Professing Professionalism: Are We Our Own Worst Enemy? Faculty Members' Experiences of Teaching and Evaluating Professionalism in Medical Education at One School

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Abstract

Purpose
To explore clinical faculty members' knowledge and attitudes regarding their teaching and evaluation of professionalism.

Method
Clinical faculty involved in medical education at University of Toronto Faculty of Medicine were recruited to participate in focus groups between 2006 and 2007 to discuss their knowledge, beliefs, and attitudes about teaching and evaluating professionalism and to determine their views regarding faculty development in this area. Focus groups were transcribed, analyzed, and coded for themes using a grounded theory approach.

Results
Five focus groups consisting of 14 faculty members from surgical specialties, psychiatry, anesthesia, and pediatrics were conducted. Grounded theory analysis of the 188 pages of text identified three major themes: Professionalism is not a static concept, a gap exists between faculty members' real and ideal experience of teaching professionalism, and "unprofessionalism" is a persistent problem. Important subthemes included the multiple bases that exist for defining professionalism, how professionalism is learned and taught versus how it should be taught, institutional and faculty tolerance and silence regarding unprofessionalism, stress as a contributor to unprofessionalism, and unprofessionalism arising from personality traits.

Conclusions
All faculty expressed that teaching and evaluating professionalism posed a challenge for them. They identified their own lapses in professionalism and their sense of powerlessness and failure to address these with one another as the single greatest barrier to teaching professionalism, given a perceived dominance of role modeling as a teaching tool. Participants had several recommendations for faculty development and acknowledged a need for culture change in teaching hospitals and university departments.

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Professionalism is a tenet of doctoring that is valued increasingly highly by the general public and that provides the basis for medicine's contract with society.[1] Moreover, the Royal College of Physicians and Surgeons of Canada, the Accreditation Council of Graduate Medical Education, and virtually every North American medical professional body and society have deemed professionalism a core competency and mandated medical faculties to teach it.[1–5] All Canadian postgraduate medical specialty residency training programs must provide trainees with instruction and evaluation with regard to this competency.[4] The Medical Council of Canada's two-part licensing exam for all Canadian undergraduate medical students includes examination questions on the CanMEDS role of professionals.[6]

The past decade has seen an explosion of both theory and research on how best to define, teach, and evaluate the knowledge, skills, and attitudes that constitute a physician's professional role,[7–28] and articles have proliferated addressing issues related to assessing and managing unprofessional behavior by trainees.[29–37] There has been a simultaneous increase in institutional position papers and statements from hospitals and universities as well as provincial and national licensing bodies defining the professional behaviors expected of physicians regulated by those institutions.[3,38] However, a gap exists between this burgeoning literature on professionalism and our ability as medical educators to effectively teach and evaluate in this domain.[39,40]

Currently, professionalism continues to receive some attention in training programs, primarily through faculty example and mentoring, yet there is no clear consensus or evidence base to inform best practice, teaching, and evaluation in this area.[28–30,39]

Our purpose was therefore to explore faculty members' knowledge, beliefs, and attitudes about teaching and evaluating professionalism and to determine their views regarding faculty development in this domain. Qualitative research is well suited to explore experiences, perceptions, and beliefs, especially when the phenomena under study are not well

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understood or defined.[41,42] We therefore used focus-group methodology and grounded theory analysis to develop a fuller understanding of faculty members' views.[43–45] We hope this will ultimately lead to a more informed process of design and implementation of faculty development resources and ultimately improve the education of trainees.

Method

Participants and recruitment

Potential participants were clinicians in the Faculty of Medicine at the University of Toronto who had direct teaching responsibilities or who were directly involved with evaluating trainees' professionalism at the undergraduate or postgraduate level. Following approval by the University of Toronto Health Sciences Research Ethics Board and the Hospital for Sick Children's Research Ethics Board, recruitment took place via a series of e-mails to faculty and department list serves. Initial e-mails were sent to the departments of surgery and psychiatry, and then expanded to include other departments because of low recruitment.

