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Ethical issues in unprofessional behavior of residents who dispute dismissal: ten year analysis of case law in hospital-based specialties

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Abstract

Background Residents who do not internalize professional values may not be a good fit for their specialty and compromise the quality of their patient care. Research aimed at recognizing residents' shortcomings in professionalism may help to prevent future shortcomings towards patients. The aim of this study was to increase insight into residents' shortcomings in medical professionalism in light of professional values relevant within residency training.

Methods We analyzed all law cases from the Dutch national conciliation board from 2011 to 2020 on the unprofessional behaviors described.

Results During the period investigated, 61 dismissed residents challenged their dismissal. In 39 of 61 cases (64%), the program director named unprofessional behavior(s) as (one of the) reasons for dismissal. The most prevalent deficit of residents deemed unprofessional was poor self-awareness (80%); less prevalent deficits were: shortness of engagement and dishonest and disrespectful behavior (31% or less).

Conclusions We describe perceived unprofessional behavior in residency, which was not about exceptional or abominable behaviors. For the most part, these behaviors concerned the accumulation of remediation-resistant day-to-day underperformance, discrediting trust and professional reliability. This finding encourages dedicated longitudinal assessment of professionalism and fuels the ethical debate about required professional values in hospital care.

Keywords Education, Organizational ethics, Professional ethics, Professional-patient relationship, Regulatory issues, Unprofessional behavior

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Background

Most residents understand the cognitive basis of professionalism but are still in the process of internalizing its moral values. They engage in a process of personal development and socialization [1], increasingly demonstrating the behaviors expected of a professional [2–3]. However, which behaviors suit a professional under which circumstances is a matter of debate. There is no cultural consensus [4], and appropriate behaviors differ by specialty [5], situation and time [6–7]. At the very least, professional behavior must meet expectations, reflect normative principles, be adapted to the situation, and congruent with a well-intended motive [8–11].

Physicians behaving unprofessionally provide suboptimal care, and may have a negative impact on patients [12], leading to patients' complaints, [13–14] criminal, civil or board actions [15]. A pattern of unprofessional behavior in medical school has been shown to form a continuum with behavior in residency training and after postgraduate certification [16], and such a pattern is one of the few observable red flags for future serious wrongdoing [17].

Domains of unprofessional behavior associated with future disciplinary action were unreliability, irresponsibility, lack of self-improvement, inadaptability, poor initiative and poor (or lack of) motivation [18]. These domains, in addition to other shortcomings in interaction and integrity, were captured in a model derived from a literature review [19]: the Four I's model (introspection, involvement, interaction, and integrity). The model was initially tested in medical students [8], and later applied to General Practice residents in focus groups consisting of various medical education professionals [20]. The model describes and categorizes unprofessional behaviors [21], and fulfils a necessity, because patterns of these behaviors may be difficult to recognize, assess and address among the different specialties [22–25]. This is especially true when compared to the other CanMEDS competencies of the Physician framework of the Royal College of Physicians and Surgeons of Canada [26–27]. Categorizing resident behaviors within such a model provides a renewed perspective on what is considered professional and what is not, and could potentially help to identify, remediate and sanction unprofessional behavior among residents.

There is little research on residents dismissed due to unprofessional behavior. Most research focuses on residents needing remediation, using focus groups or program director surveys [28–37], though reasons to dismiss residents, especially regarding patterns of unprofessional behavior are seldom described in retrospective case studies [38–39].

We conducted a nationwide retrospective case study to examine evidence-based ethics of dismissed residents who challenged the program directors' dismissal decisions. We focused on unprofessional behavior using publicly available anonymized case law of residents who disputed their dismissal from residency before the Dutch conciliation board. In this article, we describe and classify unprofessional behavior that contributed to the program directors' decisions to dismiss the residents to elucidate which resident behavior had been perceived as unprofessional by program directors in hospital based specialties.

Methods

Data collection

Retrospectively, we studied the cases of the conciliation board of The Royal Dutch Medical Association (see below) primarily focusing on unprofessional behaviors regarding residency dismissal from 2011 to 2020, during which, full reports were publicly available. Furthermore, this period was unaffected by changes in medical education regulations, and possible irregularities related to COVID-19, which could contribute to the outcomes of our study.

Context and setting: postgraduate medical school

Dutch medical school graduates subsequently apply to a residency training program. Once selected, it takes on average, four to six years of training to be registered as a Dutch medical specialist, depending on the specialty [40]. On average, 6730 residents were in training annually from 2010 till 2020 [41]. Approximately 10% of these residents never graduate, for numerous reasons [42]. During the course of their training programmes, residents are assessed during progress reviews, the annual competence assessment and the final programme assessment [43]. Graduation as a medical specialist depends particularly on the resident's workplace-based assessments by supervisors. A decision on graduation is aggregated and triangulated by the program director. Every 3 to 6 months, the program director evaluates the performance of the resident during a formative progress review, and decides whether the resident may continue training, and what focus should be applied during the next consecutive training phase. If, after careful deliberation and consultation of the supervising staff members, the program director considers that the resident is inapt for training during the annual competence assessment, a formal remediation program of at least 3 and at most 6 months tailored to the needs of the resident usually follows. If this proves unsuccessful in remediation the resident, the director may decide to dismiss. After dismissal, the resident may request mediation from the hospital's centralized educators' committee. In case of unsuccessful local mediation, the resident might subsequently request national conciliation from the board of The Royal Dutch Medical Association (RGS KNMG) (see below).

