

Why Should We Assess Professionalism in Trainees?

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Objectives

1. Know the correlation of trainees' performance with their subsequent performance as practicing physicians
2. Describe the demographics of disciplinary actions imposed by U. S. medical boards
3. Discuss the policy implications of the data that are presented

It is a privilege and a joy to be involved in the education of medical students and residents

Evaluation of Professionalism

- Must be taught in order to be evaluated
- Explicit learning objective in many medical schools' curricula and an ACGME core competence
- Sociology of professionalism-differing interpretations
- Today's focus will not be on curriculum

Pediatrics Clerkship Evaluation

Enthusiastic student

Faculty has concerns about student's self-improvement and adaptability

Disrespectful and arrogant behavior to families and nurses

Received constructive feedback but defensive in accepting it

Improved during the second half of clerkship

PASSED All Clerkships Marginal Professionalism

- No overall improvement in pattern
- Preclerkship years
Marked problematic behavior despite intensive efforts at remediation

UCSF's Professionalism Evaluation System

- Process implemented in 1995
- Goal is remediation
- Academic consequences

Physicianship Evaluation Form Years 3-4

- Unmet professional responsibility
 - Needs continual reminders
 - Cannot be relied upon to complete tasks
- Lack of self-improvement & adaptability
 - Resistant to feedback, arrogant
 - Unaware of inadequacies
- Diminished relationships with
 - Patients & families
 - Health care team

UCSF's Professionalism Evaluation System

- Goal is remediation
- Academic consequences
- Needed outcome data to support policy

Research Question

Does unprofessional behavior in medical school predict disciplinary action by the state licensing boards?

Methods

- **Design**
 - ◆ Case-Control Study
- **Subjects**
 - ◆ **Cases**
 - † All UCSF graduates disciplined by the state medical board (1990-2000)
 - ◆ **Controls**
 - † UCSF graduates matched to graduation year and specialty

Disciplinary Risk by the Medical Board of California

VARIABLE	ODDS RATIO
Age (20 years)	1.6
Male Gender	2.8
Board Certification	0.5
International Education (non US or Canadian)	1.4

N Kohatsu 2004

Disciplinary Risk by Specialties* Medical Board of California

	ODDS RATIO
Family Practice	1.7
General Practice	2.0
OB-GYN	2.3
Pediatrics	0.6
Psychiatry	1.9
Radiology	0.4
Surgery (all)	1.4 (p=.06)

*Internal Medicine is the reference group for each specialty

N Kohatsu 2004

METHODS

PREDICTOR VARIABLES

- MCAT scores
- Undergraduate GPA
- Medical school grades
- USMLE Part 1
- Unprofessional comments in evaluations at the threshold of a Physicianship Form

OUTCOME VARIABLE

Disciplinary action by the state medical board

Characteristics of the Subjects

Graduation Year (range)	1943-1989	
	Cases	Controls
	n=68	n=198
Gender (%)		
Male	88	81
Female	11	18

Predictors of Disciplinary Action

Predictor	Odds Ratio	P value
Male sex		NS
Undergraduate GPA		NS
MCAT lowest quartile		NS
Did not pass ≥ 1 course		NS
Unprofessional behavior (~Physicianship Form)	2.3	0.01

Sensitivity and Specificity of Negative Comments for Disciplinary Action

- Sensitivity = 38 percent
- Specificity = 81 percent

Unprofessional Behavior in Medical School and Subsequent Disciplinary Action by State Medical Boards

A Teherani, M Banach, C Hodgson, S Rattner,
J Veloski, D Stern, T Knettlar

UCSF, University of Michigan, Jefferson Medical College,
Federation of State Medical Boards

M Papadakis New Engl J Med 2005

Methods

Design	Case-control study
Cases	All graduates disciplined by any state medical board (1990-2003) from: Jefferson Medical College University of Michigan UCSF
Controls	Matched to: School Graduation year Specialty

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Federation of
STATE
MEDICAL
BOARDS

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alop@rmb.org

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Association of Unprofessional Behavior in Medical School with Subsequent Disciplinary Action

n = 732 physicians (1/3 cases, 2/3 controls)
3 medical schools
40 state medical boards in the U.S.

