VitalSigns

Next Steps for Professional Development

Office of Medical Education Research and Development — Fall 1997

Professional Development

In this issue ***VitalSigns*** reviews recent actions in the College of Human Medicine taken to promote the professional development of students. This review seemed timely, because the next steps in this area will require broad faculty support.

The metaphor of steps, of a quest or a journey, recurs through this ***VitalSigns*** issue. While this was unplanned, it seems right to describe the movement from one condition (student) to another (physician) with new rights and duties.

CHM is not alone in addressing issues of professional conduct. Students' development as professionals is now a lively topic in the literature of medical education. We are delighted that Louise Arnold of the University of Missouri--Kansas City School of Medicine, a central figure in this work, brings a national *PERSPECTIVE* to this issue of ***VitalSigns*** (page 5).

We invited a fourth year student, Elizabeth Warner, who has been engaged in professional development efforts at CHM, to contribute a student view. Her piece is so apt it was a clear choice for the lead article. It is heartening and instructive that once again a student has so persuasively framed the issues.

An Open Letter to the CHM Community

In August of 1994, I sat on the Task Force on Medical Student Behavior as the first year student representative. Surrounded by chairs of departments and Dean's appointees, I was not sure how I could contribute, so I plunged forth in the dialogue with idealism and a fair piece of righteousness. I thought that professional digressions were the bulk of concern. Plagiarism and cheating in the college had been rumored, but no official reports had been filed. I served as a voice of the indignant vast majority of the class who were shocked that cheating could occur in medical school. As the dialogue continued, it was clear that disciplinary actions were a minute part of the issue. The true challenge was in students maintaining and monitoring the professional behavior the medical profession expects, not readily "enforced" with rules and regulations. It was the students faced with witnessing or participating in unprofessional behavior, from cheating to discriminatory actions, who needed real support in the realm of professional development. They needed the courage to report incidents, the reflection to evaluate their actions, and the strength to set goals and higher standards for themselves.

> " I hope the College will accept the challenge..."

The Task Force completed its efforts in August, 1995, and I was hired as a graduate assistant for Academic Programs to help implement some of the Task Force recommendations. I have maintained that medical education needs to support the professional development of medical students throughout their education, and teach students practical skills to help survive their graduate training and medical careers. As a fourth year student, I have witnessed unprofessional behavior from attending physicians, residents, fellow students, and in myself. I often fumble through an ethical or professional dilemma with a sense of embarrassment or guilt but with increasing frequency am proud of my management of the incident. This reinforces my belief that we are all professional beings "in progress." I have lost some idealism, but am not broken. I am inspired by a vision of exemplary professional behavior, the seeds of which grow in each student, and are nurtured by the shaping and modeling of College faculty, administrators and peers. I am encouraged by changes made in recent years, and I hope the College will accept the challenge of encouraging trust and shaping an environment that fosters student professional development.

Elizabeth Warner

Finding a Way to Professional Virtue:

The College of Human Medicine transforms learners from students to professionals. The learning environment that prompts this metamorphosis increasingly has been coordinated since the report of the 1994-95 Task Force on Professional Development of Medical Students. The Task Force described central professional virtues for physicians and suggested changes in the CHM environment to promote professional development. Ruth Hoppe, Senior Associate Dean, has challenged CHM faculty groups to make the environment more supportive. The chart below indicates current elements of context, curriculum, and assessment designed to facilitate the professional development of CHM students.

Context

The trailhead for the students' journey of professional development is orientation week. Matriculants learn what is expected of them academically and of the values and mission of the College. In a recent addition developed by CHM student Elizabeth Warner (*Open Letter...* on page 1 of this issue) matriculants are introduced to the new graduation requirement embodied in the Virtuous Student Physician, a system of professional development for CHM students. Orientation week ends with the Matriculation Ceremony: by donning their white coats and reciting the Medical Student Oath, students take the first step in their on-going professional development.

