

**PROMOTIONS COMMITTEES: A ROLE IN REGULATION OF THE
PROFESSION OF MEDICINE**

By

Sally A. Santen

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Approved:

Professor John Braxton

Professor Larry Churchill

Professor Emil Petrusa

Professor Claire Smrekar

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CHAPTER I

INTRODUCTION

Problem and Research Questions

A profession is defined by three characteristics: mastery of a body of knowledge, the ideal of service to the client, and as a result is granted autonomy by society (Goode, 1969). Medicine is a profession that utilizes a unique body of knowledge and advanced set of skills that are not accessible to society. Medicine has a mission of service and holds the ideal of service to the patient. In other words, the physician should act in the best interest of the patient based on knowledge of medicine and based on the knowledge of the patient. Due to the complex nature of the work and the advanced knowledge and skills required to practice medicine, the medical profession operates autonomously. The privilege to function autonomously is a result of the implied contract with society. As a result, the profession of medicine is responsible for self-regulation and in return society allows the profession autonomy. It allows for autonomy and self-regulation of the profession in return for holding to the ideals of service.

Self-regulation refers to a profession's taking responsibility for ensuring that physicians perform their professional roles in a competent and ethical (professional) manner. This regulation requires social control- the various mechanisms intended to induce conformity to normative or ethical standards. Zuckerman described the social control of science as including deterrence, detection and sanctions. Thus, the profession is responsible for control of its members this includes monitoring and sanctioning the

members. The medical profession is responsible for ensuring that members adhere to the ideal of service, and mastery of the core knowledge. One proposed mechanism is through the use of formal and informal social control mechanisms (Braxton, 1986, Braxton, Bayer & Finkelstein, 1992, Goode 1957, Bosk 1979). Bosk (1979) categorized control in medicine in four areas using a framework of informal/ formal and internal/ external. These are mechanisms that serve to exercise control by providing guides for appropriate and inappropriate application of knowledge and professional behavior. Freidson further noted that these forms of control are rarely asserted (Freidson, 1972, 1975). When control is applied, he noted that the sanctions were either functional or symbolic (Freidson, 1970, 1975). Functional sanctions, are when it is believed that the sanctions specifically will prevent future misconduct, whereas symbolic sanctions serve to cause embarrassment to the individual and at times, by extension to his or her colleagues.

One of the first stages of development of a physician is in medical school; it is integral to the development of a professional. The training includes learning to master the body of knowledge and socialization into the appropriate behaviors that include the ideals of service. Medical school serves to shape the novice into the professional (Good, 1956, 1960, Merton, 1957). Formal controls prevent the progress of students who do not have the academic, intellectual, or professional behavior ability to function as a physician. Additionally, the socialization processes, as well as the formal disciplinary actions in medical schools, serve as a mechanism for deterrence of unprofessional behaviors. Since regulation of the profession once physicians are licensed, is minimal, medical schools have the opportunity and responsibility to determine whether students meet the performance expectations and possess the professional behaviors to be physicians. Recent

research has shown links between behavior issues during medical school and reports brought before medical licensing boards (Papakakis, et al, 2004, 2005).

The promotions committees of medical school serve as a major form of formal control for medical students. Using Zuckerman's framework (1977), the promotions committees have a role in the detecting and sanctioning misconduct for medical students. The promotions committees are responsible for formal identification (detection), promotion, remediation, disciplinary action or sanction of each medical student as they progress through medical school. The committees determine whether the students meet the professional behavior and performance standards required to become a physician. There is very little written about the processes and issues addressed by promotions committees.

This study will focus on three areas. First, understanding that the promotions committees serve as one step in social control of the profession of medicine, the question becomes what the initial infractions bring students to the attention of the promotions committees and what are the disciplinary actions, prescribed remediation, and eventual outcome of those students. The actions of the promotions committee are formal internal means of control. Additionally, the study will look to see if these actions are functional or symbolic as described by Freidson (1970, 1975).

The second area will seek to better understand the functioning of the promotions committee, through interviews of members of the committee. As stated previously, there is little written about social control of the profession in medical school and about promotions committees. Therefore one important aspect of the study will be to better understand the behavioral and academic triggers that bring students to the attention of the

promotions committees. In addition, the format of the promotions committees might effect the decisions that are made. One format is a promotions committee made up of course directors who make the decisions. A second format, is a committee made up of faculty who are not course directors but who follow the students through their medical school tenure and determine if they merit promotion. Therefore the second question of this study is to better understand the decisions made by the committees and to determine if the differences in format of the committee affected the identification and sanctions applied to the students.

Finally, this study will seek to determine if professional regulation in medical school serves to identify and remediate students so that they do not then have professional sanctions once in practice. This study will correlate promotions committee actions with long-term outcomes. Specifically, does identification by promotions committees during medical school predict for disciplinary actions by state medical boards later in practice?

Statement of Question

The purpose of this study is to examine the professional regulation at the level of the medical school promotions committees. The study will use three approaches to answer this question. The first is a close examination and quantifying of the promotions committees identification and actions regarding medical students. The second is to develop a deeper understanding of the deliberations, influences and decisions of the promotions committee through qualitative interview-based research. Finally the relationship between promotions committee actions and later professional sanctions will be examined. The guiding questions for this study are:

- What is the threshold and how do promotions committees administer professional control of students in the areas of academic performance and professional behaviors.
- How did changes in the format and membership of the promotions committees from course directors to a longitudinal committee change the identification of problem medical students and professional regulation.
- Do promotions committees effectively identify and remediate students so that later they do not have professional sanctions imposed by state medical boards.

Significance

This work applies the conceptual framework of the definition of a profession and the control of the profession to build an understanding of the application of professional control in medical schools, specifically by the promotions committees. As Goode, Freidson, Bosk and a few others have worked to detail medicine as a profession and to describe control of the profession, there is a gap in the understanding of professional regulation at the level of the medical school. While it promotes clarity to set out the questions as the hypotheses above, there is little described about medical school regulation of students professional and academic behavior and especially by promotions committees. Therefore, a significant part of this work is descriptive analysis of demonstrated professional regulation through the promotions committees as well as deeper understanding through interviews of the processes. This work seeks to extend our knowledge of professional regulation to the level of medical school promotions committees.

Overview of Remaining Chapters

The second chapter will provide background, literature review, and set forth the problem to be studied. The third chapter will cover methods and the fourth chapter, the results. The final chapter will base the findings of this study on the conceptual framework, discuss the dissonance in the findings and then seek to extend the conceptual framework.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter will provide background, literature review, and set forth the problem to be studied. First, I will outline the core traits of medicine as a profession. Second, I will describe medical education from application to medical school into practice with a focus on how the process of medical education and training serves to regulate the profession. Third, I will describe how the profession self-regulates with a focus on the conceptual framework of social control of students. Finally, the research questions that will guide this inquiry will be revisited in light of the background.

Medicine as a profession

The time-honored definition of a profession encompasses three core traits. First, it is a group possessing an abstract body of knowledge. Second, that knowledge is applied with the ideals of service, meaning without self-interest. And third, with this responsibility or social contract comes privilege and autonomy or the ability to control the work of the profession (Goode, 1957, 1960, Freidson, 2001). Historically medicine has held itself to be a “noble” profession as it clearly contains a vast body of knowledge. The knowledge and skills required to practice medicine are require specialized education and training. Due to the specialized knowledge, the practice of medicine places the patient in a vulnerable position that must be protected. Patients, for the most part, rely on the judgment of physicians to diagnose and recommend treatment. That reliance is based

on trust that the physicians will act in the best interest of their patients. Therefore, physicians should place the interest and needs of patients above their own interest. Finally, the profession is responsible for policing itself in exchange for the privileged position it occupies. The medical profession has a code of conduct, referred to as professionalism, that is the behavior that is expected from practitioners as a result of this social contract.

William Goode (1960, p903) noted that as an occupation becomes more professionalized it acquires additional features that are derivative from the core traits. He listed these traits below:

1. The profession determines its standards of education and training.
2. The student professional goes through a more far-reaching adult socialization experience than the learner in other occupations.
3. Professional practice is often legally recognized by some sort of licensure.
4. Licensing and admission boards are manned by members of the profession.
5. Most legislation concerned with the profession is shaped by the profession.
6. The occupation gains in income, power, and prestige ranking and can demand higher caliber students.
7. The practitioner is relatively free of lay evaluation and control.
8. The norms of practice enforced by the profession are more stringent than legal controls.
9. Members are more strongly identified and affiliated with the profession than are members of other occupations with theirs.
10. The profession is more likely to be a terminal occupation. Members do not care to leave it, and a higher proportion assert that if they had to do again, they would again choose that type of work.

Goode notes that these characteristics are closely inter-related and focus on social relationships-the relationship of the student to the profession and the profession to society. One can group these characteristics into control by the profession (regulation, legislation, standards), socialization of the students and members, and finally, identification of members with the profession.

Further exploring the manifestation of Goode's characteristics and their manifestation in the medical profession; medical education is developed, provided, and administered

primarily by the medical profession. Two accrediting committees monitor the standards of education and training within medicine. The first is the LCME (Liaison Committee on Medical Education), which has oversight of medical school. The LCME is the nationally recognized accrediting authority for medical education programs leading to the medical doctor degree. The Association of Medical Colleges, a nonprofit group of medical schools, teaching hospitals, and academic societies and the American Medical Association, the nations largest physicians group, sponsor the LCME. When medical students graduate from medical school, they receive their M.D., medical doctorate degree. However before practicing, they must complete residency post-graduate training. The second accrediting committee is the ACGME (Accreditation Council for Graduate Medical Education), which has oversight of post-graduate medical training programs, mainly residency and fellowship training. Similarly, the ACGME is made up of several physician member organizations. The LCME accredits and regulates medical school while the ACGME regulates post-graduate training in specialty areas. Thus, as Goode described, the profession through the ACGME and LCME determine the standards of education and training. Once physicians complete their training they are licensed by a state medical board, again primarily made up of physicians.

Medical training serves to regulate the profession

The traits of the profession are inter-related and as a result they form the basis of the contract with society that allows for autonomy and self-regulation of the members of the profession. That contract holds that with the privilege of operating autonomously comes

the responsibility to self regulate the members of the profession. Therefore, there are self-regulatory bodies in place to monitor the behavior of the profession.

The profession regulates at several stages of professional development including entrance into medical school, promotion through medical school, promotion through residency, and finally, while in practice there are regulatory bodies in place.

Admissions

Entrance to medical school is a highly selective process with nationwide fewer than fifty percent of applicants accepted and lower acceptance rates at more selective schools. Students are chosen by the admissions committees made up primarily of physicians. Selection is made on the basis of student academic accomplishments, extracurricular activities, interviews, essays and letters of recommendation. While the weight is placed on academic achievements (grades and Medical College Admissions Test- MCAT), other variables attempt to determine whether the applicant will succeed in the social relationships of the profession.

The academic ability is most heavily weighted in the decision by admissions committees to accept an applicant. This is judged by college grade point average especially in the science fields and MCAT. As medical school is scholastically difficult due to the broad and detailed scientific information that needs to be learned, the admissions committees use academic record and MCATs to determine if the applicant is likely to succeed.

While the ability to succeed academically is most important, the admissions process also attempts to determine if the applicant is suitable to join the community of medicine

by judging the personal and social characteristics of the applicant. There are several steps to the admission process where these characteristics are manifested. First, applicants submit a preliminary application that includes an essay. This essay topic is open but applicants are expected to use the essay as an opportunity to distinguish themselves from other applicants. A common topic is “why the applicant selected the field of medicine”. For some schools, all applicants are invited to submit a secondary application with a fee while other schools screen, and only certain applicants are invited to submit the secondary application. Many of the secondary application include more detailed essay questions. The essay questions require applicants to present their reasons for wanting to become part of the profession and then query areas of particular interest. Examples of essay questions include:

- In your opinion, what contemporary medical issue needs to be addressed in the U.S. healthcare system and why?
- Describe an obstacle you’ve overcome and how it has defined you.
- In your intellectual development and preparation for a medical career, which non-science college course has been most valuable? Why? (Stoneybrook)
- What is your best attribute? Describe how this attribute will enhance the student body at The Warren Alpert Medical School. (Brown)
- Please provide in summary fashion your reasons for wishing to attend Vanderbilt including your reasons for becoming a physician and your career plans as presently developed. (Vanderbilt, 1983)
- 1. Write a brief autobiography. Give as complete and precise as possible, a picture of yourself, your family and events you consider important to you background. 2. Describe your major extracurricular interests and your achievements or degree of participation. List any academic honors or awards you have received. (Vanderbilt, 1995)

The purpose of the essays is to elucidate an applicants’ values, reasoning and communications skills so as to determine if the student should become part of the medical profession. They are an attempt to screen for values, attributes and behaviors thought to important to the profession. In addition, the applications screen applicants for deviant behavior within school or in the community. For example the following questions might be asked:

- Are there any disciplinary charges pending or expected to be brought against you?
- Have you ever been convicted of a crime other than a minor traffic violation?
- Are there criminal charges pending or expected to be brought against you?
- Have you ever been prohibited or suspended from practicing in any professional capacity due to or as a result of alleged misconduct on your part?

Students must also submit letters of references. These letters commonly address the character, performance and personality of the applicant. Again these attest to the suitability of the applicant to become a physician. After submission of the applications, some applicants are offered interviews. The interviews are usually conducted by medical school faculty and sometimes by students as well. The goal of the interview is to determine the applicants ability to communicate, to assess their personal characteristics and to have a more three dimensional picture of the applicant.

The admissions process, thus, includes multiple methods of assessing the personal characteristics and suitability of applicants to join the medical profession. Once all of the information is gathered, the admissions committee decides if the applicant is appropriate to offer admission to medical school. Once admitted, nearly every student will become a physician. Therefore the admissions process is one of the most important steps to regulate which individuals will enter the profession of medicine. The admissions process selects those who are prone to share common goals and outlook serves and therefore as a source of common identity (Freidson, 1970).

The optimal way of assuring long-term professional behavior would be only admit those likely to behave according to professional values (Stern 2005). But while admission committees try to determine the best entrants, there is not proven method of choosing those with professional behavior. One study (Stern, Frohna, Gruppen, 2005) found that characteristics gleaned from admissions files did not correlate with professionalism

assessments in the clinical years. While the admissions process hopes to determine which students will be professional it has not been shown to have good discrimination.

Medical School

Once students enter medical school, they are considered to be an apprentice within the profession. They are responsible to uphold the norms of the profession. Although they are not full-fledged physicians, they still have the privilege of knowing intimate details of patients' lives and a responsibility to hold those in confidence as well as to uphold the ideals of service. In fact, over the past decade, many medical schools have institutionalized the entry into the profession by ceremonies where the entering students are given white coats symbolizing their professional status while they pledge oaths to professionalism. These coats are "short," symbolizing the apprenticeship role of the student, while faculty wear long white coats.

In medical school, promotions committees, made up of faculty and professors determine which students earn the right to be promoted and advance through the curriculum. In function, these committees address primarily the students with difficulties, either academic or behavioral (professionalism). The committees serve a regulatory function for medical schools, determining which students are remediated, placed on probation or expelled. In some schools, the final decision for expulsion is made by the Dean or by an executive faculty committee. It is rare for students to be expelled. At the end of medical school, the promotions committee will recommend the conferral of the medical doctorate to graduating students. The institution relies on this

assessment and then confers the degree. The details of the process and function of this committee at Vanderbilt will be addressed later in this paper.

Residency

After medical school, the new physicians enter residency training in a specialty field. Similar application to medical school, the application to residency programs include both assessment of academic and personal characteristics through, medical school grades, academic record, medical students performance evaluation or deans' letter, national objective test results (United States Medical Licensing examination), essays, interviews, and letters of recommendation from physician faculty. The purpose is to select into specialty training physicians of appropriate interest, ability and character to succeed in the specialty.

Residency is a more specialized apprenticeship compared to medical school. The physician-in-training learns about one specialty. During this apprenticeship, professional regulation is maintained by the residency program with the oversight of the graduate medical office of the institution. In addition, each residency is answerable to the residency review committee of the specialty and the ACGME (Accreditation Council for Graduate Medical Education). During residency, physicians in training are not autonomous, but are practicing under the license of the attending physician.

