



Medical Students' Perspectives on Learning Professionalism

As professionalism is now a required competency in medical education, a number of themes regarding its teaching have emerged:

- ❖ Role models are the primary influence on students' professional development.
- ❖ Activities in which trainees are explicitly taught principles of professionalism are an important adjunct to role modeling.
- ❖ Having faculty available to discuss negative behavior may mitigate the effects of such behavior.
- ❖ To promote professionalism in trainees, medical schools must hold their entire faculty to the highest professional standards.

Amy Baernstein, MD, and colleagues used qualitative analyses to explore students' perceptions about how they had learned professionalism by the end of their pre-clinical curriculum at the University of Washington School of Medicine.

Professionalism education at Washington involves both formal and informal elements. The formal curriculum includes lectures, panels, small-group discussions, written reflections, and ceremonies. The six-station objective structured clinical examination (OSCE) second-year students must pass before progressing to clerkships includes a station on professionalism. The informal curriculum emerges through student contact with faculty, physicians, or peers in clinical contexts.

As part of a survey of second-year students about curriculum improvement, the investigators asked participants six questions specifically addressing professionalism, including the student's definition of the term,

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perceived influences on professionalism, and both professional and unprofessional behaviors that the student had observed.

Based on student responses, the authors identified four domains as most salient in professionalism education: role models, formal curriculum, prior life experience or background, and experiential learning. They perceived role models—a part of the informal curriculum—as the most important influence on their professional development. They identified both classroom and clinical faculty as role models, demonstrating the need for basic science faculty to work with clinical faculty to ensure that consistent professionalism standards are practiced throughout the school.

Interestingly, to some students, just the idea of having a formal professionalism curriculum implied that the faculty or administration believed that the students lacked professionalism and therefore needed to be taught this trait. It is therefore important, say the authors, to explicitly acknowledge and appreciate the background and experience that students bring to medical school and to present professionalism in the context of quality improvement.

Baernstein A, Amies Oelschlagel A-ME, Chang TA, Wenrich MD. Learning professionalism: perspectives of preclinical medical students. Acad Med 2009;84(5):574–581.

The Reynolds Geriatrics Education Programs: Changing Geriatric Education

One of the American Geriatrics Society's goals for the future of geriatric medicine is to increase the number of health professionals who use the principles of geriatric medicine in caring for their elderly patients. To help further this goal, in 2001, the Donald W. Reynolds Foundation awarded almost \$20 million to 10 medical schools to strengthen geriatrics training for medical students, residents, and practicing physicians. Each institution could receive up to

\$500,000 per year for four years and was required to contribute a match of \$1 for each \$2 of foundation support. Furthermore, each institution had to make a formal commitment to sustain its program after grant funding ended. The first cohort of Reynolds schools completed their grants in 2006. David B. Reuben, MD, and associates developed a multimethod evaluation plan to address the foundation's primary question: Were these 10 funded programs successful at strengthening the geriatric training of medical students, residents, faculty, and practicing physicians?

The evaluation focused on the structure, process, and outcome changes as a result of the Reynolds grant programs, including dissemination activities to enhance geriatric education at other institutions. The investigators used three main evaluation activities: structured interviews with program directors; analysis of administrative data provided by the Reynolds Foundation; and analysis of relevant secondary survey data.

All 10 institutions exceeded the required match of \$1 for every \$2 in grant funds. The schools developed programs that largely incorporated geriatric content into the medical school curriculum, but resources were also devoted to residency, postresidency fellowship, and community-based practitioner training. All institutions also reported structural changes in clinical education, including new or revised geriatric rotations for trainees or placement of students in new clinical situations. On average, during the grant period, each institution trained more than 1000 medical students, 500 residents, 100 faculty, and 700 nonfaculty community physicians. During this period, students' reported geriatrics experiences increased dramatically.

Based on the experience of the 10 schools in the first Reynolds cohort, the funding strategy was highly successful in meeting its goals. Therefore, a previously unplanned fourth cohort of 10 medical schools has been funded.

Reuben DB, Bachrach PS, McCreath H, Simpson D, Bragg EJ, Warshaw GA, Snyder R, Frank JC. Changing the course of geriatrics education: an evaluation of the first cohort of Reynolds geriatric education programs. Acad Med 2009;84(5):619–626.

How Do Schools Handle Poor Performance?

Medical schools have increasingly been using comprehensive clinical skills assessments as a way to evaluate students' clinical competence. However, following these assessments, medical educators must determine follow-up plans for students who perform poorly. Remediation requirements differ across students and institutions, but the factors associated with more structured remediation are not known. Karen E. Hauer, MD, and fellow researchers hypothesized that there could be an association between institutional commitment to the comprehensive assessment and consequences of poor performance for students. They surmised that institutional commitment, length of experience with the exam, clerkship director involvement, and satisfaction with and confidence in the remediation process are associated with a strong commitment to remediation and required consequences.