Along the way, CHM students participate in groups addressing clinical and professional issues in class and less formal settings. These occasions provide significant opportunities for informal learning, and, it is hoped, promote trust and collegiality among students and faculty. Several activities have been organized to complement preclinical classes. Brown-bag seminars allow first year students to interact with administrators and faculty members around issues important to the students. Interest groups, such as the Family Medicine Interest Group and the Minority Medical Student Association, and Fourth Thursdays, monthly social gatherings, provide connections with faculty and students from other classes who are otherwise drawn apart by different schedules. In the third and fourth years, the educational enterprise moves to clinical sites in the community where students learn by practice and example.

The landscape of the medical school experience also is shaped by concerned organizations. CHM standing committees, the Offices of Student Affairs and of Academic Programs, the Center of Excellence, theStudent Advisory Committee and theWomen's Advisory Committee to the Dean monitor the interactions of students, staff and faculty, initiate policy change, and arrange student or faculty development needed to support professional development.

Curriculum

Courses include numerous guideposts for the development of professional virtues. The Clinical Skills Program instructs on the ethics and etiquette of physician interaction with patients as well as other health care professionals. Within the Social Context of Clinical Decisions (SCCD) curriculum, the responsibilities of physicians and their appropriate response to social and political pressures are explored. As part of the Mentor Program, students reflect with their faculty mentor on dilemmas in professional conduct exemplified in readings, video clips from television dramas, or other sources. Beginning in 1996-97, a guide organizing these stimulus materials for discussion was made available, resulting in mentor group sessions more often devoted to

Prematriculation | Block I | Block II

Orientation
White Coat Ceremony
Fourth Thursday
Interest Group Meetings
Brown Bag Lunches

Clinical Skills
Mentor Program
Social Context of Clinical Decisions

Admissions Ratings
Small Group Rating Forms

Designing a Path for the CHM Student Physician

Dennis Murray and Diane Singleton review mentor guide

issues of professional conduct and development. A new aspect of the Mentor Program, just begun in 1997-98, is students' creation of personal portfolios where they chronicle and reflect on personal milestones of their growing professionalism. Each portfolio will be reviewed periodically with the student's mentor. During the clinical years, as part of the Core Competencies Course, students now discuss how to respond to cases they've experienced that present difficult issues of professional conduct in health care delivery (*Clinical Training...* on page 7 of this issue).

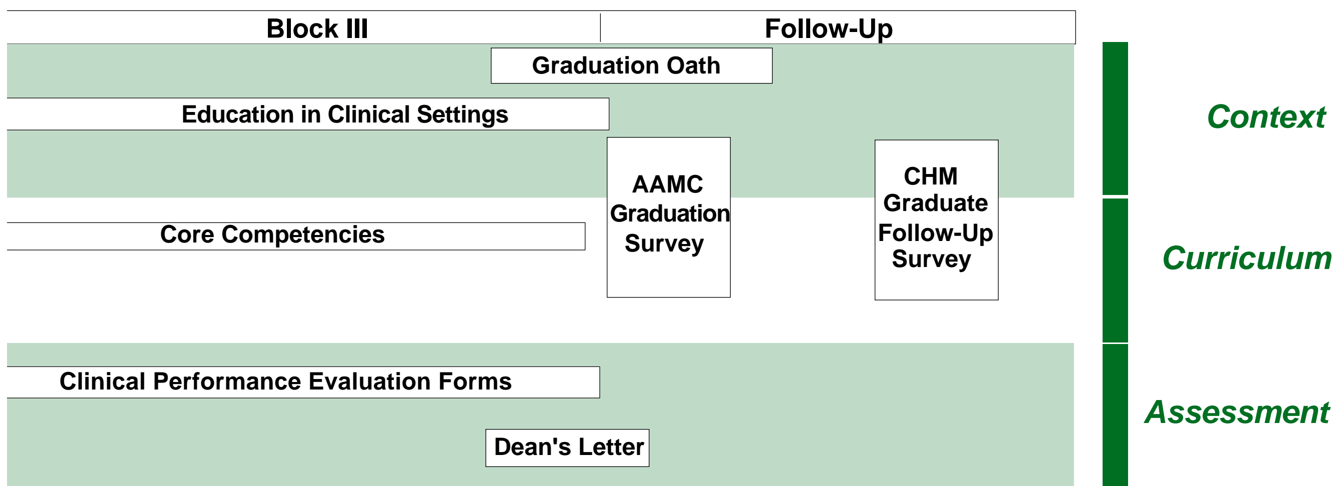
The CHM context for professional development and graduates' professional conduct is evaluated by both the AAMC Graduation Survey and CHM's own graduate follow-up survey. These surveys provide feedback about how curricular and contextual factors have influenced students' concept of professionalism in their passage through medical school.

