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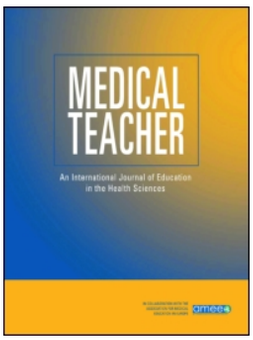

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AMEE GUIDE

How to identify, address and report students' unprofessional behaviour in medical school

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ABSTRACT

This AMEE guide provides a research overview of the identification of, and responding to unprofessional behaviour in medical students. It is directed towards medical educators in preclinical and clinical undergraduate medical education. It aims to describe, clarify and categorize different types of unprofessional behaviours, highlighting students' unprofessional behaviour profiles and what they mean for further guidance. This facilitates identification, addressing, reporting and remediation of different types of unprofessional behaviour in different types of students in undergraduate medical education. Professionalism, professional behaviour and professional identity formation are three different viewpoints in medical education and research. Teaching and assessing professionalism, promoting professional identity formation, is the positive approach. An inevitable consequence is that teachers sometimes are confronted with *un*professional behaviour. When this happens, a complementary approach is needed. How to effectively respond to unprofessional behaviour deserves our attention, owing to the amount of time, effort and resources spent by teachers in managing unprofessional behaviour of medical students. Clinical and medical educators find it hard to address unprofessional behaviour and turn toward refraining from handling it, thus leading to the 'failure to fail' phenomenon. Finding the ways to describe and categorize observed unprofessional behaviour of students encourages teachers to take the appropriate actions.

Introduction

Professionalism of doctors is crucial for the quality of health care. For a physician, behaving as a professional is not just a desirable condition, but also a requirement to safeguard patient safety and improve patient care outcomes (Martinez et al. 2017). This is relevant for medical schools, since they prepare students for their future roles as physicians. In the latter role they, as members of the medical profession, will be held responsible for their own professional performance, and also for upholding the trustworthiness of the whole medical profession.

Papadakis's seminal study displaying that unprofessional behaviour during undergraduate medical training is predictive of unprofessional behaviour as a physician, makes clear that a permissive approach to unprofessionalism in undergraduate education is unacceptable (Papadakis et al. 2005). While medical professionalism is now taught and assessed in medical schools, educators sometimes notice that students do not behave professionally. Although medical educators observe unprofessional behaviour in up to 20% of all students, they only report 3–5% (Papadakis et al. 2005; van Mook et al. 2010; Mak-van der Vossen et al. 2014). This discrepancy reflects the difficulty in evaluating professionalism, and is often denominated as the 'failure to fail' phenomenon (Yepes-Rios et al. 2016). Probable reasons for the latter are: a lack of conceptual clarity about (un)professionalism in medical school, concern for the subjectivity of one's judgment, fear of harming a student's reputation, lack of appropriate faculty development, and uncertainty about the remediation process and its outcomes (Ziring et al. 2018).

Practice points

- Medical educators can identify unprofessional behaviours among medical students using the 4 I's model. This model comprises 30 descriptors, which indicate a deficiency in four domains: *involvement, integrity, interaction*, and/or *introspection*.
- Medical educators can classify unprofessional student behaviour into four profiles *(accidental behaviour, struggling behaviour, gaming-the-system behaviour and disavowing behaviour)*, distinguished by two dimensions *(reflectiveness and adaptability)*.
- Medical educators can respond to unprofessional student behaviour in three consecutive phases: *understand and explore, remediate*, and *gather evidence for dismissal*.

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Unprofessional behaviour of undergraduate medical students, either originating from personal, interpersonal, contextual or external causes, can have an impact on peer students, teachers, health care teams and also patients (Lesser et al. 2010). As professionalism lapses are a part of learning, educators should be prepared to deal with them (Levinson et al. 2014). The implicit, hidden curriculum in medical education is more powerful in teaching professionalism than the formal and informal curricula (Hafferty 1998). If educators do not respond to unprofessional behaviour, they implicitly transmit the message to their students that unprofessionalism is acceptable, and that responding is unnecessary or not worth the effort. Thus, educators need to (both implicitly and explicitly) teach their students how to handle unprofessionalism.

