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Article

A Framework for Understanding Lapses in Professionalism Among Medical Students: Applying the Theory of Planned Behavior to Fitness to Practice Cases

Vikram Jha, FRCOG, PhD, Susannah Brockbank, MRCP, and Trudie Roberts, FRCP, PhD

V. Jha is professor of medical education and head of undergraduate school, School of Medicine, University of Liverpool, Liverpool, United Kingdom.

S. Brockbank is a clinical teaching fellow, School of Medicine, University of Liverpool, Liverpool, United Kingdom.

T. Roberts is professor of medical education and director, Leeds Institute of Medical Education, University of Leeds, Leeds, United Kingdom.

Correspondence should be addressed to Vikram Jha, School of Medicine, University of Liverpool, Cedar House, Ashton Street, Liverpool L69 3GE, United Kingdom; telephone: +44151 794 8701; e-mail: medvj@liverpool.ac.uk.

Abstract

Fitness to practice decisions are often based on a student's digression from the regulations, with limited exploration of the reasoning behind the student's behavior. However, behavior is underpinned by complex, "hidden" variables, including an individual's attitudes and social norms. Examining hidden determinants of professionalism, such as context, interpersonal relationships, social norms, and local cultures, then allows medical educators to develop a richer understanding of unprofessional behavior.

In this article, the authors propose the use of the theory of planned behavior (TPB) as a framework to help evaluate unprofessional behavior in students. The TPB is a deliberative processing model that explains how an individual's behavior is underpinned by his or her cognitions, with behavior being primarily dependent on the intention to perform the behavior (behavioral intention). Intention, in turn, is determined by three variables: attitude, subjective norm, and perceived behavioral control.

To understand the practical use of the TPB, the authors present four complex, anonymized case studies in which they employed the TPB to help deal with serious professionalism lapses among medical students. The outcomes of these cases as well as the student and program director perspectives, all explained via the TPB variables, are presented. The strengths and limitations of the TBP are discussed.

Internationally, regulatory bodies dictate that graduating medical students' outcomes move beyond acquisition of knowledge and skills to include appropriate professional attitudes and behaviors,[1–5] requiring students not just to behave professionally but also to become professional.[6–8] The importance of recognizing lapses in professionalism early is borne out by studies showing unprofessional behavior by medical students predicts subsequent misconduct.[9–13] Consequently, teaching and assessing professionalism is gaining momentum globally,[14–17] with approaches varying among nations from consensus statements (e.g., United States and Canada)[5,18] to medical student licensure (e.g., Australia).[19,20] In the United Kingdom, the General Medical Council (GMC) provides guidance regarding sanctions for unprofessional behavior;[21] however, the use of this guidance is at the discretion of individual medical schools.

Numerous theoretical approaches have been adopted to study medical professionalism. A values, ethics, and morality approach positions professionalism as a product of an individual's ethical and moral standards; his or her humanistic qualities, including integrity and honesty; and his or her attributes, such as altruism and accountability.[22–24] A professional identity formation approach adopts the notion that feeling like a part of the medical community facilitates individuals becoming professional and ethical practitioners,[25,26] a theory supported by Hilton and Slotnick's description of professionalism.[6] A sociological perspective defines professionalism as a social contract requiring doctors to behave professionally to justify the trust that society places in them.[27] Finally, sociocognitive psychology utilizes the complex relationship between attitudes and behavior to explain professionalism lapses.[28,29]

When a student's fitness to practice (FTP) is called into question, educators undertake a complex decision-making process: collecting evidence, evaluating the nature and severity of the misconduct, and deciding whether to refer the student to an FTP panel. FTP panels make decisions based on the evidence, with students who are in breach of professional behavior being subject to sanctions ranging from formal warnings to expulsion from the program. Often these decisions are based on the student's digression from the regulations, with limited exploration of the reasoning behind the student's behavior.[30–32] However, behavior is underpinned by complex, "hidden" variables, including an individual's attitudes and social norms.[33] Examining hidden determinants of professionalism, such as context,[34,35] interpersonal relationships, social norms, and local cultures,[36–38] then allows us to develop a richer understanding of unprofessional behavior.[29,36]

Given this, there is a need for a theoretically driven framework to facilitate decision making among staff involved in FTP procedures. We propose the use of the theory of planned behavior (TPB) to help evaluate unprofessional behavior in students, which two of the authors (V.J., T.R.) have used in their own practice to study such behaviors and discuss possible reasons for them.

The TPB

The TPB[33] is widely used for studying behaviors in individuals[39,40] including health care providers' behaviors.[41] It is a deliberative processing model that explains how an individual's behavior is underpinned by his or her cognitions, with behavior being primarily dependent on the intention to perform the behavior (behavioral intention). The relationship between intention and actual behavior is not absolute, but intention may act as a proximal determinant

of behavior.[42] Intention, in turn, is determined by three variables: attitude, subjective norm, and perceived behavioral control (Figure 1).

