'Colleague bashing' is unprofessional behaviour

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Professionalism is recognised as fundamental to medical practice, yet it is challenging to teach. What all students learn formally must be complemented by their latent experiences in clinical practice. Disrespectful language towards colleagues or patients is a major source of distress for medical students, and clinical teachers must promote professional behaviour.

While certain people question the value of philosophy, this discipline helps us deal with the fundamental uncertainties of life at the level of our thoughts, and helps liberate us from thought panic on the one hand and thought finality on the other (H W Rossouw, A A van Niekerk – *Introduction to systematic philosophy*, class notes, Stellenbosch University, 1990, unpublished). The field of ethics is a sub-division of philosophy, and it is here that we encounter questions of morality. As rational, sentient beings, humans make judgements on the 'rightness or wrongness' of actions. When actions are morally right they are commended, but when wrong, they become blameworthy. Blameworthy actions should be distinguished from actions that are illegal and therefore punishable, although the two may overlap. Ethics can be defined as the result of a systematic and theoretical reflection on the phenomenon of morality (Rossouw and Van Niekerk – class notes). There are of course many well-known ethics theories, some of which are older and others more recent. Each theory has its particular strengths and weaknesses, and when evaluating a moral dilemma it is generally useful to reflect on the issue using the perspective of different moral theories such as Utilitarianism, Kantianism, Virtue Ethics, Principlism or Ubuntu, to name but a few.

The problem

I was recently asked to speak on a particular aspect of professional behaviour following an e-mail message from a senior colleague. The first paragraph read as follows: 'Dear David, we constantly have problems with doctors (registrars, medical officers and consultants) who act unprofessionally towards referring doctors, passing negative comments in the presence of patients or other personnel' (translated). Simple logic might analyse this paraphrased argument as follows:

- Premise 1. We have a constant problem.
- Premise 2. Doctors (at many levels) criticise (unjustly) referring doctors in the presence of patients and other personnel.
- Premise 3. *This is also the conclusion:* Such behaviour (premise 2) is unprofessional.

These premises appear to support the conclusion. Two basic tools or 'thought structures' used in philosophy are *concepts* and *ideas*. Concepts are used to identify and classify our fields of experience. Using class characteristics, we recognise different types within the same concept. We therefore recognise the large flightless ostrich, the tiny sunbird and the ubiquitous pigeon all under the concept of 'bird'. Concrete concepts such as bird or building are not controversial. On the other hand, abstract concepts such as freedom, harm or professional behaviour are more difficult to deal with and often

'represent matters and values that are of the gravest importance for people'.[1] We use ideas to interpret our fields of experience, which is clearly different to identification and classification. Through interpretation we establish the value, importance and relevance of the things we encounter.[1] Over time, certain ideas may become clear enough to become institutionalised, as is the case with professional boards. However, ideas can also be challenged or undermined, leading to uncertainty or perplexity. When ideas are institutionalised, actions that are morally blameworthy can also become punishable by law. In this particular discussion we are dealing with the abstract concept of (un)professional behaviour, and more specifically, non-constructive criticism sometimes referred to as 'colleague bashing'.

What is professional behaviour?

'Professionalism has been recognised for centuries as fundamental to medical practice, yet it has remained one of the most intangible and difficult areas within both undergraduate and postgraduate training.'[2] Professionalism emanates from the values that society respects, but we are well aware that societies differ from one another and that societal values change over time. In the same way, public perceptions of the role of the doctor have changed over the years and are now very different to the early understanding of medicine as a vocation. Although full consensus on the values intrinsic to professionalism is elusive, many concerted efforts to clarify the nature of professionalism have been made. In the process key elements (*virtues*) of professionalism, such as altruism, accountability, duty, excellence, honour, integrity and respect, have been identified by medical boards and associations.[3,4] The ideal is that from good character (*virtues*) flow morally good actions. Unfortunately these sometimes abstract, idealistic character traits are not necessarily demonstrated in observable behaviour.[5] Nonetheless, professional values and behaviours are intrinsic to all medical practice, and medical training institutions are now acutely aware that training in professionalism must be incorporated into the curriculum. With the lack of consensus on a definition of professionalism, training institutions should at least provide institutional definitions. In 2006, 23 medical schools in the UK reported such attitudinal objectives.[6] At Stellenbosch University's Faculty of Medicine and Health Sciences, the professional characteristics of the graduate are documented in the *Profile of the Stellenbosch Doctor*.[7] This document has three sub-headings: 'Knowledge', 'Skills' and 'Attitudes/Views'. Respect for other members of the health team is specifically mentioned in the section

on attitudes.[7] The complexity of the relationship between external professional behaviour and internal attitudinal values is currently poorly understood and remains a high priority for research.[2] In South Africa there has been a call for the practice of 'ethics of responsibility' in medicine.[8] According to this model, 'people accept responsibility for all their actions, rather than hide behind heteronymous rules and regulations'. Van Niekerk believes that the higher education sector has a particular responsibility in this regard.[8]

Where is professional behaviour learned?