Conciliation by the royal dutch medical association

The RGS (registration board of medical professions) of the KNMG (Royal Dutch Medical Association) installed an independent national conciliation board consisting of two legal professionals, a program director and a resident, both from different institutions. The conciliation board doesn't judge the aptitude for residency but considers whether the program director made a deliberate and careful decision. The conciliation board can decide to continue the training program in another institution with additional, more intensive assessments. The conciliation board's decision is binding on both parties. Nevertheless, the resident is entitled to continue legal action, although residents seldom do so. The decisions of the conciliation board are published in public annual reports online, and anonymized to respect the residents' privacy [44].

Data analysis

Quantitative data analysis

The first author selected all the national Dutch conciliation board decisions in the study period by: specialty, type of dispute (dismissal of residency), and litigants (program director versus resident). Descriptive statistics were calculated with Excel version 2202.

Qualitative data analysis

The first author scored all cases regarding deficiencies in the competency domains as described in the CanMEDS competency framework [26–27]. Cases for which the categorization was not directly evident were categorized by both the first and the second author, and in case of a discrepancy the cases were discussed among the research team members until consensus was reached. The previously described Four I's model (integrity, involvement, interaction and introspection) [20–21] was used as an additional scaffolding framework for categorizing unprofessional behaviors resulting in deficiencies in the professional or communicator competency domains. Most decisions described literally in which CanMEDS competency domain(s) the resident was considered insufficient. In other cases, the authors categorized the reported behaviors underlying the dismissal decision (e.g., lack of conversation skills regarded as insufficient communication, serious attitudinal concerns as insufficiently professional). The unprofessional behaviors of the resident were literally copied from the conciliation board's decisions.

Results

Data collection

Dismissed residents challenged the decision of the program director in 120 cases. We excluded residents who had been in training for non-hospital based specialties because their residencies differ in length, educational culture, and required competencies. We finally retained 61 cases of residents who had been in training for the following specialty groups: surgery, internal medicine, diagnostic specialties, and other hospital based specialties (Fig. 1). Of these 61 remaining cases, 39 dealt with unprofessional behavior.

Quantitative data analysis

The Board followed the program director´s decision in 52% of the (61) cases. Table 1 shows that more male residents performed insufficiently in the professional domain compared to other CanMEDS domains (44% vs. 32%). The percentage of males among all dismissed residents (39%) was in conformity with the mean percentage of males in training from 2011 to 2019 in these specialties in the Netherlands [41–42, 45], with an average of 4779 residents enrolled yearly. Dismissed residents performed insufficiently on multiple competency domains (with an average of 3.5). Thirty-nine (of 61; 64%) residents specifically failed to meet sub-competencies within the CanMEDS professional domain (Table 1). Most of these residents also failed on aspects in the domain of communicator (32 of 39; 82%). These deficits were most commonly communication problems with colleagues (29 of 61; 48%) and/or supervisors (22 of 61; 36%) and least commonly involved communication with patients (10 of 61; 16%). Among residents who failed in both domains, approximately half (42%) failed in the collaborator domain as well.

Qualitative data analysis

We further analyzed what motivated the program director to consider the resident's professional behavior and communication insufficient (Table 2). Poor self-awareness was the most prevalent category (31 of 39; 80%) of deficiency within the professional domain. Poor self-awareness was considered present in the inability to accept and profit from feedback, lack of insight into one's competence limitations, and limited or absence of self-reflection. A typical example of this was an unconsciously incompetent radiology resident who was unable to participate in shifts. Most of his supervisors were worried about his trainability and correctability. He informed his supervisors rather late, and he overestimated his expertise. After a confrontation with the staff's concerns about his competence, he lacked introspection and showed severe externalization, and anger without a sense of reality with regard to his situation. His supervisors had no trust in his ability to complete training within applicable norms and values because he had shown no sign of self-reflection (CB17-63279).

Poor self-awareness overlapped considerably (19 of 31; 61%) with other categories, such as failure to engage (31%), disrespectful behavior (28%), and dishonesty (21%). These categories were less commonly found and

