The lived understanding of professional behavior: perspectives from three levels of seniority within a single US institution

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Abstract

Introduction
To gain a more fulsome understanding of professional behavior, as viewed through the lens of three levels of clinical seniority at Yale New Haven Hospital.

Methods
Sample: This was a qualitative research study. Participants included three groups who work within one hospital environment: 7 Departmental Chairs, 12 Clerkship Directors and 15 Resident Doctors (from Departments of Neurology, Surgery, Emergency Medicine (EM), Anaesthesia, Obstetrics and Gynaecology, Internal Medicine, and Psychiatry).

Data Collection: Trained interviewers implemented semi-structured individual and focus group interviews. All interviews were recorded and transcribed.

Data Analysis: Two of the authors (JEH, JPH) analysed the transcripts, coded the data, identified themes, and recorded verbatim quotes represented within those themes.

Results
The study identified four different understandings (Leadership, Communication, Reporting, and Training) of professional behavior within a single workplace culture, around a singular code of conduct policy.

Conclusions
Results indicated that one's understanding of professionalism depends on one's position and 'standing' within an organization and has important implications for policy setting. Although most medical institutions have policies and
definitions of what is expected of professional behavior, further research is needed to understand how faculty come to operationalize and ‘live’ these policies and whether steps can be taken to match definitions with the lived experience.

**Keywords:** Professional; behavior; clinical; seniority

**Introduction**

Historically, professional behavior has been viewed through a lens of personal attributes and mutable characteristics, underpinned by identity formation as an interpersonal process (Hafferty, 2018). The fundamental assumption underscoring this interpretive stance is that the development of professional identity is an inherent process, largely undefined and influenced by systems. Such a view, however, can obfuscate how social and structural systems can differentially shape behaviors and their interpretation. Little research has been conducted into what promotes and enables professional behavior, from the perspective of differing levels of clinical seniority.

Organizations such as the Accreditation Council for Graduate Medical Education (ACGME) and the General Medical Council (GMC) have characterized professionalism in the USA and UK respectively as a core competency. Equally, society expects physicians to act professionally at all times (Lynch, Surdyk and Eiser, 2004), regardless of any personal sacrifice or loss (Ofri, 2019), and this forms the basis of the trust contract between doctors and society (Passi *et al.*, 2010). Meta-analyses have explored the definitions of professionalism in medicine and the results demonstrate that there are a specific set of professional attributes, whereby physicians are worthy of the trust given to them (Passi *et al.*, 2010).

While there are definitions of professionalism (van Mook *et al.*, 2009), and while these definitions are about demonstrating professional qualities and behaviors, there is the potential for inconsistency in enforcing standards in daily practice and dealing with lapses in different ways (Madara and Burkhart, 2015). What may be considered professional in one environment may not be considered professional in another (Woodruff, Angelos and Valaitis, 2008). Furthermore, by recognising the impact of the organizational and environmental context in which a physician practices, structures may be designed to develop professionalism as a skill set throughout one’s career (Hodges *et al.*, 2011).

Clinical training environments have changed dramatically over the last 20 years, becoming more complex and often conveying confusing and conflicting messages about the values associated with sound patient care (Christianson *et al.*, 2007). Although professionalism may be clearly defined and ‘posted’ across an organization, nonetheless, it is learned in complex clinical environments with established levels of hierarchy and clinical seniority. In addition, the hidden curriculum exposes trainees to a variety of understandings dependent on the context and hierarchies that make up the organization (Joynt *et al.*, 2018). The concept of hierarchy within medicine is well documented within the literature and has been shown to be evident from undergraduate medical education and beyond into senior levels of clinical practice (Barker, 2007; Green *et al.*, 2017; Crowe, Clarke and Brugha, 2017; Panhwar and Kalra, 2019). The effects of this hierarchy have also been examined within the literature, in particular, the effect that hierarchy has upon medical undergraduate education and training, communication, patient outcomes and safety (Powell and Davies, 2012; Khan and Arsanious, 2018; Vanstone and Grierson, 2019).