Focus groups

We conducted five focus groups between July 2006 and September 2007, consisting of a total of 14 clinical faculty drawn from surgery, psychiatry, pediatrics, and anesthesia. Each group had two to five participants. The number of focus-group participants is in accordance with norms for qualitative research.[43] The focus groups were 90 to 120 minutes long and were transcribed verbatim. Two of us (P.B., N.A.) alternated in the facilitator role. A research assistant took and transcribed field notes while the facilitator conducted the focus groups. Field notes covered the following issues: relevant body language of the participants, such as nods of agreement or dissent; the intensity and fluency of discussion; whether a discussion seemed to generate heat, as might be evidenced by the number of interruptions from participants; and whether a topic seemed difficult, as evidenced by longer silences among participants or apparent reluctance to discuss certain issues in depth. Probing questions were not used after the initial structured questions. The groups tended to flow well, with few silences or hesitations. Follow-up questions focused on clarification or the generalizability of a participant's experience to other group members. Transcriptions were rendered anonymous before being analyzed; however, two of us (P.B., N.A.) were present for the focus groups and were known to some of the participants.

In the focus groups, faculty were asked to comment on a set of questions designed to elicit their thoughts and attitudes toward defining, teaching, and evaluating professionalism for medical trainees. These questions were

- What is professionalism for physicians?
- Who defines it?
- What is unprofessional behavior?
- How is it learned?
- How is it taught?
- How does unprofessionalism arise?

We developed these initial questions in collaboration with academics and teachers in the faculty of medicine at the University of Toronto, with expertise both in conducting focus groups for the purpose of qualitative research, and in teaching and evaluation of professionalism in medical settings. These questions evolved and were refined during and after each focus-group session in accordance with the theoretical underpinnings of grounded theory research.[44,45]

Coding of transcripts

We coded the transcripts for emerging themes according to grounded theory research methodology in which substantive theory is derived through an ongoing process of continually reviewing the data, refining categories, and reevaluating these changes.[44] Three of us (P.B., N.A., S.G.) independently read transcripts and highlighted recurring issues, examples, or quotes. We then discussed and iteratively revised the key emerging themes and interpretations. These discussions resulted in the grouping of dominant and pervasive ideas we identified as categories. Once the coding was deemed complete (i.e., saturation was achieved, defined as the point at which no new ideas or themes were generated), one author (B.K.), a trained research assistant, coded all transcripts using N-Vivo qualitative analysis software (QSR International Pty Ltd., Version 8, 2008). The first three authors (P.B., N.A., S.G.) met regularly with the research assistant to review and validate the N-Vivo coding. One of us (S.G.) has had extensive experience in qualitative research studies and in using N-Vivo software, and spent time individually reviewing all of the coding. All the investigators subsequently reviewed the N-Vivo codes for accuracy.

Results

The demographics of the study group are described in Table 1. A predominance of psychiatrists and surgeons among the participants reflected our initial recruitment focus on those specialties, as they match those of the two lead investigators and we were interested in exploring potential differences between faculty based on specialty. However, we had difficulty recruiting the number of faculty we had hoped for and therefore expanded our recruitment efforts to other departments. Despite this wider scope for recruitment, the number of faculty agreeing to participate in the

Table 1

Characteristics of 14 Participants in Faculty Focus Groups on the Subject of Faculty Teaching and Evaluation of Professionalism, and Perceived Need for Faculty Development, From the Faculty of Medicine, University of Toronto, 2006–2007

Characteristic	No.
Gender, male/female	8/6
Specialty	
Psychiatry	6
Pediatrics	1
Surgery	6
Anesthesia	1
Years in practice	
0–5	2
6–10	5
11–15	3
16–20	0
>20	4
Role in education*	
Teaching	14
Administration	6
Leadership	1
Research	3

* All participants were engaged in teaching in addition to one other role.

groups was lower than we had anticipated.

The five focus groups yielded 188 pages of textual material. Our analysis revealed three major thematic categories: (1) Professionalism is not a static concept, (2) a gap exists between faculty members' real and ideal experience of teaching professionalism, and (3) "unprofessionalism" persists. These thematic categories comprised 12 subthemes illustrated in Table 2.

