Abstract:
Attending physicians are the primary role models of professionalism, but little is known what their perspective is on the maintenance of their professionalism. This study characterizes the pediatric emergency medicine (PEM) attending perspective on maintaining professionalism during their career. Two qualitative methods were used: field observation and semi-structured interviews. Field observations were conducted in one pediatric emergency department (ED) based on a framework for professionalism education. Semi-structured interviews were conducted with a purposive sample of PEM attendings from across the country. Interviews were transcribed and themes analyzed using an iterative, inductive process. The two differing methods allowed for data triangulation. Forty-five hours of ED observation were completed with thematic coding of observations. Seventeen interviews were conducted with PEM physicians around the country with a wide variety of demographic characteristics. Observations and interviews revealed several themes describing the PEM attending's perspective on professionalism. Challenges to professionalism include: patient related factors (such as high volume and acuity, difficult medical situations and dissatisfied families), staff interactions (RN, ancillary, etc), trainee education and interaction, ED environment, academic pressures, and personal factors. By understanding the PEM attending perspective on professionalism, resources and education can be better targeted for professional development and interventions to solve the challenges that PEM phy-

Pediatric Emergency Medicine Attending Perspectives on Maintaining Professionalism

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Professionalism is touted as a crucial aspect of delivering excellent patient care and an important core competency to achieve during residency training.[1-5] The American Board of Pediatrics defines professionalism as being "demonstrated through a foundation of clinical competence, communication skills, and ethical understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism."[1-6] In a few studies that have been published examining the resident's perspective on learning professionalism, role modeling by attendings has been identified as an important method by which residents learn about professionalism.[7-9] A qualitative study completed by this investigator looked at the development of professionalism through pediatric emergency medicine (PEM) experiences from the resident's perspective.[10] We also identified role modeling as a crucial factor in how residents learn about professionalism from PEM experiences. A review of the literature on role modeling exists,[11-13] but falls short on specific actions and interventions that attendings can employ. Notably, there is nothing published within the fields of pediatrics or emergency medicine on how attendings feel they display and

sicians identify. Understanding the PEM attending perspective may also be useful in developing assessment tools for attendings and may provide deeper insight into the impact of role models on trainee professionalism education.

Keywords:
Professionalism; continuing medical education; pediatric emergency medicine; professional-patient relations; role modeling; core competencies

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role model professionalism and how they feel they maintain professionalism during their career.

To describe the PEM attending's perspective on maintaining professionalism, a qualitative study was conducted to delve into rich, detailed descriptions and identify common themes. By understanding this perspective, we can better understand the PEM attending experience with professionalism and may improve the assessment, training, and evaluation of the role models that are so important in professionalism education for trainees. In addition, this information may help to build curriculum and interventions that will help support the maintenance of professionalism after residency and through the years of a practicing PEM physician.

METHODS

This qualitative study had two phases: field observation and semi-structured interviews, and was approved by the institutional review board at the University of California, San Francisco.

Subjects and Setting

For phase 1 (field observation) a convenience sampling of PEM attendings working at UCSF Benioff Children's Hospital Oakland were the subjects. For phase 2 (semi-structured interviews) a purposive sample of academic PEM attendings from around the country were interviewed. Purposive sampling maximizes demographic characteristics and results in a wide variety of perspectives. Attention was given to optimize diversity in gender, age, years in practice, clinical time, region in the US, type of hospital, and size of pediatric ED for phase 2 of the study.

Data Collection and Analysis

Phase 1: Observations occurred over a 6-month period during all types of shifts and a variety of clinical situations. Attention to maximizing the variety of experiences and times of day was done to increase the credibility of the observations. A previously derived framework from a study about resident professionalism was used to create a data collection tool that focused on attending professionalism.[10] (Appendix 1) Observations were conducted by the principal investigator (trained in qualitative field observation) and subjects did not know that observations were taking place. All observations were recorded by hand, and thematically categorized using an iterative inductive process. Themes are presented in the results and were used as the

TABLE 1. Themes from observation of attendings in a pediatric ED.