Assessment

Admissions is the initial point of contact for students seeking to enter CHM; students' professional attributes are assessed for the first time in CHM, based on their written application and admission interview. The process asks if early forms of some of the professional virtues are already present and how ready candidates are for the road ahead. This assessment process has been made much more focused and explicit in the last four years.

During Blocks I and II, small group rating forms are used to give students feedback about their preparedness, ability to work as part of a group, and contribution to others' learning. Similarly, Block III Clinical Performance Evaluation ratings capture aspects of professional conduct in clinical settings, related to self-management and to interactions with patients and colleagues.

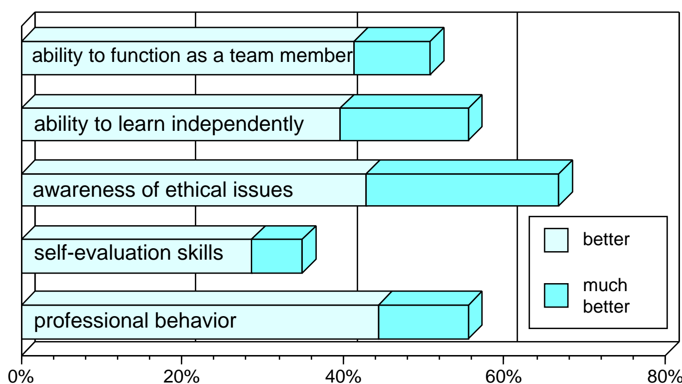
In 1996-97 the Student Performance Committee developed a description of indicators of central professional virtues among CHM students as a prologue to creating an overall system for assessing professional conduct (*Assessing...* on page 6 of this issue). However, each of the current instruments was developed before a systematic overall schema for assessing professional development was available, so current assessments are not coordinated with each other. Even the Dean's Letter, which summarizes the student's growth as a professional from matriculation to graduation, does not reflect a systematic survey of the available evidence on professional conduct over the student's path through CHM.



Grads Confident About Professional Behavior Preparation

Two years after graduation, CHM alumni compared their level of preparation to that of their fellow interns/residents in several areas associated with professional behavior. With the exception of self-evaluation skills, in which 2% of respondents reported they were less well prepared than their fellow interns/residents, all graduates felt they were at least as well prepared as their colleagues. Overall, when compared to others, grads were slightly more confident in their preparation related to professional behavior than in areas related to clinical skills (e.g., knowledge of clinical conditions, procedural skills, and ability to function in both inpatient and outpatient settings.)

Grads Rate Professional Skills Over Peers



Source: 1997 Graduate Follow-Up Study

What is not clear from this picture is how high the bar is set: do our graduates perform well above an already high standard, or do non-CHM interns/residents function so poorly in these areas that even a modicum of ability is considered above average?

Grads Give CHM Professional Environment Mixed Reviews

The most powerful factor in professional development is thought to be environmental: effective role models and the culture of the professional school and workplace.

As expected, the influence of role models at CHM is high: faculty actions leave a lasting impression on students. When recent graduates were asked about events at CHM that caused them to think about professional behavior, 47% cited the example of one or more faculty members. Although generally positive, some alumni wrote about being disturbed over incidents involving ethical judgments they questioned.

Reports from the CHM Graduate Follow-Up Survey indicate that 95% of respondents thought CHM treated students respectfully and dealt with them as learners, rather than as exploited help. Moreover, the CHM experiences most highly rated for educational quality are the clerkships and the experience in clinical communities.

Despite this positive retrospective view, there is room for improvement: in the AAMC graduation survey, over half of CHM graduates reported having been mistreated as students. The majority of instances occurred in the clinical setting. The most common form of mistreatment was public belittlement or humiliation, but there were also reports of differential treatment related to gender, ethnicity and race, and sexual orientation.