Odds ratio	CI (95%)	Attributable risk
3.0	1.9-4.8	26%

Frequency of Unprofessional Behavior in Medical School

Cases	Controls	P
39%	19%	<.001

Types of Unprofessional Behavior Associated with Disciplinary Action

	Odds Ratio
Irresponsibility	8.5
Poor self-improvement	3.1
Immaturity	NS
Poor initiative	NS
Impaired relationships with:	
Students, residents, faculty	NS
Nurses	NS
Patients and families	NS

Poor Ability to Self Improve

- Does not solicit feedback
- Does not incorporate the feedback
- Critical negatives
 - ◆ Lack of adaptability
 - ◆ Arrogant, bad attitude
 - ◆ Always need to be right

Other Predictors

	<u>Odds Ratio</u>	<u>Attributable risk</u>
Undergraduate science grade point average	1.0	
MCAT scores	0.6	1%
Medical school grades		
Years 1-2	1.6	7%
Years 3-4	1.1	
NBME/USMLE Step 1	0.9	
Unprofessional behavior	3.0	26%

Do These Relationships Persist During Residency?

American Board of Internal Medicine Study

Design	Cohort study
Subjects	All U.S. medicine residents in 1990-2000 n=66,000
Predictor variables	Performance measures Program Director ratings (6 components) Certification examination score Demographics
Outcome variable	Disciplinary action (17 years)

Six Components of the Program Director Ratings

- Medical interviewing
- Physical examination skills
- Procedural skills
- Medical knowledge
- Professionalism
 - ◆ Embedded in medical school grades
- Overall clinical competence

RESULTS over the 17-year interval of the study

Total study population = 66,171

Disciplined physicians = 1%

Bases of Disciplinary Actions

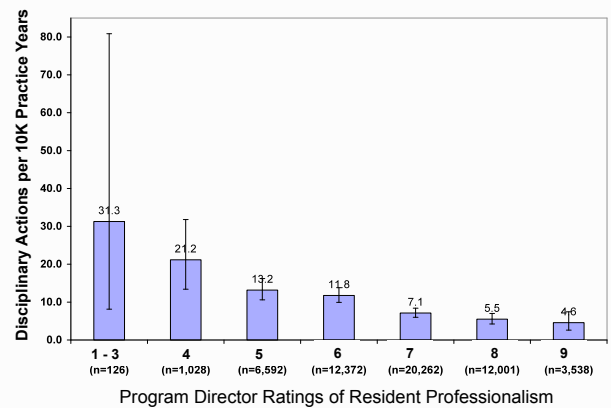
	<u>%</u>
Failure to meet educational requirement (e.g. CME)	18
General	16
Fraud/billing/tax irregularities	10
Controlled substance violations	9
Examination/license irregularities	8
Substance use (e.g. self use of drugs/alcohol)	8
Professional conduct	6
Convicted of a crime	5
Sexual misconduct	5

Significant Predictor Variables

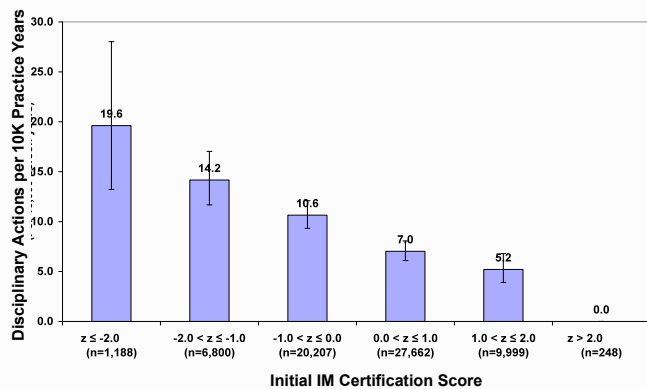
	Odds Ratio
Low professionalism score	2
Low ABIM certification exam score	2

M Papadakis Ann Intern Med 2008

Resident's Professionalism Rating and Risk for Subsequent Disciplinary Action



Score on the Internal Medicine Certification Examination and Risk for Subsequent Disciplinary Action



Practical Implications

- Study provides documentation that ratings in professionalism bear on the subsequent care of patients
- "Forward feeding" is needed to observe pattern of behaviors (see Acad Med 2008)
- Data support the ACGME's expansion of the competencies to include professionalism

What do these data NOT support?