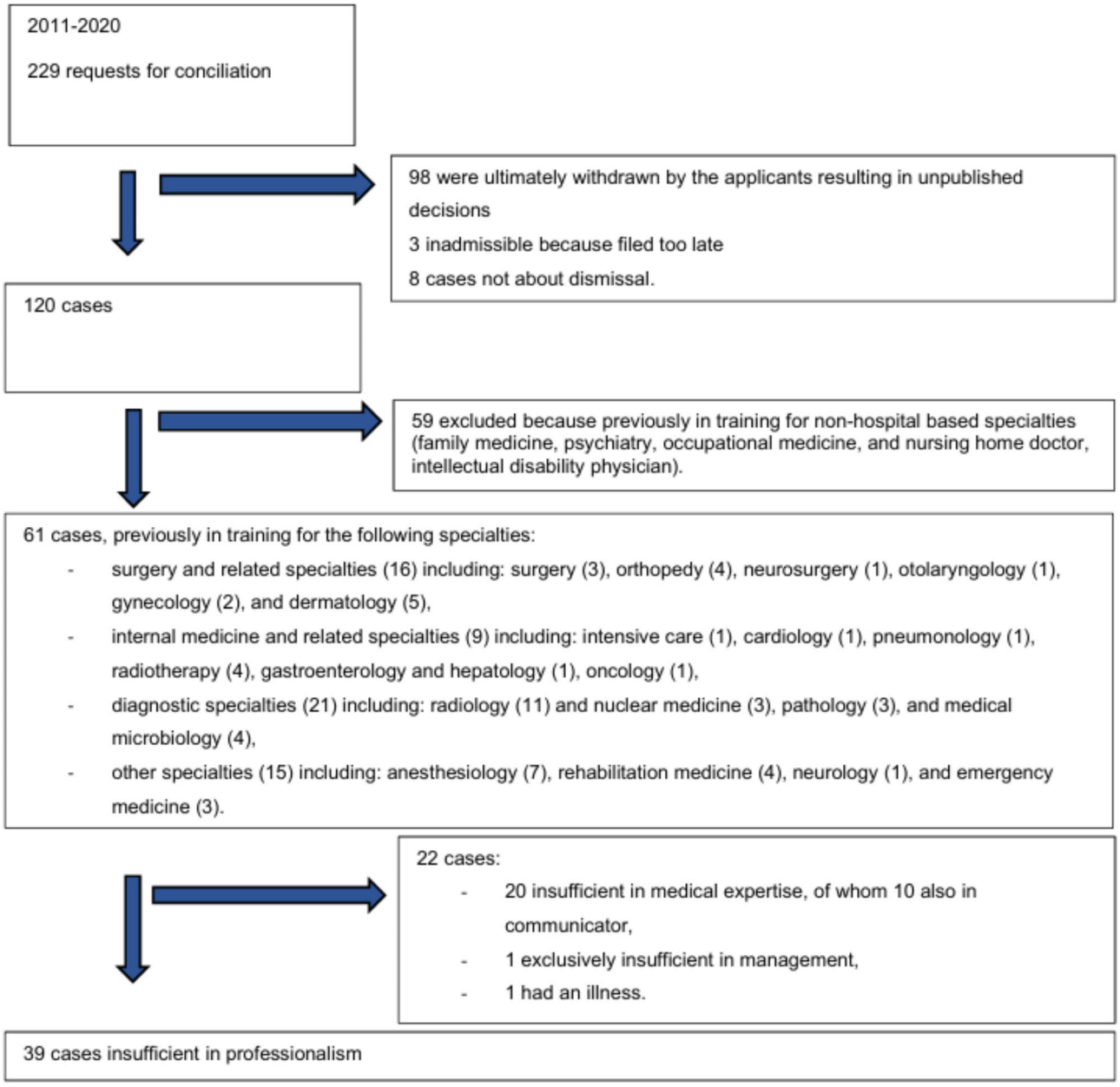

Fig. 1 Consort diagram

only half as prevalent as poor self-awareness. Many (18 of 39; 46%) dismissed residents suffered from shortcomings in at least two categories. Residents who failed to engage exhibited reduced participation in patient care, shift work, and educational activities. For example, a second-year resident in dermatology did not return patients' calls and insufficiently ensured the continuity of care. She copied medical information to patient records without adequate verification. According to her program director these behaviors suggested a lack of "authentic engagement" (CB12-63189). A third-year resident in rehabilitation medicine was not in charge of the patient's care regarding physical examination and collecting available medical information. Continuously, she behaved hesitantly, doubtfully and dependently on her supervisor, and she was unable to make complex treatment decisions herself (CB19-9).

Disrespectful behavior was related to interactional problems, resulting in conflicts. A sixth-year resident in gynecology had a disturbing attitude during meetings and a troublesome collaboration with colleagues, possibly resulting from her direct communication style, which she was unaware of despite frequent feedback (CB17-63282). Dishonest behavior included resume-fraud, lying, concealing incidents, and evasive responses regarding commitments. An example of this was a first-year resident in

Table 1 Competencies judged insufficient in dismissed residents ($n=61$) from: ethical issues in unprofessional behavior of residents who dispute dismissal: ten year analysis of case law in hospital-based specialties

	N	Male	Insufficiencies in CanMEDS competencies				
Deficiency in the competencies of…			**Communication**	**Collaboration**	**Management**	**Medical Expertise**	**Mean number of insufficient competencies**
Professionalism	39	44.0% (17)	82.1% (32)	35.9% (14)	61.5% (24)	84.6% (33)	4,2
Other competencies, but not professionalism	22	31.8% (7)	45.5% (10)	13.6% (3)	45.5% (10)	90.9% (20)	2,4
Total	61	39.3% (24)	67.2% (42)	27.9% (17)	55.7% (34)	86.9% (53)	3,5

Legend: cross table to show the number of residents (n) insufficient on professionalism, or not insufficient on professionalism (vertical), and the overlap of insufficiencies on other competencies (horizontal). Of the 39 residents with insufficiencies in professionalism 82.1% (32 residents) were judged insufficient on communication as well. Of the 22 residents without insufficiencies in professionalism 31.8% (7 residents) were male. $N=61$ cases with 60 different individual residents (one of them appealed, got another chance to remediate, was dismissed again and appealed again)

Table 2 Aspects of insufficient professionalism and communication ($n=42$) from: ethical issues in unprofessional behavior of residents who dispute dismissal: ten year analysis of case law in hospital-based specialties

Categories*	% (*n*)	Examples
Professional	**(39)**	
Failure to engage (involvement)	30.8 (12)	Absences, delays, unavailability when on call, insufficient preparation for consultations, shift work or education days
		Uncertain wait and see attitude
		Superficial interaction with peers and supervisors
Dishonest behavior (integrity)	20.5 (8)	Resumé fraud
		Concealing not honoring commitments
		Lying about medical actions that were or weren't carried out
		Concealing incidents
Disrespectful behavior (interaction)	28.2 (11)	Conflicts with staff (handling authority) and peers
		Disturbing attitude, annoyed or impolite
Poor-self-awareness (introspection)	79.5 (31)	Avoiding or externalizing feedback, unable to give or receive critiques, or recognize or profit from feedback
		Insufficient self-reflection or introspection
		Lacking insight in competence limitations
		Lacking in trainability, correctability or indulgence
Communicator	**(42)**	
Failure to engage in therapeutic relationships with patients and family	23.8 (10)	Lack of interpersonal skills, difficult, detached or stiff in contact, lack of structure, problems to tune into patients and imagine what it would be like for them, problems with observing and adequately naming non-verbal communication
Language problems	16.7 (7)	Understanding others, clarity and being understood, pronunciation, grammar errors and misspellings
Failure to accurately report relevant findings to others (oral or written)	40.5 (17)	Abruptness in communication with colleagues and supervisors, or frequent miscommunication and vagueness (when discharging patients) regularly not writing a discharge summary or daily progress notes for shift handovers

*Adopted from Vossen et al. 21

neurology, who immediately developed an administrative backlog, however when she was assessed on this, she assured the program director that she had made excellent progress, which was incorrect, damaging the program director's trust (CB12-63183).