Attitude reflects the degree to which an individual positively or negatively evaluates a behavior or favors performing the behavior. The evaluation comprises instrumental (is the behavior good or bad, desirable or undesirable) and experiential (is the behavior pleasant or unpleasant, useful or worthless) aspects. Attitude is a function of behavioral beliefs (performing the behavior will lead to consequences) and outcome beliefs (evaluation of those consequences).

The subjective norm comprises the degree of social pressure on an individual to engage in a behavior[41] and the degree to which salient people in the individual's life (such as family, friends, faculty) would approve or disapprove of the behavior. The subjective norm may be injunctive (what salient people in the individual's life think ought to be done) or descriptive (what salient people in the individual's life actually do). The subjective norm is a function of normative beliefs (perceptions of salient others' preferences about the behavior) and motivation to comply (the extent to which one wishes to comply with salient others' expectations).

Perceived behavioral control reflects an individual's perceptions of how easy or difficult it is to perform the behavior[43] and the individual's self-efficacy and control over the behavior. Perceived behavioral control is a function of control beliefs (whether one has the opportunity to perform the behavior successfully) and perceived power (the perception that certain factors have the power to facilitate or inhibit the completion of the behavior). According to the TPB,

the more favorable the attitude and subjective norm and the greater the perceived behavioral control, the stronger the individual's intention to perform the behavior will be.[33]

When examining professionalism, the TPB presents a unified approach,[28,29] bringing together several influences on professionalism described earlier: attitudes, moral and ethical values, and contextual and social interactions. It explores both factors that are under the direct control of the individual (e.g., beliefs and response to social influences) and factors that are not (e.g., resources and opportunities to perform behaviors).[33]

Application of the TPB

To understand the practical use of the TPB, we present four complex, anonymized case studies in which we employed the TPB to help us deal with serious professionalism lapses among medical students. The outcomes of the cases as well as the student and program director perspectives, all explained via the TPB variables, are presented.

Case 1

Student A, a second-year medical student, is asked to visit a family with two disabled children as part of her community placement. She submits her logbook with this visit signed off by the children's mother and a reflective essay describing her visit. Later, the year lead is surprised when the mother calls and asks why the student has not come to visit.

At a meeting with the program director, the student immediately admits to falsifying the logbook, saying it was a terrible mistake. She says she is an excellent student and challenges the decision to reprimand her for her behavior, claiming "everyone in [her] class does this." After all, the students know that no one looks at the logbooks in detail.

Student's perspective. The student probably felt that by immediately admitting to her misconduct she would demonstrate an appropriate attitude toward her behavior and escape sanctions. Her perception that other students forged logbooks but were never caught made her behavior the subjective norm. She felt getting activities signed off was sometimes difficult, making forging the signatures an easier option (control beliefs). Additionally, the student suspected that the logbooks were not properly scrutinized, making her decision to forge the entries easier (perceived power).

Program director's perspective. The student confirmed the behavior and behavioral intention but demonstrated a limited ability to evaluate the consequences of (outcome beliefs) of or consider how the medical school would view the behavior (normative beliefs). She failed to find the motivation to comply with GMC guidance.

Outcome. Student A was referred to an FTP panel for "[deliberately or recklessly disregarding] professional and clinical responsibilities;" "[behaving] dishonestly, fraudulently, or in a way designed to mislead or harm others;" and cheating.[1] Her FTP was found to be breached. She was suspended from her studies for a year and asked to work with disability teams, with faculty to develop an online guide on the implications of falsifying documents in medicine, and attend GMC FTP sessions to reflect on her attitude toward professionalism. She was asked to maintain an accurate log of activities and complete a portfolio of reflective work on these activities.

The student's claim that "everyone does it" was of concern. Was there a culture within the school that promoted fraudulent behavior? A review of the school's processes to discourage

such behavior showed systems, including a quarterly review by academic advisors, were in place to identify students struggling to complete their coursework. However, the review did find that the extent to which students were supported in their portfolio activities varied among advisors and that the number of activities that required sign off was excessive. The school has subsequently introduced an e-portfolio enabling activities to be signed off and monitored remotely, allowing struggling students to be offered timely support. In addition, the number of activities requiring sign offs has been reduced, allowing students to focus on their learning rather than paperwork.

Case 2

Student B, a first-year medical student, posts a video on his Facebook page portraying himself as a neo-Nazi with his friends as comrades, explicitly displaying racist and sexist views. The video attracts numerous comments from viewers, with student B contributing significantly with additional racist and sexist remarks.