Over half of students who reported mistreatment while at CHM told a faculty member, indicating most knew a faculty member they trusted. Of those who did not report mistreatment when it occurred, over half said they did not

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What Makes a Professional?

Scholars have long debated the question, “What constitutes a true profession?” Whether medicine represents a profession, however, has not been so debated--it always appears (along with clergy and lawyers) in even the most strict definitions. Responding to society’s calling separates the medical profession from many other careers. What makes a profession? Experts often point to three essential criteria: extensive training and a high degree of knowledge; motivated by service to society and not self interest; autonomy and self control through a code of ethics and peer review.

Unlike some professions, physicians are educated and trained at considerable public expense, yet the profession has a near monopoly on delivery of healthcare. For essential health care the public has no choice but to trust the medical profession. The public must trust in two ways: trust in the integrity of the physician to act in the patient’s best interest; and trust that the

Perspective: Louise Arnold, Ph.D., Associate Dean

University of Missouri---Kansas City School of Medicine

The College of Human Medicine, in its programmatic commitment to the professional development of medical students, has launched upon a remarkable journey. It is remarkable because the journey has no terminus. Rather, it entails continual striving toward professionalism, comprised of attitudes, values, and behaviors that hold the primacy of patients' interests over physicians' self-interest. It is complex, for it takes a comprehensive approach to developing students' professionalism. The trip offers challenges, appropriately so.

Just as any first-class journey permits stop-overs for exploration, so too does this project call for pause to assess accomplishments and chart new directions. One of these "way stations" must afford reflection upon the faculty's role in students' professional development. Why? Faculty have the responsibility to shape the environment for learning professionalism.

During the stop-over some potential concerns about the faculty role might surface. What might they be, according to the literature? Faculty might stress in their teaching technical knowledge and skills over humanistic attributes and professional behaviors. They might fail to select formal course content which addresses students' needs for examining the ethical "here and now" embedded in daily learning tasks. They might neglect their power as role models for influencing what students actually learn about professional behavior. Faculty assessment systems, thoughtfully centered on unprofessional students and their remediation, might ignore the status of professional behaviors of all their learners. Even faculty enmeshed in improving the assessment of students' professional behavior treat rating forms perfunctorily.

Reflection at the College might identify some of these concerns. But there is cause for optimism since the literature offers recommendations to aid faculty in nurturing students' professionalism. Neophytes can be useful allies in helping faculty detect assumptions in the school's culture that countervail professionalism. More seasoned students can lead discussions of student-generated ethical dilemmas. Critical incidents constitute the basis for effective discussion groups and workshops to sustain students' professional ideals. Attention is being paid to the humanism of residents, and their workplace, that should in turn benefit students. Solid research on rating professionalism of learners is progressing. Raters clearly distinguish between ratees' technical knowledge and skills and their humanistic noncognitive traits. Standardized patient examinations and feedback cards enable faculty to evaluate learner's competence regarding professional behavior.

Should the College continue this journey? Professionalism is desirable, in and of itself. It is causally related to competence and associated with patient satisfaction. It is also self perpetuating.

So too is its converse. Bon voyage!

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physician will successfully treat the disease. The former addresses motivation while the latter is competence.

To assure that medicine meets its obligations as a profession, medical education has three important goals: First, faculty must be certain that graduates are competent -- i.e., they must have the knowledge and skills to effectively treat patients. Second, there must be assurance that graduates do act in the patient's best interest and not out of self-interest. Finally, graduates must accept their mutual responsibility for the profession's self-imposed high standards of conduct. The public will not tolerate a "conspiracy of silence" in which physicians glance away from a colleague's behavior.

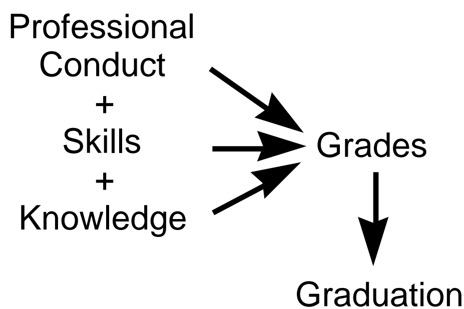
It is the responsibility of the College and faculty to address the issue of professional behavior. Arnold Relman, M.D., former editor of NEJM, targeted the problem when he wrote, "...physicians will have little opportunity to help shape the profession's future if they do not retain their public credibility. ...If physicians choose to act from self-interest they risk damaging their most precious possessions -- the trust and respect of their patients."