- **PEM Attending Direct Interactions With Residents and Staff**
  - **Residents: Majority of teaching NOT directly with patients**
    - During precepting clinical cases (1:1) outside of patient rooms
    - Scheduled "didactic" teaching
      - Teaching sessions often cancelled due to volume
    - While charting
    - Orienting a new resident to the ED
    - Non-PEM teaching (eg, future career plans, how they were handling residency)
    - Bedside teaching with patients rarely
  - **Staff: Variable approachability**
    - Variable based on attending
      - Some attendings more socially interactive with nurses
      - Some attendings would ignore staff when walking by
      - Nurses didn't approach all attendings equally
- **Others Observing Attending Interactions**
  - **Attendings aware of being observed**
    - Occasionally attending invites resident to watch how they handle a situation (breaking bad news, eliciting history, dealing with a difficult family)
    - Trauma or medical resuscitation where whole team is caring for a critical patient
    - RNs may join a resident attending discussion
  - **Attendings unaware of being observed**
    - "Private" conversations (trying to be private, but not successful)
      - Usually sensitive content (eg, negative opinions of residents, consultants)
    - Talking openly with other team members (RNs, residents, consultants)
      - Could be positive or negative
    - Patients overhear remarks, laughing or rowdy conversation.
- **ED Environment**
  - **Physical layout**
    - Physical barrier between attendings and residents (walled off room)
      - Limits attending approachability
      - Offers more protected conversation
    - Proximity of staff areas to patient rooms
      - Common for noise in staff area to have patients complain
  - **Interruptions**
    - Disrupt interpersonal relationships (eg, attending/resident discussion)
      - Types: phone calls, people, patients
      - Variable appropriateness
        - Appropriate clinical situations (eg, resuscitation)
        - Less urgent interruptions are common (eg, change an order)

basis for developing the semi-structured interview questions and prompts/probes.

Semi-structured interviews were conducted over the phone or in person (when possible) with a diverse group of PEM attendings around the country. A basic interview guide (Appendix 2) was developed based on: (1) Bandura's social cognitive theory, (2) results from a previous study looking at professionalism in residents,[10] and (3) the analyzed themes of the field observations. Interviews were conducted until thematic saturation was achieved. Audiotaped recordings were transcribed in a de-identified fashion by a transcription service. Interviews were analyzed using iterative inductive coding into themes. Using two methods of data collection (field observation and interviews) allowed for data triangulation. Themes and observations were reviewed and discussed via member checking to further enhance the credibility of the results.

RESULTS

Phase 1: 45 hours of observation were conducted over a 6-month period that occurred during all parts of the day and in a variety of situations (eg, trauma, resuscitation, discussion and teaching with trainees, patient interactions, nurse interactions.) Iterative coding of the PEM attending observations revealed three factors that frame the setting of their experiences with professionalism: (1) PEM attending direct interactions with residents and staff, (2) others observing PEM attendings interactions with residents, staff, and patients/families, and (3) unique characteristics of the ED environment (Table 1). All three of these factors were incorporated into the interview script for the semi-structured interviews.

TABLE 2. Demographic characteristics of interviewees.

Age	Average 45 years (range 36-60)
Year finished PEM fellowship	Range 1984 through 2009
Gender	44% male, 56% female
Clinical hours worked per week	Average 22 hours/week (range 8-32)
Pediatric ED volume	18,000 to 95,000 patients/year
Regions of the country	Northeast, Mid-Atlantic, Southeast, Midwest, Southwest, West
Length of interview	Average 42 minutes (range 23-78)

TABLE 3. Interview themes: challenges to professionalism and potential solutions.

