patient with carcinoma		75.7	74.1	78.4	ns
Average Sum (SD) of All Items (0-25 scale) [¶]		12.69 (4.3)	11.01 (4.6)	13.24 (4.5)	<.001
Average Mean (SD) of All Items (0-1 scale) [¶]		0.51 (.17)	0.44 (.19)	0.53 (.18)	<.001

Abbreviation: NS, no significance

* Sanctions are collapsed and dichotomized [0,1] into "short-term" sanctions (no sanction, verbal warning) and "long-term" sanctions (written warning in file, probation or expulsion). Numbers correspond to the percentage of respondents assigning "long-term" sanctions unless otherwise noted.

‡ Differences in distribution of dichotomized individual items between preclinical and clinical students analyzed with Chi-Square.

‡ Differences in distribution of dichotomized individual items between student groups and faculty analyzed with Chi-Square.

¶ Comparisons of groups for Sums & Means analyzed with ANOVA and post-hoc tests. Post-hoc tests shows significant differences between preclinical students and clinical students as well as clinical students and faculty but not between preclinical students and faculty.

Lack of Homogeneity in Sanction Assignment

Table 3 shows the percentage of respondents who assigned "long-term" sanctions for each scenario, disaggregated by level of training. Very few items generated unanimous agreement. Among medical students, using a criterion of 90% or greater as "consensus," only one item had clear consensus that a long-term sanction was appropriate - *cheats on an exam (Q10)*. Three other items - *takes history without translator (Q1)*, *arrives in clothing that does not meet dress code (Q4)*, *checks personal texts/emails during rounds (Q20)* - also showed consensus, though the consensus was that these lapses only merited a short-term sanction. Of these four items, the faculty agreed with the students on three with one notable exception - *checks personal email/texts during rounds (Q20)* - for which the faculty were more inclined to assign a long-term sanction. Additionally, although there was no consensus among students on *offers to sell Ritalin (Q6)*, the faculty unanimously agreed that the infraction needed a documented sanction.

Shift in Severity of Sanctions Applied

Generally, there was a significant decrease in tendency to apply long-term sanctions between the preclinical and clinical years. Faculty were closer to preclinical students in their pattern of sanction assignment. When comparing preclinical students to clinical students, eight items generated significantly different responses ($p < .001$).

- *takes suture materials (Q2)*
- *uses family connection to improve grade (Q7)*
- *sutures without analgesia (Q8)*
- *undertakes unsupervised elective procedures while abroad (Q9)*
- *records information in chart that was not personally elicited (Q13)*
- *dates a resident evaluator (Q18)*
- *posts an x-ray of an unnamed patient on Facebook (Q23)*
- *feeds exam questions to question bank (Q24)*

Six of these eight scenarios are directly related to clinical exposure; for these items, the clinical students were significantly more lenient (i.e. a smaller percentage of clinical students applied long-term sanctions). There was one scenario, *feeds exam questions to a question bank (Q24)*, for which the opposite held true - preclinical students were more lenient. This was one of the two items not dependent on clinical exposure.

When comparing medical students to faculty, six of the above eight items differed significantly ($p < .001$) while two [*undertakes unsupervised elective procedures while abroad (Q9)* and *feeds exam questions to question bank (Q24)*] trended towards significance. Overall, faculty were stricter than students on most accounts. There was one notable exception. For *uses a family connection to improve a grade (Q7)*, faculty were more lenient.

Expulsion for a First Time Offense

To explore which items were regarded as remediable, data for each were collapsed and re-coded as "remediable" and "non-remediable" i.e. expulsion (Table 4). Overall, there was a statistically significant difference in the average sum and average mean between cohorts. However, due to few respondents assigning "expulsion" for a first-time offense, comparisons for individual item could not be made.

