BRIEF
REPORTS

# Balancing Forces: Medical Students' Reflections on Professionalism Challenges and Professional Identity Formation

Amrapali Maitra, MD, PhD; Steven Lin, MD; Tracy A. Rydel, MD; Erika Schillinger, MD

**BACKGROUND AND OBJECTIVES:** Professionalism is essential in medical education, yet how it is embodied through medical students' lived experiences remains elusive. Little research exists on how students perceive professionalism and the barriers they encounter. This study examines attitudes toward professionalism through students' written reflections.

**METHODS:** Family medicine clerkship students at Stanford University School of Medicine answered the following prompt: "Log a patient encounter in which you experienced a professionalism challenge or improvement opportunity." We collected and analyzed free-text responses for content and themes using a grounded theory approach.

**RESULTS:** One hundred responses from 106 students generated a total of 168 codes; 13 themes emerged across four domains: challenging patients, interpersonal interactions, self-awareness, and health care team dynamics. The three most frequently occurring themes were interacting with emotional patients, managing expectations in the encounter, and navigating the trainee role.

**CONCLUSIONS:** Medical students view professionalism as a balance of forces. While many students conceived of professionalism in relation to patient encounters, they also described how professionalism manifests in inner qualities as well as in health systems. Interpersonal challenges related to communication and agenda-setting are predominant. Systems challenges include not being seen as the "real doctor" and being shaped by team behaviors through the hidden curriculum. Our findings highlight salient professionalism challenges and identity conflicts for medical students and suggest potential educational strategies such as intentional coaching and role-modeling by faculty. Overall, students' reflections broaden our understanding of professional identity formation in medical training.

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Professionalism remains a salient topic in medical education, yet it eludes definition.[1,2] The American Board of Family Medicine defines professionalism as "shared competency standards and ethical values" including a commitment to serve patients, continued enhancement of one's skills, fairness and honesty, contributing to public good, and accepting responsibility.[3] However, idealized language does not reflect the "situatedness of students' experiences" in the real world.[4,5] Clerkship students offer an opportunity to study professionalism in medical training.

Medical students encounter professionalism education in both planned and hidden curricula.[6–8] Professionalism is often taught through its inverse: videos of poor behavior, lists of what not to do, and fears of evaluation that flatten a complex dialogue.[9–12]

## Methods

*Participants*

Study participants were third- and fourth-year medical students from Stanford University School of Medicine on their required 4-week family medicine clerkship. Clerkship sites encompassed 12 academic, urban, suburban, and rural outpatient clinics in Northern California.

*Data Collection*

Stanford medical students submit patient logs aligned with Accreditation Council for Graduate Medical Education (ACGME) Core Competencies. One entry prompts them to "Log a patient encounter in which you experienced a professionalism challenge or improvement

From the Department of Medicine, Brigham and Women's Hospital, Boston, MA, and Harvard Medical School, Boston, MA (Dr Maitra); and Division of Primary Care and Population Health, Department of Medicine, Stanford University School of Medicine, Palo Alto, CA (Drs Lin, Rydel, and Schillinger).

opportunity." We compiled deidentified responses through the medical school's evaluation web software, E*Value, from students who completed the clerkship from February 2016 through April 2018, excluding entries that did not attempt to answer the question, resulting in 100 responses. Because we used preexisting data without human subject identifiable information, Stanford University's Institutional Review Board (IRB) exempted this study from formal review.

*Analysis*

A resident physician and anthropologist (A.M.) and a family medicine faculty member (E.S.) analyzed the data. Using grounded theory, transcripts were coded inductively over four rounds, using open coding to develop comparisons and produce conceptual categories across similar events until thematic saturation was reached. The first round of coding was done independently to increase reliability. Coding disagreements were subsequently adjudicated through discussion, and the codebook was developed iteratively in each round.[18] Both raters coded all responses with the last round completed using the stable, finalized codebook.

We applied a total of 168 codes across 100 transcripts (each transcript receiving at least one code; average of 1-2 codes per response). Thirteen themes emerged from student responses which were categorized across four domains. The initial interrater reliability pooled Cohen's $\kappa$ score was 0.6 for the first phase and 0.87 for the second phase. This improved to 100% interrater agreement after negotiated consensus through feedback and discussion.