Practice

In order to practice autonomously, physicians must apply for and receive a state medical license. When physicians receive a medical license, the license conveys the right

to practice medicine. A medical license must be renewed and maintained. In addition, each state medical board has the responsibility to investigate unprofessional behavior. The state medical board only acts in cases of egregious behavior, including sexual misconduct, substance abuse and professional misconduct. When unprofessional behavior is determined, the board may impose sanctions, restrict or remove a physician's license to practice medicine. Actions by state medical boards are significant violations of professionalism and are rare. Post licensure, the quality of physician services is maintained through peer review, physician profiling, the malpractice system, and disciplinary actions by state medical boards.

Control of the profession

The next section will explore how the profession self regulates with a focus on the conceptual framework of social control of students. For the most part, the patient and society cannot determine the quality of medical care. For other occupations, a product or successful completion of a process determines the success of the work of the occupation. However, in medicine there is no clear product and successful completion of a process such as treatment of breast cancer maybe completely unrelated to the medical care provided. This is because often the health outcome may not be directly related to the physician practice or medical care. When a patient's health deteriorates it may have nothing to do with the medical care provided, but instead be related to the disease process involved. For example, women die from breast cancer even when physicians do all that they can to treat the cancer. Thus the patient and or their family have difficulty determining whether the work of the physician is appropriate or not.

The opinions of the patient or the public are usually subordinated to those of the physician, the professional expert. The subordination is based on the assumption that the professional has special esoteric knowledge and understanding of disease, that he or she should be allowed to make the decisions for the patient. (Freidson, 1970). While there are some areas such as communication and satisfaction in which patients can judge their own medical care, for the most part, patients cannot determine the quality of the medical care provided, because they do not understand many of the intricacies of the field. As a result, it is up to the physician to determine appropriate care. Furthermore, it is up to the profession to ensure that each physician member is providing appropriate care. The profession needs to control the quality of medical care as well as the members professional behaviors. Society is only willing to concede autonomy if a profession members are able and willing to control the work of its members (Goode, 1969).

The control of the individual professional behavior is maintained through the community of the profession (Goode, 1957, 1967). The question then becomes, how does the profession of medicine ensure quality medical care and appropriate member behavior? Professions ensure that members adhere to the ideal of service, and mastery of the core knowledge through the use of formal and informal social control mechanisms (Braxton, 1986, Braxton, Bayer & Finkelstein, 1992, Goode 1957, Bosk 1979). One important mechanism is through social control of members. Bosk (1979) categorized control in medicine in four areas using a framework of informal/ formal and internal/ external. There are codes of conduct that serve to exercise control by providing guides for appropriate and inappropriate behavior in these realms.

The first category Bosk described is formal-internal where the group periodically reviews performance and there is formal accountability of actions. formal- internal control occurs whenever physicians are part of the formal control of other physicians. There is regular ongoing scrutiny of performance, and standards of acceptable performance are set in advance on the basis of objective criteria and negative sanctions are attached to failures to meet expectations. For example, in hospitals, there are formal review committees within a department that review poor outcomes of patient care. It also takes the form of scheduled formal assessments of performance for medical students and physicians-in-training. In addition, national testing such as the United States Medical Licensing Examination and specialty board examinations, which are designed and regulated by physicians within the profession, are examples of formal-internal control. Likewise, the control exerted by each state medical board is a form of formal-internal control for the profession. Although it may seem as though state medical boards and the National Board of Medical Examiners are external controls, for the most part these organizations are composed primarily of physicians and therefore still part of the formal-internal control of the profession.

The second category of control is informal- internal. This social control is a more subtle way that a group reminds its members of their responsibilities. However, for the most part, physicians choose not to say anything to their colleagues. Freidson (1972, 1975) describes two methods of informal- internal control. When, several episodes of norm violations have occurred or if an infraction is egregious, the physician will “talk to” the colleague. This may be a friendly talk or more strict. The physician might include other physicians into it if the issues are more serious. The second form of control he

described was when physicians do not refer their patients to physicians whose medical judgment they do not respect.

The third category is formal-external where the monitors are not part of the group whose performance is under scrutiny. This is where hospital administration, legal department and the judicial malpractice systems might review and control practice performance based on poor medical outcomes and medical care.

The final category is informal- external where the administration, who are not members of the profession, informally review behavior and practice. An example would be a hospital administrator visiting clinic to ascertain if patients wait too long to see the physician or to have their blood drawn for laboratory tests.

The few studies done in this area note formal negative sanctions are rarely applied (Bosk, 1979, Freidson, 1972, 1975). Even informal sanctions in the form of collegial advise are rare and without attempts to see if there is change in behavior. In other words, “social control mechanisms enforced by negative sanctions seem not to exist.” (Freidson, 1975) While this is a rather disparaging view, there is agreement that there is minimal detailed control of the profession.

Freidson in *The Profession of Medicine* (1970) noted that for the most part, intra-professional conduct is governed by unwritten rules. For example, it is professional etiquette not to criticize others, especially publicly. When actions of other members of the profession are not in line with the behavior of the profession, usually informal and private actions are taken. Another unwritten rule, described by Braxton and Bayer (1994) is that of adherence to professional solidarity. Professional solidarity encompasses the goal to protect the profession from interference and allows each individual maximal

autonomy, on the other hand it constrains members from identifying or taking action on deviant behavior.

Misconduct may require sanctions. When it does, Freidson noted that any number of responses are possible. He described criteria that physicians use to choose one sanction over another. Freidson (1970, 1975) described two types of criteria, functional and symbolic. The first, functional criteria entail the assessment that the sanctions specifically are intended prevent future misconduct. The use of symbolic criteria determines that the action will likely cause embarrassment to the individual and at times, by extension to his or her colleagues (Braxton & Bayer, 1996).

Freidson described these categories in practicing physicians. The following examples demonstrate how these criteria might extend to determining the sanctions for student misconduct. If a student assumes too much autonomy and takes it upon himself to tell a patient of a new diagnosis of cancer, the responsible attending physician, might take the student aside and talk to him. For this example, if the physician intends to change future behavior of the student in other words, then functional criteria are employed. Thus, the attending would explain that he, the attending, not the student has the important information about the patient, has the experience in telling bad news, and has the ultimate responsibility for the well being and care of the patient. For these reasons, it is usually the attending or one of his designates who is assigned the responsibility of telling patients bad news. The attending might talk about issues of trust and teamwork and the roles and responsibilities of a student on the team. He would be sure that the student understood how such assumption of autonomy is unacceptable. In addition, the attending might ask the Dean of Student Affairs to talk to the student. These actions are private with the

explicit intent to be sure the student understands the norm violation and to prevent the student from assuming too much autonomy when it is not warranted.

On the other hand, a criterion for choosing another sanction might be that the sanction would cause embarrassment to the student and at times, by extension to his or her colleagues. In this example, the criteria for determining the sanction was symbolic. In the same scenario, the responsible attending might choose to berate the student about his actions while rounding with the team. Another symbolic action would be to not only to place the student on probation and but then also to inform all of the students about the one student's violation and instruct them on appropriate future actions. Freidson observed that purely symbolic criteria for sanctions with the sole purpose of punishing the offending individual are to be avoided. Therefore, while formal actions such as placing a student on probation might be done in serious or repetitious offenses, for the most part these are confidential and do not rise to the level of public sanctions.

Freidson's work examined the criteria for practicing physicians. However, this study will extend functional and symbolic criteria to medical students. Further, since the study is looking at actions regarding students rather than specific criteria, the functional and symbolic categories will be applied to the actions taken by promotions committees. Thus, one question that this study will look to answer is, when medical students have either problems with academic performance or professional behaviors, are the sanctions functional or symbolic?

Freidson's work examined social control of physicians. This control can also be placed in the framework of Bosk's informal and formal control. The informal control of medicine is through a normative subculture, a body of shared and transmitted ideas,

values and standards around which members of the profession are expected to orient their behavior. The norms and standards delineate technically and morally allowable behavior, indicating what is prescribed, preferred, permitted or proscribed. While there are some formal codes of conduct including the Hippocratic oath, they are often vague in their mandated behaviors. Therefore, it is the informal social controls that attempt to assure that professional behaviors adhere to the ideals of service. The proscribed and prescribed norms or patterns of behavior function as mechanisms of informal social control. However norms of professional groups are rarely explicitly spelled out. Instead as Braxton and Bayer (1992) note, norms may be ascertained by noting when there are sanctions in response to norm violations. The degree of impropriety can be ascertained by the severity or type of sanction meted by the profession.

One method of control may be early socialization of apprentices in the profession. Through early socialization, including informal and formal control, medical students and residents are molded into professionals. Therefore, theoretically, if the socialization process is on target, the graduates will have appropriate behaviors and norms adherent to those of the profession. In other words, socialization of recruits is important to the development of professional identity. According to Goode (1957, 1960), the profession, to a certain extent, isolates new recruits, furnishes new ego ideals and impresses on new recruits the dependence upon the profession for further advancement and punishes inappropriate attitudes and behaviors. Braxton & Baird (2001) have suggested that the graduate school socialization process functions as a mechanism of deterrence of scientific misconduct. Similarly, medical school socialization serves as a mechanism for deterrence of professional misconduct for physicians. Medicine has recognized the

importance of medical school socialization through the promotion of ethical and professional training to deter professional misconduct. As students progress through medical school, they learn the norms of the profession. Significant violations of these norms are sanctioned either informally or formally.

Medical students learn the professional role of the physician including knowledge, skills attitudes and values to be able to perform this role as a physician. Socialization includes more than what is described as education and training. There is direct learning from professors, books and patient care, but also indirect learning through contact with instructors, peers, and others of the health care team. Not all that is taught is learned and not all that is learned is taught directly. The ways in which students are shaped both directly and indirectly by their environment constitute the major process of socialization. (Merton, 1957, p. 41) Many authors over the past decade have described the hidden curriculum as the norms and values taught through behavior and actions that may contradict the formal curriculum.

Merton (1957, p. 7) noted that it is the role of the medical school to transmit and advance the culture of medicine. This process needs to shape and transform the novice into an effective practitioner with good knowledge and skills as well as to develop a professional identity so that the student comes to think, act and behave as a physician. School needs to socialize the student so that when they leave school and go into practice, they maintain the same standards without close supervision and monitoring. The correlate is that- for students who are unable to perform skills and procedures adequately or behave appropriately, the medical education system will need to either remediate the behaviors or dismiss them from medical training. If they are allowed to graduate from medical

school and ultimately residency training, in medical practice, they have even less supervision and monitoring these behaviors. It is for this reason that it is so important that medical schools have the responsibility to determine which students not only have the skills and knowledge to practice medicine but also which students have the attitudes, behaviors and morals to self-monitor the ideals of the profession.

Medical schools are responsible for assuring that the development, socialization and academic performance of students is appropriate. There are two main areas in which students are assessed, academic performance and professional behaviors. Academic performance refers to the examination scores and the clinical performance in the 3rd and 4th years of medical school. Academic performance is primarily knowledge and skills. In addition to academic performance, students' professional behaviors are important. This refers to in part, their motivations, attitudes, behaviors and interpersonal skills. Students' professional behaviors influence their academic performance. For example, unmotivated students will perform poorly on examinations and students with poor communication skills will not perform well in the clinical years of medical school. Likewise students' academic performance will influence their professional behaviors. For example, students failing to perform academically may resort to deviant behavior such as cheating or retreatism (Merton, 1957).

In response to the societal pressures and to regain public confidence, over the past 30 years, medicine has renewed its focus on professionalism through articles denouncing unprofessional behavior. In response multiple medical groups have published definitions of professionalism (table 1). The definitions are similar and include basic principles of respect, honesty, and altruism. The purpose of these documents is to set out for the

members, the expected behaviors, norms and values. And in part, they are to reassure the public that the profession is adhering to the ideals of service as well as the professional control of members.

These behaviors are expected of the medical students, residents and practicing physicians. In medical school, socialization as well as formal training set the expectations of professional behavior. Students who deviate from that behavior warrant remediation, sanction or removal from professional training. Since the profession is the determinant of competence, therefore the profession must determine when members practice outside of the accepted norms (Freidson, 1970).

Table 1. Stakeholders' Definitions of Professionalism

Medical School Objectives Project (1998)

- Altruism (compassion, empathetic, trustworthy, truthful, ideals of service, ethics)
- Knowledgeable (including life long learning)
- Skillful (includes communication)
- Dutiful (collaborative, serve needy, understand finances)

Accreditation Committee for Graduate Medical Education (1999) (Six competencies)

- Patient care (clinical reasoning)
- Medical knowledge
- Practice based learning and improvement
- Interpersonal communication and skills
- Professionalism
- Systems based practice

American Board of Internal Medicine: Elements of Professionalism (1999)

- Altruism
- Excellence
- Duty
- Honor and Integrity

Physicians Charter (2001) (Three principles and nine commitments) (Sox)

Principles

- Primacy of patient welfare (altruism and trust)
- Patient autonomy (honest, informed decisions)
- Social justice (eliminate discrimination)

Commitments

- Professional competence
- Honesty (informed consent and disclosure of errors)
- Patient confidentiality
- Maintain appropriate relations with patients (no exploitation-sexual, \$)
- Improving of quality of care
- Improving access to care
- Just distribution of finite resources
- Scientific knowledge
- Maintain trust by managing conflicts of interest
- Professional responsibilities (self regulation, remediation, discipline)

The Medical School Evaluative Definition (Vanderbilt, 2002)

- Recognizes and acts within the limitations of one's knowledge and skills
- Demonstrates honesty and integrity in all professional interactions
- Advocates on behalf of one's patients
- Committed to practicing medicine in a scholarly manner, to improving one's knowledge and skills, and to lifelong learning.

License Committee for Medical Education (2004)

The objectives and their associated outcomes must address the extent to which students have progressed in developing competencies that the profession and the public expect of a physician... To comply with this standard, a school should be able to demonstrate how its institutional learning objectives facilitate the development of such general attributes of physicians.

Association of American Medical Colleges Professionalism Assessment Form (2008)

- Honesty/ integrity (truthfulness, adherence to ethical principles)
- Responsibility/reliability/ accountability (punctuality, compliance, accountability, feedback)
- Respect for others (colleagues, faculty, staff) (appearance, interactions, teamwork)
- Altruism (concern for others, empathy, compassion)
- Commitment to excellence (goal setting, motivation)
- Respect for patients (relationships, confidentiality)

Process of Medical School Formal Control

Medical schools have the responsibility to determine whether students meet the performance expectations to be physicians. This responsibility is achieved through primarily formal internal control. The next section will describe the process of formal control at Vanderbilt School of Medicine as an example of the process for one school. While there is little literature about the formal control of apprentices in the profession of medicine, each medical school has a structured formal process for sanctions and remediation.

When students have academic difficulty or inappropriate professional behavior, essentially, it is through formal internal processes that students are identified, sanctioned and remediated. There are two levels of identification and action as a response to lower than expected academic performance and professional behavior. The first level is that of the course director- when students perform poorly the course director will commonly take informal action of a “talking to ” as described by Freidson (1970, 1975, 1989). In addition, the course director may take formal action through placing a letter in the student’s file, assignment of a low, marginal or deficient grade, and comments noted on grading forms. The next level of formal internal control is when the student is brought to the attention of the promotions committee. The process of identification comes from one medical school but can be generalized to the process of other medical schools. This process is outlined below in Table 2.

