

AMA Journal of Ethics

February 2015, Volume 17, Number 2: 142-146

IN THE LITERATURE

Role Models' Influence on Medical Students' Professional Development

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Haidet P, Stein HF. The role of the student-teacher relationship in the formation of physicians: the hidden curriculum as process. *J Gen Intern Med*.

2006;21(1)(suppl):S16-S20.

In their 2006 article, "The Role of the Student-Teacher Relationship in the Formation of Physicians: The Hidden Curriculum," Haidet and Stein challenge us to consider the student-teacher bond as we educate medical students and help them develop their professional identities [1]. They approached this topic from the framework of relationship-centered care, which underscores the importance of all relationships in medical care, not just the patient-doctor dyad. This includes relationships between health care professionals, within the patient's family, and within the community as a whole. When they used these relationship ideals to examine medical education, the authors discovered that even as medical schools established more formal courses and rituals that focused on communication, compassion, and humanism, they were still turning out medical students who demonstrated an erosion of relationship skills as they progressed through their education. This raised the question: what is the culture of medicine—its hidden and informal curricula—teaching our students?

Haidet and Stein drew a connection between the implicit messages medical trainees receive (what they refer to as "assumptions") and the "premises" that underlie them. For example, the message that "doctors never admit to not knowing something" underscores the premise that "uncertainty and complexity are to be avoided" [2]. This is an undesirable belief for a number of reasons: it can affect students' educations by causing them to fear asking questions and admitting ignorance, and it also discourages students from admitting uncertainty to patients. Yet, are there not times when we do not know the cause of a patient's symptoms and need to investigate further, or times that the solution to a medical problem is not a simple fix?

Other premises that Haidet and Stein note are that "outcome is more important than process" and "hierarchy is necessary" [2]. These premises give rise to various assumptions and messages, for example, that it is acceptable to be rude while doing something important and that inferiors must never question their superiors. These kinds of beliefs can lead to "pimping," or public shaming, of students. As Benbassat emphasizes, "faculty cannot humiliate medical students and still expect them to respect patients, just as it is impossible to ignore students' distress and still teach them to empathize with patients" [3]. Haidet and Stein reflect on research showing that, when students feel intimidated,

they tend to hide what they do not know and are afraid to clarify misconceptions. Haidet and Stein contend further that, when a student “is at best emotionally disconnected and at worst emotionally attacked by the teacher,” this fosters a “professional stance that is emotionally distant from patients” and anyone else who is lower in the medical hierarchy [2].

These unspoken but clearly demonstrated relational messages are part of the hidden curriculum, which Gaufberg, Batalden, Sands, and Bell describe as “the set of influences on one’s development as a physician that is not explicitly taught. It is transmitted through interpersonal interactions on the wards or in other clinical settings, through positive or negative role model behaviors, and through the culture and hierarchy of medicine” [4]. The mention of role models raises an issue that Haidet and Stein challenge readers to consider: “to what extent do positive or negative student-teacher relationships mediate students’ adoption of the implicit premises of medical culture?” [5]. In other words, how are educator role models affecting medical students’ professional development?

Wear and Skillicorn [6] have tried to answer some of these questions, building on the work of Haidet and Stein. They examined medical students’, residents’, and attending physicians’ perceptions of the formal, informal, and hidden curricula in psychiatry. All three groups agreed that the formal psychiatry curriculum focused on building relationships and that elements of the informal and hidden curricula were conveyed by interactions, particularly those of the attending physicians with patients and students. While the attending psychiatrists reported wanting to impart only professionally desirable lessons in modeling interactions, students and residents described messages communicated in attending psychiatrists’ behavior, e.g., through expressions of cynicism or spending little time developing relationships with patients or students, that contradicted the formal curriculum’s emphasis on relationship building.

The disparity in how different members of the medical hierarchy viewed these interactions can be explained in different ways. Wear and Skillicorn proposed that the attending physicians interviewed as part of the focus group may have been the “good” role models who were not imparting these negative messages. But others have brought up the idea that attending physicians may have impacts on students and trainees of which they are unaware [7]. Often professionals are so entrenched in the culture of medicine that they are not cognizant of some of the hidden messages that are being imparted.

