MEDICINE AND SOCIETY

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Responding to Unprofessional Behavior by Trainees — A "Just Culture" Framework

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Though widely recognized as a core competency for physicians, "professionalism" is a complex and variously defined concept. It has been considered a virtue, a set of skills, or a pattern of behavior, and best practices for teaching it in the classroom and clinic remain contested.[1,2] In fact, increased attention to teaching professionalism over the past two decades has arguably only amplified its complexity, while comparatively little attention has been paid to developing practical strategies for remediating less-than-professional behavior. Addressing lapses in professionalism is critical to professional development. Yet characterizing the ways in which the behavior of emerging professionals may fall short and responding to those behaviors remain difficult.

Catherine Lucey suggests that we "consider professionalism lapses to be either analogous to or a form of medical error," in order to create "a 'just environment' in which people are encouraged to report professionalism challenges, lapses, and near misses."[3] Applying a framework of medical error promotes an understanding of professionalism as a set of skills whose acquisition requires a psychologically safe learning environment.[3,4] Lucey and Souba also note that professionalism sometimes requires one to act counter to one's other interests and motivations (e.g., to subordinate one's own interests to those of others); the skills required to navigate such dilemmas must be acquired over time, and therefore trainees' behavior will inevitably sometimes fall short.[4]

We believe that lapses in professional behavior can be addressed productively if we view them through this lens of medical error, drawing on "just culture" principles and related procedural approaches.[5] Repurposing these concepts can help medical educators promote a formative learning environment while fairly and rigorously addressing problematic behaviors.

THE COMPLEXITY OF MEDICAL PROFESSIONALISM

Even as discussions of medical professionalism have rendered its definition more diffuse, threats of deprofessionalization of medicine make this matter more pressing.[2,6] Professionalism is not only a matter of individual character or action, but simultaneously a function of systemic factors in the learning environment.[7-9] It traverses the formal curriculum and spills into our hallways, cafeterias, lounges, and offices.[10,11]

Since 1999, professionalism has been formally considered a medical education competency by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties; in 2013, the Association of American Medical Colleges adopted related professionalism competencies.[12,13] Given the lack of a universally accepted definition of the concept, however, it is not surprising that assessing lapses in professional behavior remains challenging. Medical educators' implicit "We know it when we see it" approach often captures only the more egregious lapses, leaving less serious but still substandard behaviors inconsistently addressed.[3]

As emerging professionals, medical trainees by definition fall short of the expected standards of their future profession. To promote their development, educators' responses to shortfalls must walk a fine line between formative feedback and punitive consequences. Yet faculty report discomfort with identifying and responding to unprofessional behavior, so that task is often delegated to particular faculty members or administrators and quarantined within the academic

program.[14,15] Remediation approaches vary widely among institutions.[14,16]

The challenges of addressing lapses derive from the difficulty of pinning down the concept's meaning. We struggle to specify fair levels of accountability for trainees who are not fully developed professionals, while considering how the broader learning environment may also play a role. Jha and colleagues draw on the "theory of planned behavior" to capture important components of professionalism, including attitude, norms, and perceived control.[17] That theory, however, relies on perspectives and beliefs that are relatively conscious, whereas lapses in professionalism often happen because of cognitive blind spots. Moreover, although perceived control over one's behavior is an important factor, the systemic influences on behavior also matter. A medical error framework rectifies both of these problems.[3,4]

Williams and Williams have outlined an "environmentally valid learning approach" in which assessment of professionalism has five key components: capacity, capability, readiness, action, and continuity.[18] They also encourage consideration of the ways in which the social environment might engender or reinforce a given behavior. A just culture framework supports similar considerations, but it also treats contextual features that contribute to a lapse in professionalism as an inherent part of the event. And it encourages taking greater care to cultivate a psychologically safe environment for professionalism assessment and remediation.

THE JUST CULTURE APPROACH

Thanks to a movement catalyzed by an Institute of Medicine report, error reduction has become a priority of health systems over the past two decades.[19] Their efforts have involved creating a "culture of psychological safety" that allows for open dialogue, dissent, and transparent reporting.[20] Early iterations involved "blame free" approaches, which have increasingly given way to an emphasis on balancing individual and system accountability.[21,22]

Drawing on these just culture principles, a popular approach for defining and responding to medical error recognizes the qualitative differences among inadvertent human error, at-risk behavior, and reckless behavior (the Institute for Safe Medication Practices also provides an excellent elaboration of these categories).[5,23]

"Inadvertent human errors" result from suboptimal individual functioning, but without intention or the knowledge that a behavior is wrong or error-prone (e.g., an anesthesiologist inadvertently grabbing a paralyzing agent instead of a reversal agent). These errors are not considered blameworthy, and proper response involves consolation and assessment of systemic changes to prevent them in the future.