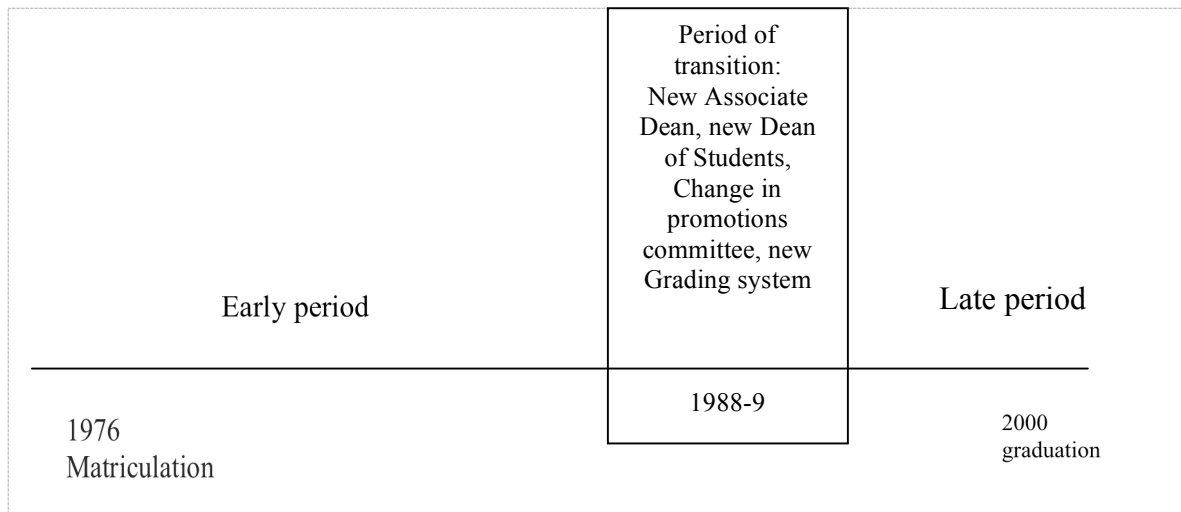
Table 2. Process of Student Identification

Process	Example
1. Performance (either performance or behavior) triggers faculty identification of a student having a problem.	Student fails first anatomy examination or student fails the entire anatomy course.
2. Course faculty decides what the immediate remediation action should be. For more serious issues, this decision is made with the input of the dean of students.	Course director and dean of students discuss the remediation actions to be taken, such as offering tutoring to the student, or advising on better study skills. Course director and possibly the dean of students meet with the student and make a plan including tutoring.
3. The student is identified to the promotions committee and discussed. Promotions committee decides on remediation action in relationship to the problem. If the behavior warrants heavier sanctions, the committee will vote on those sanctions. If a student fails a course, borderline fails more courses, the committee will determine the sanction with input the course director. The action of the committee can be either remediation or a sanction such as probation.	At the next promotions committee meeting the student would be discussed. The proposed or already implemented actions confirmed by the committee. For failure of an anatomy examination the remedial action of tutoring will be confirmed. For failure of a course, the plan for remedial action such as repeating anatomy in the summer as advised by the course director will be confirmed. In addition, sanctions may be imposed such as placing the student on probation.
4. The recommendations of the promotions committee go to the executive faculty committee for confirmation or revision	Promotions committee recommends that student Jane Doe repeat her first year; the executive faculty vote to confirm that recommendation.
5. Action is communicated with the student.	Student is notified of the action.
6. Remediation action is done and there is further performance assessment	Remediation plan is followed and student pursues tutoring and passes the next examination.
7. Follow-up and reassessment of problem with committee on student performance	Promotions committee notes improved performance and no further action required or improved performance and the student is taken off probation.

The promotions committee is responsible for determining which students earn the right to be promoted and advance through the curriculum. In function, these committees address primarily the students with difficulties, either academic or behavioral (professionalism) but in form are responsible for the progress of all students. The committee serves a formal regulatory function for medical schools, determining which students are promoted, remediated, placed on probation or expelled.

As the promotions committee is responsible for internal formal control of the profession, it is made up of medical school faculty. For the time period studied, there are two models of promotions committees' formats. The first model existed in the 1980's, where there were two promotions committees, preclinical and clinical, each comprised of the course directors. The preclinical committee made determinations for students in their first and second years. The clinical committee included the clinical clerkship directors and made decisions for students in their third and fourth years. The course directors were closely involved in and were responsible for determining the achievements and progress of the medical students. The Dean of Students Affairs, was ex officio, and sat on both committees and provided continuity between the committees.

Figure 1. Period of Transition



In 1989, Dr. Gotterer, the new Dean of Academic Affairs, changed the makeup of the promotions committee. The new committee included the Dean of Students, course directors, and 4 faculty chosen by the Dean and Associate Dean. The chosen faculty

were assigned to each class and were responsible determining progress for the class for all 4 years of training. They were the only voting members on the disposition of the students. Whereas in the previous system, the students were followed by two committees, first the preclinical then the clinical with only the dean of students providing historical background and continuity for the students. The new system allowed a group of faculty to be responsible for the class during the entire four years. The hope was that this continuity would allow the committee to be better able to intervene because they have deeper understanding of the issues of the students. The theory was that the committee would know students who had problems in the first years of medical schools and the committee would be more willing to act on issues of professional behavior. The dean and course directors were advisory to the voting members. In addition, the dean served as institutional memory and was familiar with rules and legal implications. The dean was also able to advise on issues of process, and assisted with documentation, and implementation of the recommendations of the committee. A component of the present research is to determine if the change in membership and continuity led to better identification and more rapid and effective action.

In function, the promotions committee makes recommendations to the executive faculty committee about final disposition of all of the students. The executive faculty includes the chairs of departments and represents all faculty at the school of medicine. Once the executive faculty committee makes a decision, only the Dean of the medical school can override the decision. For the most part, the executive faculty committee and the Dean accept the recommendations of the promotions committees. It is rare for students to be withdrawn involuntarily or expelled. The promotions committee and the

executive faculty committee also make positive recommendations and decisions to promote students to the next year and to confer the medical doctorate to graduating students. The details of the promotions process are detailed below in an excerpt taken from the Vanderbilt School of Medicine student handbook:

Promotion Committees of the faculty, in consultation with representatives of the departments responsible for instruction, are charged with making recommendations to the Dean, and the Executive Faculty regarding progress and promotions of students in each class. The Executive Faculty of the School of Medicine has final responsibility for the determination of medical student progress in the school. [...]The committees recommend for promotion those students who have demonstrated appropriate personal behavior and the knowledge, understanding, and skills consistent with faculty expectations at their particular stage of professional development.

Through these formal processes the faculty of the school of medicine have the responsibility to identify and take formal action when students have significant academic performance and professional behavior problems. Ultimately, they need to reevaluate the student who have difficulty and determine whether further action is necessary, such as probation, repeating a year, or involuntary withdrawal. This process hopes to shape students into competent physicians or to determine that the student is not capable of becoming a competent physician. However, there is very little known about the degree of academic performance or professional behavior that leads to identification and formal actions by promotions committees. Likewise, it is important to know the outcome of these students. Is it possible to effectively remediate students academic performance and more importantly their professional behavior?

Process of Formal Physician Control

While the goal of medical school and residency training is to teach physicians-in-training to be competent, and socialize them to behave appropriately, the determination of

competency is not perfect and some students are granted the medical doctorate when they may not meet performance or professional behavior standards. Once physicians have completed post-graduate training, they must apply for a state medical license in order to practice medicine. Post-licensure, the standards of practice are maintained through peer review, physician profiling, hospital risk management, malpractice claims, and disciplinary actions by state medical boards. The role of medical boards is “protecting the public from incompetent professionals” (Jost 1997, p. 20). On one hand the state medical boards award medical licenses to physicians who meet criteria. On the other hand, the boards have the mandate to sanction physicians, restrict or remove medical licenses.

During the 1980s there were increased malpractice claims and press reports of incompetent physicians that amplified the need for public accountability. The public looked to state medical boards to take action. As a result, actions against physicians by state licensing boards are reported and maintained in a publicly available database by the Federation of State Medical Boards. This database, began in the early 1980’s records the year of the action, the sanctions imposed, a code for the conduct leading to the action, the identify of the physician and the state in which the action originated.

Grant and Alfred (2007) looked at disciplinary actions from 1992-2004. They categorized the sanctions as severe, medium, or mild based on the severity of sanction, rather than based on the conduct of the physician. “Severe” sanctions encompass disciplinary actions that result in revocation, suspension, surrender or mandatory retirement of a license or the privileges afforded by the license. “Medium” sanctions include actions that result in probation, limitation, or conditions on a license or restrictions of a license’s privileges. The “mild” category covers other actions such as

reprimands, license modifications, or contingencies on a license such as risk-management classes or monitoring for substance abuse. This study noted a surge in all categories of sanctions from 2003. Severe sanctions outnumber others and doubled in number during the 12 year period studied. A further study looked at the rate of recidivism and found that of physicians having a severe sanction, 20% had a repeat offense during a 5 year period. Of these offenses, 10% again warranted a severe sanction.

Each action is associated with a notation that codes the reason for the sanction. Unfortunately, the most common code is “not applicable”. This code is used when the physician agrees to the sanction without being found guilty of the violation for which he or she is under investigation. In legal terms, this is similar to a “no contest plea,” but does not offer specificity of the sanction. The next most common notation is “unprofessional conduct” with 33 percent of the codes. Behaviors such as physical abuse of a patient, not recognizing common symptoms, or dishonesty are examples of unprofessional conduct (Grant and Alfred, 2007). Other codes for sanctions include negligence, failure to conform to minimal standards of acceptable practice, failure to maintain adequate records, substance abuse, sexual misconduct, gross negligence, and chemical dependency.

In order to practice medicine, physicians need to hold a medical license from their state medical board. The state medical boards respond to inappropriate behaviors such as unprofessional conduct through restrictions or removal of licenses. Returning to the categorization of formal actions as symbolic/ public humiliation and functional/ to change behavior, the actions of state medical boards have both symbolic and functional functions. The sanctions of state medical boards are public, so as to reassure the public

that the profession is holding members to professional conduct. On the other hand, for the most part the sanctions rarely remove physicians' medical licenses but instead are functional sanctions to rehabilitate physicians. For example, a physician will be allowed to continue to practice after substance abuse charges as long as they have undergone treatment and submit to drug monitoring. These sanctions are functional, serving to prevent further unprofessional behavior.

There are two studies linking state medical board sanctions to medical student professionalism performance. Pappadakis and colleagues (2004 and 2005) in two case control studies, showed that physicians with disciplinary actions (publicly available from Federation of State Medical Boards) were more likely to have notes in their medical school files about professional behavior while in medical school compared to matched controls. The first study examined University of California San Francisco Medical School graduates, and the second study expanded the sample to 2 additional medical schools. The results of the second study including the three schools will be discussed. The study looked at graduates of the medical schools who were sanctioned by a state medical board, Each graduate with a sanction (case) was matched with 2 graduates (control); they were matched by specialty and year of graduation. Then all of the case students' and control students' medical school records were reviewed including course comments, admissions records, grades and scores. Each of the case physicians were disciplined for multiple sanctions. In addition, 94% of sanctioned physicians received a violation for unprofessional behavior.

The academic performance of sanctioned physicians was slightly lower than controls; they had lower undergraduate grade point average, Medical College Admission Test

scores, National Board of Medical Examiner scores, and were more likely to have failed at least one course. More importantly, 39% of sanctioned physicians had documented unprofessional behavior in medical school compared to 19% of controls. The unprofessional behaviors documented were: irresponsibility (29%), diminished capacity for improvement (33%), immaturity (12%), poor initiative (35%), impaired relationships, and unprofessional behavior associated with anxiety, nervousness, insecurity or anxiety. On multivariate analysis, controlling for all variables, unprofessional behavior was associated with a 3 fold increased risk of disciplinary action by state medical boards. While MCATs and low grades in the first 2 years were associated with sanctions, they had less risk of sanctions. Specifically students with more notations of irresponsible behavior and resistance to self-improvement were most at risk for state medical board actions. Therefore, the important finding of this study was that students who were disciplined by state medical boards were noted to have problems with professional behavior in medical school.

The studies by Jost (1997) and Grant and Alfred (2007) looked at the types of unprofessional behaviors that were sanctioned by the profession for physicians in practice. Pappadakis and colleagues (2004, 2005) extended this work to look at unprofessional behaviors in medical school and their correlation to unprofessional behaviors in medical school and state medical boards actions. Her work was important in the field of medical education to indicate that medical students' behavior is important and predictive of future sanctions. While she specifically examined comments about unprofessional behavior, the study did not take into account the formal or informal professional regulation by the medical school in response to these actions. Therefore, one

main goal of this thesis is to extend that work by examining the profession's regulation by promotions committees during medical school and make connects to the actions by state medical boards. While Pappadakis found that the behaviors existed in medical school, the question becomes is it possible to differentiate between students in medical school who will ultimately have significant unprofessional behaviors that lead to sanctions?

Restatement of Question

A profession is defined by three characteristics: mastery of a body of knowledge, the ideal of service to the client, and as a result is granted autonomy by society. It is expected with the autonomy, that the professional will practice control of its members. Medical school is integral to the development of a professional. The training includes learning to master the body of knowledge and socialization into the appropriate behaviors that include the ideals of service. Medical school serves to shape the novice into the professional (Good, 1956, 1960, Merton, 1957). These processes should prevent the progress of students who do not have the academic, intellectual, or professional behavior ability to function as a physician. Additionally, the socialization processes, as well as the formal disciplinary process in medical schools, should serve as a mechanism for deterrence of non-professional behaviors. Since regulation of the profession once physicians are licensed is minimal, medical schools have the responsibility to determine whether students meet the performance expectations and possess the professional behaviors to be physicians.

For the purpose of formal identification, remediation, disciplinary action or sanction, each class in medical school has a promotions committee made up of faculty that determines which members of the class meet the professional behavior and performance standards required to become a physician. While the actions of promotions committees are intended to mold medical students into professionals capable of independent practice, there is little information about the efficacy or outcome of this process.

This study will focus on three areas, first what the initial infraction brings students to the attention of the promotions committees and what are the disciplinary actions, prescribed remediation, and eventual outcome of those students. The second area will seek to better understand the functioning of the promotions committee, through interviews of members of the promotions committee and review of committee documents. Finally, seeking to determine long-term outcomes, does identification by promotions committees during medical school predict for disciplinary actions by state medical boards later in practice?

As promotions committees serve as an initial step in self-regulation, this study will first examine what types of behaviors or performance raise the concern that student might not be an appropriate member of the profession. I will seek to understand what types of students' substandard academic performance or professional behaviors trigger faculty identification and action by the promotions committee. While it is expected that low academic performance is the trigger for identification by promotions committees, professional behavior is also important. Therefore special notation will be made of issues of professional behavior that are addressed by the promotions committees. Looking at remediation and sanctions, are they intended to be functional, to prevent reoccurrence or

symbolic, meant to embarrass? Finally, I will look at the outcome of the remediation or action of the promotions committee. As the formal control of the promotions committees serves to regulate which students are permitted to continue their studies to become a physician, examination of those students forced to withdraw by the promotions committees will give a better understanding of the professional control in medical school.

The second major focus is to better understand the functioning and process of the promotions committee. In 1990 the promotions committee composition changed. Prior to this time, the course directors from the 1st and 2nd years made up the preclinical promotions committee. Similarly, the promotions committees for the clinical years were made up of the course directors from those years. In 1990, as a result of a task force, the executive faculty approved the change in the format of the promotions committees. From that date, the committees consisted of faculty members from both preclinical courses and faculty from clinical courses. The committee would follow the class of students from the first year to graduation. The purpose of this change in format and process of the committee was to allow a group of faculty to know the details of the issues longitudinally through the students progress through medical school. The question then becomes, did this modification in promotions committee change the major issues that caused students to come to the attention of the promotions committees, or change the remediation or sanctions?

Finally, medical schools are the initial step to entry into the practice and independent professional practice, and promotions committees are responsible for recommending the conferral of a medical degree. Thus the final area of focus is- does identification by promotions committees during medical school predict for disciplinary actions by state

medical boards later in practice? And were students who have serious professional practice sanctions by state medical boards identified by promotions committees in medical school to have either academic performance or professional behavior problems?

Summary

This section outlines the core traits of the profession and how these apply to the profession of medicine. Next, the regulation of the training of the profession of medicine through formal and informal controls is discussed. Finally, three broad areas of research are proposed. First, as promotions committees serve as an initial step in self-regulation, what types of behaviors or performance raise the concern that student might not be an appropriate member of the profession or what types of behaviors determine that a student cannot be a member of the profession and should be dismissed from medical school. How effective are these actions. Second, do changes in the format of the promotions committee change the issues identified and actions prescribed? And finally, as medical school is the initial step to entry into the practice and independent professional practice, are there students who are identified by promotions committees who later go on to have serious professional practice sanctions by state medical boards.