Professionalism is not a static concept

A participant from Focus Group 2 noted, "I still think that our definition of professionalism is governed by social mores that are unwritten but are constantly evolving, changing, being redefined, becoming more sophisticated in their definition or in their perspective." This quotation exemplifies the notion that professionalism is a concept in flux.

Within this thematic category, six clear subthemes emerged, all deriving from faculty members' experience of professionalism as difficult to define. This difficulty was emphasized in all the focus groups. Specific illustrations of the subthemes are provided in Table 2. Despite the plenitude and depth of the participants' responses to the question regarding definition, the participants had difficulty in settling on a single definition, a function of their perception that professionalism actually has multiple potential bases for definition. These bases included those chosen by and characteristic of the particular group defining it; moral or ethical frameworks; specific behaviors; definitions of exclusion (i.e., what professionalism is not); values, qualities, and attitudes; and, finally, the notion of professionalism having an intangible nature that does not lend itself easily to definition.

The most widely explored subtheme stemmed from faculty members' understanding that particular groups provide differing definitions of professionalism, according to each group's specific codes of conduct and legal frameworks, the influence of its specific medical context, geography, culture, gender and generational balance, and its societal background, which encompassed media, culture, economic framework for health care, and religion. For example, faculty described different professional cultures specific to different specialties, with the surgeons in particular referring to the unique nature of their role as "captain of the ship" in the operating room and the assumption of responsibility entailed in that role and the peculiar stresses of their work. One participant talked about the differences inherent in a surgical notion of responsibility:

> I think [for surgeons] the whole responsibility thing is of primary importance because people can actually die if you don't make sure that the XYZ gets checked . . . . We blow it up beyond where it needs to go [sometimes] but the message is that you have to take responsibility for things that you do and it has direct consequences *tonight*. Whereas in other specialties, you do have to take responsibility but it may have consequences in two weeks. You may have a little bit of time, it's a little bit different.
>
> ——Focus Group 1

In addition to cultural differences between specialties with regard to definitions of professionalism, faculty identified the sometimes conflicted relationship that exists between different societal influences on the medical group: for example, between the public's notion of an ideal physician, the health care field's increasing focus on team work and multidisciplinary collaboration, and the economic structure of modern health care and research.

They pointed to the plethora of idealized television physician–heroes who are portrayed in ways that are far from the day-to-day experience of most physicians. One group talked about *House* (a popular and critically acclaimed U.S. medical television show), in which the abrasive, drug-addicted physician–hero plays an individualistic, cowboy role and places individual patient benefit before all other priorities, in contrast to the conservative, liability-conscious administration of the large teaching hospital where he works. One interviewee remarked,

> [*House*] is about a doctor who does many things we would consider unprofessional and yet I do think that there's a cultural context where certain people are given the purview to act this way [because] it reassures people of their technical ability . . . . I'm sure if you asked people . . . "Would you go to someone like *House*?" they would all say yes.
>
> ——Focus Group 2

Another participant reflected on how the doctor of *House* refuses in one episode to promote a new drug despite pressure from his hospital to do so, and contrasted this with the medical profession's complacency regarding its relationship with the pharmacological industry.

> I think the largest conflict of interest we have not managed as a profession is our relationship with the industry. And it is one of those things that the media has become well aware of, that more and more people are talking about . . . we really have to grapple with and have a coherent response.
>
> ——Focus Group 2

A gap exists between faculty members' real and ideal experience of teaching professionalism

A participant from Focus Group 1 remarked, "I don't think that there's a forum [where] people can discuss these things [and] they don't feel judged. I don't know how you do that; I'm sure it's not with staff people . . . . I don't think you can talk about the stuff that you've really screwed up."

This second major thematic category arose from participants' discussion of their current teaching and learning strategies as well as their perceptions of more desirable approaches. The category's two subthemes distinguished between faculty members' perceptions of how professionalism is learned and taught and the participants' ideas of how it should be taught. Discussion of the subthemes identified the teaching and learning that occur explicitly in the formal curriculum as well as the implicit learning and teaching inherent in the informal and hidden curricula. Participants also discussed the importance of integrated, context-specific teaching, encouragement of self-reflection on the part of both faculty and trainees, and a nonjudgmental teaching environment; see Table 2 for examples.