Table 4. Percentage of Medical Students and Faculty Choosing "Expulsion" for Each Dichotomized Item (None or Remediable Sanction vs. Expulsion)*

Question	Medical Students			Faculty		
	N	Preclinical	Clinical			
Q1. Takes history without use of translator		0.0	0.0	0.0		
Q2. Takes suture materials		0.3	0.0	0.0		
Q3. Fake excuse to postpone exam		0.6	0.0	0.0		
Q4. Clothing does not meet dress code		0.0	0.0	0.0		
Q5. Smells of alcohol and "hung over"		1.3	1.6	5.4		
Q6. Offers to sell Ritalin		25.4	14.3	27.0		
Q7. Uses family connection to improve grade		13.1	6.3	2.8		
Q8. Sutures a laceration without analgesia		7.4	1.6	0.0		
Q9. Unsupervised procedures beyond training		5.1	2.2	2.7		
Q10. Cheating on exam		32.5	25.5	32.4		
Q11. Derogatory comments about medical profession		1.6	0.0	0.0		
Q12. Asks classmates to sign him/her in		0.0	0.5	0.0		
Q13. Records information in chart not personally elicited		0.3	0.0	0.0		
Q14. Dates a former patient		1.0	2.1	0.0		
Q15. Accepts shoes as gift from patient		0.0	1.1	0.1		
Q16. Smoking marijuana outside hospital		26.2	14.3	8.1		
Q17. Derogatory comment about patient on Facebook		6.3	1.1	10.8		
Q18. Dates resident evaluator		0.6	0.5	0.0		
Q19. Makes demeaning comments to patient		1.6	1.1	2.7		
Q20. Checks personal email/text during rounds		0.0	0.0	0.0		
Q21. Derogatory remarks about body donated for dissection		0.0	0.0	0.0		
Q22. Derogatory comments on twitter about a named MD		3.8	0.5	2.7		
Q23. Posts x-ray of unnamed patient on Facebook		11.8	3.2	10.8		
Q24. Feeds questions to question bank for future students		4.8	4.3	2.7		
Q25. "Zoo" remark about homeless patient with carcinoma		11.5	6.3	8.1		
Average Sum (SD) of All Items (0-25 scale) [†]		1.55 (1.9)	0.86 (1.4)	<.001	1.16 (1.5)	<.001
Average Mean (SD) of All Items (0-1 scale) [†]		0.06 (.1)	0.03 (.1)	<.001	0.05 (0.1)	<.001

*Respondent remediation choice are collapsed and dichotomized into "none/remediable" sanctions (no sanction, verbal warning, written warning in file, probation) or "non-remediable" sanction (expulsion). Numbers correspond to the percentage of respondents assigning expulsion.

† Items analyzed with chi-square test. Sums and means analyzed with ANOVA after assumption testing.

Using a criterion of more than 10% by at least two of the three groups, only four items warranted expulsion.

- offers to sell Ritalin (Q6)
- cheats on an exam (Q10)
- smokes marijuana (Q16)
- posts x-ray of unnamed patient on Facebook (Q23)

For all four items, clinical students were less likely to choose expulsion than their preclinical counterparts. Faculty were more similar to the preclinical students on three items; however, faculty were less likely to expel a student seen smoking marijuana than either cohort of medical students. No group had >35% of respondents selecting expulsion.

Justification for Sanction Assignment

A representative sample of comments for items generating significantly different sanction assignments is shown in Table 5. There were few common explanatory ideas shared between cohorts. When comparing preclinical to clinical students, only one common theme emerged - a concern for patient safety. Both groups noted that some lapses "*could be dangerous for patients.*"

Table 5. Representative Sample of Comments for Questions Generating Significant Differences

Q2. After being told by the chief resident that he/she needs to practice his/her technical skills, the medical student is seen taking suture materials from wards for personal use.

Preclinical Students

Did the student have reason to believe that this was allowed? They should have asked for sutures.
If this is for practicing at home, doesn't seem like a problem unless the student has been told not to remove sutures.
They were told to practice by the resident so the resident needs to be clear about where students can get resources.

Clinical Students

This happens all the time. Very common. Learning is learning.
Isn't this implied permission to take sutures? They told us to practice. Stealing is wrong but what else are we supposed to do?
If we don't, we get yelled at for being incompetent medical students. How else are we supposed to succeed?

Faculty

Should not take hospital property without permission.
Instruct student that unsterile sutures are available for use.

Q7. A medical student uses a family connection with a faculty member to improve his/her grade.