CHAPTER III

METHODS

The purpose of this study was to examine the formal regulation of medical students. The promotions committees in medical school were responsible for identifying and remediating students who have difficulty. The questions regarding formal internal control of medical students include- what were the issues that cause students to come to the attention of promotions committees? And what were the sanctions, prescribed remediation, disciplinary actions, and outcomes for students identified by the promotions committees? The data to answer these questions were contained in the promotion committee files. This study had IRB approval.

Subjects

The population was graduates from Vanderbilt School of Medicine from 1980 to 2000. Vanderbilt School of Medicine was chosen for four reasons. The first reason was that Vanderbilt is an elite institution, as such it has the obligation to be beyond reproach (Carlin, 1966). Therefore, it provides a good example of how an elite institution manages issues of professional control. Second reasons was an issue of convenience, the records were easily available to be reviewed. The second reason was also pragmatic. Medical schools consider the student records and deliberation on medical students to be protected information much like patient information. Therefore, access to other schools' records and promotions committees would be limited. As a member of the faculty of the school

of medicine, I have access not available to outside researchers. Finally, I have spent more than a decade at Vanderbilt, as a part of the medical education community. While I have not been a voting member of a promotions committee, I have an understanding of the history, positions and roles of the administration and faculty. This familiarity allows me a deeper understanding of the data obtained.

The years from 1980 to 2000 were chosen for several reasons. The first reason for the choice of this times period was the goal to have an adequate sample size. There were approximately one hundred students in each medical school class. Over the two decades the promotions committees were responsible for over 2000 students professional behavior, academic performance and promotion through medical school. It was felt that from this time period would provide a reasonable understanding of the issues and disciplinary actions, and remediation could be understood. In addition, this period were environmental changes including increased focus on professionalism and behaviors, a change in the composition of the promotions committee members, and increased attention to legal documentation. The choice of these years allowed examination of the influence of these differences on the issues brought to the promotions committee and the actions taken.

Choice of this time period allowed the graduate to complete residency (3-5 years), become licensed and be in practice sufficiently long enough to have a sanction against their license. There were 29 Vanderbilt graduates from the years 1980-2000 disciplined by state medical boards. It was felt that these students provided a robust enough sample to draw conclusions.

Source of data

Medical school administration keeps files of each promotion committee. The file contained notes and minutes from each meeting as well as supporting documents such as letters and notation of test scores. The promotions committees met several times a year to discuss the progress of medical students. The meetings during the year were to discuss and update the committee and discuss students. At the end of the scholastic year, the committee made formal recommendations to the executive faculty for promotion to the next year for students without difficulty or for remediation or other sanctions for students with academic or behavioral difficulty. The committee wrote a formal letter of recommendation to the executive faculty committee and the Dean. If there were significant issues during the year, the committee made formal recommendations in addition to the end of the year. Since this study was concerned with formal regulation of students, this letter of recommended actions from the promotions committee to the Dean and executive faculty committee was used for data collection.

Data to be collected: promotions committees

As promotions committees serve as a step in self-regulation, data was collected to examine what types of behaviors or performance raised the concern that students might not be responsible members of the profession. Specifically, what types of students' substandard academic performance or professional behaviors triggered faculty identification and action by the promotions committee. From the promotions committee letters was extracted information on the students identified to the promotions committee for either unprofessional behavior or low academic performance. In the process of data extraction, students were assigned a study number so no names were used to protect the

identity of the student. The data collected included year of entry, gender, scholastic year that student was identified to the promotions committee, the reason for identification, the recommended actions of the committee and the outcome. Each identified student was tracked through the promotions committee files to determine whether there were additional professional behavior or academic performance issues.

For each student identified, the professional behavior and academic performance issues were categorized as to the types, severity and frequency of issues. Academic performance was categorized as marginal/ low grade, failure/ deficiency. These were noted in major courses, minor courses and electives.

The American Association of Medical Colleges and the National Board of Medical Examiners developed the Professionalism Assessment Form (2008) as noted below. Professional behaviors were categorized. The intention was to use the rubric of professional characteristics noted below, however, promotions committee notes lacked significant details to allow categorization.

- Honesty/ integrity (truthfulness, adherence to ethical principles)
- Responsibility/reliability/ accountability (punctuality, compliance, accountability, feedback)
- Respect for others (colleagues, faculty, staff) (appearance, interactions, teamwork)
- Altruism (concern for others, empathy, compassion)
- Commitment to excellence (goal setting, motivation)
- Respect for patients (relationships, confidentiality)

In addition to the issues with academic performance and professional behavior, the proposed remediation, sanctions and outcomes were noted. Remediation included additional scholastic work and testing. At times the students were required to repeat the class or repeat the year. In addition, the promotions committee might have recommended behavioral remediation such as counseling, testing for learning disorders, referral to study skills classes. Sanctions included probation and the requirement for remediation. The

remediation and sanctions were examined to determine if they fit functional or symbolic purposes.

Each student identified from the letter to the Dean and executive faculty committee was followed through the promotion committee notes to determine the inciting issues, the remediation, and sanctions. Finally, the outcome of each of these students was noted, including whether the actions were effective in altering the behavior or performance of the student so that they were deemed worthy of the promotion to the next year and ultimately conferral of the medical degree or whether they withdrew from medical school. The contextual framework described above was used to frame the question of how does the medical profession regulate its members while they are in training in medical school.

Data to be collected: understanding the process of the promotions committee and the effects of the change of the make-up of the committee

The second major goal was to gain a better understand the functioning and process of the promotions committee. Through the interviews of the members of the committee, the study sought to better understand the student problems and issues that identify students to the promotions committees. In addition, the interviews with members of the promotions committee were able to clarify the issues found in the written documents such as triggers that identified students to the promotions committee. Specifically, one question to be asked was did the changes in the format and membership of the promotions committees from course directors to a longitudinal committee increase identification of problem medical students and professional regulation?

Interviews of members of the promotions committees who were part of the committee both before and after the change in the format of the committee were performed. To decide who to interview, the members of the promotions committees were determined for the time period studied from 1980 to 2000. Members of the committee who were available, and were part of the committee during the first decade for 1980-to 1990 and also in the second time period were be asked to consent and participate in an interview. As required by the IRB, the confidentiality of the committee members was protected. Nine committee members consented and were interviewed. One identified committee member refused citing “personal reasons” and one did not respond the request for interview. Some of the interviewed faculty members were on the earlier promotions committee as voting members while they were course directors and then served as non-voting members after the change in the format of the promotions committees. Others were deans who sat on both committees.

Interviews were conducted using a semi-structured interview protocol asking participants about the process of the promotions committee and the key academic performance and professional behavioral issues of consequence for the committee. Each interview was approximately an hour in duration and was recorded. The interview

questions included:

- I. Professional Behavior and academic performance issues
 - What types of issues with professional behavior were noted or addressed by the promotions committee?
 - Why were these issues noted?
 - What types of professional behavior issues triggered what types of actions or did not trigger actions by the committee?
 - Can you provide examples?

 - What types of issues with academic performance were noted or addressed by the promotions committee?
 - Why were these issues noted?
 - What types of professional behavior issues triggered what types of actions or did not trigger actions by the committee?

- Can you provide examples?
- II. Change in the Committee
 - The process and make-up of the promotions committee changed in 1989 to be 2 committees made up of either pre-clinical faculty or clinical faculty to promotions committees that followed the a class of students through their medical education. What kind of changes did this change in the committee cause in the issues addressed and the actions of the promotions committees?
 - Why were there changes?
 - Can you provide examples?
- III. Promotions committee overruled
 - On occasion, the decisions of the promotions committee was over-ruled by the executive faculty committee. Why were they over-ruled?
 - What were the issues for the promotions committees at that time?
 - Can you provide examples?
- IV. Professional control
 - Do you think that promotions committees address issue of professional control?
 - What are the strengths and weaknesses of the promotions committee's ability to be part of the professional control?
 - Do you think the promotions committee's role in professional control has changed over time?
 - Why?
 - Can you provide examples?
 - Of the graduates from 1980 to 2000, 30 graduates had a sanction by a state medical board. However, only 2 of those had formal action by the promotions committee. Why do you think that this is so?
 - What are the issues with the promotions committees identifying students who later go on to have disciplinary actions?

In a preliminary review of the promotions committee files, there were some students who stood out because the promotions committee struggled with the remediation and sanctioning of these students. One example was that on rare occasion the executive faculty committee did not accept the recommendations of the promotions committee. In addition, students who were involuntarily withdrawn were uncommon and indicate the formal control of the medical school. During the interview, these students were discussed to see if the committee members could offer insight into the process.

In addition to the interviews of committee members, the data collected in the previous section from the promotions committee letters were used to determine if objectively the incidence of identification by promotions committees and the issues addressed by the committee changed for two time periods. The intended purpose of the change in format and process of the committee was to allow a group of faculty to know the details of the issues longitudinally through the students' progress through medical school. Information

obtained from the members of the promotions committees and review of the data collected will answer the question as to whether the format of committee changed the identification and actions.

The interviews with members of the committee were recorded, transcribed verbatim and reviewed. The names of committee members interviewed were removed and they were assigned a letter code from A to I. The transcripts were analyzed first holistically and looking for key constructs and patterns. Then, using the transcripts, interview protocol questions, the conceptual framework and the questions of the study, descriptive codes were assigned to segments of the transcripts. Analysis looked for central constructs and concepts as well as differences between the two decades of promotions committee meetings (Erlandson, Harris, Skipper, & Allen, 1993, Rubin & Rubin, 2005, Straus & Corbin, 1998). These patterns and differences were coded through iterative coding informed by the archival data. Themes were developed based on the conceptual framework. In addition, the interviews with members of the promotions committee provided supporting evidence for observations made from the review of the committee files.

Archival data was collected from the promotions committee files including memos, handouts for promotions committee members and other documents found in the files. These documents were reviewed for their contribution to the process. In addition, the School of Medicine Bulletin was reviewed as it outlines the grading, promotions and remediation process for the 2 decades.

For the most part the source of data was the promotions committee files. However, at times, clarification was obtained by looking specifically at the student records. In

addition, all of the student records of the 29 students with state medical boards actions were reviewed. During the review of the student records and the promotions committee files, I was not blinded to the students' outcomes.

Data to be collected: consequences of identification and disciplinary actions by state medical boards

The final research question focuses on whether there were later consequences of identification by promotions committees. Specifically, were there students who were identified by promotions committees who later went on to have serious professional practice sanctions by state medical boards? Further, were graduates who had state medical board actions identified by promotions committees. The actions of state medical boards were of public record. In addition, Vanderbilt School of Medicine yearly received a letter from the Federation of State Medical Boards noting the graduates who have had sanctions by state medical boards. Using these reports and the information extracted from the promotions committees, I was able to determine the students identified by promotions committees who went on to have disciplinary actions by state medical boards.

Categorization of behavior leading to state medical board disciplinary actions was compared to the issues identified by promotions committees for students who came to the attention of both groups. In addition, the individual student records for each of the graduates with state medical board actions was reviewed to determine if there were professional behavior issues that might have brought those students to the attention of the promotions committee, but did not.

Statistical Procedures

Collected data of reasons for students' identification and action was listed in tables to allow the details to be apparent. Generalizations were developed the specifics of the students. In addition, frequencies for categorical variables were calculated. Specifically, the frequency of the following variables was noted: identification of students for behavioral or academic reasons, the actions recommended by the promotions committees- dismissal, promotion, probation, behavioral recommendation. As there was a change in the promotions committee in 1989, there were 2 periods described- the early period with students matriculating from 1976 (graduating in 1980) to 1988 and the later period with students matriculating from 1989 to 1996 (graduating in 2000). Chi squared statistic was used to compare differences in frequencies between the earlier and later period for reasons for identification (academic or behavioral) and actions recommended by the committee. In addition, Chi squared statistic was used to compare the frequency of identification of students between the first, second, third and fourth years of medical school.

For the promotions committee members interviews, data analysis was ongoing and iterative, using the constant comparative method of analysis and grouping of data chunks. Interviews were coded according to categories and recurring concepts and themes.

For graduates identified by state medical boards, the promotions committee files were reviewed to determine issues for those specific students and reported with descriptive statistics. Comparisons were made between the number of students identified by the promotions committee who had state medical board actions and those who were not identified by promotions but also had state medical board actions using a chi squared

statistic. As the numbers of students identified by state medical boards was small (29 students) more robust statistics could not be reliably performed.

CHAPTER IV

RESULTS

Introduction

There were 3 broad areas of study within the promotions committee actions. The first was what behaviors, or performance brought students to the attention of the promotions committee and what were the recommendations or sanctions of the committee? In each area, comparisons between the 80's time period and the 90's time period were made, to attempt to determine if the change in the committee changed the number or types of recommendations made by the committee. Second, specifically, how did changes in the format of the promotions committee change the issues identified and actions prescribed? The data obtained from the promotions committee provided numeric trends and statistical significance, while the qualitative data obtained from interviews with the promotions committee enriched the understanding of the decisions made and processes of the promotions committee. Finally, the study examined the relationship of the promotions committee recommendations and sanctions by the state medical boards.

The study included students who graduated in 1980 to 2000. Thus, there were 2131 students who matriculated from 1976 to 1996. There were 2078 students who graduated from 1980-2000. There was a difference in 53 students between matriculation and graduation. This was accounted for by the small amount of flux in student numbers each year by students who took leave of absence for various reasons, such as to do an internship, complete a PhD, took leave for personal or medical reasons, withdrew

voluntarily to pursue other career paths, or were dismissed (17 students). For the purpose of this study, the denominator was the number of students who matriculated during the time period.

The membership of the promotions committee changed in 1989 from members who were course directors in the pre-clinical years and in the clinical years, to a committee of 5 members who followed the students during the 4 years of medical school. For the purpose of analysis, the results of the study are divided into these 2 periods. The early period included 1320 students who matriculated during the 12 years from 1976 to 1988. This will be referred to as the 80's or earlier time period. The later time period, spanned 8 years of matriculated students and included the 811 students who matriculated from 1989 to 1996. This will be referred to as the 90's or later time period.

The promotions committees met several times during the year. The meetings during the semester were to discuss the progress of students, but for the most part the committee did not make formal recommendations during these meetings.

Recommendations concerning promotion, remediation, dismissal or commendation will be made once each year after the conclusion of all course work for the year. The committees will nevertheless be expected to meet periodically during the year so as to become knowledgeable about each student in the class and be aware of issues related to the academic progress of each student. (From The Charge to Promotions Committees)

At the end of the academic year, the promotions committee made recommendations for all of the students. The committee recommended that the majority of students be promoted to the next year. However, students who had difficulty would have other actions recommended such as probation or dismissal from the school of medicine. For the purpose of this paper, I addressed only the recommendations by the promotions committee that included negative actions or sanctions. The recommendations for commendation for the highest achieving students and the annual recommendation for the

majority of the class to be promoted to the following year were not be included in the analysis.

What brought students to the attention of the promotions committee?

The primary purpose of the promotions committee was to make recommendations to the executive faculty committee regarding the performance of the promotions committee. During the 2 decades, the promotions committee made 171 formal recommendations to the executive faculty committee on based on low academic performance or unacceptable professional behavior. Some students have multiple committee recommendations over several years. As a result, there were 140 students for the 2 decades with committee recommendations (6.6% of students). Further calculations were made using the number of promotions committee actions and the number of students matriculated as the denominator since we were interested in the types and frequency of actions of the promotions committee. For the early time period there were 118 actions, approximately 8.9% students had actions. For the later time period there were 53 actions or 6.5% of students had actions. There were more promotions committee actions in the early time period than the late one (Chi square 7.7, $p < 0.005$). Tables 3 and 4 contain a summary of findings categorizing student difficulty.

Most of the committee members noted that the committee dealt with the rare student. For example, one committee member noted:

Well first of all there weren't many decisions that were made – we're talking about a several hour meeting, that might have really boiled down to maybe three decisions. So most of it was checking off people and feeling as though due diligence had been done, more than anything else. (Committee member A)

Only students with significant problems were identified by the committee, but the majority of the students were not specifically discussed by the committee.

Academic performance

The students come to the attention of the promotions committee for a variety of reasons. The reasons for identification were divided into two broad categories, academic difficulty and problems with professional behavior. Academic difficulty included receiving marginal or failing grades. In the first year of medical school, 59 students failed at least one major course and 28 in the second year of medical school. During the preclinical years, for those who failed a course, the average number of courses failed was 1.4 and for those who received a marginal grade, the average number of marginal courses was 2.6.