'Professional values and behaviours remain one of the most difficult subjects to integrate explicitly into a curriculum.'[2] In order to do so, the impact of the formal, informal and hidden curricula must be both understood and utilised. In other words, what students learn in classroom lectures and tutorials must be complemented by their latent experiences in clinical practice. Bernard *et al.* have defined the hidden curriculum as 'the organisational structure and culture that influences learning' and the informal curriculum as 'the interpersonal experiences between students and teachers, other students, and patients'.[9] These authors believe that, while not detracting from formal teaching, the learning experience through observations of and interactions with role models in clinical practice (training) is even more influential than what is formally taught. It is therefore essential that formal learning be demonstrated in the workplace. If prominent doctors behave unprofessionally without consequences, students or colleagues may perceive their behaviour to be acceptable or even advantageous. This insidious environment can form part of the hidden curriculum, as trainees learn by observation followed by emulation.[10]

Critical reflection on the concept of professional (and unprofessional) behaviour is an illuminating exercise in this regard. Both positive and negative role models are influential. By way of example, students in the mid-clinical undergraduate rotation in gynaecology at Stellenbosch University are given a self-study exercise at the start of the rotation. Within the context of the doctor/health worker-patient relationship they are asked to reflect on both positive and negative interactions that they experienced personally. Thereafter, in a regularly scheduled session led by a dedicated, senior consultant clinician during the final week of the rotation, they are invited to share and discuss their experiences. The aim is to utilise experiences, promote reflection and provide mentoring. In a study investigating the hidden curriculum to teach professionalism, Rogers *et al.* found this type of session to be the most highly rated feature among medical students.[11]

Practice point: 'Colleague bashing' is unprofessional behaviour

Unfortunately, the literature shows unprofessional behaviour to be widely prevalent.[12] In an analysis conducted on 377 professionalism narratives by medical students, Bernard *et al.* found 'manifesting respect' to be the most frequent theme, while Feudtner *et al.* found that 98% of students noted derogatory language about patients.[9,13] It is clear that unprofessional behaviour such as gossip or disrespectful language towards colleagues or patients is a major source of distress for medical students. In a further example, Holmes *et al.* investigated students' experiences of exposure to non-constructive criticism ('colleague bashing'), specifically within different medical specialties.[14] The 105 students surveyed experienced this behaviour in all rotations, and most (79%) believed it to be unprofessional. But what about the experiences of professionals? In 2008, a survey of doctors and nurses

from 102 hospitals found that 77% of respondents witnessed 'disruptive behaviour' in physicians and 65% witnessed it in nurses.[15]

Addressing the issue

Various strategies can be employed to address this problem. One is to emphasise the interdisciplinary character of medicine, as for example in the 'Attitudes/Views' section (point 9) of the *Profile of the Stellenbosch Doctor*.[7] However, as stated previously, this must be demonstrated in practice. Another tool is to evaluate professionalism regularly. Although it is challenging, there are guides for integrating professionalism into under- and postgraduate training using the formal, informal and hidden curricula. Such guides propose multiple assessment tools integrated throughout the course.[2] Accurate evaluations require specific observations in authentic settings, using multiple observers on multiple occasions, to ensure reliability and validity.[16] These tools could also be used in annual work evaluations. Accurate and constructive feedback is an important means of effecting improvement in professionalism. It has been demonstrated that most doctors appreciate help and guidance and are able to respond appropriately by making behavioural adjustments that demonstrate improvement after being informed of a pattern of unprofessional behaviour that does not conform to recognised standards.[17,18] However, a few individuals will not be able to engage in the process of corrective self-analysis and require a higher level of intervention, including evaluation plans and monitoring.[12]

Conclusion

Clinical teachers have a vital role to play in developing and modelling professional behaviour among under- and postgraduate trainees. In the words of Buchanan *et al.*, 'Great clinical teachers promote professional behaviour.'[18] Perhaps not all of us can be great, but we can at least be good!

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