Including a systems view of behavior allows for concentrating on changing not only the behavior but also on the structures and processes of the system that enable or even incentivize that behavior (Williams and Williams, 2004). Rather than a focus on individual lapses, professional behavior can be viewed from a perspective in which a
complex mix of maladaptive behaviors and the systems that respond to that behavior (Williams and Williams, 2004).

Unprofessional behavior has been shown to cause disruptions to healthcare systems, and are associated with poor adherence to practice guidelines, death of patients, low staff morale, eroded job satisfaction, medical errors and adverse outcomes (Hickson et al., 2007). There are also tangible costs associated with disruptive physician behavior, including increased staff turnover, and greater time spent in investigations and counselling (Grissinger, 2017). Therefore, a lack of psychological safety within the workplace may lead to overall poor patient care (Edmonson, 1999).

Conversely, professional behavior has been shown to have a positive impact on both patient satisfaction and outcomes (Bahaziq and Crosby, 2011; Boamah et al., 2018). In addition, despite the emphasis on the teaching of professionalism, the hidden curriculum exposes trainees to instances of both professional and unprofessional behavior (Joynt et al., 2018). Formal and hidden curricula have a powerful influence on the formation of professional identity and professional behavior. What Lesser et al. (2010, pp. 2733) call the ‘lived approach’ underscores the importance of professionalism in daily practice and makes the pursuit of professionalism more ‘accessible and attainable’ (2010, pp. 2733).

**Methods**

We designed a qualitative research study to explore the understanding of professional behaviors within a single US institution, across three levels of seniority in the clinical setting at the Yale New Haven Hospital.

**Sample**

An invitation to participate was emailed using the internal directory of Yale New Haven Hospital. Of the responses received, the groups were stratified according to their level of clinical seniority. Eight departmental chairs were emailed the invitation to participate with only one not participating due to scheduling conflicts. All 12 clerkships directors were invited and participated in one focus group interview. All invitees from the group of residents attended focus group interviews.

Overall, participants included seven Departmental Chairs (Neurology, Surgery, EM & Anaesthesia, Obstetrics and Gynaecology, Internal Medicine and Psychiatry), 12 Clerkship Directors from these same departments and 5 more from other disciplines, and 15 Residents from the same departments as the chairs.

**Data Collection**

One of the authors (JEH) conducted face to face semi-structured interviews, lasting between 20-60 minutes with each departmental chair, followed by a single focus group interview with the clerkship directors, and one of the four focus group interviews with residents. Three trained interviewers conducted three of the four 50-minute focus groups with the residents. Interviews were recorded and transcribed by the author JEH. All interviews were recorded for responses to the following five questions, please see Table 1.

**Table 1:** Questions for face to face sem-structured interviews
Question 1: What promotes professional behavior?
Question 2a: Give examples of scenario(s) that demonstrate clear unprofessional behavior?
Question 2b: Give examples of scenario(s) that demonstrate unclear unprofessional behavior?
Question 3: What encourages and allows people to speak up about professional behaviors?
Question 4: In your role, are there specific strategies that can, or might, help you to continue to promote professional behavior in the faculty, Residents and students?
Question 5: In your role, are there specific strategies that can, or might, help you to deal with unprofessional behavior in the faculty, the Residents and/or students? Probe: Please comment on the current reporting system for a student to report an incident. How effective do you find this system?

Data Analysis
JEH and JPH analysed the free text transcripts qualitatively, a coding frame was developed to identify and group the interview responses (Miles and Huberman, 1994). Exemplar verbatim quotes were identified for all the emerging themes.

Institutional Review Board approval was sought and granted to the authors from Yale University.

Results
The study noted that all three groups had exposure to the same Yale New Haven Hospital policy on the code of conduct that is intended to guide their understanding of what constitutes professional behavior (Yale New Haven Health, 2020).