## Results

One hundred-six medical students submitted responses to the prompt over the study period. Six responses were excluded as they did not answer the question, resulting in 100 essay transcripts and a 94% response rate. Thirteen themes emerged within four domains: challenging patients, interpersonal interactions, self-awareness, and health care team dynamics (Figure 1). Three themes comprised almost half of all code applications—77 of 168 codes (46.0%): (1) emotional patients, (2) managing expectations, and (3) trainee role. Definitions, frequencies, and examples of each theme are elaborated in Table 1.

*Challenging Patients*

Emotional patients and inappropriate patients were cited as challenging archetypes. Emotional patients brought heightened feelings or distress into the encounter. Inappropriate patients crossed boundaries, made sexist or racist remarks, or otherwise behaved in ways that made it difficult to proceed with usual physician-patient roles.

*Interpersonal Interactions*

Interpersonal challenges formed the broadest domain; students highlighted communication, time management, and conflict resolution as useful skills. Managing expectations entailed reconciling the patient's agenda. Managing time and complexity arose with complex patients, interpreters, or family members present. Self-presentation was the challenge of maintaining equanimity under duress. Sensitive issues related to patients' personal challenges or identity markers like gender or sexual orientation. Setting boundaries manifested in communicating limits of the health care role.

**Figure 1: Four Domains of Professionalism Challenges in 100 Clerkship Students' Reflections (N=168 Codes)**

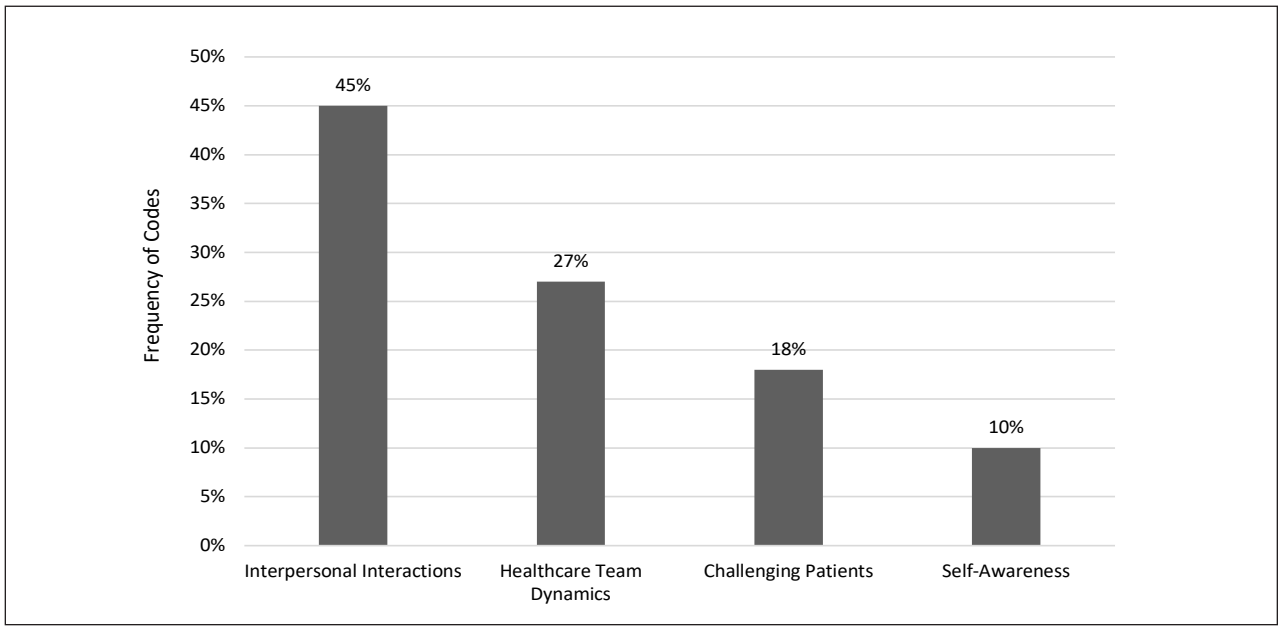

**Table 1: Professionalism Challenges: Domains, Themes, Definitions, Frequencies, and Examples**

| Themes | Definition | No. Codes Applied (%), N=168 Codes | Example |
|---|---|---|---|
| **Domain: Challenging Patients** | | **31 (18.0)** | |
| Emotional patient | Encounters with patients who are angry, frustrated, or otherwise emotional. | 22 (13.0) | "Patient was a 63-year-old female with fibromyalgia and depression who had repeatedly made clinic appointments in the past month for a Pap smear[…] When I went to speak with the patient, she was very frustrated when I explained that she didn't need a Pap till next year and kept saying that I was wrong. I found it harder to be professional when a patient was so angry towards me but was able to remain professional by reminding myself that her anger wasn't personal towards me and that I am ultimately here to help her in any way I can…" |
| Inappropriate patient | Encounters with patients who exhibit sexist, racist, prejudiced, or otherwise inappropriate behaviors or seek secondary gain. | 9 (5.0) | "60-year-old male presenting for refill of pain prescription. We were able to look him up in the CURES database and determine that he had multiple prescriptions filled by multiple physicians […] suspicious for selling opiates. This was a great professionalism challenge because I did not want to accuse him of illegal activity but certainly could not prescribe more opioids. The resident and I worked together and decided to decline the prescription and defer to his nursing home, and in future would conduct random urine screening and follow his prescriptions closely." |
| **Domain: Interpersonal Interactions** | | **76 (45.0)** | |
| Managing expectations | Managing conflict that arises from the discord between patient and provider expectations from the encounter, which may stem from differences in priorities, health care beliefs, or treatment goals. | 30 (18.0) | "91-year-old male, new patient to my preceptor, formerly the patient of another doctor who had left the practice, presenting for establishment of care and for refills of alprazolam and Prilosec […] He was also very unwilling to engage in dialogue about his medications, and particularly the alprazolam—this was also demonstrated with my attending. Since he was a new patient and we only had so much time, we ended up prescribing him a 3 months' supply of alprazolam but then told him he needed to check in, with plans to continue discussing his medications with him at future visits." |