Discussion

This nationwide in-depth study examines Dutch data on the unprofessional behaviors of residents dismissed from hospital specialty training programs from 2011 to 2020. In subsequent sections, the main general findings and the classification of resident behavior in the Four I's model (involvement, interaction, integrity, and introspection) will consecutively be discussed in the context of available literature, highlighting some critical ethical aspects.

General findings

61 residents appealed their program director's decision and requested conciliation. The general characteristics of our data correspond with the characteristics found

in other studies about residents with remediation needs [46]. Previous studies, program director surveys among specific specialties in the United States reported on dismissed residents with lapses in professional behavior from 1990 to 2018. Between 0.1% and 2.6% of these residents were dismissed, with a mean percentage of 0.6% [34, 38]. The present study revealed a dismissal percentage of 0.6%, comparable with the mean percentage found in the other studies. The current study brings forward three important findings.

First, according to the training program directors, approximately two-thirds of the 61 dismissed residents (64%) failed to meet the level of competence for the CanMEDS professional domain. Previous studies found a lower percentage of residents (in remediation) insufficient in the professional domain: from 41–51% [34, 38–39, 47–48]. Explanations might be that insufficiencies found in the current study were overrepresented in dismissed residents who appeal compared to studies about resident remediation. Program directors' sensitivity to unprofessional behavior and their competence to detect such behavior may have increased over time, especially in medical education and residency training in the Netherlands [49–54].

Second, poor self-awareness was the most prevalent characteristic of the reported and perceived unprofessional behaviors (80%). The current study is comprehensive in its scope, analyzing all available Dutch case law on dismissed residents with a wide range of specialties over a ten-year period. It shows the importance Dutch program directors place on developing self-awareness with reflection for residents.

Third, residents rarely exhibited insufficiencies solely in the professional domain. Most of them failed in the domain of communicator and/or medical expert (32 of 39; 82%) as well. Dismissed residents performed insufficiently in multiple competency domains, in conformity with the literature of residents on probation/remediation and dismissal [34–35, 38–39]. This highlights the importance of professionalism as a (meta)competence, a value that significantly connects to other important competencies [6] and is primarily expressed via the performance of other competencies [54]. Program directors were specifically able to name and describe the perceived shortcomings of professional behaviors in the residents, and the behaviors were verifiable and categorizable from case law with the help of the Four I's framework [20–21].

The Four I's model, trust and responsibility

To our knowledge, this is the first study in postgraduate medical education (other than general practice) that applied the Four I's model [20–21] containing introspection, involvement, interaction, and integrity. The remainder of this section is devoted to discussing unprofessional behavior from an ethical viewpoint, based on the Four I's [20–21], and the cornerstone concepts of medical professionalism: trust and responsibility [55].

Introspection or self-awareness

Residents lacking self-awareness were unable to improve through feedback and showed a pattern of avoiding, ignoring, or externalizing feedback and discarding responsibility. This pattern is problematic because medical specialists have institutional responsibility for the quality of care as a whole [9, 32, 56–57]. For example, as part of an integrated care chain, as chief of a multidisciplinary team, or as future residents' supervisor. Professionalism is, therefore, in part, a relational, social, collective, and institutional value [57–61]. During their socialization as medical professionals, residents have to show their supervisors that they can practice their specialty as accountable physicians and bear the appropriate trust and responsibilities. By the time they graduate, residents ideally have become role models who responsibly and consciously influence the therapeutic climate and the working atmosphere positively.

Self-awareness is specific to competence, context and moment in time [62] and demands an integrated perspective of self-consciousness and consciousness about how one is perceived by others. Residents who resist feedback and criticism of others, for example from supervisors, may lack insight into the limitations of their competence and continuously fall short in self-knowledge and humility [10] contrary to excellent physicians who use self-monitoring, self-reflection and critiques from others to improve competence, cure and care [63]. Diminished capacity for self-improvement in medical students is three times more likely to lead to disciplinary action by supervisory boards [16]. Lack of self-awareness may lead to unsatisfactory and unacceptable standards of care through insufficient self-reflection, self-improvement, and adjustment after feedback.

Promoting self-reflection is classically taught with the guidance of mentors to critically examine professional behavior, such as discussing critical incidents and difficult situations [64]. As part of moral consideration, reflection develops self-awareness about preconceptions, customs, values, and emotions. This means that ethical reflection does not necessarily have to be aimed at complicated issues in medical practice. Themes for moral consideration, therefore, do not have to be exotic, exceptional, or grandiose (such as end-of-life decisions and organ donation). Everyday clinical behavior is a subject matter of moral consideration as well. Residents regularly encounter ethical dilemmas, often resulting from conflicting values in day-to-day requirements [64], which enable them to deliberate about what accountability, integrity, and engagement mean in daily practice. Practicing medical

ethics is itself, thus, a form of reflection. Dilemma training provides a variety of contextual factors and promotes reflection with peers [65]. Such dilemma training promotes their professional identity and exposes residents' dysfunction to the training staff. Residents' progress and remediation needs could be tracked through longitudinal programmatic assessment of professionalism including repetitive dilemma training settings.