Interview Themes	Potential Solutions
Patient-related Challenges	
Patient conflicts	
Angry parents (long wait times)	Relay wait times and expectations clearly
Unmet patient expectations	Review patient complaints and incident/safety reports, QI conferences
Patients who don't seem to care	Teach patient/customer satisfaction
Patient demands (eg, consultant demands like plastic surgery)	Adopt patient-centered perspective
	Read patient cues to assess their needs
	·Educate patients and families about ED experience
Time pressure to see patients quickly	
For patient satisfaction	Anticipate increased coverage needs
For severely ill patients waiting	Time management skills
High volume of patients	Stress management skills
High acuity of patients	Evaluate and provide feedback on attending work habits and efficiency
Not enough staffing	System and leadership support ED pressures—not measuring success by clinical productivity alone
Unpredictability of volume and acuity on any given day	
RVU / Economic pressures	
Medically challenging situations	
Death in a child	Teach coping skills
Error/poor medical outcomes	More time to have discussion and receive support from colleagues
Language and/or cultural barriers	Deeper investigation and understanding of how much clinical stress is tolerable
Child abuse	1:1 meetings with leadership for social support
Malpractice concerns	Systematic debriefing after incidents
	Cultural competency
	Strengthen interpreter services
Staff and Medical Team Interactions	
Work relationships with MDs and staff	
Conflicts or difficult interactions	Learn team building and conflict resolution skills
Personal relationships that may interfere with work	Leadership and culture to build ED systems where good communication is supported
Need for camaraderie and stress relief WITH co-workers	Encourage and facilitate open forums for discussion with fellow PEM colleagues
Wide variety of team members, hard to get to know them all	Get to know staff outside of the ED (hospital-sponsored social events)
Difficult to find time outside of work	
During work, people are busy with patient care	
Educating trainees	
Difficult situations: poor performing trainees	Develop and support robust assessment and evaluation skills and tools
Educating trainees at different levels with few resources and little time	Investigate novel approaches to education
	More opportunity for observation
Not having enough teaching skills	Expectation for 360° feedback
Deficiency in giving feedback	Dedicated time to discuss professionalism
	Positive reinforcement for teaching
	Some shifts seeing patients on your own
	Better understand trainee tasks
	Using own clinical skills
	Gives clinical shift variety
Environment	
Open layout	
Close proximity of patients to staff results in lack of privacy and patients seeing and hearing staff noise and conversations	Create private space within the ED for staff
	Provide breaks in clinical schedule for all team members
	Investigate and implement interventions to decrease interruptions
	Leadership setting tone for professionalism

Table 3 **(continued)**

Interview Themes	Potential Solutions
Frequent interruptions Overall culture may not support professionalism	Be cognizant of the balance between an open layout with need for private conversation
Personal Factors	
Personal well-being on shift (eating, drinking, bathroom) Fatigue (multiple shifts, overnights, aging) Balancing home and work	Adequate staffing; breaks; reduction of overnights over time; optimize scheduling to minimize fatigue Mentorship from senior PEM physicians about maintaining personal life Peer mentorship and faculty groups (eg, early career, women faculty, etc.)
Knowledge and Skills Expectation that you know all the answers Maintaining knowledge and skills over time Lack of support (time and money) for CME Recertification that doesn't emphasize practical knowledge, core knowledge	Stress relief skills Family/spouse/partner/community Exercise, sleep Prayer Mindfulness Time and support for CME and skills workshops Encourage time and habit of self-reflection about professionalism Acknowledgement from leaders and teams that attendings can't know everything Procedure labs, simulation, conferences
Division/Departmental Level Factors	
Lack of Departmental understanding of a PEM clinical schedule	Hospital leadership understanding (and PEM leadership advocacy) of demands of PEM schedule Commitment to building infrastructure to create long-lasting, system-wide change
Hard to meet together as an attending group (because someone is always working)	Attention to non-clinical activities where attendings can meet and talk Mentorship
Academic pressures Promotion One-upmanship (pressure to perform at or above colleagues)	Create a culture of professionalism Medical and nursing leadership Accountability for unprofessionalism Dedicated time to talk about professionalism Positive recognition for professionalism

Phase 2: All interviews conducted were with PEM fellowship trained physicians working in an academic pediatric ED (both urban and community-based). Thematic saturation was reached after 14 interviews, 3 additional interviews revealed no new themes (for a total of 17 interviews). Seventeen attendings were approached and all attendings accepted the invitation to interview. The interviewees represented a wide variety of demographics including: all regions of the country, university affiliated and non-university affiliated pediatric EDs, and clinician educators, researchers, and administrators. All interviewees had teaching responsibilities during most of their clinical time, but some also had clinical shifts where they saw patients on their own without involvement of a trainee. Additional roles amongst the interviewees included: division chief, medical director, fellowship director, ED safety officer, director of quality and safety, director of ultrasound. Additional demographic information is presented in Table 2.

What is Professionalism?