| Communication | Challenge related to communication such as patient education, cross-cultural barriers, or use of medical interpreters. | 14 (8.0) | "92-year-old Vietnamese-speaking female presented to clinic with family for follow up. She had a long list of chronic conditions, and no one in the family spoke English. We used a phone interpreter which was very helpful. However, throughout the course of the interview, it felt that the phone interpreter was having side conversations with the patient many times and may not have been interpreting some of the recommendations correctly gauging from the family's follow up questions. However, due to time limits and many family members participating with their own questions, it was difficult to keep asking the interpreter to clarify. I think this may have been avoided if we had an in-person interpreter, or if I had talked to the interpreter ahead of time to make sure that we set expectations to be on the same page." |

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**Table 1: Continued**

| Themes | Definition | No. Codes Applied (%), N=168 Codes | Example |
|---|---|---|---|
| **Domain: Interpersonal Interactions** | | **76 (45.0)** | |
| Managing time and complexity | Managing time and heightened patient complexity (eg, medically ill or socially vulnerable patients). | 12 (7.0) | "Saw two patients in the same room. Both were elderly patients with multiple chronic conditions. The husband said he had nothing to talk about, but the wife kept on wanting to tell me about his medical problems. It was a challenge to listen to the wife but also not make the husband feel alienated. Time was also an issue, as both patients had many issues to discuss during their short follow up visits." |
| Self-presentation | Challenge of appearing professional in the eyes of the observer (patient, preceptor, etc) or the ability to stay calm during a crisis or adverse event. | 8 (5.0) | "I had a patient with chronic osteonecrosis of the sinus cavities due to radiation for oropharyngeal carcinoma. He had chronic purulent sinus infection, which had a strong odor of decay. I sat with him in the office for an extended period of time to perform his annual checkup and clarify his diabetes regimen. The smell was overwhelming, and I was desperate to leave the room, but I tried my best to make the patient feel respected and confident in his care." |
| Sensitive issues | Conducting sensitive parts of the history and physical exam. Discussing personal topics like gender identity or sexual health. | 6 (3.5) | "28-year-old female patient seeking abortion services for unintended pregnancy. Patient was heavily distraught. Encounter was medically straightforward but required delicate language and utmost professionalism to provide the best care and resources available to the patient. Spent considerable time on counseling and reassurance to the patient and providing safe space for her to express herself." |
| Setting boundaries | Setting boundaries related to personal effort in the interest of self-care. Such boundaries in the health care role could include time spent working, balance between work and self-care during time off, etc. | 6 (3.5) | "Patient with complex medical and psychosocial history who at the end of the appointment requested email contact information to be able to continue to ask questions electronically regarding her symptoms and medications. While I had very low suspicion that she had nothing but good intentions and simply wanted to continue our conversation from the day and potentially ask new questions as they arose at home, I referred her to the messaging system on MyHealth to both enable her to continue communication w/ health providers while also protecting her own health information…" |
| **Domain: Self-Awareness** | | **16 (10.0)** | |
| Empathy | Challenge of exhibiting empathy, especially when emotionally fatigued or unable to identify with the patient's perspective. | 10 (6.0) | "We had a 27-year-old male with history of anxiety and depression presenting with bilateral wrist pain. I struggled with not dismissing his pain issue. Maybe it was because I knew about his history of anxiety, or maybe the way he was talking about his pain seem disproportionate compared to his appearance...but I kept thinking that his pain can't be that bad. History and exam gave us no red flags about his wrist pain, yet he expressed extreme burden and concern […] I struggled to not be dismissive and annoyed by it." |