Moreover, if an unsatisfactory evaluation has been given to a student because of unprofessionalism, it is not clear what can be done to remediate this behaviour (Papadakis et al. 2012). The guidance of such a student takes a toll on the resources, time and effort of faculty. Medical schools can optimize such guidance by adopting a clear strategy to guide students who, through their behaviour, show that they need extra help to develop their professionalism. A uniform strategy could also form a source for evaluation of the educational context and education research.

This guide aims to provide practical guidance in detecting and responding to unprofessional behaviours of medical students. The guide is based on the medical education literature on students' unprofessional behaviour, complemented by the authors' research on this topic and their extensive personal experiences with managing unprofessional behaviour of medical students. The guide outlines various approaches, aiming to facilitate medical educators to recognize students who behave unprofessionally and to acknowledge a student's need for extra guidance in developing a professional identity. Also, attention is paid to factors in the educational context that might contribute to students' unprofessional behaviour. Furthermore, the guide describes the steps that can be taken after identification of a student who has behaved unprofessionally.

What is 'unprofessional behaviour' in medical education?

The essence of the various definitions of medical professionalism is the necessity for physicians to adhere to high ethical and moral standards, in order to gain the trust of their patients (Swick 2000). Correspondingly, for medical students professionalism necessitates that they gain the trust of their peers and teachers and, if applicable in the context (simulated) patients. Showing professional behaviour requires knowledge, skills, and judgment to deal with dilemmas that occur in specific situations (van Luijk et al. 2010; Irby and Hamstra 2016). Professional identity formation is the process of acquiring such knowledge, skills and judgment qualities, and integrate these into a developing professional identity. Thus, unprofessional behaviour may be a sign of the student's need for guidance in this process of professional identity formation.

Medical schools define their own standards for professionalism as a foundation for teaching and assessing the professionalism domain (O'Sullivan et al. 2012). Concerns about a student's professionalism need to be identified and corrected before graduation. As behaviours can be defined and observed, the most frequent way of assessing professionalism takes place through observing professional behaviour. Assessment methods for professional behaviour are critical incident reports, and routine evaluations based on direct observations of students' behaviour, which is sometimes a stand-alone evaluation or integrated into ongoing evaluations (Ziring et al. 2015).

Critical incidents reports by educators or peer students can be used to identify unprofessional behaviours that warrant action. This provision is necessary for egregious and unlawful behaviours, such as sexual harassment, intimidation, plagiarism or falsifying official records. Such behaviours call for punitive responses like probation or dismissal.

For assessments during scheduled educational activities, a combined formative and summative approach is recommended (van Mook et al. 2010). The educator's formative feedback regarding the observed unprofessional behaviour is intended to trigger the student's individual professional development, aiming to reach the intended outcome when the summative assessment takes place. A reason to use formative assessments is to lower the stakes for both the student and the educator. Another reason to initially assess professional behaviour formatively is the dependence of behaviour on observer and context. Combining the opinions of different assessors based on observations of the student in different contexts, so-called triangulation of assessments, can ensure a sound summative evaluation (van Mook et al. 2010). Any resulting unsatisfactory evaluations call for pedagogical approaches toward the student to correct unprofessional behaviour during the course. Furthermore, observer factors and contextual factors supporting professional behaviour need to be strengthened (Lesser et al. 2010)

Descriptors of students' unprofessional behaviours

The recent version of the United Kingdom's General Medical Council (GMC) guidance for undergraduate medical students provides descriptors of key areas of concern regarding students' professionalism (General Medical Council 2016). The guidance describes examples of student behaviours that will undermine the trust of patients and society in the medical profession. The key concern areas are: persistent inappropriate attitude or behaviour; failing to demonstrate good medical practice; drug or alcohol misuse; cheating or plagiarizing; dishonesty or fraud; and aggressive, violent or threatening behaviour. The guidance stresses that medical students must display professional behaviour not only inside the medical school, but also outside. Examples of unprofessional behaviour outside the medical school refer to the misuse of alcohol and drugs. The GMC's key areas of concern partially overlap with the domains that are proposed by Papadakis: responsibility; relationships with health care team and the environment, including systems and organizations; relationships with patients; and capacity for self-improvement (Byyny et al. 2015).