Involvement or engagement

Comparable to our result (31%), other studies found similar percentages (21-38%) of shortcomings in engagement (such as excessive and unexplained tardiness or absences) in residents needing remediation [29, 39, 47–48, 66]. Residents who fail to engage are often not involved enough in the care of their patients. Involvement concerns physical and emotional attendance and availability (for patients, colleagues, and staff). This concerns reliability and responsibility for distributed tasks and shifts [10]. Involvement means dedication to patients, including things like ownership or coordination of patient care: knowing who's going to be taking care of the patient and being a part of it [11]. The issue of responsibility is at stake here. Responsibility is not an ethical principle but involves a relational commitment rooted in concrete practices, more specifically, regarding patient care, responsibility concerns at least three elements [67–68]. First, residents must be willing to accept the responsibility for others (patients, families) whom they have never met. Second, these patients are in need and dependent upon the ability and capacity of the medical professional (in training) to help and organize the required care. Third, and related to this, is the responsive character of this responsibility; medical professionals are obliged to help because they know how to help (knowledge, skills, experience) and others do not. Passivity and lack of motivation are related significantly to disciplinary actions of state boards [18]. The dismissed residents with a lack of involvement studied in the study showed a pattern of absence from activities in which they were expected to participate, unavailability when on-call, and lack of ownership for organizing patient care. Shortcomings revealed in such situations can be important signals for a pattern of unprofessional behavior to be discussed, initially with clinical supervisors and subsequently by program directors with residents in progress meetings.

Interaction or communication and collaboration

Interaction problems (28% of the deficient sub-competencies of professionalism), such as problems with communication and collaboration, involved insensitivity to the needs of others or conflicts. Conflicts may arise in interprofessional relations because of organizational hierarchy or dependency on other professionals [11]. The most commonly reported unprofessional behaviors in the literature were shortcomings in interaction or respect. Those behaviors were present in 23–60% of the residents studied needing remediation [29, 34, 48, 66, 69–72]. Residents with difficulties in patient interactions might also fall short in interpersonal skills, and the ability to tune into patients and imagine what care would be like from their perspective. They might lack a professional demeanor with sufficient sensitivity, empathy, or compassion [10].

Integrity or honesty

The percentage of residents that displayed dishonest behaviors found in the current study (21%) is comparable with percentages (15-31%) found in other studies of residents needing remediation due to shortcomings in integrity (dishonesty/classical unethical behaviors) [29, 37, 39, 48, 66, 72]. Dishonesty is especially problematic among residents because it undermines trust in both the professional and the profession. Dishonesty was the most robust predictor (OR 3.23) for dismissal from neurosurgery in a group of residents who needed remediation [37]. Other unprofessional behaviors in the literature pertain to issues with boundaries, privacy, and record-keeping [39]. Such unethical behavior seriously damages the trust relationship, the trustworthiness of the resident, and his or her professional integrity. This may lead to serious questions about the professionalism of the particular resident, and patterns of such behavior during residency need to be recognized and studied.

Residents and their supervisors are inevitably involved in a relationship of trust. Conceptually, relationships of trust share common characteristics [73–74]. Trust implies a position of vulnerability. A supervisor of a residency program enters a relationship with a trustee– a resident– believing that this trustee will successfully pursue residency training and develop as a medical professional within the CanMEDS framework and EPAs (Entrustable Professional Activities) [75–76]. Both the supervisor and the resident assume that the other has 'good will' and will not act to undermine that trust. In other words, trust is accepted vulnerability to another's possible, but not expected, lack of good will [74]. Since trust cannot be demanded, it must be freely given, and has an element of voluntariness. The relationship of trust comes about voluntarily. These characteristics highlight the moral underpinnings of trust and show that at its core, residency training is a moral enterprise.

Strengths and limitations

The present study includes all appealed cases of dismissed residents– nationwide– before the conciliation board over ten years. The transparency of decisions required for legal certainty illuminates well-documented

performance shortcomings of residents in litigation, reporting the judgments of program directors involved in these disputes and preventing memory bias possibly present in previous focus group and survey studies. However, due to privacy protection regulations, the numbers of all dismissed or remediated residents per specialty are unavailable, making it difficult to estimate selection bias. Some residents may not have disputed their dismissal; those cases were thus not included in this study. The cases in our study are, an anonymized selection of those that challenged the program directors' decision. That makes these cases interesting to study because they might represent a group of unconsciously incompetent residents [77].

We use data on a mixed sample of residents, just like previous studies from Canada [39] and Denmark [36]. In contrast, others used data from a United States program director surveys of a single specialty, such as pediatrics [34], internal medicine [38, 66], emergency medicine [35], pathology [48], neurology [47], and surgery [67, 69–72, 78], including neurosurgery [37], otolaryngology [29], and gynecology [33]. We lack cases of pediatrics, ophthalmology, rheumatology, clinical genetics, geriatrics, plastic surgery, thoracic surgery, and urology, as none of those residents received an appeal decision from the conciliation board during the study period. We can only speculate about the reasons for this, which is outside the scope of the current study.