Faculty identified large-group didactic formats for specific discussion of institutional and legislative codes of professionalism as a current teaching method, but they saw a limited role for these approaches, feeling the real "meat of the matter" lay in role modeling and in

Table 2

Themes That Emerged From Qualitative Analysis of Five Faculty Focus Groups on the Subject of Faculty Teaching and Evaluation of Professionalism, and Perceived Need for Faculty Development, Faculty of Medicine, University of Toronto, 2006–2007

Theme or subtheme	Example or quotation
Theme: Professionalism is not a static concept	
Definition can be based on the group defining it	Codes of conduct, legal documents:
	• "Professionalism is defined contextually and it is changing constantly as a society, the world is evolving, etc."
	• "Regulated Health Professionals Act."
	• "College of Physicians and Surgeons."
	• "There are also legal definitions of what is professional and what isn't, again, which is only a part of it."
	Specific medical context/cultures:
	• "It becomes complicated if you're looking at multiprofessional evaluations . . . . Different professions will have a different sense of what professionalism is."
	Society, media, culture, religion, etc.:
	• "I do think that [professionalism] is culturally determined."
	• "The definition of what is professionally acceptable or unacceptable changes over time as the culture changes."
	• "I think that professionalism is defined contextually and it is changing constantly as society, the world, is evolving."
Definition can be based on moral or ethical frameworks	• "I think ethics and integrity are a big part of professionalism and having a caring approach to your patients."
	• "I simplistically refer to professionalism in two components. One is technical competence and the other is moral competence."
Definition can be based on specific behaviors	• "To me it has to do with following through, being on time . . . being reliable, turning over information appropriately . . . things that are not a function of knowledge or skill but are critical to making sure that things get done for the patient."
	• "For me professionalism is good behavior. It's the way we want doctors to behave . . . not just with patients but with students, with our colleagues."
Can define it by what it is not	• "The line in the sand tends to be a lot of 'let's codify it' in terms of the 'thou shalt nots.' The 'thou shalts' are tougher I think to quantify, to measure. We have a shared sense of what's the right thing to do, and a much a more articulated sense of what's the wrong thing to do."
Can define it based on values, qualities, or attitudes	• "It's the people who teach you, who mentor you, and probably some preconceived ideas of what the profession should be. You grow up on *Reader's Digest* or something and it's the farmer out there who dreams to become a doctor and then helps all the people and gets chickens in return. You think of things like that and so it's probably from your social experiences, possibly your family, and then I think the culture that you grew up in in the medical school, but I don't think it's explicit."
	• "Erik Erikson what he said, give me a child at 5 and I'll give you the man or the woman, so we're products of our upbringing as well. So what we bring from that as well."
	• "In the sense of what defines your identity; it's not how you dress necessarily, it's a collection of behaviors and responsibilities and attitudes."
It's hard to define because it's intangible	• "I think it's an abstract concept."
	• "In a way it's such a broad concept that it's hard to say anything about it without feeling like you must be leaving something out."
	• "I can't define pornography, but I know it when I see it."
	• "It's one of those things that when you sit in rounds and you talk about 'what is professionalism,' it's something, you know . . . it's very difficult to put into words."

(*Continues*)

Table 2
(*Continued*)

