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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Professional Resistance Be Integrated Into Conceptions of Professional Accountability?

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Abstract

As more health professions students, trainees, and clinicians engage in acts of professional resistance, professional accountability is needed when acts of resistance influence patient care. This article suggests standards that can help distinguish between professional and nonprofessional resistance and prioritize minimizing harm and injustice to patients.

Case

Dr A is a resident physician working with a patient, MM, in the emergency department. MM wants their nasogastric (NG) tube for feeding removed, and it is unclear to Dr A whether MM understands the risks of doing so when the NG tube is still needed from a clinical standpoint. Dr A, therefore, conducts a cognitive assessment to determine MM's capacity to make this specific decision at this point in time to remove their NG tube against clinical indication to keep it placed. Dr A determines that MM has capacity to make an informed refusal to continue with the NG tube and then calls the on-call surgeon, Dr S. Dr S is irritated that MM, a patient frequently seen in the emergency department, wants their NG tube removed and orders Dr A to administer medication to MM to "calm them down and help them tolerate the NG tube." Dr A is not comfortable administering medication to MM for this purpose when MM has capacity to make an informed refusal. Dr A considers how to respond.

Commentary

This case prompts a question: whether and how Dr A should resist Dr S's order about how to treat MM, their patient. Specifically, if Dr A does resist, which standards should guide Dr A's decision making, actions, and responses to consequences of those actions that might affect their patient?

Students and clinicians engage in acts of resistance in response to many injustices, including those related to racism, sexism, homophobia, patient and trainee mistreatment,[1] and structural underinvestment.[2] This is not a new phenomenon, as clinicians have long engaged in such acts, both overtly and covertly, but it is one that is growing in prominence and that is increasingly taxing schools' and professional bodies' ability to respond.[1] As an indication of the challenges that professional resistance can

create, the authors have all observed that some relatively mild acts of professional resistance are punished, while other acts that seem quite unprofessional are allowed to continue unchecked.[3] Without structure, professional resistance is random, ungrounded, and open to abuses that can harm or compromise those who resist, those who respond to acts of resistance, and bystanders. The problem is not simply one of naming and providing structure to professional resistance; it is ensuring that principles of professional resistance (what it means and how it should be pursued) are adopted as professional standards and then used to hold all professionals accountable for their actions. Without accountability, acts of professional resistance can undermine the integrity of individual professionals and the trust that society invests in the profession as a whole.

Accountability

In earlier work, the first and third author advanced the concept of professional resistance as a way to legitimize the discussion of resistance in health professions education.[4] We based this work on 4 core principles, in that professional resistance should be:

- Affirmative and principled: it should be for something rather than against something.
- Deliberate: it should be undertaken intentionally and mindfully.
- Proportionate: it should be sufficient to achieve its ends.
- Constructive: it should be about finding and building solutions.

In the case above, if the resident decides to resist the on-call surgeon, then they should affirm the patient's desire for the tube's removal; they should clearly communicate this intention; and they should act mindfully to achieve this end in ways that respect professional boundaries to achieve high-quality care for the patient. That said, we need to add the principle of accountability to standards, since being affirmative, deliberate, proportionate, and constructive are insufficient to resolve conflict and ambiguity regarding whether acts of resistance are or are not professional. In the case, this determination is not simply a matter of the resident's accountability to their supervisor; it is about mutual accountability and the accountability of both parties to the standards of their profession as a whole.

Professional accountability has both an internal and an external orientation.[5] From an internal perspective, being accountable involves an individual or group taking responsibility for their actions, and, from an external perspective, being held accountable centers on the judgments of others (such as patients and peers) that matter. Both are needed; neither will suffice on its own. To that end, the Medical Professionalism Project writes that physicians are expected to "participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards.... These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance."[6]

Accountability can have multiple facets. For instance, health care professionals have legal accountabilities (for their actions or omissions), ethical accountabilities (to the rights and integrity of persons and collectives), contractual accountabilities (to their employers), personal accountabilities (to their families, friends, and communities), and professional accountabilities (to the standards of their profession). While these facets

have served us well to this point, we now add one overlooked dimension of professional accountability to the list: that of accountability for professional resistance. This accountability is not to persons but rather to professional principles expressed as standards of conduct, such that all professionals are bound by them, both internally as a guide to behavior and externally as means of being held accountable by a professional collective for their individual behaviors.

Why Do We Need Standards?