Implications for practice and future research

The results of the present study have several implications for research and practice. First, the present study illustrates common unacceptable breaches of professionalism by residents from the perspective of program directors. Consensus among clinical supervisors must be reached about behavioral norms and the lower limits of what is acceptable regarding professional functioning, to be able to effectively identify, signal, and address unprofessional behaviors among medical professionals. Secondly, clinical supervisors must discuss minor lapses of professionalism in residents, as a subgroup of residents has minor shortcomings when reports are considered in isolation; however, when triangulating data during the residency, they aggregate an overall picture that emerges, presenting unacceptable patterns of unprofessional behaviors that thus might have remained unnoticed easily. Third, by bringing these strategies into practice, hospitals, residency training programs, and their supervisors are made aware of the necessity, and stimulated to reflect more on their ability to detect and remediate residents with unprofessional behaviors, ultimately learning from these prior cases specifically, and indirectly improving professional assessment and the quality of patient care in general.

Longitudinal follow-up of dismissed residents who change specialty may provide additional information on the existence (or absence) of specialty-specific (un) professional behavior. Such longitudinal follow-up provides information for optimizing residents' remediation, matching, and transfer to alternative positions as a physician. When hospitals facilitate the resident's transfer to non-hospital-based specialties, this might be an opportunity to develop competencies to overcome previous deficiencies and explore better-fit positions for the individual physicians while also retaining these physicians for health care service in general. Future research on the unprofessional behavior of residents should include dismissed and successfully remediated residents from other European and non-European, non-North American countries because previous research was predominantly performed in North America. Research and education directed at the role, relevance, and promotion of self-reflection in residency training would likewise contribute to preventing unprofessional behavior, for example, using longitudinal programmatic assessment of professionalism, including, e.g., dilemma training focusing on aspects of medical ethics and moral aspects of professional behavior.

Conclusion

This study presents unique insights into program directors' reasons for dismissing residents with patterns of unprofessional behavior. Residents, judged by their program directors as unprofessional, were most often considered to lack self-awareness (most prevalent characteristic, 80%) and less often to fail to engage (31%) or display dishonest and disrespectful behavior (21%). These reasons describe the value program directors attach to reflection as a part of professionalism. Residents' dismissal was not about big moral issues but an accumulation of remediation-resistant underperformance, discrediting trust and professional reliability. Residency training should provide measures to promptly recognize such patterns of unprofessional behavior and underperformance in the practice of hospital care.

Author contributions

JG and WvM designed the research, JG and SP collected and coded the data. All researchers analyzed and interpreted the data. JG wrote the first draft, WvM assisted writing and revising the manuscript, GO wrote the second draft. SP and RtH critically revised the manuscript. All authors reviewed and approved the final manuscript.

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Data availability

All data was anonymized by The Royal Dutch Conciliation Board before published publicly available online: https://www.knmg.nl/opleiding-herregistratie-carriere/rgs/wat-doet-de-rgs/bezwaar-beroep-en-geschil/geschillencommissie-geschillenprocedure/uitspraken-en-jaarverslagen-geschillencommissie.htm#Jaarverslagen_Geschillencommis_(Uitspraken_en_jaarverslage

n_Ge)-anchor. (Retrieved 23 January 2022). Coded data is available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

All methods were carried out in accordance with relevant guidelines and regulations. All data was anonymized and publicly available online collected and published by the conciliation board itself. This study was exempt from medical ethical review in the Netherlands (IRB Medisch-ethische toetsingscommissie Maastricht University / Academisch Ziekenhuis Maastricht file number 2022-3369) because this research was not subject to the Dutch Medical Research Involving Subjects Act (WMO). The research was carried out in accordance with the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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References