Theme or subtheme	Example or quotation
Theme: A gap exists between faculty's real and ideal experience of teaching professionalism	
Perceptions of how it is learned/taught	Formal curriculum:
	• "I mean there are some parts that you can teach—the rules, the huge violations you can teach, and it's worth teaching some of those things."
	Informal or hidden curriculum:
	• "You can have professional conversations on every single patient you see . . . . The idea is making what's implicit explicit."
	• "I think everyone of us could think of a doctor that we met in our training which would be, that's the kind of doctor I'd like to be."
	• "I definitely see the role modeling."
	• "It's probably an iterative process that is as much a part of the environment one's working in as what the person's bringing to the environment."
	• "You pick up on the style of whatever leader you're following at the time."
	It can't be taught:
	• "So to me those are kind of, I guess motherhood issues; that the idea of trying to teach somebody to do that, I mean, it just seems if you don't get that that's what you're supposed to do, there's no hope."
Ideas of how it should be taught	It should be integrated and context-specific:
	• "I think we need to bring it to [the] bedside and it will become relevant and meaningful."
	Through self-reflection:
	• "Teaching a concept of looking at yourself and who you are and asking those kinds of questions of yourself."
	Nonjudgmentally:
	• "I think it's that it's not in front of other people, that somehow what they convey is not I'm mad at you or I'm annoyed with you, it's more I want you to think about this a little bit."
	• "Maybe just discussing it, too. I don't think that there's a forum that people can discuss these things that they don't feel judged."
	• "They just want to see that we're as vulnerable as them. We don't have to have answers, but we're prepared to talk about it. There isn't a real easy comfort zone . . . but I think by talking about it and sharing some, 'yeah, I also grapple with this and I didn't know what to do, but this is what I did and these are my reasons.' They don't expect us to have answers because they're not really answers but just to show our humanity and also our vulnerability."
Theme: Unprofessionalism is a persistent problem	
Professionalism is not taught	Because it's hard to define:
	• "We don't have a language to label it, we don't have a clear construct to define it and therefore we don't have a good way of measuring when it's not working."
	• "I think it's because it's they are sort of gray areas. It's not well defined as wrong and right. So maybe we don't want to engage into a debate with people. We can easily say, 'Well, I'd agree with you . . .' Who's right?"
	Because of lack of time:
	• "There are so many other things to learn about, things like documentation and confidentiality. Those are technical things that we maybe don't spend enough time emphasizing to the medical trainees."
	Because it's not valued:
	• "Maybe if we valued it. Maybe there should be an award for the staff that is the best model of professionalism."
	• "The dept really has no incentive to actually encourage professionalism on the part of its staff and faculty unless there are problems with resident education or inappropriate behavior from a research standpoint."

(*Continues*)

Table 2
(*Continued*)

Theme or subtheme	Example or quotation
Institutional and personal tolerance and silence	Faculty feel powerless to act:
	• "We recommended at the evaluation meeting that that person would not get a passing mark and that person graduated."
	• "I think we do not police ourselves and that's why, I mean this stuff will happen anyways, but I think we're not very good at putting an end to it when it happens. And I think we need to own that. And I'm as guilty as the next person. I grumble in the corners but don't do anything about it because I don't feel like I have enough power say or whatever."
	Disincentives exist:
	• "I think another reason is if you start pointing fingers you might be scared that people might start becoming more critical of you and start pointing fingers at everything you do wrong."
	• "I don't want to create a big conflict that will make our future working together more difficult than it is."
	• "I don't think I would feel skilled enough to make a correction, but if I felt strongly about it I would speak up about it."
	• "How do you interact with a colleague who is taking advantage of you? How do you work out conflict?... How do you deal with a staff person who has been horrible to you in a public setting . . . we never, ever, ever talk about it."
	Insufficient observations to make judgments:
	• "It's hard to monitor what your colleagues are saying to patients. I don't know who's going to have oversight over that. So again only the most egregious breaches rise to surface."
	Other:
	• "I think that sometimes the head of the department ... the boss, it's their job to take this up. It's not my responsibility."
Stress	• "Highly stressful environment leads to people with less experience to decompensate and that just leads to breaches in professionalism."
	• "People's characters under stress lead to unprofessional behavior ... certain stresses act in ways that they may or may not have insight into."
	• "I see it in the ICU quite frequently. If there's going to be problems they come to light typically in my experience in the ICU or operating room. Rarely do these things come to light just with daily ward activities."
Personality or character issues (individuals and mentors)	Insight and awareness of behavior:
	• "I think that a lot of the motivations for unprofessional behavior are actually unconscious. I don't think that most people who act in unprofessional ways think to themselves, 'I'm acting unprofessionally.'"
	• "Those people with the least amount of professional behavior . . . have the least amount of insight into their problem. So if you're trying to teach them they need to have to have insight. Hard to teach them that because they don't think they don't have insight."
	• "I think it can arise in a vacuum of modeling where they just don't get to see it. I think it can be quite inadvertent for some people; that they just don't know or they're not tuned in to the impact of their behaviors."
	Character deficiencies:
	• "The other I think is deficit. And the implication of deficit is it ain't fixable. There's a hole there. There's a hole there, can't be taught, can't be treated. And those people exist. They're the most painful ones to deal with."
	• "But there is a fourth group that are those that I think have an even more serious and dangerous disorder, which are the ones that are aware and they're not distressed, and they don't have deficit, but they do things because they feel can get away with it."