The investigators surveyed medical school curriculum deans to characterize the consequences for students of poor performance on a comprehensive assessment using standardized patients (SPs), and to determine whether institutional investment in the assessment and satisfaction with the remediation process relate to required consequences for poor performance.

A large majority of medical schools surveyed (88%) conduct a comprehensive assessment using SPs after the core clerkships; all planned to continue these programs. However, only a minority of respondents restricted academic progress on the basis of exam results.

The investigators say that their findings suggest that most schools do not hold themselves accountable for bringing students up to an acceptable performance standard, as although most require remediation, they do not require retesting, nor do they report the results externally. It is possible that institutional leaders trust students or residency program directors to address their skill deficiencies in subsequent training; however, there is no proof that this actually occurs. The authors assert that medical schools invest significant time and resources into these assessments, and they have an obligation to students, faculty, and society to determine whether their programs

are successful, to remediate students with identified deficiencies, and track outcomes during and beyond medical school.

Hauer KE, Teherani A, Kerr KM, Irby DM, O'Sullivan PS. *Consequences within medical schools for students with poor performance on a medical school standardized patient comprehensive assessment.* Acad Med 2009;84(5):663–668.

Critical Consciousness: Beyond Cultural Competency

Although cultural competency is one of the educational outcomes required by the Liaison Committee on Medical Education, cultural competency initiatives are often implemented without an explicit link between the idea of diversity and the underlying concept of social justice in health care. Arno K. Kumagai, MD, and Monica L. Lypson, MD, propose that educating physicians skilled at addressing the health care needs of a diverse society involves not only the fulfillment of a competency, but also the development of a critical consciousness — an orientation that places medicine in a social, cultural, and historical context and that is coupled with an active recognition of societal problems and a search for appropriate solutions.

Cultural competency, say the authors, is not a static requirement to be checked off on a competency list, but rather is the fostering of a type of thinking and knowing of oneself, others, and the world. In the context of the social practice of medicine, critical thinking alone may lead to technical skill, but without an understanding or the ability to effectively address health-related issues that confront today's society. Critical consciousness, however, maintains that the thinking subject does not exist in isolation, but rather is in relationship to others in the world. This involves a reflective awareness of the differences in power and privilege, and the inequities inherent in social relationships, which will give the trainee the knowledge and awareness to carry out the social roles and responsibilities of a physician.

How can medical schools foster the development of critical consciousness? Discussion is not enough, say the authors, who describe their program at the University of Michigan, in which small groups of

students remain together for two years. This allows for a degree of comfort and familiarity when discussing personal issues.

Education, say the authors, must involve the development of a professional and personal perspective and critical, reflective awareness that incorporates the student's own values, worldview, and experiences. In their program, students are encouraged to reflect critically on the moral basis of their beliefs and assumptions, given the overall professional mandate to provide effective health care to all members of society.

Kumagai AK, Lypson ML. *Beyond cultural competence: critical consciousness, social justice, and multicultural education.* Acad Med 2009;84(6):782–787.

A Call to Speak Out for Gay Rights

In a Perspective article, Anne Dohrenwend, PhD, maintains that social responsibility requires that medicine use its influence to end discrimination and reduce barriers to health care. Although the gay, lesbian, bisexual, and transgender (GLBT) population suffers from a high degree of health care disparity, the medical community and its affiliated organizations have done little to advance the causes of the GLBT population, including using its influence to change the misconceptions regarding GLBT relationships.

Even in medical schools themselves, says the author, GLBT students and faculty often do not have safe, equal environments in which to study and work. There are no credentialing provisions that require residency programs and their affiliate hospitals to include GLBT status in their nondiscrimination policies or to offer equal benefits to GLBT faculty and residents.

The author suggests 10 ways in which academic medicine can support GLBT rights: creating task forces; requiring teaching hospitals to offer equal benefits to GLBT residents and faculty; requiring training programs to provide protection from employment discrimination; creating a Web site for GLBT medical students, residents, and faculty; inviting the president of the Gay and Lesbian Medical Association to give a keynote address at the AAMC annual meeting; publishing a special issue of

Academic Medicine focusing on GLBT issues; developing additional standards for peer review; encouraging constituent groups; providing relevant medical and scientific research on GLBT concerns; and encouraging the hiring of GLBT faculty.

Dohrenwend A. **Perspective: A grand challenge to academic medicine: speak out on gay rights.** *Acad Med* 2009;84(6):788–792.