In an earlier review conducted to explore, describe and categorize results of empirical studies describing medical students' unprofessional behaviours, witnessed by stakeholders or admitted by students themselves (Mak-van der Vossen et al. 2017), an overview of 30 descriptors for

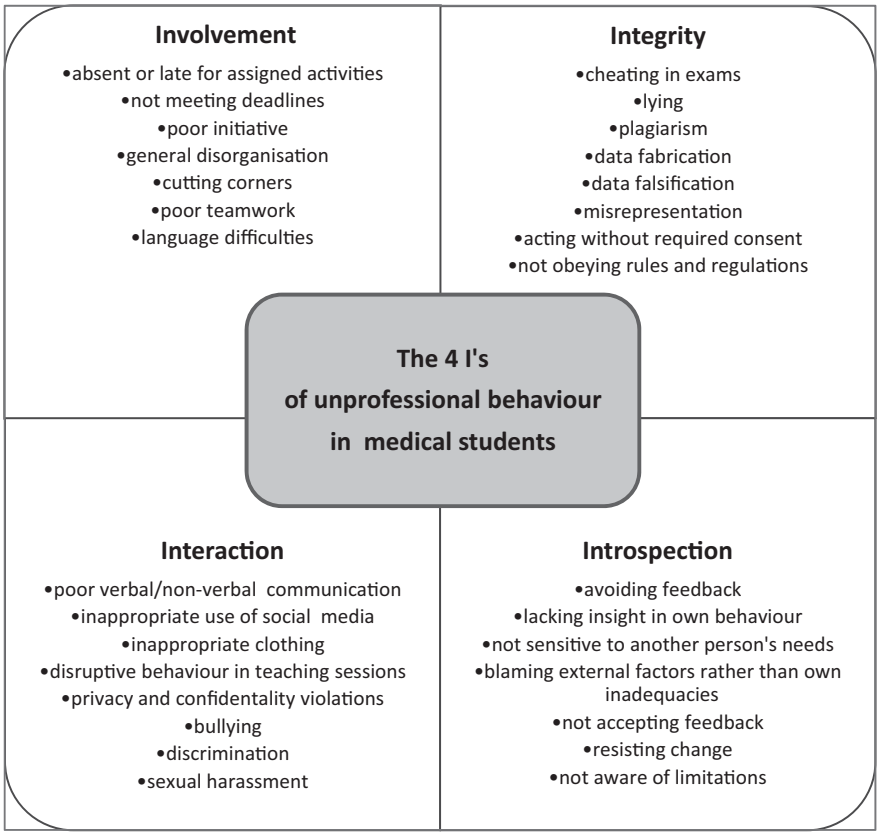

Figure 1. Four categories including 30 descriptors for unprofessional behaviours in medical students (Mak-van der Vossen et al. 2017).

unprofessional behaviours was generated. These descriptors could be divided into four distinctive categories, denominated as '*the 4 I's*'. These are lack of: Involvement, Integrity, Interaction, and Introspection (Mak-van der Vossen et al. 2017) (see Figure 1).

These descriptors clarify to medical educators what to document and how to document it, in order to clearly articulate their concerns about the unprofessional behaviour they encounter. In this way, supporting documentation for poor performance in assessment forms can be generated explicitly.

Factors contributing to unprofessional behaviour

Triggers for the occurrence of unprofessional behaviour can originate from personal issues, interpersonal issues, external factors and contextual factors (Hickson et al. 2007; Levinson et al. 2014). See Table 1 for examples of contributing factors to unprofessional behaviour originating from these four sources. Trainees might not recognize these triggers in time, e.g. because they fail to realize that the adopted style is unprofessional (Yates 2014). Educators need to keep in mind that the display of a professionalism lapse should not be used to label a student as an 'unprofessional' person. Mostly, students with good intentions *temporarily* lack the skills or attitudes to manage the professionalism challenge in front of them, or the context in which they operate does not encourage or facilitate professionalism (Lucey and Souba 2010). Structural unprofessionalism is thus far less common, but can be revealed when assessing students longitudinally over longer periods of time, using a framework of triangulated assessments (van Mook et al. 2010).