the hidden and informal curricula. As one participant put it,

> Virtually nothing is learned in lecture halls . . . it's about teachers and leaders modeling behavior, they [trainees] learn by observing. [Medicine] is still—no matter what technology we bring into teaching—an apprenticeship, and in the absence of modeling appropriate behavior, we can talk up the wazoo about professionalism, [but] it means nothing.
>
> ——Focus Group 5

Another participant referred to role modeling having both a positive and negative impact:

> If I'm having a patch where I'm feeling turned off and bitter and I'm making sarcastic comments, I notice that the housestaff team will pick up on that and they'll start behaving that way and it always sort of catches me up that I've got to turn this around or nobody's going to want to see us coming.
>
> ——Focus Group 1

Faculty felt that for education in this area to be relevant and meaningful for trainees, it needed to be integrated into the day-to-day fabric of their clinical lives. One faculty commented,

> I think it's one of those concepts everyone agrees is very important but when you are studying for your boards maybe you skip the seminar on professionalism . . . it somehow needs to be incorporated into the training experience so that it feels more immediate and salient.
>
> ——Focus Group 2

Self-reflection and nonjudgmental teaching environments were both identified as desirable. As one participant put it,

> What we don't do enough of is expose our own ignorance, our own vulnerabilities, and our own conflicts around these sorts of things which can open the doors for trainees to be talking about similar sorts of things.
>
> ——Focus Group 2

"Unprofessionalism" is a persistent problem

The final theme can be seen in a quote from Focus Group 5, where one participant noted, "I doubt that there's a single physician that hasn't been characterized by a patient, a colleague or [someone] as having behaved unprofessionally in a given circumstance."

In all of the focus groups, the most heated discussions centered on the third thematic category—the persistence of "unprofessionalism"—and the reasons for this persistence. Minor to moderate lapses in professionalism were perceived as widespread among faculty and trainees. One participant in Focus Group 3 went so far as to say, "I've experienced a lot of issues related to poor professionalism on the part of the residents . . . . I am constantly disappointed because of professionalism issues."

Specific examples given of these types of lapses on the part of both trainees and faculty were failing to change voicemail to alert patients and colleagues to absences, constant lateness, failure to arrange coverage for absences, issues related to appropriate dress, lying about holiday time, lying about work that has been done or not done, making negative comments in front of students regarding colleagues or patients, trainees refusing to see patients referred from the emergency room, financial conflicts of interest for faculty related to relationships with the pharmaceutical industry, and the use of medical interventions for financial gain rather than as a response to clinical indications. The majority of such lapses were perceived to be related to stress, inexperience, poor role modeling, and institutional tolerance; that is, they involved otherwise "good" people in difficult situations where the explicit and implicit rules for behavior did not always cohere.

Four major subthemes emerged that faculty identified as explanatory regarding the persistence of unprofessionalism. These were the fact that professionalism is not taught; institutional and personal tolerance and silence regarding unprofessionalism; stress; and individual lack of insight and character deficits (Table 2).