Table 3: Categorization of Student Difficulty During the Two Decades

Year of medical school	Number of students	Failed courses*	Marginal courses*	Behavioral issue (# students)	Incomplete minor course or elective	Incomplete major course (s)
1	91	1.4	2.6	14	5	2
2	57	1.3	2.6	14	2	3
3	19	1.6	1	10	0	7
4	4	2	0	4	0	0

Total students 171 *For those who failed, the average number of failures and for those who received a marginal grade, the average number of marginal courses.

There were differences in the frequency of student problems between the 4 years of medical school. The first year of medical education was academically rigorous and includes anatomy and biochemistry. It was likely the most difficult year due to the adjustment to medical school as well as the vast material covered. Therefore, it was not surprising that the number of students who had difficulty in the first year of medical

school (91 students) was greater than those in the second year (57 students) (Chi square 13.7, $p < 0.05$). The third year was rotating clerkships of medicine, surgery, pediatrics, obstetrics/ gynecology, psychiatry and neurology. Fewer students had difficulty in the clinical years; 23 students in the clinical years as compared to 148 in the preclinical years (Chi square 182.7, $p < 0.005$).

Promotions committee members noted that academic problems included learning disabilities, poor cognitive skills, difficulty memorizing, inability to see things visually, difficulty putting things together, the ability to memorize but not use the information, the failure of minor courses due time management and studying for major courses, and inability to formulate clinical day-to-day notes and presentations.

Some students received an incomplete grade, and that identified them to the promotions committee. In reviewing the promotions committee files, it was found that this category was heterogeneous. For most major courses, if a student performed poorly on the final examination, the score would be calculated into the grade and ultimately they would pass or fail based on the final grade. For minor or elective courses, the final examination was often the only examination, therefore if students failed the final examination, the course director could either assign a failure or could assign an incomplete grade. For the most part, course directors would assign a grade of incomplete, rather than fail. They would allow the students to retake the exam or do remedial work and reassign the grade from incomplete to pass. The record of an incomplete grade would not be apparent on the final transcript. While not specifically stated, the purpose of the assignment of incomplete was to prevent penalization the student by having the grade of fail on their record, when the course was either an elective or minor course. However,

some course directors did assign a failure grade in the elective or minor course. These grades would be replaced on the permanent transcript with the passing grade when the work was completed. The grade of incomplete could also be assigned when the student did not complete the course due to illness, family emergency or other reasons at the discretion of the course director. When the incomplete grade or failure in a minor course brought the students to the attention of the promotions committee, the recommendation was that the students complete the course by remedial work or passing the examination. Finally, some students experienced life altering events such as attempted suicide, major depression, other types of illness leading to an inability to complete their coursework, in those cases, often the grade of incomplete was assigned. As a result, the category of incomplete includes diverse etiologies.

Table 4: Categorization of Student Difficulty by Time Period

Year of Medical school	Number of students	Failed courses*	Marginal courses*	Behavioral issue (number of students)	Incomplete Minor course or elective	Incomplete major course
1pre 1989	58	1.4	2.6	6	4	2
1 post 1989	33	1.3	2.7	8	1	0
2 pre 1989	43	1.3	2.4	9	2	2
2 post 1989	14	1.0	3.2	5	0	1
3 pre 1989	16	1.3	1.0	10	0	9
3 post 1989	3	2.0	1.0	2	0	0
4 pre 1989	1	0	0	1	0	0
4 post 1989	3	2	0	3	0	0

Comparing the two different time periods, there about the same frequency of first year students (4.4%) in the 80's were identified by the promotions committee as compared to 4.1% in the 90's. There were more 2nd year student actions in the 80's (3.3%) compared to the 90's (1.7%) (Chi square 4.5, $p < 0.05$). In addition, considering both preclinical years, there were more students identified in the 80's (7.6% vs. 5.8%, Chi square 2.7, $P < 0.05$). There was a trend towards the promotions committee having identified more students in the clinical years for the 80's. For this early period there were 16 students (1.3%) with recommendations by the promotions committee, compared to 6 (0.7%) in the late period (Chi square 1.1, $p > 0.05$).

Professional behavior

Professional behavior was expected of medical students and covers a broad spectrum of behaviors as they train to become physicians. During the time of the study, professional behavior was important for the promotion of medical students. The Bulletin of The School of Medicine/ Academic Regulations in 1976 noted "...and students who indicated by work or conduct that they are unfit for the practice of medicine may be required to withdraw from the school at any time." (p 40, 1976) "The committees recommend for promotion those students who have demonstrated personal, professional, and intellectual achievement consistent with faculty expectations at their particular stage of pre-professional development." (Bulletin of the School of Medicine, p 75, 1990)

Noted in the committee documents, the behavioral issues that triggered discussion by the promotions committee were diverse (Table 5). The behaviors included problems with

motivation, maturity, communication, and emotional instability. The descriptions of the behavioral triggers were general and not specific.

Based on the promotions committee documents and the interviews the following categories of unacceptable professional behavior were determined. The first was poor interpersonal skills. This was noted as an inability to work with people including peers, patients or faculty. It might be manifested as inappropriate comments or anger. Some students would isolate themselves while others had boundary violations such as stalking of the students or resident physicians.

The second type of behavioral trigger was a lack of responsibility. Examples of this were students not showing up on time, or not attending classes, and not participating in group sessions. The third trigger was a lack of commitment to medicine. There was overlap between lack of motivation and lack of responsibility.

The fourth trigger was failure to adhere to ethical standards and conduct. When students did not act in a manner of honesty and integrity, for example, cheating, there was great concern. Often these were managed by the Honor Council and the Dean of Student Affairs but also came to the attention of the promotions committee.

The fifth trigger was issues with the health and wellbeing of the student. Usually this was psychological such as major mental health issues. One student was diagnosed with bipolar (manic depressive disorder) and one with schizophrenia. Other students were dealing with depression and anxiety. One student attempted suicide during her preclinical years. Also in the area of psychological issues were personality disorders which were much more difficult to change. These bordered on character issues. For example, one committee member noted:

In order to socialize a child, you have to lay down limits, and insufficient limits tend to produce children who are narcissistic, and self-inflating, and more likely to engage in behavior that violates the rights of others. The problems that I ran into with students, behaviorally, always had to do with excessive narcissism and arrogance and willingness to try to reverse roles, to be the so-called parent. (Committee member A)

The sixth trigger was violation of social norms. The examples given were female students acting immodestly or chauvinistic male students. (Committee member C) The final trigger was substance abuse including alcoholism, drug use (Ritalin) and drug abuse. Promotions committee recommendations based on this area of behavioral aberrancy were rare for reasons that will be addressed later in this section.

There were a variety of types of behavior that might trigger action by the promotions committee. The behaviors noted that triggered promotions committee actions included violation of norms, poor interpersonal skills, lack of motivation. These types of behaviors would be concerning for members of the profession. That these behaviors were triggers indicate an attention by the promotions committee to the socialization of behaviors in medical students. Ultimately the committee was responsible for determining the best approach to remediation and management of these behaviors. The specific actions of the committee will be discussed in a later section.

Issues of academic performance were more likely to bring students to the attention of the promotions committee. Students were less commonly identified to the promotions committee for behavioral issues. For only 28 students of the 148 student identified in the preclinical years (first and second years of medical school), was the trigger due to behavioral issues. Nearly all of these students had academic performance problems as well. Only 3 students of the 148 students identified in the first 2 years had purely behavioral issues without academic problems. However, there was not a clear line that distinguished behavioral problems that effect academic performance. Committee

members mentioned a lack of motivation or poor attitude as a trigger for students to be identified to the committee. The manifestations would be apparent in both academic performance as well as professional behavior. For example, one committee member described a student problem:

But I had a student threaten me once. I did not document that, but I told my chairman. My chairman went and talked to Dean. I was a young teacher. And also talked to other people, the word I got back was don't worry, this guy will never pass pathology. And what that meant was they intended to get rid of him. My chairman told me, he is a poor student, we are going to get rid of him on academic grounds, but everyone is aware. (Committee member E)

While behavioral issues were not the main topic in the preclinical years where course work reigns, in the clinical years behavioral issues were more apparent. There were few academic difficulties in the clinical years. The grading in these years was different. For most courses, the examination was only a portion of the grade, with the major portion of clinical performance assessed by residents and faculty. While some of the clinical performance was based on academic knowledge, professional behavior was equally as important. The third year was really a year of socialization, where students were caring for patients, working with the team of physicians. As a result behavioral concerns proportionally were more common during the clinical years, with behavioral issues noted in 12 of 19 students in the 3rd year (63%) and all (4 of 4) of the 4th year students. Of the 19 students identified in the 3rd year, 4 of these students had purely behavioral problems and 3 of the 4th year students (see Table 3). This demonstrated that the main focus and student assessment of the 3rd year was clinical performance and behaviors. It was hard to tell from the promotions committee notes, whether the issues with students in the clinical years stemmed from unprofessional behavior or academic performance. For example, a student who came late to rounds or does not know the details of her patients, manifested

unprofessional behavior, but the result would be a lowering of the grade since the grade was based on clinical performance.

For students identified by the committee, there was a trend towards more students identified with behavioral (18/53, 34% compared to 26/118, 22%) in the later period than the earlier period (Chi square 0.8, $p > 0.05$). One committee member noted:

I think that prior to the change, almost all of the actions were based on academic performance. The behavioral performance had to be fairly egregious and I can't really remember, prior to the change, that there were very many actions taken solely on the basis of their behavior. Subsequent to the change the committee continued to make decisions on academic performance, and I think that was consistent with both. But I think they felt much more empowered to make decisions based on behavioral problems. My sense was that more of them were efforts at remediation rather than dismissal. (Committee member G)

Table 5: Behavioral Issues

Period	Student #: issue
2nd yr of medical school	
1980's	55: Lack of motivation that in retrospect was apparent in college 22: Behavior was concerning (belief in God and harassing a female student) 223: Behavioral issue of not taking exam with colleagues in the past 301: Concern for her emotional and psychological stability 305: Behavioral issues which have raised concerns about suitability for a career in medicine 213: Poor attendance
1990's	269: Not clear description of behavior but recommendation of learning disability testing and that he undergo psychological testing over the summer in order to identify any other obstacle to his success and to provide him with the tools he needs for future success. 276: Behavior immature and occasionally disruptive to the class 335: Lying issues 1st yr 331: Lack of commitment 338: Concerned about his level of maturity and difficulty grasping concepts. 340: Disorganized and needed further help with his study skills 341: Aware of the personal, family problems and feels she would benefit from counseling. 339: Concerns about emotional state following events of the 1st yr honor council hearings
2nd yr of medical school	
1980's	222: PC notes that student is to be interviewed and determined to be "fit" to be promoted 220: Be promoted to 3rd yr but that the EXF be aware of the PC concern over this student's professional skills (as opposed to academic skills) and marginal clinical

	<p>potential</p> <p>8: Besides unsatisfactory performance with poor preparation and lack of basic understanding of material, demonstrated erratic attendance, attitudinal problems, with inappropriate and manipulative behavior and in the PC opinion, unsatisfactory potential to continue the study of medicine.</p> <p>48: Working below his potential due to problems with attitude and motivation. Student be promoted to 3rd yr on probation with appropriate notification of such action to the faculty of that year.</p> <p>241: Had been 1st year class president. She “went into a tail-spin, and by Thanksgiving was dysfunctional. She flunked everything but was given incompletes because she was very emotionally ill. She has been in therapy since then and seems to be making progress.”</p> <p>301: Dismiss based on her lack of ability to synthesize information. This decision was based on faculty observation and as well as psychological psycho-neurological testing</p> <p>308: Required to get the help of a counselor with follow-up to the PC and repeat 2nd semester of 2nd yr due to a combination of academic difficulty and personal problems</p> <p>309: Combination of personal problems and academic difficulty</p> <p>231: Dismissed due to continues marginal performance as well as behavioral and attitudinal problems with the grades to follow</p>
1990’s	<p>284: Non-academic “probation because of the faculty's loss of confidence in your judgment”, be placed on non-academic probation, that a letter would be written to outline Problems of the past and state that she exhibited poor judgment</p> <p>285: Issues of communication and interpersonal skills</p> <p>335: In view of the serious nature of the behavior issues that had been the basis for placing student on probation and the difficulties associated with determining whether such behavioral issues had been resolved, PC recommends that student be retained on probation.</p> <p>336: Severity of concerns about student with continuing behavioral problems</p>
3rd yr of medical school	
1980’s	<p>220: Behavioral issues not specified</p> <p>226 “Whose acquisition of professional skills are borderline”</p> <p>248: Professional skills considered to be unsatisfactory in several categories</p> <p>61: “She has lost a considerable amount of time from several rotations due to illness, some of which is considered to have self-inflicted components.”</p> <p>62: “By virtue of having flunked the final exam due to inadequate fund of knowledge, and an inappropriate comment on the exam paper. At this point he has retaken and passed the exam, and expressed regret to the department of psychiatry for his inappropriate behavior.”</p> <p>63: Performance in pediatrics was marginal and more than one department has questioned her interest and motivation in medicine.</p> <p>77: Behavior with psychiatry pts was considered inappropriate</p> <p>60: Behavioral issues (likely related to substance abuse but not spelled out.)</p>
1990’s	<p>335: Repeated patterns of problems with honesty and working with others.</p> <p>337: Poor performance and poor interpersonal behavior</p>
4th yr of medical school	
1980’s	<p>241: There are behavioral issues in her 4th year. The student had had some problems earlier. She has psychiatric evaluation. The diagnosis is made of bipolar disorder. There were meetings to determine if she should be allowed to graduate and she will be able practice as a physician given her diagnosis. The decision is made</p>

	that she will be conferred the MD degree. Her Dean's letter, summarizing her academic performance does not note the diagnosis.
1990's	<p>287: Student lied about taking a weekend off and then lied about other related issues. He had significant behavioral issues in the 1st yr, then was dismissed from PhD program. From the minutes" the PC has constructed a program for #287 of remediation with #287 taking a year leave of absence to work closely with faculty mentors in the pediatric genetics clinic and HIV clinic. The goal was to enable him "to develop the characteristics of honesty, integrity, team work and compassion which the PC believes are the characteristics to be necessary in a good physician."</p> <p>269: Poor performance and behavioral issues. Failed 2 clerkships and had to repeat year. (need to pull wording from letter</p> <p>335: Continued lack of confidence in her professional behavior</p>

Threshold of identification of students to the promotions committee

In the committee member interviews and promotion committee notes there was difficulty identifying what student behaviors were significantly important to be addressed by the promotions committee and furthermore, to warrant action or recommendation by the committee. Committee members expressed questions on how to determine what behaviors trigger identification by the committee and the threshold of behaviors both for identification or action by the committee. One common theme from the interviews was the sense that the faculty were not as aware of behavioral issues as were the students. One committee member (Committee member E) said gave the example that students came to her because they were concerned about alcohol use in a peer.

In the clinical years, the students worked closely with a team of resident physicians, who likely knew about behavioral issues. However, often there was not a mechanism in place for documentation or value placed on the behavioral observations of peers or residents. Therefore, there was the potential for deviant behaviors to go unidentified by the promotions committee.

Second, there was a resistance by the faculty to make comments about students in part because of a lack of certainty of their observations. There was a variability of student performance, and faculty were uncertain whether the behavior they observed as an isolated event or a trend. In addition faculty were hesitant to make comments in part because students become upset about negative comments. Also committee members expressed a lack of support from the dean and administration that disempowered the faculty from noting behavioral misconduct. For example, one committee member noted:

I think many of us are hesitant to speak out unless we really feel that there is a serious problem- that failure to speak out when we sense minor problems. The minor problems may be what you were seeing. And the student is hiding a lot from you and the true is that if you are picking up anything at all it is probably important. ok? and there's other issues, for reasons I .. I'm not sure I would ever want to be on tape with,.. Every once and awhile there is a student who is a problem and the faculty jump up and down and nothing is done about it and we do not understand why that is and it may be for reasons that I don't really like very much. I can think of some students I know many of the faculty were upset about. Didn't want the person in medicine, whatever, and lo and behold it was decide they would, they would. And the faculty were like "what". And there was some executive decision that was made. (Committee member E)

Faculty, therefore, rarely commented on student behavior for a variety of reasons. As a result, the documentation of behavioral misconduct was often scanty, making action by the promotions committee difficult.