Profiles of unprofessional behaviour

Medical professionalism can be assessed by observing behaviours. Various researchers have grouped such behaviours into categories or patterns (Teherani et al. 2009; Hays et al 2011; Mak-van der Vossen et al. 2016; Ainsworth and Szauter 2018). The reason for using this approach is that such patterns are easier to recognize for an educator than single behaviours, and also, that different patterns might need different guiding or remediating activities. Grouping unprofessional behaviours thus yields distinctive behavioural profiles. Research-generated profiles of student behaviours are based on two factors: the student's reflectiveness and their adaptability (see Figure 2). Reflective behaviour (listening to feedback and willingness and ability to incorporate it in future behaviour) is the basis of these profiles, as it predicts the future professionalism of a student better than the common engagement behaviours educators tend to denominate (Mak-van der Vossen et al. 2016; Hoffman et al. 2016; Krzyzaniak et al. 2017; Ainsworth and Szauter 2018). A student's behavioural profile can become apparent over time in different ways: by one teacher observing the student over a period of time; by forward feeding of performance from present teachers to new teachers, or by combining evaluations from different teachers by someone who has an oversight of the assessments. When a student's behaviourial profile has become apparent, it can be used to design an appropriate remediation strategy.

How to facilitate educators' responses to unprofessional behaviour

The *Expectancy-Value-Cost* model by Barron describes that a person's motivation to engage or not engage in a certain

task is based on the balance of the expectancy of being successful in that task *(Can I do it?),* the perceived value of engaging in the task *(Do I want to do it?)* and the costs of engaging in the task *(Are there barriers that prevent me from doing it?)* (Barron et al. 2015). This model appeared to effectively explain the motivation of *students* to respond to unprofessional behaviour in medical school (Ainsworth and Szauter 2018). Assuming that this model also applies to educators' motivation to respond to unprofessional behaviour of students, the facilitators for educators to respond to unprofessional behaviour of students, as found in the literature, were summarized using this model (see Table 2). The two main strategies to facilitate educators to respond to unprofessional behaviour of students are (i) strengthening educators' personal skills and qualities through faculty development, and (ii) strengthening organizational policies to mitigate the assessment procedure and improve remediation outcomes.

Table 1. Examples of factors involved in the occurrence of unprofessional behaviour.

Personal factors
- Competency deficits (Levinson et al. 2014)
- Learning disabilities (Hays et al. 2011, Guerrasio et al. 2014)
- Mental health issues (e.g. depression, autism spectrum type symptoms, personality disorders (Bennett et al. 2005; Hickson et al. 2007; Hays et al. 2011; Levinson et al. 2014)
- Physical health issues (Parker et al. 2008; Levinson et al. 2014)
- Substance abuse (Bennett et al. 2005; Hickson et al. 2007; Guerrasio et al. 2014; Levinson et al. 2014)
- Lack of motivation for medical school (Teherani et al. 2009)
- Unmet needs (fatigue, hunger) (Levinson et al. 2014)

Interpersonal factors
- Different cultural expectations (Parker et al. 2008; Hays et al. 2011; Barnhoorn et al. 2017)
- Hierarchy (Levinson et al. 2014)
- Poor understanding of roles and responsibilities (Parker et al. 2008; Hays et al. 2011; Levinson et al. 2014)
- Poor communication (Guerrasio et al. 2014; Levinson et al. 2014)
- Language difficulties (Levinson et al. 2014; Barnhoorn et al. 2017)
- Poor organizational skills (Hays et al. 2011; Guerrasio et al. 2014)