Analysis of the interview data revealed four distinct themes; Leadership, Communication, Reporting, and Training. Sub-themes that emerged within Leadership were: the importance of role-modelling, provision of clear guidance to junior staff and the recognition of professional behavior as a clinical competency. Communication sub-themes included ubiquitous mission statements and values, upheld by clear, standardised expectation settings, opportunities for longitudinal remediation, and facilitation via efficient IT and equipment. Reporting covered anonymised reporting systems, which are protective against retribution, alongside the importance of ‘being heard’, using a variety of methods which include Schwartz rounds (The Schwartz Center, 2019). The sub-themes within training covered sharing of best practices, a range of measured and appropriate options, closure of the feedback loop and improved communication methods (e.g. newsletters), constructive interventions with fair and just approaches, bystander training and coaching programmes.

All respondent groups agreed on what constituted clear examples of unprofessional behavior, and that these were easier to identify and agree upon than those that were deemed unclear examples. Clear examples included bullying, (sexual) harassment and verbal abuse to colleagues. Definitions of these terms were not clarified during the interviews or group discussions.

Leadership
One theme of general consensus across all three groups was the importance of effective leadership in promoting professional behavior. All three groups expressed that leaders need to role-model professional behavior in order to establish a culture of professionalism, with:

…a top-down approach, and a culture set by its leadership.

This group also discussed the use of guidance to more junior clinical staff on ways to reflect on the observed
behavior of senior clinicians who they may or may not wish to emulate. This arose from a discussion of the importance of the paradigms of professional behavior by senior leadership:

> When we see our senior leaders not embodying the values that we are trying to align to, it becomes very hard for us remain aligned. We need real champion behavior.

Clerkship Directors also discussed professional behavior as a clinical competency. They expressed that assessment of this competency should be included in the promotion and career progression so that faculty in leadership roles would model professional behavior and that:

> professionalism should not be seen as separate to our clinical expertise.

**Communication**

Departmental chairs, in turn, called for ubiquitous mission statements and values, of which staff must be reminded. However,

> beyond the words of these guidelines there needs to be behaviors which support the mission and live by the values of that mission.

Residents expressed a need for clear, standardized expectation setting, which for them needs to begin on ‘day one’, via:

> Clear communicating what is expected of you.

Clerkship directors, interestingly, suggested that one should not assume that all staff interpret the guidance on the standards of professional behavior in the same way. The interpretation of the guidance is reliant on each person individually.

The group of residents and chairs discussed that conducting robust analyses of "the conditions or structures that got us here, can be difficult, but "would help a greater understanding of the problem" as the standards which define professionalism are often context-dependent and that definitions are not always consistently interpreted.

Both departmental chairs and clerkship directors spoke about improved communication regarding areas for remediation and the opportunity for that to take place longitudinally across training rotations. They mentioned the need for:

> …better communication when [students] come into your clerkship and inheriting students from another clerkship in which they have areas to remediate upon – how do we coach through the continuum?

Clerkship directors also discussed professional behavior in terms of work environments that promote and enable efficient and effective communication between clinicians around issues such as accurate entries into patient records:

> Ensure that issues like IT, technology or equipment work well to enable you to do the job. Fix the things that need to be fixed.

Departmental chairs mentioned that better communication of what constitutes professional behavior is needed. They discussed senior colleagues who employ strict supervision styles that manifest as unprofessional behavior:

> …militant approaches, which are made in the name of a good cause, where the end is seen to justify the means.

Residents also mentioned unclear professional behaviors in the context of:

> Forceful telling that someone has not met clinical standards.

Both residents and department chairs wanted better communication that would lead to a ‘lived experience’ of
professional behavior within different contexts:

*Conditions and structures need exploring to enable a greater understanding of a problem.*

Honest communication was found to be important. Reference to ‘lying’ emerged in the responses from residents:

*It is ok to make a mistake, just don’t lie about it. And: for example, people lying about how many people seen during shift.*

Further examples of communication issues included discussions within clerkship directors and residents groups on the use of profanity, slang, and vulgar language in clinical areas, where some thought, but others did not, that such language was unprofessional, depending on mitigating issues such as the presence of patients and level of familiarity between the parties present. Both clerkship directors and departmental chairs mentioned ‘social conversations’ in the clinical setting as being potentially inappropriate and unprofessional. Clerkship directors asked the question:

*to what extent are social conversations a part of collegiality, and to what extent are they inappropriate?*

Departmental chairs mentioned striking a balance between the ‘overtly social’ and the ‘sterile’, to:

*…adopt a middle of the road approach, which must then be modified per patient.*

Residents also talked about other unprofessional behaviors that some may not regard as unprofessional and are generally not reported, but which manifest as a:

*…refusal of consults from another service or a lack of response.*

Other examples of unprofessional behaviors that emerged around communication included observations that some behaviors may go unnoticed or may not be regarded as unprofessional, including racial and gender-based micro-aggressions: "referring to women by first name", "more respect shown to male colleagues", and "only inviting speakers of a certain type to academic events". The department chairs mentioned that there is a "lack of diversity and inclusion in recognition of academic achievement". Chairs and resident groups both mentioned how professional dress standards are communicated and interpreted is not clear, including the use of the doctor’s white coat, personal hygiene and grooming. Also, chairs and residents discussed that encroachment into a colleague’s personal space and physical contact, where such contact may set up a power dynamic between patients and/or colleagues could be understood as unprofessional. Residents mentioned that some physical contact can be ‘avuncular’ in nature (not having crossed a boundary) but when applied to a certain group (for example from male to female staff) or where the hierarchy of seniority is involved can be uncomfortable.

Clerkship directors offered ideas on wider methods of communication, for example one described an idea for a newsletter which would be considered part of a training program:

*…provide outcomes [of unprofessional behavior] in a generalized way.*

**Reporting**

The residents group stressed the importance of anonymity in reporting systems. While the current system for reporting unprofessional behavior does not require the entry of personal details for the reporter, it does require a login name and password to access. This was felt to undermine the true nature of anonymised reporting:

*The vast majority of behavior is never reported. Only exceptionally egregious or reported behavior usually enters formal reporting, due to lack of anonymity around the login required to access online forms.*

Reporting systems which integrate protection against retribution against the reporter were also mentioned by residents who felt that it was important to feel:

*…empowered to speak up, [people] need to know that leadership wants them to*
[do so] and values what they have to say. They have to know that retaliation and retribution are unacceptable. In the end, people will speak up if they know that the value of doing the right thing is supported, that they believe that there is a culture that is just and fair.

Clerkship directors echoed these sentiments, commenting that ‘being heard’ was vital to any reporting system. These responses linked to those of the clerkship directors group:

The reporting feedback system has to allow people to feel that they have received feedback – loop closure process needs to take place.

Clerkship directors also suggested that Schwarz rounds and/or forums to allow for speaking up about unprofessional behavior and/or critical incidents sessions could be used, in order to:

…enable people to: unload their feelings from a situation. Debriefing about the emotion within the room.

Training

Departmental chairs talked specifically about the need to:

…share best practices, with alignment of the mission and general alignment of the process.

The importance of training systems which allow for appropriate and measured approaches in dealing with a range of unprofessional behaviors from minor misdemeanours to repeat or egregious types, need to be agreed upon.

A collaborative collegial approach should not be a substitute every time for egregious behaviors. Those sometimes do require a punitive action. The individual who is unwilling or unable to demonstrate insight often needs a different approach.

This group cited that minor issues often require interventions and training that are not punitive, but rather constructive, in helping to promote professional behavior within the system.

The intervention need not be punitive. Some of the escalated interventions can be constructive.

This proposal was supported by the residents, who also mentioned that:

…the person reporting wants to see something happen. It is hard to do that without making something public.

The types of training required were not clarified, however the departmental chairs and clerkship directors mentioned the need for robust training, and agreement was reached that this:

needs to be fair and just.

Departmental chairs discussed the importance of bystander training, while recognising that the hierarchy within a team influences member experience about ‘speaking out’. This group commented that when the goal of ‘patient safety’ is seen as the end-point then speaking up about unprofessional behaviors takes precedence. Bystander training should embody the values that:

…speaking up is the right thing to do.