When the promotions committee was aware of behavioral problems, they had to struggle with the meaning of that behavior. Was it a single event, or was it a trend? Was the behavior in itself significant enough to warrant action? For example, if a student was reported as having drunk too much alcohol, or having gotten in a fight, were these single episodes or part of a bigger pattern of behavior? The committee was resistant to take action and the threshold for action was set high. Furthermore, there was increased difficulty when the students' grades were acceptable but their behavior was not. One committee member described it as:

You walk this line when a kid makes a mistake about making a decision about whether that's a mistake a person can learn from, does the person have the moral—whatever, to deal with the problem and you don't worry about them in the future, or whether this is somebody who is likely to make the same mistake over and over again and this is going to be problem for somebody else down the line and maybe kill a patient. (Committee member E)

Several committee members during the interviews used the metric of “would you want this student to be your physician?”. This measuring stick was very pragmatic. It was based on whether the committee member would be willing to use the services of that student if in fact they became a physician. “ So I told him that this girl was really, really bright but I would never send someone I loved to her. It is one of the big measures.” (Committee member E) It was also noted that someone has to be the bottom of the class, so how does that factor into the decisions. Would you want your physician to be the bottom of the class? (Committee member E)

There was a tension around what issues the promotions committee was intended to address. While in form they were responsible for professional behaviors as well as academic behaviors, in function, they did not address all professional behaviors. Many of the behaviors were addressed by the dean's office and never came to the attention of the promotions committee. Behavioral issues that impacted on academics were more likely to come up for discussion for the promotions committee. There were a lot of behavioral issues that were dealt with in the dean's office, that seem to have no academic impact, so what was seen in the promotions committee was not the sole record of behavioral problems in students. Committee member D described in detail management of behavioral issues:

If you took the issues that were not strictly issues of grades, I would say two-thirds of those wellness or cheating-type issues would be handled outside the promotions committee. But when the issue came up and was first identified in the promotions committee, of course it was something that needed to be tended to there. [...]A lot of the management would be outside the promotions committee. Some things that were small – there would be accusations that would be managed by the student conduct council, and

those things might not get to the promotions committee. If one student accused another student of cheating, and the student conduct council managed that and it turned out there was no cheating, that would never get to the promotions committee. If it turned out that there was cheating, then that became an issue and of course the promotions committee would hear, but they wouldn't manage it, (Committee member D)

There were probably five students in every class, on average, who had either a drug, alcohol, or psychiatric problem of some sort. I would say there were at least five in every class. Some of them – manic depressives – they were treated, they were seeing a psychiatrist – what do you do with that? Do you tell the promotions committee that a student is doing beautifully and has this disease and is on medicine? (Committee member D)

But, if a person has an alcoholic problem, they've been a physician for twenty years, and they've managed it, they've taken excellent care of their patients, and we don't have any data that shows that a person who has a tendency to alcohol can't be a good physician, then what you're doing, you've got two issues here. You're looking at the rights of the individual versus the needs of society, and this is a huge issue for medicine in all things. (Committee member D)

As can be seen by the statements from committee members, the Dean of Student's office managed the majority of the behavioral issues so that the promotions committee, were informed of behavioral issues only on a need to know basis (Committee member D), meaning when the behavior effected academic performance. At least one of the Deans of Students during the 2 decades had a private file for student issues that was not a part of the official student file. The role of Dean of Students was multi-faceted including being an advocate to the students, a screener of behavioral issues and determination which issues would come to the promotions committee.

In addition, the Dean of Students was responsible for maintenance of social norms. One committee member described the Dean of Students holding a class meeting to discuss behavior that was unacceptable.

The Dean of students was responsible for the students on a day-to-day basis. As a result, much of the information, Dean of Students knew was confidential. One committee member (Committee member G) described the role as preventive. The Dean of Students would manage student issues both behavioral and academic and at times prevent the

issues from reaching the threshold of promotions committee identification or action.

There may have been some role conflict in terms of disclosing the confidential information the Dean of Students knew about students and the responsibility to share that information with the promotions committee as well as their role to protect and help the students. This would be in opposition to the duty to inform the promotions committee so that sanctions or recommendations can be made. Finally, when the promotions committee recommended actions, it was the Dean of Students who was responsible for ensuring implementation of the action. In other words, the Dean of Students was often in the role and position of social control.

During the 2 decades there were 3 Deans of Students, each of whom likely had a different approach to the position and roles. The exact influence of each was not clear from the promotions committee files, nor from the interviews as this was not a direct focus of the study.

Identification of problems with academic performance was relatively straight forward compared to the identification of behavioral issues. Once the students were identified the promotions committee would need to determine the appropriate action for the student.

What were the recommended sanctions or actions of the promotions committee?

The promotions committee identified 171 of the 1983 students with behavioral or academic problems who matriculated during the 2 decades. Once the promotions committee identified students, they would make academic or behavioral recommendations. The academic recommendation options were promotion, promotion with probation, remediation of the course, repeat the course, repeat the year, or dismissal/

withdrawal. These are summarized in Table 6. Students could have recommendations in several categories, such as they might be told to complete a course, then be promoted on probation. Of the 1983 matriculated students over the 2 decades only 21 were dismissed or 1% of students. Considering the 171 students identified by the promotions committee, 12% (21/171) were dismissed. The majority of these were in the first year of medical school.

Very few students, about one percent, were students dismissed. More first year students were dismissed in the early time period than in the 90's (Chi square 4.5, $p < 0.05$). Examining the records to determine what would constitute recommending dismissal rather than repeating the year, the Medical School Bulletin was not absolutely prescriptive, but instead gave options. For example, if students failed 2 classes, they may be dismissed or told to repeat the year.

Table 6: Recommendations of Promotions Committee

Year	# of students	Promote	Promote /Probate	Repeat course	Repeat yr	Remed	Complete	Other*	Dismiss
1pre 1989	58	16	27	18	2	20	4	3	11
1post 1989	33	4	21	5	7	2	0	15	1
2 pre 1989	43	21	13	1	2	24	2	2	6
2post 1989	14	9	9	1	1	3	0	6	0
3 pre 1989	16	5	7	1	**1	4	8	10	1
3post 1989	3		1					1	2
4 pre 1989	1							1	
4post 1989	3				1	1		1	

* Behavioral recommendations, details described in Table 8, ** to repeat 2nd yr courses. Some students had multiple types of recommendations, so the columns do not add up.

In the 80's, first year dismissals were recommended when students failed 2 major courses. A couple of students failed a major course and a minor course (for example, medical statistics) and were not dismissed. However, one student (#305) failed only one course and was dismissed. The recommendation notes that the student (#305) be dismissed from the medical school on the basis of academic performance as well as behavioral issues which have raised concerns about suitability for a career in medicine. Yet another student failed both histology and neurology but was not dismissed. These cases indicate a variability of actions depending upon more than just the grades of the students. In the earlier time period, the 2 students who repeated the year had no failures, but had instead multiple marginal grades. In the later time period, 5 of the students who repeated, ultimately graduated, some with difficulty and 2 did not graduate.

In the 1990's period, only one student was dismissed in the preclinical years. On the other hand, there were students who failed 2 major courses who were required to repeat the year instead of dismissal. In the earlier period, these students might have been dismissed for this sort of academic failure. Part of what may have been happening was an effort by the promotions committee to remediate behavior rather than to summarily dismiss students. See the committee member comments regarding the effects of the changes in the committee.

As a result, there was a shift to allow students to repeat the year rather than to dismiss them in the 1990's time period. Of the 9 students who repeated the first year (from both time periods), 7 graduated. If graduation was an indicator of successful completion of medical school, then allowing students to repeat the year was an acceptable option since

the majority of students graduated although they may have had problems. This study does not speak to their performance in residency nor in medical practice.

The question becomes, if a student had difficulty in the first year of medical school will she continue to have difficulty as she advances. In terms of recidivism, less than a third of students, (28 students) who had problems in the first year class, had problems in the second year. When looking at the clinical years, 5 of the 16 in the first time period had had issues prior to the 3rd year, but the majority did not. Of the 8 students with behavioral issues in the clinical years, 3 had problems previously and 5 did not.

Therefore, one cannot make clear determinations that students who have difficulty in the clinical years have a history of academic difficulty or behaviors problems. Nor can it be said that if students make it through their preclinical years, they will perform competently in the clinical years.

Table 7: Dismissals and Withdrawals

	Deficiency (courses)	# Marginal	Other
1st yr of medical school			
1980's	321: Anatomy 342: Histo, neuro 214: Histo, neuro 221: Histo, neuro, physio 224: Histo, neuro, physio 225: Histo, neuro, physio, biochem 2: Histo, anat 5: Histo, neuro, physio 304: Anatomy, biochem & microbio 305: Anatomy 1: Anatomy, Biochem	2 4 2 1 2 2 2 2 3 2	Spring-was ill, did not complete semester In spring took half load of courses. Voluntary withdrawal
1990's	298: Anatomy, neuro, physio	3	
2nd yr of medical school			
1980's	223: Micro, clinical science 255: Did not complete 8: Path 9: Path and micro 235: Path, micro, physical diagnosis and psych 231: None 301: Path & physical diagnosis	 2 1 c in 4 1	Had repeated first yr and was on probation Poor performance voluntary withdrawal Was on probation Was on probation Was on probation Was on probation Was on probation
1990's	None		
3rd yr of medical school			
1980's	308: Obstetrics/gynecology		Had multiple failures in preclinical years
1990's	335: None 337: Peds, surg		Behavioral only: concern was with honesty and repeated patterns of poor behavior with working with others Poor interpersonal behavior
4th yr of medical school: None			

For the most part, the promotions committee made recommendations concerning academic status or in relationship to academic courses, but the promotions committee could have also recommend a behavioral action. Table 8 contains the behavioral

recommendations. The least invasive form of recommendation was simply a letter of encouragement suggesting the student work harder, or decrease extra-curricular activities. Sometimes the recommendation was more of a warning such as a letter noting unacceptable behavior, followed by the statement of “recurrence of inappropriate behavior is cause to reconsider desirability of continuation in the school of medicine.” The more directive action would have been that student be referred for counseling, psychiatric evaluation, study skill training, or learning disability assessment. Occasionally, the committee would make very specific recommendations such as “1. He be in the monitoring program of Tennessee impaired physician, 2. if this program does not included chemical monitoring of his status, he be required to participate in such a program.”

In the clinical years, the recommendation was likely to be a mandated structured curriculum. The committee looked at the student’s deficits and determine what rotations or which clinicians would be most likely to help the student address the deficiencies. One committee member described the process as:

That was the plan...to try to come alongside and to set a base of support and encouragement, to try to help the student remedy...if they needed more experience, if they needed more direction, if they needed to be shown...I remember those things coming to mind now. This was not an uncommon event at all. I remember that occasionally the implications of this would be “how do they structure the fourth year?” And there were one or two occasions where a student was purposely directed to a given rotation like an ambulatory medicine rotation or they could work with a faculty member in a clinic session or even an inpatient rotation, to have a hand-picked faculty attendee that would spend time with this student to help them develop the clinical skills that it seemed they might not be developing as well as another. (Committee member I)

Using Freidson’s (1970, 1975) categorization of functional- sanctions to change behavior, or symbolic- to serve as an embarrassment, all of the recommendations were functional. The actions aimed to change the behavior or performance of the students.

None of the recommendations were public or served to cause embarrassment. Even dismissing students was done quietly. The recommendations served to help the students become better doctors. In the example above, of the student referred to Tennessee Impaired Physicians Program, the intent was to prevent future misconduct. Similar to what Freidson found in his study of practicing physicians (1970, 1975), nearly all of the recommendations were functional.

When the frequency of behavior recommendations were compared between the early and later period, the later promotions committees were more likely to recommend behavioral interventions for the first year students (45.5% vs. 5%, chi square 21.5, $p < 0.001$). Both time periods included counseling or psychiatric evaluations. The earlier period did not refer student to study skills or learning disability evaluation.

In 1989, there were two changes, the first was the change of the promotions committee, but there was also a change in the grading system. Grades previously had been assigned as a number, and were changed to a letter. The letter assignment gave less precise representation. In addition, the faculty were given the mandate to grade on behavior as a sole criterion for failure or marginal performance. One committee member described the change as follows:

But the change from numbers to letters allowed for less precise grading, and therefore you could factor in more qualitative information. The other component of that was the actual change in the grading sheet that sought information about behavior. There was a grade in which, if I recall correctly, a basic science person could, at any level, fail someone even though they had performed satisfactorily on a test. The grade sheet allowed them to document really gross, problematic behavior. (Committee member G)

These changes were made as a result of a new Associate Dean and the Dean of Students. These two individuals were instrumental in the grade changes and the changes in the format of the promotions committee. While specifics were difficult to come by,

they created a culture change where professional behavior was expressed as important as noted by several the committee members.

One of the issues medical school administration and promotions committees had to address were psychiatric problems. Over the decades there were several students with significant psychiatric disease. There was a student, who was dismissed likely because he had schizophrenia. Another student, who had depression and a suicide attempt in her 1st year; in her 4th year she was diagnosed with bipolar disorder. The promotions committee met several times and struggled with the question of- could a person with bipolar disorder perform adequately as a physician. In the end the promotions committee determined that her academic performance was competent and her professional behavior was acceptable, and she was recommended for graduation.

While substance abuse and alcoholism are not uncommon for physicians, there were only few students that were identified to the promotions committee for this. There was one student in the early period. The promotions committee recommendations did not mention the problem but recommended close monitoring of the student. The documentation that the sanctions of close monitoring were to address alcoholism was sealed in the student's file. However in the 1990's, the one student with substance abuse was clearly noted both in the promotions committee notes and in the file.

Issues of substance abuse were managed by the Dean of Students' office and not brought to the attention of the promotions committee. It was possible that the promotions committee discussed substance abuse, but it did not make it into the notes. It was likely that these students were only identified by the committee when it affected their academic performance. This process was described by 2 committee members:

It didn't get to promotions. Promotions Committee was about their academic performance. That was what I was saying before. If a student had an alcohol problem and they were getting all As and Bs and they were performing well and their professors thought they were great, than we dealt with that and we sent them to student health. They were required to be in these programs and that was part of my office's record. But that was not part of their official transcript because I think, for example, alcoholism and bulimia and those sorts of things, schizophrenia, we had manic depressives, those are diseases. You don't go to the committee and say "the person's a diabetic," unless the student wants to release it. It's a privacy thing, so unless their grades were suffering and they came before the promotions committee with some...the promotions committee had questions about them these things were not raised. (Committee member D)

I think the interventions for those are rarely, if ever, by committee decisions, it's more the role of the dean of students and the dean's office. It may come up in the committee because the dean of students, as part of this discussion of behavioral issues, might say there has been a substance abuse problem and the student's in therapy, being treated for that. That's more an issue of a contributing factor rather than an action taken by the committee, in my sense. There are a lot of behavioral issues that are dealt with in the dean's office, particularly the dean of student's office, that don't necessarily surface in the promotions committee. If they're being dealt with and they have no academic impact, so what you see in the promotions committee is not the sole record of behavioral problems in students. (Committee member G)

The substance abuse behavior itself was not considered to be a violation of the professional behavior norms but instead was treated as a disease that had confidentiality protection. Please refer to other comments made by committee member D above.