External factors
- Psychosocial stressors (Hickson et al. 2007; Parker et al. 2008; Hays et al. 2011; Guerrasio et al. 2014)
- Family problems (Hickson et al. 2007; Hays et al. 2011; Levinson et al. 2014)
- Financial challenges (Parker et al. 2008; Hays et al. 2011; Levinson et al. 2014)

Contextual factors
- Unclear standards (Hickson et al. 2007)
- Bureaucratic organization (Hickson et al. 2007; Levinson et al. 2014)
- High expectations, high workload in medical school (Hickson et al. 2007; Levinson et al. 2014)
- Learning environment does not encourage professionalism (Hickson et al. 2007)
- Inadequate supervision (Levinson et al. 2014)
- Poor role modeling (Hickson et al. 2007)
- Culture that rewards bad behaviour (Hickson et al. 2007; Levinson et al. 2014)

How should educators respond to medical students' unprofessional behaviour?

Responding to reported unprofessional behaviour is theoretically described as a graduated approach, e.g. in the Vanderbilt 'disruptive behaviour pyramid' (Hickson et al. 2007). Recently, five zones of success and failure for medical students have been presented, including failure in professionalism (Ellaway et al. 2018). The basic philosophy of such models is that students are growing and developing, and sometimes fail, for which they need help. Students need pedagogical support, in which a balance between personal accountability and emphasis on contextual causes must be sought. The profiles of student behaviour can help in designing such supporting remediation strategies. Punitive actions are reserved for those instances in which a student does not improve, despite remediation (Lucey and Souba 2010). A road map for handling unprofessionalism includes three phases: (i) Explore and understand, (ii)

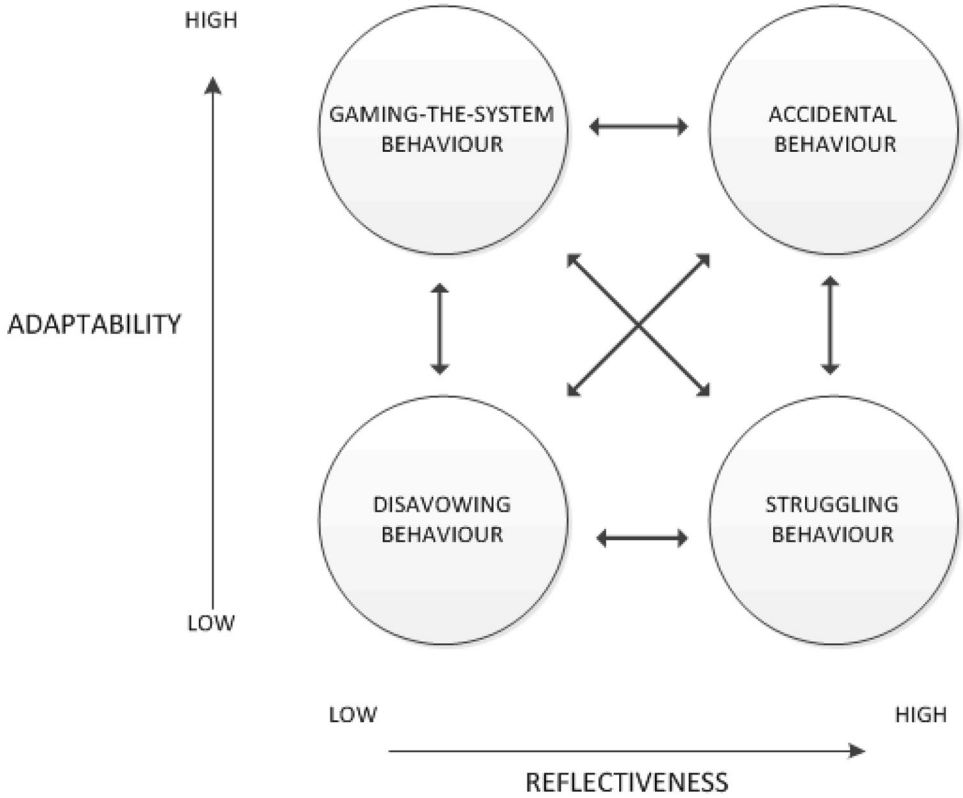

Figure 2. Profiles of unprofessional behaviour (Mak-van der Vossen et al. 2019).