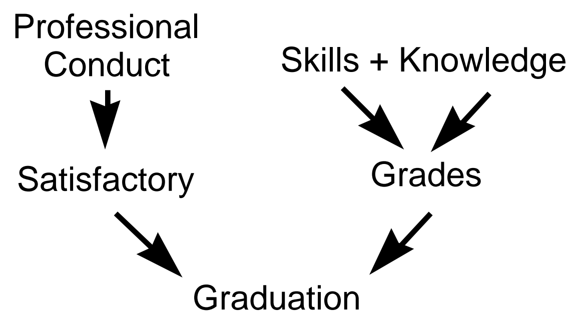
Assessing Students' Professional Conduct in CHM: Not If, But How!

The faculty of the College of Human Medicine is faced with a significant choice. How will the faculty make students' professional conduct an outcome of medical education that is assessed as systematically and as openly as students' knowledge and clinical skills? The CHM Student Performance Committee (SPC) is considering the question and has committed to bring a proposal for systematic assessment of students' professional conduct to the CHM faculty. As Nina Mattarella, M.D., Assistant Professor in Pediatrics and Human Development and an SPC member, puts it, "The question is not if, but how?"

In both approaches it will be clear that the college expects its graduates to demonstrate both professional virtues and intellectual competence in their conduct. However, the first approach makes existing courses and clerkships the vehicles for evaluating the appearance of these virtues and assures attention to them by making their assessment part of the course grade. Satisfactory professional conduct would be required for a passing grade, and an exemplary level of conduct required for an honors grade. Dr. Mattarella comments that this approach would broaden and might blur the meaning of course grades, but its assessments of professional conduct and their recognition or remediation would be tied to specific clinical education settings.

Which Way?





Discussion in the SPC has generated two fundamentally different approaches to assessment to assure that CHM graduates professional development had been appropriate and their professional conduct acceptable. After further consideration of these approaches the SPC will bring a recommendation to the faculty later this year.

Whatever the approach student professional conduct will be systematically assessed during courses that are most like clinical settings--clerkships, and the preclinical small group courses, such as Clinical Skills and the Block II Problem-Based Learning Groups. In one approach these assessments would be explicitly incorporated in the course or clerkship grade. In a second approach, assessments of professional conduct would not affect grades; instead, the assessments would form a parallel scheme of evaluation for professional conduct. A satisfactory evaluation of professional conduct would be required for graduation, mirroring the requirement of satisfactory mastery of the knowledge and skills central to the CHM curriculum.

In contrast, the second approach would leave course grading unchanged, although assessments of professional conduct from each relevant course and clerkship would be funneled into a separate system for appraising student professional conduct. Dr. Mattarella notes that many of the details of the approach remain to be worked out: how (and by whom) the course/clerkship reports would be processed to produce judgments of exemplary, adequate, or unacceptable professional conduct, and how these judgments would be reported and remediated.

Dr. Mattarella indicates that the SPC will try to recommend the best scheme for the college, but she suggests that, in the end, no scheme to assess students professional conduct will be effective unless "faculty are willing to take it seriously."

A Core Competency: Dealing with Professional Dilemmas

Are there choices beyond silence or career-destructive showdowns open to the third-year medical students who have questions about treatment options communicated to patients, or wince from disparaging public remarks from residents, attendings, or patients? CHM is attempting to provide students with timely and practical training in anticipating and developing strategies for dealing with troubling professional behaviors or situations. CHM medical students now participate in an innovative, required applied clinical ethics sequence initiated in 1996-97 as part of the third-year Core Competency course. Students present cases they experienced as troubling--omitting treatment options in discussions with some patients, mocking the comments of health care team members, favoritism to some students and residents--to their fellow students and a clinical preceptor. They consider strategies for working through the challenges presented in the specific cases and the more general problems the case might represent.