Clerkship directors discussed the importance of implementing coaching programmes for faculty, residents, and undergraduate medical students. A third-party coach was suggested as a useful resource to discuss any issues or problems related to unprofessional behavior. They suggested reflective writing workshops as a conduit for discussion of professionalism, which could take place at the end of each clerkship. Also, multisource, 360-degree evaluations for all faculty was suggested:

Reflective therapeutic conversations, delivered by third party company to allow for candid conversations.
Discussion

The results explore the understanding of professional behavior as seen through the lens of three different groups, departmental chairs, clerkship directors, and residents, all in different roles at the same institution, Yale New Haven Hospital. They provide evidence of how the different groups each have their own understanding of what constitutes unprofessional behavior, although they all function within one clinical system, under one code of conduct policy of professional behavior.

Analysis of the data revealed that many of the responses focused on individual behavior, rather than the systems in place which promote, support and measure that behavior. In particular, mention of leadership values and example-setting by senior colleagues featured highly and most frequently across all participants. This finding, and the ways study participants talked about leadership issues, strongly suggests that individuals within an organization may be more comfortable with the concept of professional behavior as a set of personal attributes, uninfluenced by the systems within which they are expected to flourish. The results raise questions around what type of training could be provided that would integrate the institutional structures that all faculty and residents operate within so that there would be a common understanding of professional behavior in the ‘lived experience’.

The emergence of four key themes within data highlighted issues of Leadership, Communication, Reporting, and Training. Across all three levels of seniority there was an assumption that reporting is made in an upward direction, towards a more senior level, with little to no consideration of scenarios where reporters or perpetrators of unprofessional behavior may themselves be in a position of senior leadership. Such a lacunae has important implications along a number of training fronts, including role modelling and reporting, as leadership within highly hierarchical environments carry a particular responsibility to encourage and support physicians to act professionally and to learn from challenging situations. The literature makes clear the important role that senior colleagues play in enabling professional behavior through a focus on a set of behaviors (and not attitudes) that explicitly demonstrate professionalism in practice (Bahaziq and Crosby, 2011).

Residents discussed the need for orientation sessions to include clear expectation setting, showcasing examples around professional standards of behavior, with the aim of achieving standardization. However, departmental chairs were less concerned with the mode of delivery of messages and more concerned about issues of building a unified understanding of the definition of professionalism. Ultimately, both groups were concerned with professional standards setting as a ‘moving target’, to which responses must demonstrate adaptive measures to changing situations.

The focus by residents on the systems for reporting unprofessional behavior and the importance of robust methods for ensuring anonymity suggests that residents are more likely to be users of reporting systems. This group also highlighted the importance of closure of the feedback loop, with information provided to the reporter on what actions had been taken following a report. Clerkship directors and departmental chairs also discussed how receptive leadership styles contribute to enabling reporting, and that those that speak up should feel ‘listened to’. However, the departmental chairs also raised concerns around the difficulty of balancing closure of the feedback loop with maintaining the confidentiality of the reporting process.

Departmental chairs were the sole group who discussed the topic of accountability and the significance of avoiding overt internalisation or externalisation of problems. They reported that holding individuals accountable was important, but also recognized the importance of systems that support in a positive, collaborative, non-punitive way, where appropriate when mistakes are made. This group also made reference to the usefulness of examining the structures and conditions that contribute to problems of unprofessional behavior. Again, this might reflect the
responsibilities that a chair has in providing feedback or designing a program for remediation.

The departmental chair group took a view on issues around remediation and effecting change. Specifically, the need to demonstrate, particularly to residents that a collegiate approach to dealing with unprofessional behavior can result in improvements, but also that egregious unprofessional behavior, at any level of seniority will result in appropriate punitive measures being taken. The level of seniority at which this process occurs is also perhaps reflective of the group in which this was discussed.

Both the clerkship directors and the departmental chairs discussed the need to ensure that the clinical working environment operates efficiently with IT systems, technology and medical equipment, which is readily available and maintained to a standard that enables the trainee to work without hinderance. Clearly, at the trainee level, the group of residents has a vested interest in working in well-resourced environments. However, they lack the responsibility for managing resources, which instead falls to the departmental chairs. Ideally, all stakeholders must take a role in the planning and creation of structures that support professional behavior, and communication must take place between the users and creators of such systems.