Preclinical Students

This is an unfair advantage and equivalent to cheating. Medical education should be merit based.
The faculty member is at fault. He/she should be the one reprimanded.

Clinical Students

Can give a warning but nothing will come of it because the student clearly has influence.
Faculty member should have worse repercussions.
Unfair but happens a lot in clinics. Also hard to prove.

Faculty

Hard to say because three people are culpable here.
What was he/she thinking? The faculty can solve this problem.

Q8. A patient presents to the ER with a facial laceration. After an introduction to procedures workshop, the medical student begins to suture the wound without providing analgesia for the procedure despite the patient expressing pain.

Preclinical Students

Why wasn't the student supervised? Did they know they didn't have analgesia? Obviously has no idea what they are doing.
The student shouldn't have continued. This is messed up.

Clinical Students

The resident or attending should have been there to supervise. This is the resident's fault.
We can't always get pain control and as medical students, we can't write for it. And residents do not prioritize it.

Faculty

Need more detail about intent.
This is moral failure and student should be better supervised.

Q9. During an elective in a foreign country, a medical student undertakes unsupervised elective procedures beyond his/her level of training.

Preclinical Students

Depends on what type of procedure (how dangerous) and depends on local laws of the country and institution. There shouldn't be punishment for increasing experiences but doing something unsupervised is stupid.

Clinical Students

In developing countries, this is sometimes expected. Dangerous but really depends on what procedure they were doing.

They did the procedure and then they grew in their level of training.

This is not Baylor College of Medicine's responsibility. Who would report this anyways?

Faculty

This kind of bad judgment may be repetitive.

The same policy as in the US should apply.

Q13. A medical student records information in a patient's chart that he/she did not personally elicit through history and physical examination.

Preclinical Students

This is dishonest and harmful to patients.

Depends on the circumstances. Maybe if they got the information from another medical professional it is not too bad?

Clinical Students

Depends on what information they wrote. Everyone does this for reviews of systems without really asking.

Sometimes we are told to do this. But student needs an explanation of the legal implications.

Faculty

Unfortunately, this has become common and the student may not realize the gravity.

It is fraudulent behavior and could impact the supervising physician and the state medical board.

Q18. During a clinical rotation, a medical student starts dating a resident who will be evaluating him/her.

Preclinical Students

The residents should excuse himself/herself from evaluating this student.

This is unfair to other students.

Clinical Students

The resident shouldn't evaluate the student. They should wait until after the rotation to begin dating.

I have friends who met their wives this way. This happens all the time.

How else are you supposed to meet people? We are in the hospital all day.

Faculty

The student should wait until after the evaluation.

Be very careful kid.

Q23. A medical student posts an x-ray of a patient with a beer bottle in his rectum on Facebook. The patient's name IS NOT explicitly mentioned.

Preclinical Students

This is inappropriate but technically not a HIPPA violation?

Very serious. May need to consider expulsion.

Clinical Students

Could easily be found on the internet as well but the student should be trained not to post anything work related on Facebook.

Just tell them to take it down otherwise they will have a warning in their file.

Faculty

Highly inappropriate and could violate HIPPA.

Just stupid and don't do it again and take it down stat.

Q24. A medical student feeds questions from his/her exam to a question bank for use by future classes.

Preclinical Students

We are not explicitly told not to do this. Professors should make new questions every year.

This is okay if the student remembers the question. It is less acceptable if he/she illegally accesses or copies the actual test.

Future exams can always change unless there is an explicit rule about not giving out information.

Clinical Students

This is the same as cheating.

This is really unacceptable and passing on information should be taken seriously because it demeans the hard work of others.

Faculty

Moral failure.

They sign not to do this on their exams.