Table 8: Promotions Committee Behavioral Recommendations

1st yr of medical school	
1980's	<p>220: To be interviewed by the PC with respect to the advisability of continued enrollment</p> <p>240: [Suicide attempt 3 weeks before end of semester, did not complete coursework].</p> <p>301: Committee confirmed leave of absence.</p> <p>Recommendation of psych evaluation before the beginning of 2nd yr. The evaluation is meant to help the student. It is based on the concern for her emotional and psychological stability as well as her marginal performance.</p>
1990's	<p>292: Decrease extracurricular activity</p> <p>295: Required study skills help</p> <p>296: Strongly recommend psychiatric evaluation</p> <p>283: Require psychiatric counseling and evaluation</p> <p>281: Be required to undergo learning evaluation</p> <p>269: Follow-up on learning disability testing and that he undergo psychological testing over the summer in order to identify any other obstacle to his success and to provide him with the tools he needs for future success.</p> <p>271: Take study skills course offered by the counseling center and he be evaluated for learning disability in order to identify possible obstacle to his success.</p> <p>272: Letter to student encouraging him to work harder</p> <p>273: Letter of encouragement</p> <p>274: Letter to student encouraging her to work harder</p> <p>275: Encouraged to take study skills course over the summer</p> <p>331: She will participate in classes with commitment equal to that of her classmates</p> <p>340: There was the sense that am was disorganized and needed further help with his study skills before starting the 2nd year... Recommends to promote on probation with an expectation that that he be evaluated at Oxford house for study skills.</p> <p>341: Committee is aware of her personal and family problems and feels she would benefit from counseling. The recommendation is to promote #341 on probation with an expectation that she will seek counseling throughout the summer.</p> <p>339: PC had concerns bout #339's emotional state following events of the 1st year honor council hearings. PC believes that with time and counseling, #339 will become a successful medical student. The recommendation is that #339 repeat the 1st year after a required one year leave of access for health reasons.</p>
2nd yr of medical school	
1980's	<p>222: To be interviewed by the PC and was determined to be fit and was determined made significant strides in the development of insight</p> <p>308: Get help of a counselor</p>
1990's	<p>297: Resolve deficiency, take and pass USMLE, then re-evaluate by PC</p> <p>284: PC stated that even one act of poor judgment as judged by the PC would be cause for dismissal. 2) placed in specific clinical setting for the summer. 3) you will comply with the wishes of Nashville cares and have no further contact with pts 4) required to undergo psychiatric evaluation and receive counseling as judged by psych evaluation. This is required because of the question concerning your judgment and the concern that psychiatric illness may be a contributing factor.</p> <p>285: PC suggests that if you have any undisclosed medical or psych problems that you receive counseling and help for them.</p> <p>278: PC was concerned about student and felt that there was no significant improvement over last yrs performance. " we wish to encourage you to try your</p>

	<p>best and to do better work in the future.”</p> <p>280: Pass USLME</p> <p>336: In light of the severity of concerns about continuing behavioral problems, the PC recommends that a decision on promotion to vms3 be deferred and that until that decision is made : 1. He be in the monitoring program of TN impaired physician, 2. if this program does not included chemical monitoring of his status, he be required to participate in such a program. 3. he demonstrate satisfactory performance in the PhD phase of his combined program.</p>
3rd yr of medical school	
1980's	<p>220: Promoted with structured curriculum and some reservation</p> <p>226: Promote with structured curriculum</p> <p>61: Probation in this instance is to imply that significant absenteeism is cause to reconsider the desirability of her continued enrollment in school of medicine.</p> <p>62: Probation with recurrence of inappropriate behavior is cause to reconsider desirability of continuation in the school of medicine.</p> <p>63: She needs to complete in sequence 4th year rotations with a structured curriculum, assuring patient contact and responsibilities, failure to do so is cause to reconsider.</p> <p>77: Probation with structured curriculum and repeat a psychiatry rotation</p> <p>60: Specific conditions defined: therapy, regular contact with assigned physicians, academic counseling, support group, and student must complete in satisfactory manner each educational experience of the 4th yr.</p>
1990's	<p>295: Continued probation due to low grades and there was some concern on the PC that much of your difficulty might lie in your ability to take standardized tests and they suggest you seek counseling on your test taking abilities.</p>
4th yr of medical school	
1980's	<p>241: There are behavioral issues in her 4th year. The student had had some problems earlier. She has psychiatric evaluation. The diagnosis is made of bipolar disorder. There are meetings to determine if she should be allowed to graduate and she will be able practice as a physician given her diagnosis. The decision is made that she will be conferred the MD degree. Her Dean's letter, summarizing her academic performance does not note the diagnosis.</p>
1990's	<p>287: Student lied about taking a weekend off and then lied about other related issues. He had significant behavioral issues in the 1st yr, then was dismissed from PhD program. From the minutes" the PC has constructed a program for #287 of remediation with #287 taking a year leave of absence to work closely with faculty mentors in the pediatric genetics clinic and HIV clinic. The goal was to enable him "to develop the characteristics of honesty, integrity, team work and compassion which the PC believes are the characteristics to be necessary in a good physician.</p> <p>269: Poor performance and behavioral issues. Failed 2 clerkships and had to repeat year. (need to pull wording from letter.)</p> <p>335: Student PC had recommended dismissal several times, but had been over-ruled. In the 4th yr they refused to make recommendations about this student, instead "we defer judgment regarding 335 graduation to the executive faculty committee."</p>

Executive Committee acceptance or rejection of Promotions Committee recommendations

The promotions committee members were actively involved in the decisions that were made. Their role was to monitor progress through the year and to make recommendations to the Executive Faculty Committee about the actions regarding the students. From the charge to the promotions committee from the Dean of the school of Medicine given to the members of each promotions committee in the 90's period was noted:

The Promotion Committee for each class shall have responsibility for following each student in a class, making preliminary judgments concerning the progress of students under their charge, and making recommendations concerning these matters to the Dean and the Executive Faculty of the School of Medicine. (Charge to Promotions Committee from files)

The promotions committees' recommendations were presented to the executive faculty committee by the Associate Dean or the Dean of Students. There were times during the 2 decades when the executive faculty committee did not confirm the promotions committee recommendations. The details of these are found in Table 9. There were 12 recommendations from the promotions committee that the executive faculty committee did not confirm and concerned 8 students. The recommendations on 2 students were overruled more than once. Of the 8 students, 6 went on to graduate although, half had other problems along the way and 2 ultimately were dismissed. The last 3 students in Table 9 were during the 90's time period. There was no significant difference in the number of recommendations overruled between the two time periods.

An example of promotions committee and executive faculty discordance was a student who had behavioral issues of lying and poor interpersonal interactions. The Promotions committee recommended her dismissal on the grounds of inappropriate

professional behavior after her first year. The Executive faculty committee did not confirm this, but instead recommended a year off and then continue to the 2nd year. In her third year, she again had professional behavior issues and the committee again recommended dismissal. It was again not upheld by the executive faculty committee. In the end the promotions committee refused to recommend but simply deferred to the executive faculty the conferral of her degree.

Table 9: Executive Faculty Committee Over-ruling

#	PC recommend	EXF recommend	Disposition
221	Withdraw	Repeat 1 st yr	Problems but eventually graduated
223	Withdraw	Repeat 1 st yr	Voluntary withdrawal after failing 2 nd yr
224	Withdraw	Repeat 1 st yr	No problems, graduated
302	Repeat 1 st yr	Promote on probation	No problems, graduated
307	Promote on probation	Promote no probations	No problems
296	Promote on probation with psych eval	Promote on probation Did not confirm psych eval	See below
Same	Promote on probation	Reassessment by PC	Promoted without probations but ultimately dismissed
277	Repeat year	Promote on probation	No problems
335	Dismiss	Leave of absence for yr before returning to continue in 2 nd yr	See below
Same	Promote on probation	Promote without probation	See below
Same	Dismiss	Promote on probation	See below
Same	Did not recommend to confer diploma	Confer diploma	

The reasons for the executive faculty committee to overrule the promotions committee were not always clear. In some of the promotions committee files, there were handwritten notes from the Associate Dean, noting that there was not sufficient documentation to justify the action that was recommended by the promotions committee.

The concern was that if the school were to be sued, they would not have adequate documentation of the students' problems.

Both the Dean of the School of Medicine, and the Dean of Student Affairs were concerned with careful documentation of student behavior and remediation. For example, the Dean of the School of Medicine clarified the procedures in a letter to the Dean of student in 1976 highlighting the need for complete documentation of the management of problem medical students. "... the circumstances which need to be addressed both from the standpoint of helping the student as well as from a purely legal standpoint in notifying the student in a timely ways regarding progress, particularly when that progress is marginal or insufficient to carry credit." (from the promotions committee file January 20, 1976) Furthermore, The Dean asked that all of the members of the promotions committees receive a copy of an update from Higher Education, September 17, 1976 noting that a court ordered a medical school to reinstate a medical student dismissed for doing marginal work because "the school had not ever established any definition and thus was acting subjectively when the committee on educational evaluation found the student's work "marginal" and dismissed him." (Higher Education 1976)The same attention to documentation was present in the 90's period as evidenced by most of the promotions committee files after 1989, there was an article titled "The **legal context** for evaluating and dismissing **medical students** and residents" (Irby, 1989) Throughout all of the years there were references to the fear of lawsuits. As a result some of the promotions committee recommendations were rejected due to a lack of documentation.

Another reason the executive faculty committee might have not accepted the recommendations of the promotions committee was that the promotions committee had

more detailed knowledge of the students' academic performance, professional behaviors and his or her response to the recommendations and interventions of the promotions committee and Dean of Students. For example, one committee member noted:

I recall a few where the executive committee had not yet bought into dismissing people solely on behavioral issues. So the committee, having dealt with something and having found that there was no change, there was a reluctance on the part of the executive. Then a student would appeal, and I think if you review it, that was probably a significant factor-there weren't that many-but I think that may be a significant factor. (Committee member G)

The process was that the recommendations of the promotions committee were brought to the executive faculty committee who then voted to accept or decline. There were several layers above the executive faculty committee, including the Dean of the School of Medicine, the Graduate School, the Vice Chancellor, and Chancellor. One student was brought to the promotions committee attention because it was found that he had lied on some forms. As this was investigated, it was discovered he had lied about other issues. The Promotions Committee recommended a year off with mentorship on ethic behavior. This was confirmed by the Executive Faculty committee and the Dean. The student who appealed his ruling to the graduate school of the University. The council did not agree with the decision and over ruled the Executive faculty committee. He determined that the sanction would only be to take a 2 week-long ethics course. In this case the promotions committee refused to recommend conferral of diploma, instead conferral was recommended by a subcommittee of the executive faculty committee. Information about these higher-level deliberations and decisions were limited in that only promotions committee files and student files were reviewed.

There were pressures exerted on the faculty, promotions committee, executive faculty committee and the Deans and were noted by committee members. These included the

influence of students and their parents. A number of the students with difficulty were offspring of physicians, some of whom worked at Vanderbilt. One committee member gave an example of:

There was a girl who the faculty felt had anorexia, really smart girl, really felt there were some really bad emotional problems that she should have to deal with. Even though the faculty jumped up and down, I even know the chairman of my department, XX jumped up and down, but nothing was done. I was told later that her father was a very influential physician. And that really horrified me. Because I did not think he was acting in the interest of his daughter. Apparently, he had called the dean of students and he was very angry at the faculty. And this sort of thing, and we all felt think he not was acting in the best interest of his daughter, or future patients of which, he should have been more cognizant. (Committee member E)

In each of the steps the decision to sanction a student might not be supported. Committee members noted that the Dean of the School of Medicine for this time period was very supportive of students. He believed in individual attention paid to each student. He was reluctant to dismiss students. (Committee member G) Therefore, the external pressure of whether decisions might have the support of the Dean would effect the decisions that were made.

In addition, the committee felt a responsibility to the students. To sanction a student might affect their ability to match in a good residency. To dismiss a student was to force them to abandon their goals to become a physician, to crush their psyche, and to incur great debt. The committees also felt a responsibility to the ensuing years. When a committee passed a student on to the next year who had problems, the faculty were passing the problems on to the next year's faculty. Thus, there were multiple pressures both to ignore problems and identify them.

Effects of the change in the promotions committee in 1989

The second question of this study was did the promotions committee change from course directors to a longitudinal committee change the identification and recommendations? From the previous sections, we note that there were more students identified by the promotions committee students in the early time period than the late one. There was a trend towards more students identified in the later periods with behavioral problems in all 4 years (34% compared to 22%). However, the promotions committee made more recommendations in the clinical years for the 80's compared to the 90's. When the frequency of behavior recommendations were compared between the early and later period, the later promotions committees were more likely to recommend behavioral interventions for the first year students (45.5% vs. 5%). Both time periods included counseling or psychiatric evaluations. The earlier period did not refer students to study skills or learning disability evaluation. In the 80's, there were more first year dismissals whereas in the 1990's period, only one student was dismissed. As a result, there was a shift to allow students to repeat the year or remediate rather than to dismiss them in the 1990's time period.

The new committee knew the students and followed them through their medical school course. As a result they could draw on the history of the student and monitor for changes based on their understanding. For example, one committee member noted:

And so the advantage of the new edition promotions committee was that, when I meet with them, this committee knew this class because they had been meeting for two years. They knew students that were strong; they knew student tendencies, so that seemed to me to be very good. But when problems arose, they were handled pretty much the same way. It was getting the wisdom of many counselors, that is getting multiple observations, getting multiple assessments or judgments about what the nature of the problem is, a lot of the discussion would be different individuals with different backgrounds and insights sharing that insight. What would often come out of that was an

understanding, a consensus understanding, a better understanding of the student and a plan for how to proceed. (Committee member I)

Several changes occurred around 1989: membership of the committee, the grading sheets from numbers to letters and including professional behaviors, and a new Associate Dean and Dean of student Affairs. These mark an interest and responsibility to look at the professional behaviors of the students. Several committee members made comments that showed an increased attention to professional behaviors:

There was increasing emphasis placed on the doctor-patient relationship. And my class actually took advantage of that by coming up with lectures on doctor-patient [...] So there's no question that there was more and more of an interest in that, and by the end there was an explicit standard – you would be graded on your attitudes and your behavior. We didn't know how to do it, exactly, we didn't know how to grade you on this really but – I guess we'll wait for something really bad to happen and then we'll give you your grade, and otherwise we'll probably pass you. It was a definite change in what we felt we should be looking at. (Committee member A)

I think that prior to the change, almost all of the actions were based on academic performance. The behavioral performance had to be fairly egregious and I can't really remember, prior to the change, that there were very many actions taken solely on the basis of their behavior. Subsequent to the change the committee continued to make decisions on academic performance, and I think that was consistent with both. But I think they felt much more empowered to make decisions based on behavioral problems. My sense was that more of them were efforts at remediation rather than dismissal or involuntary (Committee member G)

The Promotions committee is aware on a longitudinal basis, so when we meet now, when we come to certain student's name, say this group of students are my students, I come to the name, and I look up and say the last time we met, sally raised the issue that this student was rude to her, I want to know if any of the other clerkship directors are having exactly the same issue with her. So we have been following this person say with and attitude problem since year #1, so now in year number 3, we want to see whether was this is just some developmental maturational situational –whatever, or is it a stable personality characteristic that we care about and so I think there's less chance for students to fall through the cracks, and again it is not so much academic as falling though the cracks on these other things. (Committee member E)

It was a different committee, and it was oriented differently as to what was expected, and we weren't just looking at grades, we were looking at professionalism because obviously this is a profession and there's more at stake here than whether a student understands diseases. They need to be honorable people. (Committee member D)

To summarize, appeared to be more identification and some remediation in the 90's but also a concurrent decrease in more serious sanctions such as dismissal. The theory on the part of one committee member when interviewed was that part of what may have been happening was an effort by the promotions committee to remediate behavior rather than to summarily dismiss students. The 90's promotions committee knew the students better and was more willing to act, on the behalf of the students and prevent serious repercussions. For example, one committee member noted:

I can recall situations where with the new committee there were real concerns about students with their first and second year. I remember, I've forgotten her name, but it was an older woman who came in thinking, particularly with younger faculty, she knew everything, and it was clear that she was going to have problems as she moved into the clinical years. So she was paired up with somebody, I think in her second year. She really turned things around. I mean she developed a tutoring program for her classmates, and it was an example of in the prior committee, she wouldn't have gotten any attention, whereas in the new committee structure there was attention to behavior. She was identified early, she was put into remediation, it really turned her around and gave us a very positive member of the community, (Committee member G)

Some interviewed members thought the committees were more fair. Because they had more information, the decisions made were better. However, one committee member noted that since the promotions committee members did not know the students as well as the course directors and did not have the same investment as the course directors in the grades and progress of each student, that maybe the decisions made were less invested in the students. In other words the objectivity and distance of the promotions committee members might have a drawback as well as an advantage. It was felt that the types of issues addressed changed some, but really that it was the way that the issues were addressed that was the big change. For example, the committee paid attention and acted on unprofessional behaviors whereas in the past they might have made not of them, but not acted on them. "There are more subtle factors that raised concerns in the early years

that certainly would not have been even talked about earlier, or marginally talked about” (G) “The difference is that the newer committees feel empowered to act on them.” (G) In addition, the committee questioned itself on its values and consistency, whether mixed messages were getting sent around topic of behavior. There was an openness and self-reflection on the process of melding physicians. (E)

In summary, the change in the promotions committee was felt to change process of addressing the academic performance and professional behaviors of students. Numerically some of these changes were seen when comparisons were made between the promotions committees of the 80’s and 90’s. However, there were not great differences.