Why do we need standards and accountability for acts of professional resistance? First, we need standards to be able to distinguish professional resistance from nonprofessional resistance, in which acts contesting power are unrelated to professional practice, such as political activity as a private citizen (although we acknowledge that separating private and professional lives can be challenging). When resistance is carried out in a professional context, it is critical to distinguish professional from unprofessional acts. For instance, sometimes an act of resistance may be an expression of pique, unfocused anger, frustration, or selfishness, such as when a resident, who is tired from long shifts and does not feel they are paid enough to treat patients and teach, barks orders at a student. Even acts of resistance that lack an ethical basis, such that resistors have no clear sense of what needs to change, are unhelpful, and their concerns can be easily dismissed by leaders as mere complaints.[7] Rather, acts of professional resistance should be constructive and aimed at changing how the collective thinks about and imagines the world.[8] In a positive sense, professional resistance typically responds to and seeks to address social harm and injustice and could be added to existing guidelines on professional behavior. In a negative sense, physician resistance can also be self-serving and coercive.[9]

Second, standards are needed for health professionals acting as change agents, particularly with respect to addressing social determinants of health, as what constitutes professional resistance is unclear and acts of resistance can conflict with each other.[10] For instance, there are those who campaign for greater social accountability in health care based on clinicians' obligations to respond to problems such as education and income inequity and food scarcity. Such acts challenge long-held beliefs that physicians, in particular, should attend to a biomedical model of care and instead extend physicians' roles into society at large. Additionally, there are those who argue that the social sciences have no place in health professions education, stressing instead the development of medical expertise, in particular.[11] Rather than taking a side, we note positive examples of resistance (engaging in public debate, focusing on patient and population health) as well as negative examples (shutting down debate, engaging in ad hominem attacks) on both sides. Again, standards can serve as a guide for individual behavior and as a basis for fairness, transparency, and accountability to health professions.

Third, standards are needed because professional resistance often happens in a vacuum (it is neither taught nor modeled by preceptors) and can take many different forms (eg, protest, workarounds, noncompliance, disengagement). Advocacy and resistance are part of a continuum; therefore, acts of resistance can be hidden or protected by describing them as advocacy while more substantial acts of advocacy (such as noncompliance) can be delegitimized as acts of resistance.[12] Engaging in professional resistance can be like walking a tightrope: too little resistance fails to effect change while too much resistance leads to individuals being punished or excluded.

With standards in place, it would be easier to distinguish between professional and nonprofessional acts of resistance and to do so in ways that are themselves fair and accountable. For instance, acts of resistance that are objectively judged to fall short of professional standards not only could lead to sanctions or remediation for those involved, but also could help to guide ethical reasoning. Recognized standards for professional resistance would also mean that they could be integrated into the training and subsequent professional development of health professionals, such that all members of the profession could ensure that their acts of resistance were both grounded in and bounded by professional values and expectations.[13]

Standards for professional resistance can also form a basis for meaningful discussions about resistance as a principle and its application. Resistance grounded within professional standards can help motivate shared understandings of what these acts should accomplish (ie, signal real or perceived social harm) and provides individuals with a space to discuss differences in experience or perception. By contrast, resistance outside of a professional context cannot be easily recognized as an effort to be constructive. Rather, it is often perceived to be lawless, ungovernable, and dangerous.

Accountability Grounds Authority

A profession that refuses to set or uphold standards loses its authority. While there are standards for providing patient care, interacting with colleagues, and social and fiscal probity, until now there have been no standards for professional resistance.[4] This article has outlined 5 principles of professional resistance (affirmative, deliberate, proportionate, constructive, and accountable) that we have found effective in establishing meaningful conversations and guiding policy development.

Care will be needed in translating these principles into professional standards and in identifying who decides whether these standards have been followed or breached. That is the work of existing professionalism committees that can add the standards for professional resistance to those already in place for professional practice. Some thought is also needed in balancing accountability for professional resistance with other accountabilities (eg, legal, fiscal, contractual) in ways that uphold a professional's responsibilities to respond to perceived harm and injustice.

Not only should those engaging in resistance in the context of a professional role follow standards of professional resistance; standards for professional resistance need to be solid, well understood, and woven into policy. They also need to be upheld, championed, modeled, and exemplified by the profession as a whole. Clearly, these kinds of changes cannot happen without the commitment of leaders as well as the investment of the profession. The bigger threat is letting the status quo continue, with professional resistance having no boundaries or structure, not least because resistance without accountabilities can destroy that which the profession seeks to heal.

Although we have set out a case both for professional resistance as a whole and for the need for standards for professional resistance and broad accountability (both internal and external) to those standards, further work is needed in establishing, reviewing, and implementing these standards by professional societies, medical schools, and licensing and credentialing boards (to name but a few). More research is also needed to explore the impact of this work on individual practitioners, on the profession as a whole, and on the quality of patient care.

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