Dr. Barbara Supanich, Assistant Professor in Family Practice, who directed the design of this sequence, explains that the purpose of the module is to empower students, by giving them tools for and practice in identifying, presenting, and working with professional dilemmas. In developing the module with the community preceptors, she emphasized that the discussions should try to evoke the everyday challenges of clinical training and practice, rather than dramatic, unusual life-and-death scenarios. Dr. Supanich stressed that an important resource on which the course could draw was the existing network between the Center for Ethics and CHM clinical faculty active in applied ethics in each community. The clinical faculty in each campus work with the students to help them present cases in ways that make the cases amenable to problem-solving addressing the central issues. The clinical faculty also model this approach for students and for each other.

Barbara Supanich and students work through a case

Dr. Supanich expressed her admiration for the students and faculty who have made the abstract idea that collegial, critical review of clinical ethics is valuable into a vivid, immediate reality through their interactive case-based discussions. She is delighted that students recognize that, with awareness, they can formulate strategies that anticipate and perhaps even prevent potential dilemmas.

Join the Grapevine!

Send your reactions to *VitalSigns*

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feel the incident was serious enough to warrant a report. Unfortunately, 30% of those who experienced mistreatment said they did not report it because they feared retaliation, and 38% did not feel reporting would be effective.

CHM graduates have been more likely than their counterparts nationally to report all classes of mistreatment. While mistreatment may be higher among CHM students it may also be that CHM students are more sensitized to mistreatment and more likely to recognize it when it occurs. In any event, mistreatment of students occurs at CHM and affects the context for professional development of those touched by it.

Public Trust: Zigs and Zags

In a 1984 poll, two-thirds said that people are losing faith in doctors. The poll found patients assume their physicians are technically competent, but it is warmth and interest in patients as individuals that are important.

The National Practitioner Data Bank records actions of questionable practice; it is used to screen prospective associates, etc. In 1996 the Data Bank received notice of almost 20,000 malpractice payments and of 2,731 serious disciplinary actions (license revocation, probation, etc.) with wide, unexplained, variations between states.

Will such data reassure the public? A 1991 study found that most patients did not think of themselves as wary consumers. They preferred to trust their doctor, and did not actively seek information about their physician.

Recently, warnings have multiplied that patients' trust of their physicians is at risk in the managed care setting as patients question if decisions are intended to protect patients or to serve the physician's own interests.

Grapevine

Our mail continues to point us to interesting questions. Two of the responses to our last issue appear below. Let's hear from you!

"I read with interest the *VitalSigns* on student evaluation. We in Kalamazoo wrestle with grade inflation. I was at a meeting where it was suggested that we examine all the high grades on the Clinical Performance Evaluation, line them up by their numbers, and rank the students in quartiles. This does NOT imply an obligation to flunk any of the students, but it at least gives a relative assessment.

We also need to tighten up criteria for such performances as procedures, interviews, focused exams, etc. It is more labor-intensive for the faculty to document all these things, but so be it. The 'soft aspects' of the evaluation such as attitude, punctuality, affability, reliability, honesty, etc. are more difficult to evaluate, and are usually the'fluff' that inflates grades. I equate failing these 'soft' signs with pornography. It is hard to define, but you know it when you see it. We like to think assessment problems will be solved by tighter objective criteria, but what do we do with a student who may be procedurally competent, score very high on his clerkship exam, but is totally dishonest and arrogant? How much weight does each criterion get?" *Arthur N. Feinberg, M. D., Assistant Professor, Pediatrics and Human Development, Kalamazoo Center for Medical Studies*

"Your spring issue on assessing clinical performance did an excellent job of raising questions and defining goals for performance assessment of medical students. I have been a member of the Student Performance Committee for many years, and we have struggled with the interpretation of various types of student assessment in determining the potential of students to achieve professional competence. An expanded system of performance assessment to evaluate the achievement of core competencies would be a great asset in assuring the clinical competence of our graduates and in assessing the progress of students through the curriculum." *Kathryn Lovell, Ph.D., former Chair, CHM Student Performance Committee*

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