During a meeting with the program director, student B appears embarrassed, immediately acknowledging his inappropriate behavior. He created the video for "a bit of fun" and, following its success on Facebook, carried on with the offensive discussion. He repeatedly states the video does not reflect his beliefs and he will accept the decision of the program director.

Student's perspective. The student confirmed his behavior and behavioral intention, admitting that he had acted without evaluating the consequences (outcome beliefs). He clearly had access to social media (control beliefs) and thought he would not be caught

(perceived power). He felt pleased by all the comments from his peers and continued to participate in the discussion (normative beliefs).

Program director's perspective. Demonstrating negative racist and sexist attitudes was unacceptable and thinking it was funny demonstrated a failure to consider the outcomes (behavioral beliefs) or evaluate the consequences (outcome beliefs). Afterward, however, the student demonstrated insight, projecting an appropriately negative attitude toward his behavior. He acknowledged that there was no peer pressure on him to behave the way he did (normative beliefs) and recognized that his behavior deserved punishment, appreciating the outcomes of his behavior and showing evidence that he had reflected on it.

Outcome. The GMC states "failure to keep appropriate boundaries in behaviour," including sexist and racist behavior, is unprofessional.[1] Given student B's remorse and demonstrated awareness of his projected attitude, he was allowed to continue his studies but received a formal warning from the dean that was kept in his records and advised to evaluate the consequences of his behavior carefully in future. The other students involved in the video were also issued formal warnings. Considering the role of normative beliefs in this professionalism lapse, the students involved in the video were asked to develop a teaching tool on the responsible use of social media, highlighting national guidance[44] and the university's policy on its use. To further address any underlying social norms that may still be prevalent in medical schools, student B's school has formal teachings on sexism and racism embedded within the curriculum, as well as awareness-raising workshops run by the Lesbian, Gay, Bisexual, and Transgender society.

Case 3

Student C, a fourth-year medical student, goes to Uganda for his elective. He is excited when his hospital supervisors involve him in all types of clinical work. He sees patients with conditions that he has not seen before and cannot wait to share his experiences with his friends. He takes photographs of some of the patients and posts them on Facebook, boasting that he has performed minor procedures he would never be allowed to do back home. One of his colleagues informs the school of his posts.

At a meeting with the program director, the student expresses surprise at being summoned. When asked to reflect on his actions, he demonstrates some remorse for taking photographs of patients without their consent, but states he was "only trying to help" the busy doctors at the hospital. He admits he had not been trained to perform the procedures, although he had practiced them during his clinical skills sessions.

Student's perspective. The student probably felt that the school was being unfair in reprimanding him for helping busy doctors in Uganda. He expressed normative beliefs that were culturally nuanced by thinking that in Uganda, performing procedures without adequate training and breaching confidentiality might not be problematic. Moreover, the opportunity to practice skills and tell his friends were too good to forgo (control beliefs).

Program director's perspective. The student behaved unethically, performing procedures without appropriate competence, not recognizing his limitations, and posting patient photographs on social media without their consent. He demonstrated an inappropriate attitude toward confidentiality and informed consent (behavioral beliefs). His argument that he was helping out the local doctors was inappropriate because he had not adequately explored the

consequences (behavioral beliefs) or the outcomes of his behavior (outcome beliefs), such as harm to the patients and disrepute to his medical school.

Outcome. The student was referred to an FTP panel for "failure to keep appropriate boundaries in behaviour," breach of confidentiality, and acting beyond his abilities.[1] At his meeting with the FTP panel, the student took full responsibility for his actions and provided a mature account of his personal reflections on his behavior, demonstrating insight into and remorse for his actions. He had already written to apologize to the doctors in Uganda and the patients whose photographs he had used. He was allowed to continue his studies but was required to write a piece on the importance of patient confidentiality and a written warning was placed on his record.

This case highlighted to student C's school the importance of the accountability of medical schools in sending their students to host organizations and the ethical responsibility of the visiting students.[45] At student C's medical school, clear guidance on the need to behave professionally and not practice beyond their means is now given to students before they go to host organizations. Students are also asked to consider the cultural nuances of the host country and to be sensitive to cultural differences.

Case 4

Student D, in her final year, contacts the program director to confess to a previous misrepresentation of a drug-related conviction. She had previously reported the conviction after being caught at a music festival in possession of ecstasy tablets. However, she had failed to mention that she also had some cocaine, which was part of the conviction. On finding that she had to declare this to the GMC when applying for registration, she decided to make a full

confession. At an interview with the program director, she claims she was carrying the drugs for her boyfriend and did not previously confess to the cocaine part of the conviction as she was worried about being expelled. There is no evidence of personal drug use or other drug-related convictions.

Student's perspective. The student did not confess completely when she was first convicted; having evaluated the consequences of her behavior, she worried that if she gave a full confession she would be expelled (outcome beliefs). She had acted on behalf of her boyfriend (normative beliefs) and had motivation to comply with his request. She had not considered the consequences of carrying drugs (behavioral beliefs) nor the impact it would have throughout her career (outcome beliefs).