1. Jarvis-Selinger S, Pratt DD, Regehr G. Competency is not enough: integrating identity formation into the medical education discourse. Acad Med. 2012;87:1185–90.
2. Creuss RL, Cruess SR, Boudreau JD, et al. Reframing medical education to support professional identity formation. Acad Med. 2014;89:1446–51.
3. Cruess RL, Cruess SR, Boudreau JD, et al. A schematic representation of the professional identity formation and socialization of medical students and residents: a guide for medical educators. Acad Med. 2015;90:718–25.
4. Rumayyan A, van Al, Mook MNKA, Magzoub ME, et al. Medical professionalism frameworks across non-western cultures: a narrative overview. Med Teach. 2017;39(sup1):S8–14.
5. Roberts NK, Dorsey JK, Wold B. Unprofessional behavior by specialty: a qualitative analysis of six years of student perceptions of medical school faculty. Med Teach. 2014; 36(7):621–5.
6. van Luijk SJ, van Mook WNKA, van Oosterhout WPJ. Het leren en toetsen Van de professionele rol. [Learning and testing the professional role.] Tijdschrift Voor Medisch Onderwijs 2009:107–18.
7. van Mook WNKA, de Grave WS, Wass V, et al. Professionalism: evolution of the concept. Eur J Intern Med. 2009;20(4):e81–4.
8. van der Vossen MC, Croix A, de la, Teherani A, et al. Developing a two-dimensional model of unprofessional behaviour profiles in medical students. Adv Health Sci Educ Theory Pract. 2019;24(2):215–32.
9. Swick HM. Toward a normative definition of medical professionalism. Acad Med. 2000;75:612–16.
10. Wear D, Kuczewski MG. The professionalism movement: can we pause? Am J Bioeth. 2004;4(2):1–10.
11. Goold SD, Stern DT. Ethics and professionalism: what does a resident need to learn? Am J Bioeth. 2006;6(4):9–17.
12. Roberts NK, Williams RG. The hidden costs of failing to fail residents. J Grad Med Educ. 2011;127–9.
13. van Mook MNKA, Gorter SL, Kieboom W, et al. Poor professionalism identified through investigation of unsolicited healthcare complaints. Postgrad Med J. 2012;88(1042):443–50.
14. Barnhoorn PC, Essers GTJM, Nierkens V et al. Patient complaints in general practice seen through the lens of professionalism: a retrospective observational study. BJGPO 2021;30(5– 3).
15. Papadakis MA, Hodgson CS, Teherani A, et al. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. Acad Med. 2004;79(3):244–9.
16. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. N Engl J Med. 2005;353:2673–82.
17. Dubois JM, Anderson EE, Chibnall JT, et al. Serious ethical violations in medicine: a statistical and ethical analysis of 280 cases in the United States from 2008–2016. Am J Bioeth. 2019;19(1):16–34.
18. Teherani A, Hodgson CS, Banach M, et al. Domains of unprofessional behavior during medical school associated with future disciplinary action by a state medical board. Acad Med. 2005;80(10 Suppl):S17–20.
19. van der Vossen MC, van Mook WNKA, Kors JM, et al. Distinguishing three unprofessional behavior profiles of medical students using latent class analysis. Acad Med. 2016;91(9):1276–83.
20. Barnhoorn PC, Nierkens V, Mak-van der Vossen MC, et al. Unprofessional behaviour of GP residents and its remediation: a qualitive study among supervisors and faculty. BMC Fam Pract. 2021;22:249.
21. van der Vossen M, van Burgt MW, et al. Descriptors of unprofessional behaviors of medical students: a systematic review and categorization. BMC Med Educ. 2017;17:164–76.
22. Warren AE, Allen VM, Bergin F, et al. Understanding, teaching and assessing the elements of the CanMEDS professional role: Canadian program directors' views. Med Teach. 2014;36:390–402.
23. Renting N, Gans ROB, Borleffs JCC, et al. A feedback system in residency to evaluate CanMEDS roles and provide high-quality feedback: exploring its application. Med Teach. 2016;38(7):738–45.
24. Daignault-Leclerc D, Daly N, Farmer O, et al. Evaluation of residents in psychiatry: perspectives and alternatives. Acad Psychiatry. 2017;41(6):846–48.
25. Nittur N, Kibble J. Current practices in assessing professionalism in United States and Canadian allopathic medical students and residents. Cureus. 2017;9(5):e1267. https://doi.org/10.7759/cureus.1267.
26. Frank JR. The CanMEDS 2005 physician competency framework. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2005.
27. Directive CGS. B2 lid 1 jo lid 2 sub a t/m g.
28. Guerrasio J, Garrity MJ, Aagaard EM. Learner deficits and academic outcomes of medical students, residents, fellows, and attending physicians referred to a remediation program, 2006–2012. Acad Med. 2014;89(2):352–8.
29. Bhatti NI, Ahmed A, Steward MG, et al. Remediation of problematic residents—A national survey. Laryngoscope. 2016;126(4):834–8.
30. Vermeulen MI, Kuyvenhoven MM, Groot E, et al. Poor performance among trainees in a Dutch postgraduate GP training program. Fam Med. 2016;48(6):430–8.
31. Godschalx JA. Premature dismissal of psychiatry residency training in the Netherlands. Tijdschr Psychiatr. 2021;63(11):789–95.
32. Wynia MK, Papadakis MA, Sullivan WM, et al. More than a list of values and desired behaviors: a foundational understanding of medical professionalism. Acad Med. 2014;89(5):712–4.
33. Adams KE, Emmons S, Romm J. How resident unprofessional behavior is identified and managed: a program director survey. Am J Obstet Gyneacol. 2008;198(6):e6924–5.
34. Riebschleger MP, Haftel HM. Remediation in the context of the competencies: a survey of pediatrics residency program directors. J Grad Med Educ. 2013;5(1):60–3.
35. Silverberg M, Weizberg M, Murano T, et al. What is the prevalence and success of remediation of emergency medicine residents? West J Emerg Med. 2015;16(6):839–44.
36. Christensen MK, O'Neill L, Hansen DH, et al. Residents in difficulty: a mixed methods study on the prevalence, characteristics, and sociocultural challenges from the perspective of residency program directors. BMC Med Educ. 2016;16(1):69.
37. Raman HS, Limbrick DD, Ray WZ, et al. Prevalence, management, and outcome of problem residents among neurosurgical training programs in the United States. J Neurosurg. 2018;130(1):322–26.
38. Dupras DM, Edson RS, Halvorsen AJ, et al. Problem residents: prevalence, problems and remediation in the era of core competencies. Am J Med. 2012;125(4):421–5.
39. Zbieranowski I, Takahashi SG, Verma S, et al. Remediation of residents in difficulty: a retrospective 10-year review of the experience of a postgraduate board of examiners. Acad Med. 2013;88(1):111–6.
40. EC Directive 2005/36.
41. Capaciteitsorgaan. Capaciteitsplan 2020–2023 Deelrapport 1: Medische Specialismen. [Capacity body 2019 Report on Medical Specialties] Utrecht 2019.
42. Bustraan J, Dijkhuizen K, Velthuis S, et al. Why do trainees leave hospital-based specialty training? A nationwide survey study investigating factors involved in attrition and subsequent career choices in the Netherlands. BMJ Open. 2019;9:e028631.