Remediate, and (iii) Gather evidence for dismissal (Mak-van der Vossen et al. 2019) (see Figure 3).

Explore and understand

After a student has been cited for unprofessional behaviour, a professionalism remediation supervisor (PRS), often the dean of student affairs, course director or clerkship director, invites the student for a conversation about the lapse. Jha demonstrated that the Theory of Planned Behaviour can be used to explore and understand students' unprofessional behaviour (Jha et al. 2016). This theory encompasses that a student's ultimate behaviour is influenced by intentions and beliefs about the behaviour and its outcomes, the subjective norm, and the perceived behavioural control. Another

Table 2. Facilitators for educators to respond to unprofessional behaviour of students.

	Improving expectancy of success of responding *(Can I respond?)*	Improving value of responding *(Do I want to respond?)*	Diminishing cost of responding *(Are there barriers to respond?)*
Faculty development	• Teach practical skills how to address unprofessional behaviour (Howe et al. 2010; Ziring et al. 2015; Yepes-Rios et al. 2016) • Provide individual guidance by staff (Howe et al. 2010)	• Stress the effect of students' unprofessional behaviour on future patient-safety (Howe et al. 2010; Yepes-Rios et al. 2016; Wong et al. 2017) • Emphasize role modeling of responding to unprofessionalism to educators (Rougas et al. 2015) • Inform teachers about policies (Rougas et al. 2015)	• Offer the possibility to educators to discuss their experiences with colleagues and get mutual support (e.g. in teacher communities). (Mak-van der Vossen et al. 2014; Ziring et al 2015; Yepes-Rios et al. 2016; Rougas 2015)
Institutional strategies	• Make 'triage' of observed unprofessional behaviour possible (Mak-van der Vossen et al. 2014; Rougas et al. 2015) • Create a strong (longitudinal) assessment system (Parker et al. 2008; Yepes-Rios et al. 2016) • Give institutional support, e.g. through faculty development (Ziring et al. 2015; Yepes-Rios et al. 2016) • Create an online repository of examples of remediation policies and procedures (Ziring et al. 2015)	• Organize forward feeding of professionalism concerns (Mak-van der Vossen et al. 2014; Parker et al. 2008) • Create effective opportunities for students after failing (Ziring et al. 2015; Yepes-Rios et al. 2016) • Provide feedback about the results of remediation, give evidence of student support (Howe et al. 2010; Mak-van der Vossen et al. 2014; Rougas et al. 2015) • Formulate clear expectations and policies (Ziring et al. 2015) • Focus on help, not on punishment (Ziring et al. 2015)	• Give teachers adequate time to observe and evaluate behaviours (Daelmans et al. 2016) • Provide short assessment and report forms that are easy to use (Howe et al. 2010) • Make assessment of professionalism part of normal assessment procedures (Howe et al. 2010) • Separate teaching and assessing of professionalism (Howe et al. 2010)