Program director's perspective. The student only admitted to possessing cocaine when she realized she had to declare convictions to the GMC. She had not weighed the consequences of a partial versus a full declaration to the school (outcome beliefs). Not only did she find it easy to carry the drugs (control beliefs), but by carrying the drugs for her boyfriend, she demonstrated her motivation to comply with a salient other. Furthermore, all students at her university were provided with professionalism teaching, which includes the potential consequences of criminal convictions (including drug possessions) and non-disclosure of such convictions; therefore, this behavior clearly demonstrated a lack of motivation to comply with such guidance.

Outcome. The student was referred to an FTP panel for "dealing, possessing or misusing drugs" and failing to make a full declaration of a criminal conviction.[1] Her FTP was found to be breached, although the offence had occurred some years previously, the panel did not feel

confident that she was currently fit to practice. She was suspended from studies for one year, during which she undertook a remedial program involving working with patients and caregivers who had suffered harm from doctors with addiction problems. She was asked to write an essay on why honesty was central to the work of a doctor.

A worked example

Table 1 presents Case 1 as a worked example to illustrate the application and utility of the TPB in the decision-making process, including sanctions and remediation, as well as how it was employed to analyze the school's culture with respect to fraudulent behavior.

Discussion

Though the challenge of defining medical professionalism has led to operational definitions focusing on behavior,[22,46,47] there is an emerging acknowledgment in the medical education community that studying attitudes is equally important.[48] The four cases we presented here contribute to the debate on decision making related to FTP in medicine through their use of the TPB to examine students' attitudes toward professionalism.

Strengths of the TPB

A strength of the TPB is that it enables behavioral determinants to be systematically examined, offering a method of standardizing FTP processes. It contextualizes behavior, accounting for factors such as cultural influences[36,37] and medical school environments (i.e., the hidden curriculum[49,50]). For example, student C behaved inappropriately in a different cultural context; while this may not mitigate his misconduct, it needs to be acknowledged as a determinant of this lapse in professionalism. As another example, student D had been informed about the consequences of drug possession but still behaved inappropriately,

possibly demonstrating an acceptance of such behavior among her peers. Exploring these normative beliefs in the context of students' professionalism lapses allows them to also be tackled at an institutional level, enhancing the development of professionalism across curricula.[16]

The TPB provides a framework for the analysis of apparent remorse and can help determine whether students are faking it (i.e., aligning their behavior with normative expectations).[29,51] For example, students A, B, and C all expressed remorse; however, student A challenged her referral to an FTP panel, whereas students B and C accepted the program director's decision without dispute.

Limitations of the TPB

The application of the TPB relies upon the assessment of beliefs and attitudes that are difficult to measure.[48] Identification of an attitudinal problem theoretically allows the development of a targeted remediation strategy; however, there is little evidence to support that such an intervention will lead to attitudinal change.[48] Returning to the concept of faking it,[51] the lack of such interventions provides the opportunity for a student to complete a remediation process, ostensibly having undergone an appropriate shift in attitude, without any substantive change.

Another limitation of the TPB is that it uses an individual's behavior as a proxy to analyze an organization's culture of professionalism. Given students' described respect for the medical hierarchy,[34] students may not report contextual factors that could be relevant to both the evaluation of the individual's lapse in professionalism and the school's hidden curriculum, thus limiting the generalizability of any findings.

Finally, the use of the TPB is only as good as the evidence collected. As the TPB does not inherently contain a system for collecting evidence, it relies on non-standardized systems of evidence collection. This is not an insurmountable obstacle: the application of psychological theory to the collection of such evidence has already been proposed.[29] A combined psychological-TPB theoretical framework is certainly within the realm of possibility.

Conclusion

The interpretation of medical student lapses in professionalism poses a challenge to medical schools' FTP panels. We propose that the TPB, with its inherent requirement for the incorporation of behavioral intention (via attitude, subjective norm, and perceived behavioral control) into FTP judgments, provides a framework to facilitate this process. The TPB is not the only theoretical framework that could be adopted, and it may not address all the subtle nuances of professionalism; however, by applying it to four complex examples of professionalism lapses among medical students, we have demonstrated how it could be used in this way.

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Figure Legend

Figure 1

Graphic representing the theory of planned behavior (TPB), a deliberative processing model that explains how an individual's behavior is underpinned by his or her cognitions, with behavior being primarily dependent on the intention to perform the behavior. Intention, in turn, is determined by three variables: attitude, subjective norm, and perceived behavioral control. The solid lines indicate how the TPB variables are related to intention and thus to behavior. The dashed line indicates the direct impact perceived behavioral control can exert on the behavioral outcome.