Faculty members' perception that professionalism itself is not well taught derived from their identification of difficulties related to its definition and from lack of time given to it in the curriculum and in faculty members' clinical teaching allotments for teaching and discussion of both professionalism and "unprofessionalism," as well as from faculty members' sense that their departments and educational institutions did not truly value professionalism, let alone its teaching. As one participant stated,

> We aren't evaluated as faculty and kept on as faculty because of our professionalism. I know several faculty members that come to mind who are valued for their publications and contributions who are distinctly unprofessional. And everyone recognizes it, but it's okay because they've done all these other things.
>
> ——Focus Group 3

Participants identified a second explanatory theme as perceived institutional and faculty tolerance of and silence regarding unprofessional attitudes and behaviors among faculty, resulting in poor role modeling for trainees. Faculty identified several potential reasons for this tolerance and silence, including their own perceived lack of power within their institutions, disincentives such as time, paperwork, and fears of repercussion, inadequate feedback skills on their own part, lack of a remediation and support network once unprofessional behavior was identified, and, finally, lack of confidence in their own judgment. The theme of faculty feeling powerless arose in every focus group and was particularly discouraging for the participants. As one expressed it,

> If there is a really extreme example then it would probably be identified, although maybe not. But there are lots of kind of borderline things that are happening from day to day and nobody feels that they are in the position of strength to say, "What you just did was wrong, and let me tell you why and how you're going to improve that."
>
> ——Focus Group 1

Faculty identified stress as the third contributing factor to physician unprofessionalism. As one participant put it,

> I think [when good residents have unprofessional behavior] they're often acting out, because they are stressed and they're just under too much pressure.
>
> ——Focus Group 1

Faculty pointed to certain environments as likely to elicit stress and its perceived corollary of greater vulnerability to professional lapses, such as the operating room, the emergency room, and being on call. Participants also reflected on the impact of relative inexperience as well as

environment on the relationship between stress and unprofessionalism:

> I think that a lot of us could manage our emotions and manage our interactions with others when there are no distractions. We can focus on just being polite and just managing. But as soon as there's some additional stressor, the ability to do that drops off significantly.
>
> ——Focus Group 3

The fourth theme explaining the persistence of a different type of unprofessionalism, consisting of major lapses, related to an individual trainee or faculty member's character deficits. In all five focus groups, participants distinguished between two types of professionalism problems: minor unprofessional behaviors that are harder to define but are potentially remediable versus behaviors that are easy to define as unprofessional but are more likely to be irremediable. One participant stated,

> It's easy to identify the egregious unprofessional behavior. It's the more subtle ones that [are] . . . more difficult to get a handle on.
>
> ——Focus Group 3

Participants saw these egregious or criminal behaviors as rare, easily recognizable, but not easily remediable. They were largely perceived as characterological issues rather than related to discrete lapses in professional judgment. Interestingly, because of their rarity, ease of recognition, and the fact that there are systems in place for dealing with such lapses, most participants were not unduly troubled at the prospect of addressing them in their own practice and teaching.

Discussion

To our knowledge, our study is unique in its content and adds importantly to the field of medical education as it is a descriptive analysis of faculty members' beliefs about teaching and evaluating professionalism. The study has several methodological strengths. Although there were only 14 participants, they constituted five separate focus groups, consisting of representation from diverse clinical departments, and our dataset consisted of 188 pages of textual material for analysis. Qualitative interviewing methods lend themselves to smaller sampling opportunities given the depth of questioning they permit, and, indeed, our major themes were consistent across all focus groups, suggesting theoretical saturation. Although the majority of our participants were specialists, they are all involved in teaching at both the undergraduate level (i.e., involved with a generalized approach to medical education) and at the postgraduate level. Moreover, many of them described a specific interest in education related to professionalism, which may challenge the perception that this topic is of interest primarily to primary care physicians.

We conducted the classic qualitative method of focus groups as it has been described by others,[43,46] and, using this method, we were able to achieve saturation of themes and ideas. Descriptive validity and the readers' experience of the study population's language and perspective were preserved by presenting direct quotes (lowest inference descriptors) from transcripts. This decreases the risk that we have imposed our own interpretation of participants' comments on the reader. Interpretative validity was optimized and researcher bias was minimized by negative case sampling, a method in which investigators purposefully and iteratively search for findings discordant with expectations and the developing theoretical framework.[46]

Our results are informative for those interested in faculty development in this area, both in terms of what faculty believe may be useful and feasible initiatives, particularly with regard to the need for more static and practical definitions for professional behavior, and also with regard to the limits that faculty development can achieve in environments where faculty see themselves as powerless in the face of professional, departmental, and institutional apathy.