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**Table 1: Continued**

| Themes | Definition | No. Codes Applied (%), N=168 Codes | Example |
|---|---|---|---|
| **Domain: Self-Awareness** | | **16 (10.0%)** | |
| Countertransference | Managing the conscious and unconscious emotions that the patient produces; not letting these reactions impact patient care. | 6 (4.0) | "Family of three seen all together at the same time. Mother was extremely aggressive making comments to her son such as, 'Oh look, that's the doctor talking down to us using his fancy terms,' and 'I married an Army ranger and raised a Marine, so I have very little patience for stupidity.' I found it difficult to separate my emotional response to the dynamic brewing in the room and what I needed to provide as a physician." |
| **Domain: Health Care Team Dynamics** | | **45 (27.0)** | |
| Trainee role | Challenge unique to the fact that the medical student is in a trainee role within a hierarchy. Includes difficulty of articulating dissent to a supervisor, patient wanting to see the "real doctor," or balancing learning with patient-centered care. | 25 (15.0) | "Elderly man, new patient to my preceptor […] From the beginning, the patient did not respect me as a care provider and kept telling me things and then telling me I could tell them to my attending, and not taking my physical exam seriously. It was a challenge to stay calm and professional and not get frustrated with the patient, especially when he said I could use him for "practice" with my physical exam (clearly implying I didn't know what I was doing), but by staying focused on his complaints and asking directed questions while being as polite and engaged as possible, I was able to obtain the information I needed and to then share it with my preceptor." |
| Structural factors | Managing health systems issues, using advocacy, or negotiating factors beyond the trainee's control (eg, wait time). | 10 (6.0) | "A middle-aged diabetic Latina woman came in with her daughter for med refill and check-up […] eager to get all of her prescriptions. Yet the provider was saying that a specific set of strips and lancets had to be prescribed to match the specific glucometer […] I felt like I was the middle woman in an argument relaying information between doctor and patient and ultimately resolved the patient's strong desire to have a prescription and the doctor's practical perspective of what was possible by calling Walgreens, asking which glucometer is covered, and then relaying the info to the physician so a prescription for strips and lancets could be written then and there. Ultimately, I felt positive about the opportunity to advocate for both parties, even if it took some extra time and effort." |
| Team interactions | Challenges unique to being part of a health care team, including interactions with other providers (attending or supervising physician, nurses, medical assistants). | 10 (6.0) | "The patient was a middle-aged male with a history of brittle type 1 diabetes […] He came to the clinic with the objective getting an insulin pump. However, because of his episodes of hypoglycemia, my preceptor did not feel comfortable managing an insulin pump for this patient and asked that he be followed by an endocrinologist. The patient felt that he didn't have the means to do this, becoming very upset. […] First, it was incredibly difficult to see this patient in such distress. I could sense that he felt abandoned by his doctors […] I could sense his despair and wanted to offer words of comfort, and at the time I also did not completely understand why the patient could not be managed in the office. It was difficult for me to stand by the attending while she explained her reasoning." |

*Self-awareness*

The domain of self-awareness centered on managing internal reactions—empathy and countertransference—and processing emotion within the encounter. The challenge of empathy arose in situations that made it difficult to see the patient's perspective. In countertransference, students negotiated conscious and unconscious emotional reactions in response to patients.[19]

*Health Care Team Dynamics*

Challenges related to health care team dynamics included the nature of the medical student role and interactions with other providers. The unique challenges of the trainee role ranged from not being viewed by patients as the real doctor to facing disempowerment in the hierarchy of supervision. Structural factors encompassed barriers like clinic logistics, difficulties accessing care, or advocacy. Challenges related to team interactions arose in visits including the attending or other providers, where trainees walked the line between individual ethics and fitting in.