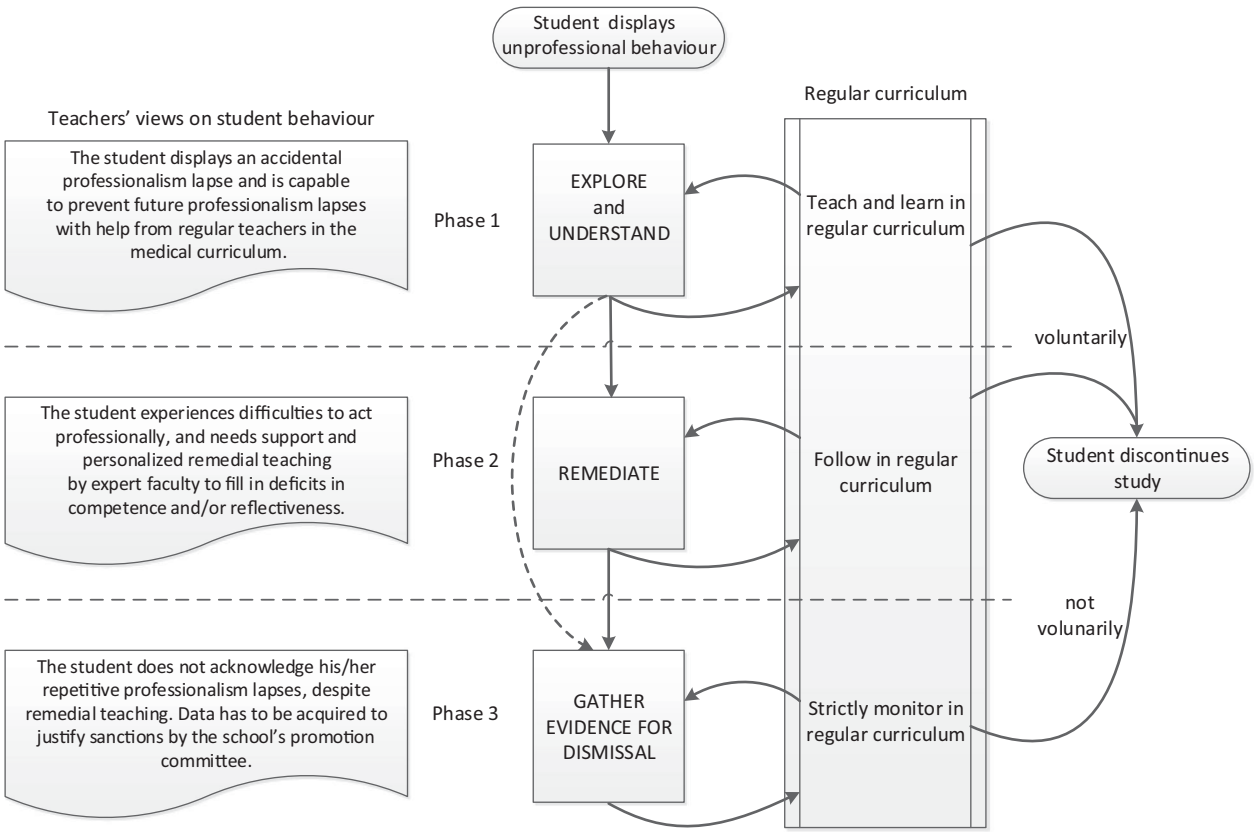

Figure 3. A roadmap for responding to professionalism lapses (Mak-van der Vossen et al. 2019).

Table 3. Ten questions to explore a student's unprofessional behaviour.

To be explored	Question
1. Student's perspective about the facts	What happened?
2. Alignment with assessment outcome	Do you agree with the unprofessional behaviour judgment?
3. Intentions	What did you intend to do?
4. Beliefs	What did you expect to happen?
5. Context	What circumstances influenced your behaviour?
6. Power	Were you able to influence the circumstances?
7. Effect on others	What do you think your behaviour did to others?
8. Emotions	How do you feel about it now?
9. Causes	Are there any circumstances that make it more difficult for you than for other students to comply with the professionalism expectations?
10. Plans	How would you act in a similar situation next time?

theoretical approach is offered by the 'Onion model', consisting of the following layers: environment, behaviour, competencies, beliefs, identity, and, in the center, mission (Barnhoorn et al. 2019). Based on these models, ten questions to be posed in a conversation with the student are summarized (see Table 3). The goal of this conversation is to create awareness about professionalism in the student, and to stimulate the student to formulate individual learning objectives that can be reached with the help of educators in the regular curriculum. For most students, this approach is sufficient to prevent future unprofessional behaviour. Furthermore, these conversations can yield important information about (hidden) organizational and contextual causes for students' unprofessional behaviour that can be fed back into the organization (Lesser et al. 2010; Rougas et al. 2015).