Faculty expressed themselves as thirsty for an approach to defining professionalism that encompasses its nonstatic nature. That approach should acknowledge the conflicts that can emerge between what individual patients want from a physician and what "society" wants, a gap supported by a recent study by Boudreau et al[47]; it should also acknowledge the conflicts that can occur between definitions from different groups of physicians based on their specific relationship networks and their clinical and financial contexts.[48]

Institutional failures both to recognize exemplary professionalism and to confront unprofessional behaviors were consistently seen as undermining faculty efforts. Perhaps more important, all groups identified that faculty members' own lapses in professionalism and their failure to address these with one another posed the greatest barrier to teaching professionalism to trainees, given a perceived dominance of role modeling as its most influential teaching tool. From this perspective, faculty defined themselves and their colleagues as teaching faculty members' own worst enemies.

It is surprising that a group of academic physicians—respected by their patients, trainees, and colleagues for their participation in teaching and research at one of Canada's premier medical faculties—view themselves as powerless to confront colleagues whom they perceive to be behaving unprofessionally. Given the existing literature on the importance of retaining and promoting clinician educators in addition to clinician researchers in our academic medical centers[49,50] and the high risk to faculty retention posed by a lack of communication with institutional leaders or an effective voice in governance,[51] our findings are both informative and a source for concern.

This research supports a perception among faculty that the professional and educational culture has failed to provide our clinician teachers and educators with clear, practical approaches to articulating standards for professional behavior in the face of multiple perspectives and interpretations. Faculty identify that this multiplicity of definitions can result not only in conflicts of values but in conflicts between definitions. In addition, faculty see a lack of concrete institutional supports that would facilitate their own adherence to, as well as their teaching and evaluation of, professional behavior, however defined.

As a result of these failures, faculty perceive themselves and their colleagues as colluding to create a culture in medical education of permissiveness and nonconfrontation around minor to moderate lapses in professionalism. This

culture, if not addressed, will result in a larger failure to educate and inspire future generations of physicians to support one another in collaborative reflection and the amelioration of their own and others' inevitable lapses in professionalism. Such a failure, in turn, will serve as a barrier to the open, nonblaming culture seen as necessary for rigorous investigation of the causes of medical error.[52,53] If minor to moderate lapses in professionalism are either covered up or treated as solely the province of the profession's outliers, the corollary is that their probable impact on team function, delivery of patient care, and patient safety will not be explored or addressed.

Our study has several limitations. First, it was conducted at a single center located in an urban, academic setting, so the findings may not be fully generalizable across all cultural and socioeconomic communities. Second, the focus-group facilitators were known to the study participants, which may have introduced bias; however, given the richness and honesty of the discourse, we feel that participants felt unencumbered to discuss issues freely, including those of a personal or sensitive nature. Third, as noted, recruitment for the study was difficult, ostensibly because of geography and scheduling conflicts, and the number of participants was lower than we had initially anticipated. It is therefore possible that our participants represent a minority of medical teachers who do ascribe primary importance to this area. The overrepresentation of female clinical teachers, particularly from surgery, in our focus groups also raises interesting questions regarding women faculty members' specific interest in professionalism.

In conclusion, our research supports the recommendation that any faculty development interventions that hope to change our current culture of teaching and evaluating professionalism will need to promote greater identification, discussion, and remediation of our own, our colleagues', and our trainees' minor to moderate lapses in professionalism. Such interventions will require a collegial, supportive, and open environment that promotes both self- and group reflections on these complex and difficult matters.[40] In addition, such interventions will need to engage faculty in identifying the societal, professional, and institutional cultures in which they and their learners train and practice, and the influence of these cultures on our definitions of professionalism.

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