Most commonly, PEM attendings described their behaviors, interactions and relationships with people as the most important aspect of professionalism. One attending stated, "I would say it means upholding a standard of behaviors and altruism; putting others first —essentially your patients, but also your colleagues and the people you're teaching and always acting in a way that has the highest standards of integrity and consideration for others." Another attending explained, "Exhibiting model behavior for junior colleagues and trainees…which means how I not only treat the patients and families, but also how I discuss those patients in an open forum with other doctors, and also how I treat my staff—ancillary staff, techs, nurses—professionalism is mostly about interactions

with those people." Additional individual concepts linked to professionalism included: responsibility, accountability, integrity, respect, trustworthiness, being ethical, advocacy and sensitivity.

A few PEM attendings also acknowledged appearance and behavioral factors in professionalism including: dress, being on time, cultural competence, treating people as equals, and holding themselves to the highest standard. Finally, attendings discussed acquisition and maintenance of knowledge and skills as a part of professionalism. Continuing medical education such as "continuing to read and understand the literature, do procedures, and learn new procedures" was an example.

Challenges and Stresses Being a PEM Physician

PEM attendings had a long list and wide variety of factors they identified as challenges to their professionalism (Table 3). These fell into several different categories with subthemes: (1) patient care in the ED, (2) staff interactions in the ED, (3) ED environment, (4) Division/Departmental level factors, and (5) personal factors. Time pressure, a busy department, and high acuity patients were some of the most frequently cited examples. Just as important were personal factors such as fatigue (in particular on overnights), hunger, and no time to compose oneself (or even go to the bathroom). Added to that were the challenges of teaching multiple residents at varying skill levels, interacting and leading a large team of nurses and ancillary staff, and parents with expectations that are difficult to meet and/or who are upset by long waits.

PEM attendings universally recognize that it's hard to perform at your best behavior when the various forces and stresses are at play. They felt professionalism was an extremely important part of being an attending, but acknowledged that it can be difficult to maintain professionalism at all times. As one attending described, "I think that the balance is how do we … realistically say look, we're human beings, we have a really stressful job at times. And we don't mean to be unprofessional. We wouldn't do this job if our intent was to be unprofessional. Sometimes we are unprofessional and it's like a coping mechanism. There's got to be a better way to deal with it, but [it's not because we're] bad people."

Layout and environment of the ED were also recognized as adding an additional challenge to maintaining professionalism, "We're out there charting and we're visible and talking, making small talk and laughing. It's normal. [During long shifts]…things are going to happen that are funny. But, the patient diagnosed with leukemia across the hallway, his parents don't care. They don't want to hear anybody laughing." Many attendings felt that one of the most influential factors was to create an overarching culture of professionalism. "If you're in an environment where others are acting professional and there's a culture of professionalism, then it's much easier to be professional. When you're in an environment where there's gossip behind everyone's back and no one really cares about the rules, then it's difficult. It's much easier to just conform than it is to act outside of what's considered to be the norm."

Teaching and Being a Role Model

PEM attendings recognize that they are important role models to everyone in the department, in particular the trainees. PEM attendings frequently talked about learning professionalism from their own attendings and role models. Many realized that professionalism is taught to residents every moment of every day, "I think we have a lot of power and influence. If we stop and think about it, I think we'd realize it, but I think in our day-to-day actions we don't realize that everything we do, is a reflection on who we are, what we say and what we do. And so, I'm role modeling for people even when I don't know that they're watching me."

The interviewed physicians struggled with the concept of being a role model for professionalism all the time. "You hope that you have enough of it instilled inside you to act professional always, but there are times when the persistence of working long hours really drains you, when you're completely frustrated by a situation. When the waits are really long, and you can't seem to make a dent on the waiting room, and you're worried that there could be sick children that aren't getting care, and the team just isn't functioning right that day."

In addition, PEM attendings talk about how they don't have enough time to directly observe residents interacting with patients. Many had tactics to try and get a sense of interactions whether it be asking the family about the resident, talking with nurses, assessing the skill from how the resident presents the case, or trying to sneak or join in on a part of the resident-family discussion. Observation was recognized as a crucial way to see how residents were interacting with patients. However, many acknowledged that it would take a significant, dedicated physician effort (that was unlikely to generate revenue). In addition, observation may change the dynamic in the room such that it doesn't simulate real patient experiences. Many acknowledged that this is a challenge that needs novel solutions.

Intermittent observation through video or one-way mirror was one idea suggested.