Whether physicians are aware of what they are communicating or not, the effects of role modeling on medical students can be profound. One study used longitudinal narratives to examine the impact of role models’ behavior on the development of students’ professional identities [8]. Some of the encounters were affirming: students encountered engaged doctors who demonstrated empathy and helped them to understand the emotional demands placed on physicians and ways to strengthen the patient-doctor relationship. Others experienced the opposite: one student who started out enthusiastic described being “profoundly changed by witnessing harsh treatment from a negative role model” [9]. In institutions where teamwork and collaboration are often emphasized in the preclinical years of education, encountering examples of harassment, or at the very least emotional disregard, in the clinical setting can be a rude awakening.

Mentoring behavior has a long reach—its effects extend beyond those who experience it firsthand. It can even influence students with whom the role model has no contact, as negative and positive stories are shared [10]. It can affect patients by informing how students will eventually practice medicine themselves, and it can affect younger trainees by informing how students will act when they become residents or, in some cases, attending physicians.

For example, one study examining student “mistreatment” according to specialty found that students experienced more mistreatment in surgery, obstetrics-gynecology, and internal medicine clerkships [7]. Although resident physicians were most often the inflictors of the abuse, some of the faculty saw the negative comments as mere jokes—something that should not be taken seriously. These results seem to suggest that this kind of treatment from role models teaches students to accept and, indeed, repeat it when they are in positions of authority.

The authors of this study suggested that mindfulness interventions could help attending and resident physicians become more aware of their negative comments and behaviors and their impact on medical students [7]. It is incumbent upon resident and attending physicians to practice mindfulness and to consider, “Is this how I would want my family member treated?” when communicating with patients. When interacting with trainees, educators need to consider that, as Haidet and Stein point out, negative feelings of anger and anxiety can interfere with learning. The idea that “pimping” is good for students may not be accurate, and just because we survived this behavior doesn’t mean that we should perpetuate it.

Students by themselves cannot change the hidden curriculum. As Gaufberg et al. note, “All too often, student ‘professionalism’ is simply equated with subservience within the hierarchy” [11]. It is next to impossible for students to challenge the messages communicated through the hidden curriculum, even if they contradict the objectives of the formal curriculum. It is the responsibility of educators to change the tone and the culture.

Some educators are working to find ways to combat ethically undesirable messages about, for example, how to talk with and about patients and families. A daylong workshop, entitled “Difficult Conversations at the End of Life,” developed in 2002 by the Program to Enhance Relational and Communication Skills (PERCS) at the Boston Children’s Hospital Institute for Professionalism and Ethical Practice [12], combats some of the pernicious tenets of the hidden curriculum—that insensitivity to patients is acceptable and that physicians should be detached, unemotional, certain, and devoid of anxiety. It emphasizes that, within difficult health care situations, anxiety and vulnerability are not only normal but expected [12]. The program also works on helping team members relate to patients and families in a more humanistic manner. For example, a clinician taking a detached tone, such as talking about “harvesting organs” to a grieving family, receives feedback in a debriefing session regarding ways that such communication could be insensitive. This method can be helpful in a number of ways for professionals mentoring medical students. It allows attending physicians participating in the workshop to become aware of undesirable behaviors that they may be displaying in their clinical work and thereby modeling to

students. If we can change the attitudes and behaviors of the teachers, then we will change the attitudes of the learners. The designers of this program focused on the importance of relationships and the hidden messages that Haidet and Stein alluded to in their article.

The learning that matters most in the development of health care professionals occurs in the context of relationships. The question is whether these relationships foster the qualities that we want in our future physicians. Ultimately, we need to recognize that forming a professional identity is influenced as much, if not more, by relationships, mentoring, role modeling, and the hidden curriculum as by formal teaching experiences [13]. Attending physicians need to be mindful of our influence and the power dynamics not only in patient interactions but also in teaching. To promote satisfying relationships and good clinical care, we need our patients, other health care professionals, and students to feel comfortable so they can ask questions, clarify understanding, and be active members of treatment teams.

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ISSN 2376-6980