## Discussion

This study highlights medical student perspectives on professionalism and broadens our understanding of professional identity formation in training. Students' reflections encompassed patients, as hypothesized, and also displayed how professionalism manifests through inner qualities and within health care systems.[20] Students conceptualized professionalism as a balance of forces, whether in reconciling the patient's perspective, maintaining self-awareness in emotionally-demanding situations, or navigating teams. This study focuses

**Table 2: Professionalism Challenges Mapped to Potential Educational Strategies**

| Professionalism Challenge | Educational Strategies |
|---|---|
| Emotional patient | Encourage debriefing after challenging patient encounters. Teach de-escalation skills. Provide training on handling clinical uncertainty and medically unexplained symptoms. Incorporate patient and caregiver voices into training to better contextualize the illness experience. |
| Inappropriate patient | Provide modeling and coaching, as well as opportunities for reflection. Emphasize inclusivity. Recognize and respond to bias or microaggressions that students may face from patients. |
| Managing expectations | Teach agenda-setting. Provide training on redirection, empathetic listening, reflection, and boundary setting. |
| Communication | Provide opportunities to practice challenging communication scenarios, such as visits with medical interpreters or multiple family members in the room. Offer clinical "prebriefs" and debriefs. |
| Managing time and complexity | Encourage preceptors to describe challenges and share solutions related to time management. Set goals before interactions. Acknowledge and accommodate learners' need for more time in clinical encounters. |
| Self-presentation | Acknowledge that self-presentation may not always match internal emotion. Cultivate self-compassion. |
| Sensitive issues | Teach sensitive topics (eg, mental illness, substance use) with destigmatizing language and in social context. Emphasize non-judgmental communication. Supervise early exposure to sensitive parts of the physical exam (eg, pelvic exam) with asynchronous feedback (so as not to embarrass patient or student). |
| Setting boundaries | Provide support on limit-setting related to personal boundaries. Empower authentic relationships but encourage pursuit of self-care and asking for help. |
| Empathy | Reflect on the emotional work that medicine demands. Celebrate efforts to show empathy. Acknowledge times when empathic relationships with patients can be difficult. Foster resiliency. Recognize burnout. |
| Countertransference | Teach self-awareness. Acknowledge the emotional aspects of patient care that linger after encounters. Create formal spaces for reflection like Balint groups or peer-led debriefing. |
| Trainee role | Ensure faculty training to select appropriate patients for medical students at various levels of training and to better prepare patients and caregivers for the medical student's valuable role on the team. |
| Structural factors | Integrate students into the outpatient practice environment including better orientation to front-desk staff and medical assistants who may assist students in navigating structural and systemic barriers in health care. |
| Team interactions | Incorporate professional identity formation as a framework for medical education. Create intentional, supportive relationships with preceptors. Define meaningful, value-added roles for students. Train faculty and residents to role model and support students in interactions. Offer longitudinal clerkships. Recognize shared values as well as diverse approaches among physicians. |

on a small sample from one medical school involving both third- and fourth-year students and is therefore limited in generalizability. No definition of professionalism was provided, which may have resulted in varying interpretations.

Our analysis reveals the pervasiveness of professional identity conflicts in medical training. Internally, being too much oneself or too little is a challenge of emotional modulation. Interpersonally, communication remains an area of desired development.[21] Externally, not being seen as the real doctor interferes with confidence and growth, and the hidden curriculum[22–24] including role-modeling by faculty shape values.[25] We suggest potential educational strategies to mitigate these challenges (Table 2). Overall, integrating a framework for professional identity formation may give students a language to reflect, refine skills, and balance competing forces on the journey of becoming a physician.

**CORRESPONDING AUTHOR:** Address correspondence to Dr Amrapali Maitra, 75 Francis St, Boston, MA. 713-858-1212. amaitra@bwh.harvard.edu.

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