Remediate

This phase starts when the unprofessional behaviour appears to be repetitive, or when both student and PRS acknowledge that additional teaching is needed to fill in certain deficiencies to prevent future unprofessional behaviour. The approach is mainly pedagogical, although sometimes also punitive actions are deemed necessary, such as an informal or formal warning, or probation (Howe et al. 2010). The PRS, in collaboration with the student, creates a remediation plan that is tailored to the supposed underlying cause, and the student's capacities. Several authors have described pedagogical measures that can be applied to remediate unprofessionalism, which span from remediation assignments or curricula, matching to a (self-chosen) role model, individual mentoring and coaching/counseling, deliberate practice and feedback in simulated situations, repeating part/all of course/clerkship, community service, up to mental health evaluation/treatment (Bennett et al. 2005; Levinson et al. 2014; Guerrasio et al. 2014; Ziring et al. 2015; Kalet et al. 2016). All measures are intended to support the student in reaching his/her learning objectives, to improve professionalism knowledge and (inter)personal skills, and to create insight into professionalism values. This is preferably done through an individual relationship by specialized faculty within the school, or by specialists outside the school. Although it sometimes seems desirable that remediation measures are mandatory, this is difficult to accomplish, since the student is the one who should decide to act or not. Thus, expectations must be set out clearly and at most a strong advice can be given how to attain them. Ultimately, the effect of the remediation has to be established by further assessment in the regular curriculum, within a given time frame (Bennett et al. 2005; Guerrasio et al. 2014; Kalet et al. 2016). The student's progress over time should be monitored by the PRS (Ziring et al. 2015).

Professionalism remediation takes far more faculty time and effort than remediation of academic knowledge and skills deficits (Guerrasio et al. 2014). This calls for specific faculty development for remediation teachers. All individuals involved in the remediation process ideally form a community of practice to share experiences and support each other (Kalet et al. 2016).

Gather information for dismissal

Not every student develops a strong professional identity. A handful of students, less than 2% of all learners referred for remediation, appears to insufficiently demonstrate reflectiveness and improvement, showing the profile of *disavowing behaviour*, as evidenced by a structural pattern of unprofessional behaviour despite remedial teaching (Bennett et al. 2005; Guerrasio et al. 2014)., Especially if (future) patient care is potentially compromised, faculty must take their role as gatekeepers of the medical community. That's when the final phase commences, in which strong evidence has to be gathered for dismissal, through very clear processes that are specified in the institutional policy documents. Although remediation may continue in this phase, the main goal of the effort has changed from guiding the student into the medical community to guiding the student out of it. Therefore, assessment outcomes have to be documented carefully. To avoid conflicts of interest, in this final phase the responsibility for the process and guidance of the student should be shifted from remediation teachers to other people within the institution, e.g. a Professionalism progress committee (Mak-van der Vossen et al. 2019).

Implications for practice

Lapses are a part of learning, and discussing lapses among teachers and students can effectively enhance students' professional identity formation (Lucey and Souba 2010). Thus, responding to unprofessional behaviour to prevent future lapses should be part of the normal curriculum (Kalet et al. 2017). Medical educators need to be taught about how to recognize and respond to unprofessional behaviour, and to be informed about the way the behaviour is dealt with after reporting.

Not only students, but also teachers may display unprofessional behaviours. That's why, ideally, professionalism values are developed in collaboration between educators and students (O'Brien et al. 2017). If professionalism expectations for both groups align, professionalism of students,

and professionalism of teachers can be evaluated using the same standards.

Future research should focus on the effectiveness of remediation of unprofessionalism. Possibly, the behavioural profiles are a means to determine remediation measures. Especially, 'gaming the system' behaviour needs further research. Is it a phase in the learning process? (Neve et al. 2016). Or is it a result from an extensive focus on behaviours, instead of on values? In further research contextual and cultural factors of unprofessional behaviour should also be taken into account. It would be worthwhile if educators would know how they could help to prevent unprofessional behaviour by bringing about changes in the educational context.

Conclusion

Poor professional behaviour is a symptom, not a diagnosis. By giving feedback to each other, and talking about unprofessionalism both students and educators can potentially learn. Students can learn that unprofessionalism is not tolerated, since it has a negative effect on (future) patient care. Educators can learn which factors in the educational context need to be influenced to support professional behaviour of medical students.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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