Dismissal of trainees for fear of subsequent disciplinary action

- Performance measures during medical school and residency are poor screening tests for disciplinary action
- Decisions to promote residents should be based on achievement of ACGME competencies and specialty standards

Medical Council of Canada Qualifying Examination

- Physicians from Ontario and Quebec 1993-1996
- Lower MCCQE scores on patient-physician communication and clinical decision making predicted future complaints to the licensing board

Tamblyn JAMA 2007

**Performance Measures During
Residency for Subsequent
GOOD Care of Patients**

**Do Medical Council of Canada
Qualifying Examination and Quebec
Licensing Examination scores predict:**

1. Mammography screening rate
2. Continuity of care visit rate
3. Contraindicated prescribing rate
4. Consultation rate

Tamblyn JAMA 2002

**HIGH-SCORING PHYSICIANS
WOULD ORDER 347 MORE
MAMMOGRAMS PER 1000
WOMEN THAN LOW-SCORING
PHYSICIANS**

Tamblyn JAMA 2002

We Need

Expertise in remediation

Remediation best practices

Should students repeat rotations?

Guidance to toxic residents?

How do we know if our remediation efforts are
successful?

**What do we know from
remediation studies?
National Board of Medical Examiners study**

“There is an urgent need for multi-institutional, outcomes based research on strategies for remediation of less than fully competent trainees and physicians with the use of long-term follow-up to determine the impact on future performance.”

Hauer et al Acad Med. 2009; 84:1822-1832

What should we do?

The educational community
should advance a mandate
to determine best practices
for remediation

How does an admission committee identify applicants who are most likely to be professional?

The largest challenge

Existing personal interview has limited ability to assess non-cognitive domains

Multiple Mini-Interview

- Kevin Eva et al, McMaster University
- Admission Objective Structured Clinical Examination (OSCE)
- Scenarios
 - ◆ Medical student with alcohol on breath
 - ◆ You inadvertently give the wrong drug
 - ◆ Patient asks you out for a date
 - ◆ Patient asks for antibiotic for family member to be paid by patient's insurance
 - ◆ Classmate gives you test answer sheet

Multiple Mini-Interview for Medical School

- Best predictor of:
 - ◆ Much preclerkship and clerkship performance, including OSCE
 - ◆ Not predicted by other admissions measures or grade point average
- Grade point average best predictor of performance on multiple-choice questions of medical knowledge
- McGill: MMI 70% of final rank

How do we create a "culture of professionalism"?

Educational Environment

Must address unprofessional behavior by faculty

Two "Respect" Questions

1. Treat Me with Respect
"I was treated with respect by this attending physician"
2. Treat Others with Respect
"I observed others (students, residents, staff, patients) being treated with respect by this attending physician"

Student evaluation of "respectful" treatment by faculty at UCSF

This faculty member:

1. Failed to treat me with respect and generally displayed an unprofessional or abusive manner in all interactions
- to
5. Consistently treated me with respect

Treat me with respect - Reasons

<input type="checkbox"/>	Belittled or humiliated me
<input type="checkbox"/>	Spoke sarcastically or insultingly to me
<input type="checkbox"/>	Intentionally neglected or left me out of the communications
<input type="checkbox"/>	Subjected me to offensive sexist remarks or names
<input type="checkbox"/>	Subjected me to racist or ethically offensive remarks or names
<input type="checkbox"/>	Engaged in discomfoting humor
<input type="checkbox"/>	Denied me training opportunities because of my gender
<input type="checkbox"/>	Required me to perform personal services (i.e. babysitting, shopping)
<input type="checkbox"/>	Threw instruments/bandages, equipment etc.
<input type="checkbox"/>	Threatened me with physical harm (e.g. hit, slapped, kicked)
<input type="checkbox"/>	Created a hostile environment for learning
<input type="checkbox"/>	Other

Central Monitoring of Data

- Critical to the success of the initiative
- Know up front what is expected
- Assessment drives performance
- Other uses:
 - ◆ Reward faculty
 - ◆ Uncover systems-based problems

Richard and Sylvia Cruess

"...Students need to know if they are meeting professional expectations...Professionalism is so fundamental to medicine's relationship to society that evidence that its cognitive base has been learned and its values internalized and reflected by behaviors must be recorded...The public must be assured of the competence and the character of graduates of both undergraduate and postgraduate programs..."

Medical Teacher 2006

Summary

- Professionalism should be a CORE academic (not just disciplinary) competence