43. Summary of the regulations of the medical specialties council of the royal dutch medical association retrieved. September 9th 2024, https://www.knmg.nl/download/kaderbesluit-cgs-engelse-vertaling-samenvatting-kb
44. https://www.knmg.nl/ik-ben-arts/rgs/mijnrgs/bezwaar-en-geschil/geschillencommissie-1/samenvattingen-uitspraken-en-jaarverslagen-geschillencommissie, retrieved September 9th 2024.
45. Capaciteitsorgaan. Capaciteitsplan 2016 Deelrapport 1: Medische Specialismen. [Capacity body 2016 Report on Medical Specialties] Utrecht 2016.
46. Guerrasio J, Brooks E, Rumack CM, et al. Association of characteristics, deficits, and outcomes of residents placed on probation at one institution, 2002–2012. Acad Med. 2016;91(3):382–7.
47. Tabby DS, Majeed MH, Schwartzman RJ. Problem neurology residents: a national survey. Neurology. 2011;76(24):211–23.
48. Domen RE, Talbert ML, Johnson K, et al. Assessment and management of professionalism issues in pathology residency training: results from surveys and a workshop by the Graduate Medical Education Committee of the College of American Pathologists. Acad Pathol. 2015;2(3):2374289515592887.
49. Godschalx-Dekker JA, Gerritse FL, van Mook WNKA et al. Do deficiencies in canMEDS competencies of dismissed residents differ according to specialty? Med Teach 2023;1–6.
50. Godschalx-Dekker J, van Mook W. Dismissed psychiatry residents who appeal: exploring unprofessional behavior. Acad Psychiatry. 2023;47(4):344–51.
51. Barnhoorn PC, Houtlosser M, Ottenhoff-de Jonge M, et al. A practical framework for remediating unprofessional behavior and for developing professionalism competencies and a professional identity. Med Teach. 2019;41(3):303–8.
52. Mak-van der Vossen M, Peerdeman S, Kleinveld J, et al. How we designed and implemented teaching, training, and assessment of professional behaviour at VUmc School of Medical Sciences Amsterdam. Med Teach. 2013;35(9):709–14.
53. O'Sullivan H, van Mook W, Fewtrell R, et al. Integrating professionalism into the curriculum AMEE Guide 61. Med Teach. 2012;34(2):e64–77.
54. Verkerk MA, de Bree MJ, Mourits MJE. Reflective professionalism: interpreting CanMEDS professionalism. J Med Ethics. 2007;33(11):663–6.
55. Anthony-Pillai R. Ethics and communication skills. Medical professionalism. Medicine. 2016;44(10):586–8.
56. Hodges BD. Sea monsters & whirlpools: navigating between examination and reflection in medical education. Med Teach. 2015;37:261–6.
57. van Mook WNKA. Teaching and assessment of professional behaviour: rhetoric and reality. Datawyse / Universitaire Pers Maastricht; 2011.
58. Hafferty FW, Castellani B. The increasing complexities of professionalism. Acad Med. 2010;85:288–301.
59. Hodges BD, Ginsburg S, Cruess R et al. Assessment of professionalism: Recommendations from the Ottawa 2010 Conference. *Med Teach* 2011;33:354–63.
60. Hodges B. Assessment in the post-psychometric era: learning to love the subjective and collective. Med Teach. 2013;35:564–68.
61. Hodges B, Paul P, Ginsburg S. Assessment of professionalism: from where have we come– to where are we going? An update from the Ottawa Consensus Group on the assessment of professionalism. Med Teach. 2019;41(3):249–55.
62. Ramani S, Könings K, Mann KV, et al. Uncovering the unknown: a grounded theory study exploring the impact of self-awareness on the culture of feedback in residency education. Med Teach. 2017;39(10):1065–73.
63. Swendiman RA, Marcaccia CL, Han J, et al. Attitudes and habits of highly humanistic surgeons: a single-institution, mixed-methods study. Acad Med. 2019;94(7):1027–32.
64. van Mook WNKA, van Luijk SJ, de Grave W, et al. Reflections in internal medicine. Teaching and learning professional behavior in practice. Eur J Intern Med. 2009;20:e105–11.
65. Gordon J. Fostering students' personal and professional development in medicine: a new framework for PPD. Med Educ. 2003;37(4):341–9.
66. Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. JAMA. 2000;284:1099–104.
67. van Heijst A. Professional loving care. An ethical view of the healthcare sector. Leuven: Peeters; 2011.
68. de Lange F. *Andermans handen. Over flow en grenzen in de zorg*. [In someone else's hands. About flow and boundaries in healthcare]. Zoetermeer: Meinema; 2011.
69. Bergen PC, Littlefield JH, O'Keefe GE, et al. Identification of high risk residents. J Surg Res. 2000;92(2):239–44.
70. Resnick AS, Mullen JL, Kaiser LR. Patterns and predictions of resident misbehavior–a 10-year retrospective look. Curr Surg. 2006;63(6):418–25.
71. Torbeck L, Canal DF. Remediation practices for surgery residents. Am J Surg. 2009;197(3):397–402.
72. Melton W, Jackson B, Koon D, et al. Orthopaedic resident remediation. Frequency, interventions and outcomes. JB&JS. 2018;3(4):e0011.
73. Kerasidou A. Trust me, I'm a researcher! The role of trust in biomedical research. Med Health Care Philos. 2017;20(1):43–50.
74. Baier AC. Moral prejudices. Essays on ethics. Harvard University Press; 1995.
75. Wijnen-Meijer M, van der Schaaf M, Nillesen K, et al. Essential facets of competence that enable trust in medical graduates: a ranking study among physician educators in two countries. Perspect Med Educ. 2013;2(5–6):290–7.
76. Duijn C, Welink L, Bok H, et al. When to trust our learners? Clinical teachers' perceptions of decision variables in the entrustment process. Perspect Med Educ. 2018;7(3):192–9.
77. Maslow AH. A theory of human motivation. Psychol Rev. 1943;50(4):370–96.
78. Williams RG, Roberts NK, Schwind CJ, The nature of general surgery resident performance problems. Surgery 2009;145:651-8.

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