Exposure to mistreatment in the form of discrimination, abuse, harassment and subsequent burnout has been recently documented in clinical specialties such as surgical residency training (Hu et al., 2019), and respondents across all participant groups mentioned both bullying and sexual harassment as clear examples of unprofessional behavior. However, these terms were not clarified during discussions so a consensus was not established across levels of seniority in defining bullying and harassment. For example, the departmental chairs expressed that "militant approaches, which are made in the name of a good cause, where the end is seen to justify the means” could arguably be seen as clear bullying in one context but not so clearly in another. The subsequent disruptive effects of poor professional behavior on individuals and teams were mentioned, as well as the negative effects exerted over patient care.

Self-regulation within clinical practice exists on a macro and micro level, albeit within a framework of national and local regulatory guidance. Professional behavior is, therefore, in part motivated by a set of values that are defined by the profession itself. Birden et al. (2014) cite the traditional elements of a profession are:

- autonomy in action and self-regulation by members of the profession,
- an identified moral code developed by those within the profession, to which all pledge (vow) to adhere.

Hafferty (2018, pp. 534) reflects on this when writing about an important challenge to issues of professionalism and, how identity, as a conceptual lens, furthers conversations about professionalism and does so at both the level of individuals and organizations.

However, assessing professional behavior via a set of individual characteristics and behaviors alone risks overlooking the systemic forces that shape and control what constitutes acceptable behavior. Since the majority of healthcare is delivered within teams that exist within complex organizations and hierarchies, it is essential to look towards improving the structural element of healthcare establishments. Only then can the assessment of professional behavior consider the specific working environment rather than on the individual's autonomy or self-determination (Hodges et al., 2011). If the organizational leaders and culture make professionalism explicit and supported, then it can be both taught as well as lived.

Limitations

Limitations of our study include the relatively small sample size with data collected from a single institution, further replication of the study is suggested to explore the extrapolation to other countries and clinical institutions.
In addition, due to time constraints, the use of individual interviews (Clerkship Directors) versus focus group interviews (Residents) may have had an unintended bias effect upon the conversational dynamics and the issues raised. The residents have been more reticent to share their experiences of ‘unclear professional behaviors’ in a focus group rather than one-on-one interviews.

Finally, medical students enrolled in the undergraduate programme at Yale School of Medicine were not invited to participate in the study with the intent of exploring the views of more senior community members. Further research is need to replicate the study with other subjects such as program directors and medical students who work within the hospital system and examine their lived understanding of professional behavior within the international context.

**Conclusion**

Across the four principal themes identified during this study; Leadership, Communication, Reporting, and Training, the departmental chairs, clerkship directors and residents expressed different priorities and approaches to promoting professional behavior within the clinical environment. A key finding was that the understanding of professional behavior in the ‘lived experience’ was not consistent within one institution.

In the highly hierarchical environment of clinical medicine, this study demonstrates that there is a stratification as to what is both understood and recognised as important in the promotion of professional behavior. Interestingly, this occurred despite each group working under a single code of conduct policy of professionalism at one institution. Findings also indicated that all the participants expressed that professionalism can be demonstrated in practice with a set of behaviors, but that the setting of expected standards of those behaviors can be context dependent across the levels of seniority. However, all levels of seniority expressed that training is critical to generate an understanding of professional and unprofessional behavior within one institution. Further research is needed to study what training can be designed to have an outcome that all staff and faculty understand what constitutes professional behavior.

**Take Home Messages**

1. The understanding of professional behavior in the ‘lived experience’ was not consistent within one institution.
2. Different priorities and approaches to promoting professional behavior exist within the clinical environment.
3. The setting of expected standards of professional behaviors can be context-dependent across the levels of seniority.
4. One's understanding of professionalism depends on one's position and 'standing' within an organization and has important implications for policy setting.
5. The key themes of what promotes professional behaviors, identified during this study, were Leadership, Communication, Reporting, and Training.

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Appendices

None.

Declarations

The author has declared that there are no conflicts of interest.

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Ethics Statement

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