In general, preclinical students tended to be more "policy-oriented," seeking clarity of both rules and intent. When asked about taking suture materials for personal use (Q2), some preclinical students noted that *"the student probably thought that this is expected"* and that the *"student was told to practice - resident needs to be clear about where student should get those resources."* This is in contrast to comments made by clinical students who were more "context-oriented," citing the conflicting evidence in their environments as justification for sanctions assigned. A number of clinical students stated that *"this happens all the time..."* and one noted, *"They told us to practice. Stealing is wrong but what else are we supposed to do?"* Many distributed or shared blame for infractions. For example, when asked about suturing a laceration without analgesia (Q8), several students responded, *"the resident or attending should have been there to supervise. This is the resident's fault."*

Faculty expressed similar concerns as preclinical students with respect to policy violations. However, faculty tended to be more "morality-oriented" in how they viewed these violations, regarding them as character flaws or failures, describing students as *"fraudulent."* Though moral issues were of primary importance, sometimes the behavior on the part of the medical student could be excused if someone else held a supervisory role. For example, when asked about recording information in a patient's chart that was not personally elicited [Q13], one faculty member noted, *"this is moral failure but not fatal since someone else is in charge of the patient."*

A higher order analysis of these items suggested that the hidden curriculum might underlay these patterns of explanation. This is particularly true among clinical students, who offered several justifications modeled after prior observed behavior. When asked about taking a history without the use of a translator, one student noted, *"we get mixed messages about this all the time. It is bad form but I've seen residents and faculty do this knowing ~50 words of Spanish."* When asked about recording information in a patient's chart that was not personally elicited, one student said, *"depends on what information was written. Everyone does this for the review of systems without really asking."* When asked about a derogatory remark made about a body donated for anatomy dissection, another student commented *"this is bad but I've known attendings and residents to say worse about living patients. The student is not actively hurting anyone."*

Discussion

The goal of this study was to examine learner and faculty views on appropriate consequences for lapses in professionalism. We predicted that the sanctions assigned would vary with level of training. To develop this

hypothesis, we sought answers to three questions. First, was there consensus within each cohort? Second, did views change with increasing level of training and if so, was there an explanation for the shift? And finally, were there items that the respondents felt were not remediable, i.e. scenarios that were egregious enough to merit immediate expulsion?

Lack of Consensus

When examining the views of preclinical students, clinical students and faculty, we found a great deal of disagreement within cohorts - very few scenarios had consensus on sanction assignment though, the items that did, were generally consistent between groups. One possible explanation is that respondents had difficulty deciding whether a first-time offense was indicative of a momentary lapse in judgment or a more troubling pattern of behavior. In fact, many participants noted that they assigned sanctions taking into account that the subjects had no previous history and that their responses would change if there was a documented pattern of bad behavior. This commentary highlights the difficulty faced by professionalism committees - the bodies tasked with remediating lapses in professionalism. Scenarios presented to these committees are sometimes isolated reports, similar to the scenarios we presented to the study participants. Thus, in the absence of more data, these committees are challenged with assigning sanctions to first-time offenses for which there are often no clear policies or precedents.

The Hidden Curriculum

Despite the discord within cohorts, we noted that there was a significant shift towards leniency as learners transitioned from preclinical to clinical students while faculty perspectives were more in line with those of students in earlier levels of training. This suggests that we reconsider the "hidden curriculum" discussion as we seek to better understand the environmental factors that cause such a shift in views.

The hidden curriculum is classically defined as a set of influences that includes institutional regulations as well as behavior learned through the process of role modeling - two forces that are often in opposition to each other (Hafferty and Franks, 1994; Hafferty, 1998; Hafferty, 2006; Stem, 1998). Prior studies have found that much of the hidden curriculum is driven by resident and faculty behavior and that unprofessional behavior on the part of residents and attendings is a major source of distress for medical students during their clerkship years (Stern, 1998; Inui, 2003; Medical Professionalism Project 2002; Brainard and Brislen, 2007; Rogers *et al*, 2012; Haidet and Stein, 2006).

As students transition from the preclinical to the clinical stage, they are faced with new rules of the community they are trying to join. They are thus torn between the formal curriculum - what they hear us say - and the hidden curriculum - what they see us do (Papadakis, 1998). We suggest that as they assimilate into their clinical teams, they emulate the behavior of those around them and eventually, as past studies have found, shift their attitudes to become more consistent with these behaviors (Kunda, 1990), often without recognition of that change (Satterwhite *et al*, 2000). In other words, when there is "cognitive dissonance," a discordance between actions and beliefs (Festinger, 1957), students experience discomfort and attempt to reduce the dissonance through mechanisms such as "avoiding responsibility, minimizing harms and emphasizing benefits (Chimonas *et al*, 2007)."