"At-risk behavior" involves actors knowingly doing something inappropriate, but with a genuine though incorrect belief that the action is inconsequential or justifiable (e.g., a surgeon skips a preoperative time-out because she is running late and operates on the wrong limb). Despite the name, at-risk behaviors sometimes lead to actual errors with real harms and therefore warrant some individual accountability. Appropriate responses involve coaching in order to raise awareness about the purpose and significance of the rules violated.

"Reckless behaviors" involve a conscious disregard for protocols and procedures (e.g., an error results after a student unilaterally decides to perform a procedure without proper training or supervision). In response, it is important to institute disciplinary actions as a deterrent.

There are several algorithms that help differentiate error events into the categories described above.[24-26] However, they have in common sets of questions that assess the intention and knowledge of the actor and whether there were special circumstances surrounding the event itself, and they all entail consideration of the roles of both systemic factors and individual actors, promoting accountability at both levels.[21] Alberta Pedroja offers the most robust such framework, in which the analysis considers skill-based, rule-based, and knowledge-based contexts.[26] Corresponding questions include whether the staff had appropriate skills and relevant training; whether the risks were known; whether the rules were, or should have been, known; whether the expectations were clear; and whether there were relevant exceptional circumstances that justify or mitigate the violation. These questions suggest corresponding ways to interrogate lapses in professional behavior: Was the expectation clear to the trainee? Were there factors beyond the trainee's control? What were the trainee's inten-

Table 1. Adaptation of Terms from Just Culture to Situations of Unprofessional Behavior.*

Kind of Error or Lapse	Response	Examples
Medical error		
Inadvertent human error: an error, usually resulting from shortcomings of human cognition, that was unintended	Console	Error caused by forgetting a scheduled repositioning of a patient, or not hearing a patient call-button alarm
At-risk behavior: a knowing violation of a rule or procedure but with a good-faith belief that the violation is inconsequential	Coach	Error caused by failing to scan a patient's bedside barcode before delivering medication because the system often doesn't work correctly, or ignoring a medication dosage alert in the electronic medical record because such alerts pop up constantly
Reckless behavior: commission of an error out of intentional disregard for the rule or procedure, its consequences, or both	Discipline	Error caused by failing to complete a procedure because it is too time-consuming, or allowing a student or resident without sufficient training or experience to perform a procedure unsupervised
Lapse in professionalism		
No-fault suboptimality: a lapse caused largely by environmental factors, but that could have been handled better by the student	Affirm, support, advise	Lapse caused by or entailing student assuming that an order from faculty member or supervisor is valid, or student's alarm clock failing to go off after a power outage and student missing a mandatory class session
Nonegregious unprofessionalism: knowing engagement in an unprofessional behavior but with a reasonable and good-faith belief that the violation is minor or inconsequential	Remediate	Lapse entailing a student skipping a mandatory orientation session out of a belief that the material is redundant, repeatedly being late for lab sessions (citing traffic as the cause), or submitting a blank exam sheet for a mandatory, formative, or diagnostic evaluation
Egregious unprofessionalism: knowing violation of a professionalism expectation without a reasonable claim or good-faith belief that the violation is minor or inconsequential	Discipline	Lapse entailing student who has completed HIPAA training logging into the medical record of a family friend, or student using a crib sheet during an exam

* HIPAA denotes Health Insurance Portability and Accountability Act.

tions? Did the trainee understand the consequences? Was there a genuine belief that the violation was inconsequential? The answers to these questions, in turn, lead us to varied responses ranging from formative to punitive.

A MEDICAL-ERROR MODEL

We can adapt the kinds of errors described above in a parallel way for lapses in professionalism (Table 1).[5,22] Consider the following case that arguably falls somewhere between "no-fault suboptimality" (i.e., inadvertent human error) and "nonegregious unprofessionalism" (i.e., at-risk behavior).

A medical student was instructed by her faculty research mentor to download a data set for analysis. The mentor assured her that the project constituted a quality-improvement study and did not need to be approved by the institutional review board (IRB). The research office instructed the student not to download the data until a formal excusal had been issued by the IRB, but the mentor insisted she begin right away, so she downloaded the data. When her action was observed by the data analyst, the student was reported for unprofessional conduct.