Changes Over Time

PEM physicians described several changes (relating to professionalism) that have occurred during their time as an attending. A few attendings felt that with experiences over time, they became more cautious in their reassurance to families when children were very ill, as they had times where they might have over-reassured parents and children ended up having bad outcomes. A prevalent theme was the increase in confidence over time with medical knowledge and ability to lead critical resuscitation. All attendings acknowledged that the nature of PEM was you could never master everything and there would always be things to learn. But in general, they felt that with more experience they were less "fazed" by diagnostic dilemmas and challenging medical situations during practice. This confidence led some attendings to describe feeling more comfortable dealing with emotional issues around critical situations and death. As one attending stated, "I think I'm probably a little bit more in tune now. Because in the beginning, you feel overwhelmed, right? There's just a lot going on, there's a lot to keep in mind. And once you get more comfortable in that, it's not so hard to do the [things] that come now automatically, and so you can actually devote some of your time and energy towards slightly different things."

PEM attendings in the latter half of their career discussed their concern over diminishing experience with procedures the further they are from training (eg, rare procedures and those that trainees do instead of attendings). Some older attendings felt they were not as motivated as their younger colleagues in adopting new evidence, skills, and using new therapies. One reason for this was their personal experience seeing new therapies come and go—being touted as the "next best thing" one minute and ultimately being "a complete failure and causing more harm." Older attendings also expressed concerns over the challenges of continuing practice with the changes that come with aging. Fatigue, especially from overnights, was identified as a major stressor.

Those attendings with children described a better understanding of how to talk with parents and an increase in empathy for the child's suffering and pain. Many also felt less judgmental of parents and more understanding of extenuating circumstances (and social problems) after they became parents. When dealing with bad outcomes in children, most described that they've learned how to manage their emotions in the workplace. As one attending put it, "in the ED you do eventually develop a little bit of comfort breaking bad news. It's not that you're jaded in any way, I hope. It's more that you've been down that path before and so you have a little bit of experience doing it … it's more familiar." Some also described how extreme sadness might occur at unpredictable times. For example, if the patient with a bad outcome had some characteristic that was similar to their own child (eg. same age, similar appearance, even something random like the same clothing).

DISCUSSION

Since the initiation of the Outcome Project by the Accreditation Council for Graduate Medical Education (ACGME) in 1998, professionalism has been elucidated as one of six core competencies in which residents must be evaluated and achieve competency during training. Existing literature on professionalism education identifies role modeling by attendings as one of the most crucial influences to the development of professionalism during residency.[7-13] However, no literature exists on how attendings feel they navigate their own professionalism during their careers. Given the high burnout rates in the field of emergency medicine, it is imperative we delve into academic PEM physician wellness both for the health of the workforce and the impact their wellness has on role modeling to trainees. This study looks at the PEM physician perspective on professionalism and the challenges they face. With this key stakeholder's perspective, scaffolding can be built towards developing interventions for the various challenges that PEM physicians face. The themes may also relate to those in other fields, such as general emergency medicine.

In the right column of Table 3 is a list of suggestions that were identified from the interviews. One systematic review that examined the hidden curriculum (a related, but separate construct) in medicine also created lists of proposed solutions, but noted that most of those solutions lived at the individual and organization level.[14] In this study, the rich data from stakeholder investigation helped to lend itself to individual, organization-based, as well as systems-level solutions.

In addition to describing proposed solutions for helping attendings maintain professionalism, an evidence-based approach to studying the efficacy of possible interventions is also needed. To study that robustly, assessment tools for professionalism will also need to be developed. Investigators in the

Netherlands performed a systematic review of role modeling to characterize its important attributes and used that to create and validate an assessment tool.[12,15] Of the 17 items in their instrument, 2 questions were rooted in professionalism ("conveys empathy for patients" and "is honest and has integrity"). This study may add to more development of assessment tools.