One might expect that if the faculty are the architects of the hidden curriculum, then their views should be more in line with those of the "context-oriented" clinical students. This was not the case. On the contrary, the "morality-oriented" faculty were more similar to the "policy-oriented" preclinical students. One possible explanation for this paradox is that faculty, given their supervisory role, are able to both drive the culture of the teaching hospital while, at the same time, achieve a certain degree of dissociation from it. Their beliefs are more in line with what they preach (i.e. what is heard by the preclinical students) although what they practice (i.e. what is perceived by the clinical students) might actually be quite different.

Potential for Remediation

Given the emphasis placed on preservation of self, it not surprising that respondents favored non-expulsionary sanctions. In fact, there were only four items, consistent among cohorts, for which >10% of

respondents considered expulsion. Yet, even for these items, the percentage of respondents who chose expulsion was consistently below 35%. This hesitation to expel can best be explained by comments made at the end of the survey:

In general, a pattern needs to be seen before expulsion.

We all make mistakes. The point of punishment should be to correct problems, not hinder future accomplishments.

These comments reveal that across cohorts, there was a sense that learners should be given the benefit of the doubt unless there is a documented pattern of bad behavior. Although there was little consensus within groups regarding the most appropriate sanction, generally all cohorts agreed that expulsion was not a preferred option. Even faculty, who were inclined to assign more severe sanctions, shied away from expulsion. One possible explanation is that the faculty were torn between two opposing forces. On one hand, there was concern that a lapse in professionalism was a sign of moral failure but on the other hand, there was a competing notion that although the action itself was wrong, not much harm could come from it because the students were constantly supervised and thus an opportunity for remediation was present.

Limitations

We identified several limitations of this study. First, this study was conducted at a single institution. Although we hypothesize that the sample is representative of the views held by medical students and faculty nationally, we cannot make generalizations. Second, there was attrition in response rate between first-year and fourth-year students. This is largely because the accessibility to students becomes increasingly difficult as students disperse during clinical rotations. However, we note that the gender distribution within each sub-group is relatively consistent with the gender distribution by class suggesting that the sample is representative of the views of each class. Additionally, we note that the faculty sample size is relatively small and that all respondents were members of the Department of Internal Medicine; thus, we are unable to generalize results to other or all departments.

The use of the term "sanction" may be perceived as a limitation; however, we chose this term as it has been used previously in the professionalism literature (Roff *et al*, 2011; Guerrasio *et al*, 2014; Roff and Dherwani, 2011). Although "sanction" may have a negative connotation we argue that the term is appropriately used as students in the pilot study noted that any action is perceived as a punishment with a verbal warning being the least severe. Lastly, participants were asked to assign sanctions to first-time lapses in professionalism. We do not know how responses would change for repeat infractions. Further research looking at views on remediation for patterns of poor behavior needs to be conducted.

Recommendations

The results of this study raise several issues for medical educators. One, because it suggests that there is a lack of consensus within groups as to the most appropriate sanctions for lapses in professionalism; two, because a significant drop in severity of sanctions assigned is observed between the preclinical and clinical years despite the many tools in place to teach professionalism (Kao *et al*, 2003; Hickson *et al*, 2007; Hauer *et al*); three, because much of the variability seems to be guided by preservation of self and four, because there is a very high threshold for expulsion. We propose three interventions that could potentially help reverse these trends. First, we must continue to improve faculty and medical student professionalism training as many students in our survey cited that clinical learning occurs through modeled behavior. Second, we must either focus our efforts on establishing clear policies that explicitly define inappropriate behavior and subsequent consequences of policy violations and/or we must focus our attention on ensuring a more individualized approach to remediation. In the former case, it can be argued that a call to reduce ambiguity is of primary importance while in the latter case, it can be argued that standardization may not be the right approach because no two scenarios are identical and thus the focus should be on mechanisms through which remediation can occur. Lastly, we must find ways to reconstruct the framework in which learners and faculty see themselves - one that is less self-serving and more in line with the professional ideals held in medicine.

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