The difficult situation in which this student found herself might persuade many observers not to classify her action as a lapse in professionalism. But though she was clearly under pressure, the way the student responded was suboptimal, and applying principles of a just culture approach yields a helpful analysis. Certainly, the student was uncertain about the rule, given the contradictory instructions she received. She also appears to have had no intention of violating a research protocol, and she expressed contrition during a meeting about the event. Thus, the response focused primarily on consolation in the form of recognizing and affirming that she had been put in a tough situation. At the same time, the process offered an opportunity to coach the student about handling such conflicts, including

strategies for diplomatically addressing her mentor without being perceived as insubordinate. Another example allows us to consider how we might assess and respond to behaviors that are more squarely in the nonegregious unprofessionalism category.

Policy allows students to "check out" three pairs of surgical scrubs at a time from a dispensing machine. The medical school was notified that a student had "tricked" the machine into dispensing additional pairs by inserting towels into the machine in lieu of used scrubs. In a subsequent meeting, the student explained that a resident had unexpectedly asked him to observe a procedure but he had no surgical scrubs with him. He admitted knowing his action was wrong, but at the time he'd felt it was justified to avoid irritating his supervising resident and missing an educational opportunity. He also said he'd seen other residents and attendings do the same thing.

Health system leaders considered the student's actions a form of theft and had previously punished employees for such behavior. But a just culture framework suggests a more nuanced and formative approach. In this case, the student knowingly violated the rule, but he did so on the basis of a genuine, though mistaken, belief that the violation was both inconsequential and justifiable. The student's action thus called for coaching, particularly regarding the underlying reasons for the scrub policy, the loss-prevention efforts of the hospital, and alternative ways the student could have responded to the resident's request. The case also highlighted systemic issues, including potential policy modifications (e.g., allowing a small cash deposit on additional scrubs), as well as problems with role modeling in the learning environment. Although this case fits into the nonegregious unprofessionalism category, a repeat violation might warrant more serious consequences, because the student could no longer claim a good-faith belief that the violation was justified.

A final example illustrates a more serious lapse in professional behavior.

A patient reported that a rotating student had given him religious proselytizing material. After first denying the accusations, the student admitted doing so on several previous rotations, but he claimed he was unaware that it was unprofessional and against school policy. Several members of the professionalism committee found his claim of ignorance suspect, because he admitted that he had never distributed the religious material in front of his preceptor.

This is an especially daunting type of case because the facts necessary to adjudicate it are not entirely verifiable. It was true that school policy did not specifically prohibit proselytizing to patients — an omission that highlights a potential institutional issue. Certainly, intrusions like proselytizing clearly violate relatively obvious professional norms, yet the student also clearly believed that his actions were well-intentioned and harmless. One might, therefore, consider this a case of nonegregious unprofessionalism. However, the surreptitious way he went about distributing his religious tracts suggests some awareness that doing so was unprofessional or at least that his supervisor would disapprove.

Giving the student the benefit of the doubt, his superiors treated this situation as nonegregious unprofessionalism and coached him about navigating personal and professional boundaries and power differentials between physicians and patients. Some weeks later, the student was observed giving patients medically unsound advice about vaccinations and milk pasteurization, which he admitted were motivated by his religious convictions. Because the student could no longer claim ignorance of the expectations or genuine belief that the violation was inconsequential, it was addressed as egregious unprofessionalism and met with serious punitive consequences.

This final example underscores important aspects of a medical error approach to remediating lapses in professionalism. The complexities and ambiguities of individual cases cannot be completely alleviated by any algorithm. Disputed or unverifiable facts will always be challenging, and discussions of such fraught cases can become rather chaotic. But even where reasonable people might disagree, repurposing just culture principles and practices provides a common language and organizational architecture for these discussions.

Our approach to evaluating and remediating lapses in professionalism achieves several goals. It is broadly applicable to situations in which expectations of professional behavior are not met. It is grounded in shared values of medical educators with respect to the development of professionalism in trainees. It distinguishes help-

fully among kinds of lapses on the basis of relevant factors, including the trainee's knowledge of expectations, intentions, and foreseen consequences, and the influence of confounding systemic factors. And it promotes fairness in the evaluation process and consistency in the response, which are particularly important for avoiding accusations of faculty bias and trainee mistreatment. Although research is needed to validate the outcomes of using a medical error framework for addressing unprofessional behavior, the case analyses above suggest that it can help clarify an aspect of professional development that is as complex as it is vital to the profession.

Disclosure forms provided by the authors are available at NEJM.org.

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DOI: 10.1056/NEJMms1912591