The American Board of Pediatrics' Milestone Project has broadened this discussion by laying out developmental steps that are to be achieved for attaining various competencies.[16] Achievement of developmental milestones in pediatrics includes professionalization, professional conduct, humanism, cultural competence. Interestingly, when PEM attendings are asked about "professionalism" they include areas that are traditionally included in all five other competencies: medical knowledge, practice-based learning, patient care, systems-based practice, and interpersonal/communication skills. This underscores the reality that physicians view professionalism as being imbued within every aspect of medical care. From this study, milestones can be strengthened by considering the behaviors and challenges that PEM physicians identify and ensuring these aspects are incorporated the behavioral language used in creating professionalism levels.[17]

Some limitations of this study include field observation at one site with one single investigator and although attempts were made to conceal the observation and participants were not aware of the study objectives, a Hawthorne effect may have altered behavior. Given both professional and unprofessional interactions were witnessed, this was likely minimized. For the interviews, one limitation is the single investigator review of all interviews and transcripts. However, the triangulation of data through two methods (observation and interviews) helps to increase the credibility of the findings. In addition, member checking (reviewing themes with original interviewees and other PEM experts to check credibility of findings) also adds to the robustness of the study. Lastly, the focus on PEM and the qualitative nature of the study limits generalizability to other settings. However, the focus on PEM is vital to those who have chosen to go into the field. The unique features of the ED (high volume, high stress, unique combination of cases, etc.) may make the pediatric ED an ideal lab in which to study professionalism. In addition, residents in pediatrics, emergency medicine, and family practice are some of the multiple programs that rotate through pediatric emergency departments, and therefore the study of PEM has a broad applicability to multiple groups of trainees.

CONCLUSION

This exploration of the attending perspective on maintaining professionalism provides deeper insight into the impact of role models on trainee professionalism education. Next steps could include development and implementation of interventions and educational curriculum that focus on answering the challenges identified in this study. Other important research will include development of robust assessment tools to measure professionalism, measuring how role models influence trainee education, and novel educational tools and strategies for teaching and fostering a culture of professionalism.

DECLARATIONS

Ethics approval and consent to participate: Approved by the Institutional Review Board at University of California, San Francisco

Consent for Publication: N/A

Availability of data and material: The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

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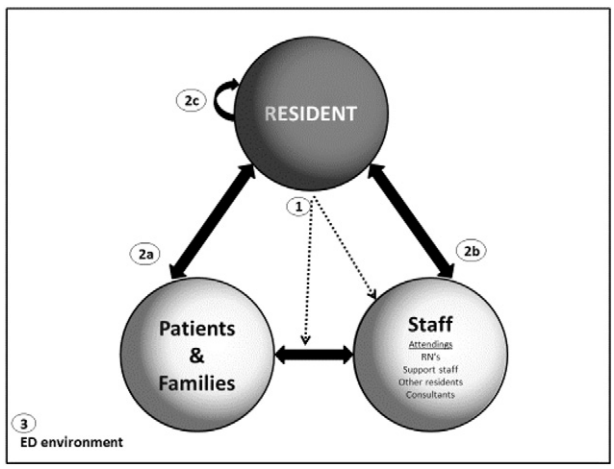
APPENDIX 1. FRAMEWORK FOR HOW RESIDENTS LEARN ABOUT PROFESSIONALISM



Residents self-describe learning about professionalism through:

1. OBSERVATION

Resident observes staff interactions with each other, patients, and families

2. INTERACTION

a. Resident interacts with patients and families
b. Resident interacts with staff
c. Resident self-reflects

3. ENVIRONMENT

Residents learn about professionalism in the context of the complex ED environment

APPENDIX 2. BASIC INTERVIEW GUIDE FOR INTERVIEWS WITH PEDIATRIC EMERGENCY MEDICINE ATTENDINGS

Introduction: This is an interview study looking at your perspective on how you exhibit and maintain professionalism during your career as a PEM physician. This interview will be recorded and transcribed without any identifiers. The recordings will then be destroyed. You may choose to end this interview at any time. There are no right or wrong answers—I'm interested in hearing your individual perspective.

1. When I say the word professionalism, what does that mean to you as it relates to being a PEM physician?
2. What are the things that affect your professionalism while working in the ED?
3. Give me an example of where you felt your professionalism was challenged?
4. How do you maintain professionalism despite the [specific challenges listed by interviewee]? (also probe for environment, time pressure, and difficult medical situations, ie, death)
5. Have you had an experience where you felt you displayed unprofessionalism in front of a patient or trainee?
6. Do you think residents learn about professionalism from you? How?
7. Have you been taught to teach professionalism? Do you ever talk about professionalism with residents while working in the ED?

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