Graduates with State Medical Board Actions

Medical school should serve as gatekeeper for who should enter the profession of medicine, and the promotions committees and the executive faculty committee serve in that role. Therefore the third and final question was were graduates of the school of medicine who were later sanctioned by state medical boards identified by the promotions committees? And the parallel question, were students who either academic or behavioral difficulty later at risk for actions by state medical boards?

During the 2 decades, the promotions committee made 171 formal recommendations to the executive faculty committee on based on low academic performance or unacceptable professional behavior. Some students had committee recommendations over repeated years; as a result, there were 140 total students for the 2 decades with committee recommendations. There were 2078 students who graduated from 1980-2000.

Over the 2 decades, there were 29 graduates who had state medical board sanctions. Of these graduates, only 4 had recommendations by the promotions committees. Thus, 4 of 140 students (2.9%) identified by the promotions committees had sanctions once in practice compared to the 25 of the 1938 (1.3%) graduates who were not identified by the promotions committee (chi square 2.3, $p>0.05$). Thus students identified by the promotions committees were not significantly more likely to have had problems with state medical boards once in practice. Of the students who had both state medical board actions and were noted by the promotions committee, 3 of them failed one course in their first semester of medical school and then had no further difficulty. The last student had difficulty throughout. While not explicit in the promotions committee documents, it was due to substance abuse.

The question then that needs to be answered was, did the other students who had state medical board actions, have behavioral problems which should have brought them to the attention of the promotions committee, but did not? In addition to the promotions committee files, each student has an individual file as a record of their progress through medical school. These files contain all of the admissions documents, grades, grading comments, and Dean of Students letter of recommendation for residency. Therefore, the individual files of the students who did have state medical board actions were reviewed. Many of these students had grading or comments about performance such as a student was given a marginal score on fund of knowledge, or a note that some written workups were poorly organized. The difficulty was in determining whether these were aberrant in relationship to their peers since the records of other students did not undergo systematic blinded review for comparison.

Being conservative, from the files, 4 of the state medical board identified students did have significant comments in their files that might have brought them to the attention of the promotions committees. Three examples follow, including 2 comments from the Dean's letters of two students with state medical board actions.

By her own assessment xx brought with her to into medical school a certain arrogance based on past honors and recognition achieved without hard work and without good study habits. Instead of studying in her first 2 years here she spent her time skimming.....not until her 3rd yeas did she begin to appreciate the seriousness of the study of medicine and with that her attitude and application have improved dramatically. In other words xx has begun to mature in medicine. (SMB 22)

A situation concerning xx requires special note. Initiated by concerns expressed by his classmates, m recognized a problem with his drinking. Clearly from the narrative comments presented, this problem in no way interfered with or compromised his academic and professional activities. based on concern for his future and his patients well being. XX this past summer entered an alcohol recovery program and completed the entire 4 wk program and entered the after care experience. He is now abstinent and confident of his future. (SMB 29)

The following was one of several comments from grading sheets on one student.

[XX] did not perform as well as other 14 students on his rotation. Several house officers felt he needed extra help. They note at the times he seems rather defensive. At the same time he had the knack of getting patients nurses, and housestaff upset. His write-up were not up to standard and had poor discussions. the HO and attending conceded he made progress during the clerkship, but overall felt that he was immature and poorly organized, thus his grade is clearly below average. (SMB18)

Reviewing these comments, it was possible that these students had issues significant enough to be identified for sanctions or actions by the promotions committee, but were not.

Table 10: Basis for State Medical Board Actions and Review of Student Files

#	Basis for action	Yr	Yr of last action	Details in file that might have lead to identification by promotions comm.
1	Dept Health & Human Services** Fraud, Miscellaneous, Record	1997	2001	No
2	Professional misconduct,Quality	2003		No
3	Controlled substance violation Miscellaneous, Professional misconduct	2002	2003*	No
4	Miscellaneous, Substance Abuse	1992	2003	No
5	Dept Health & Human Services Miscellaneous,	1997		Identified by Promot. Com (student 60)
6	MISC, PRO	1997	2005	No
7	Dept Health & Human Services Impairment, Professional misconduct, Substance Abuse	1999	2004	Identified by Promotions Com. (student 226)
8	Controlled substance violation Miscellaneous, Professional misconduct	2000	2004	No
9	Miscellaneous	1995	1996*	Yes, 12 course comments about lack of motivation , marginal performance
10	Quality	2000		No
11	Miscellaneous	2003		No
12	General, Miscellaneous,Professional misconduct, Substance Abuse	1994	1999	No
13	Impairment, Miscellaneous, Professional misconduct,	2002	2004	No
14	Dept Health & Human Services	1999		Identified by Promot. Com. (stud. 294)
15	Miscellaneous, Professional misconduct, Quality	2003	2005	No
16	General, Professional misconduct	2005	2006*	No
17	General, Supervision	1991	2001	No
18	Impairment	2005		Yes, see text
19	General, Miscellaneous, Professional misconduct,	2004		No
20	Miscellaneous, Professional misconduct, Quality	2005	2006*	No
21	General, Quality	2004	2006	No
22	Controlled substance violation, General, Miscellaneous,	2002	2003*	Yes, see text
23	Impairment	2005		Identified by Promotions Com.
24	General, Miscellaneous, Substance Abuse	2004	2005*	No
25	Dept Health & Human Services General, Miscellaneous,	2000	2004	No
26	Continuing Medical Education	2005		No
27	Dept Health & Human Services	2005		No
28	Impairment, Substance Abuse	2005		No
29	Impairment, Order violation, Substance Abuse	1992	2005	Yes, see text

* Last action was within 1 year of initial action and may be related to initial action.

** Dept Health & Human Services indicates problems with Medicaid or Medicare

The basis for state medical board actions were diverse. Four graduates were sanctioned for professional misconduct. Six graduates had issues with substance abuse, impairment, or prescribing controlled substance. There was a high rate of recidivism; of the 29 graduates, 18 had sanctions in multiple years. Of these 6 were within a year of the initial action and therefore may be related to the initial infraction. That leaves 12 graduates (41%) with multiple sanctions by state medical boards. Looking at the 4 graduates who had been identified by promotions committees, only one of them had multiple years of state medical board actions.

The question was posed to the promotions committee members as to why he or she thought that the promotions committee had not identified more of the graduates who went on to have state medical board actions. There were conflicting themes of responses. The first was that graduates with state medical board actions have same traits in medical school but the traits were not apparent. The system of evaluation was suboptimal and the metrics were not sensitive so that the behaviors were not identified but that they do exist while they were students. “It did not rise yet to the level of a problem. They may have been drinking but not yet too much.” (I) In addition, since many of the state medical board actions were related to substance abuse and impairment, it may be that the Dean of Student’s office managed these student without their behavior coming to the promotions committees. In cases of aberrant behavior, again, the dean’s office may have addressed these issues, but not the committee.

The opposing theory was that the behaviors did not exist in medical school but instead developed in practice. This was either because there was increased stress in practice, or life changes that pushed the graduate to aberrant behavior.

You know, Vanderbilt medical school was a very protective environment. I mean, students are generally given positive feedback and made to feel good about themselves. We pride ourselves on being student-friendly and positive, not competitive, pass/fail grading and all that. And when you go out in the world as a practicing physician, people are harder on you. You know, you may have more patient demands than you can handle at certain time, you may lose sleep in an uncontrolled way. (H)

In addition, there was more autonomy in practice that allows behavior to go unchecked. Along the same line, state medical board issues may not have existed or had direct corollaries in medical school. For example, some of the state medical board actions were related to fraud. While in medical school fraud was not an issue. As medical students were unable to prescribe medications, especially narcotics, practicing physicians were able to do so and may have abused that ability.

The other answer is that we only demonstrate our lack of professionalism and our self-interest where we're placed in a situation where we're challenged. It may be that in medical school, none of the thirty individuals, or none of the twenty-seven individuals, were ever placed in a situation where they wanted to put themselves before others, and then when they got out they were tested in a way that they'd never been tested before. (D)

In this section, I have detailed the findings from the promotions committee recommendations, interviews of committee members and state medical board actions against Vanderbilt graduates. In summary, the majority of students did not come to the attention of promotions committees. The students who had major promotions committee sanctions were not the ones who later had state medical board sanctions. In the fifth and final chapter, will revisit these findings in light of the theoretical framework.

CHAPTER V

CONCLUSIONS AND IMPLICATION FOR RESEARCH AND PRACTICE

This final chapter, first will discuss implications from the findings in context of the conceptual frameworks. The next section will describe the limitations of the study. Finally, I will suggest ideas for policy implications and future research in light of these findings.

This study has focused on three questions, first what the initial infraction brings students to the attention of the promotions committees and what are the disciplinary actions, prescribed remediation, and eventual outcome of those students. The second area was to seek to better understand the functioning of the promotions committee, in light of the change in the promotions committee. Finally, did identification by promotions committees during medical school predict for disciplinary actions by state medical boards later in practice?

Promotions Committee Identification and Actions

Medicine as a profession is defined by three characteristics: mastery of a body of knowledge, the ideals of service to the client, and autonomy granted by society. Medical school education is the first step to acquire the knowledge and skills required to practice medicine. In addition, schools are the first step to provide the socialization leading to the values and behavior to adhere to the ideals of service.

With medicine's grant of autonomy by society comes the responsibility to regulate the members of the profession. The profession regulates at several stages of professional

development including entrance into medical school, promotion through medical school, promotion through residency, licensing, board certification, and finally, monitoring in practice. As seen in this study, neither the entry into medical school, nor the promotions committee 100% identifies physicians who subsequently have further disciplinary actions. In fact, physicians are identified or disciplined at each of these developmental steps. Therefore, continued regulation in practice is necessary.

Professions are responsible for ensuring that members adhere to the ideals of service, and mastery of the core knowledge through the use of formal and informal social control mechanisms (Braxton, 1986, Braxton, Bayer & Finkelstein, 1992, Goode 1957, Bosk 1979). In addition, the socialization of students has a role in this process. There are codes of conduct that serve to exercise control by providing guides for appropriate and inappropriate behavior. In the medical schools, the promotions committees serve as one of the formal internal controls, in function, ensuring the mastery of knowledge and acceptable professional behavior. This study has focused specifically on the promotions committee, on what Bosk (1979) termed as internal formal regulation, at the level of medical school.

In an ideal perfect system, only students with enduring professionalism and adequate ability to achieve competency would be accepted into medical school. Further, these students would be taught the specialized knowledge and socialized to support professional behavior. However, the system of medical training is not perfect. At each step along the way, there are students, residents and physicians who are limited or sanctioned through regulation of the profession. Through professional regulation, some students will not successfully match in a residency, some residents will not be able to

complete residency, some residency graduates will not achieve board certification, some physicians will not earn a license, will incur malpractice suits based negligence or failure to conform to accepted standards of care, will have restrictions on practice by hospitals and restrictions on their licenses. In other words, the system of selection of training is not perfect and requires continued monitoring of competency and professional behavior.

From this study of one medical school's promotions committees, a few generalizations can be made. The majority of medical students performed adequately, did not have any significant issues, and were not detected as problems by faculty and the promotions committee. The committee only identified a small number of students for actions and less than 1 percent of students were dismissed. This is only a small fraction of students, yet students, residents and physicians incur professional regulation later in practice. While it is unknown if these students with later sanctions could be have been identified in medical school, it calls into question the effectiveness of professional regulation at the medical school level.

Since few students are dismissed, it is apparent that the majority of the professional regulation is done by socialization. So that the promotions committee is there for those that do not conform to academic standards and less commonly for those who have behavioral problems, the rest are appear to have adequate socialization while in medical school since they are conferred a medical diploma.

Those students who had problems, it was primarily on the basis of low academic performance. In other words, the formal control of promotions committee really dealt with academic performance, and was the confirmation of the acquisition of knowledge. This was regulation of competence and assurance that the members of the profession

have the specialized knowledge required to practice. Competence is extremely important given the vulnerability of the patient and the potential for harm if the physician does not have adequate academic performance and knowledge. The committee less often dealt with issues of professional behavior and ethical conduct.

While there may be some behavior issues along with the low academic performance, it was rare that unprofessional behavior was the sole basis for identification by the promotions committee. Furthermore, the rate of attrition in medical school was very low. In this study only a handful of students were recommended for withdrawal. The adage is that “P = MD”, meaning that no matter how poorly you might do, if you pass your courses you will get the MD degree. Once students gain entrance into medical school, they were rarely expelled from the profession. To some extent, there may be adherence to professional solidarity as described by Braxton and Bayer (1994). Professional solidarity serves to protect the profession from interference and allows each individual maximal autonomy, on the other hand it constrains members from identifying or taking action on deviant behavior. Some interviewed members of the promotions described a lack of the administration’s support at times when dealing with students’ problems. On the other hand, members also noted the difficulty in determining what behavior met the threshold to identify the student to the committee. The difficulty may reflect what has been noted in the realm of social control and identification of deviance, the criteria are nebulous making labeling of deviance problematic. In other words, the determination of when behavior was egregious enough to sanction the student was hard to determine and other pressures influenced this decision.

The qualitative work provided a depth of understanding of the promotions committees that the files were not able to show. From the committee member interviews, the following behaviors were noted as unacceptable. These behaviors were also noted in the promotions committee notes in relationship to specific students.

- Poor interpersonal skills
- Lack of responsibility
- Failure of ethical standards and conduct
- Issues of problems with health and wellbeing
- Violation of social norms
- Substance abuse

The antithesis of these behaviors overlaps with the behaviors targeted for professionalism assessment by the Association of American Medical Colleges and the National Board of Medical Examiners (NBME, no date).

- Honesty/ integrity (truthfulness, adherence to ethical principles)
- Responsibility/reliability/ accountability (punctuality, compliance, accountability, feedback)
- Respect for others (colleagues, faculty, staff) (appearance, interactions, teamwork)
- Altruism (concern for others, empathy, compassion)
- Commitment to excellence (goal setting, motivation)
- Respect for patients (relationships, confidentiality)

Other definitions of professionalism outlined in the first chapter in the table of stakeholders' definitions also refer to similar expected behavior from physicians and medical students. While all of the groups agree that professional behavior is important, the promotions committee infrequently addressed these behaviors, instead focused on academic performance and the medical competence of the graduates.

It is important to note that the professional behaviors that the promotions committee is addressing pertain to behaviors that if violated are harmful to patients. For example, poor interpersonal skills with both patients and other members of the team can result in medical errors and put the patient at risk. Likewise substance abuse and depression, bipolar, or other psychiatric illness have the potential to impair the skills or decision

making of the physician. Thus, the expectation of these professional behaviors are to protect the vulnerability of the patient and protect the trust of society.

Considering the few studies done in the area of professional control in medicine, formal negative sanctions are rarely applied (Bosk, 1979, Freidson, 1972, 1975). Freidson (1975) noted that “social control mechanisms enforced by negative sanctions seem not to exist.” This study demonstrates that negative sanctions were applied in medical school by promotions committees, however they were not common. For the most part the sanctions were related to academic performance and involve repeating courses or probation. These recommendations had the potential to be over-ruled by Dean or executive faculty committee.

Recommendations related to professional behavior tended to be either vague such as encouraging the student to work harder, or prescriptive- require or recommend psychiatric evaluation, counseling, study skills course. One might expect stronger social control sanctions given the vulnerable population physicians care for, but that was not degree of professional regulation that was seen from the promotions committees. It was possible that the informal social control that Freidson (1972, 1975) described as “talking to” was communicated by the Dean of Students. The control was also functional, hoping to change behavior rather than symbolic, to embarrass the student. The study did not have specific information on the different Dean’s of Students to know if they managed students’ problems differently.

While there were promotions committee sanctions for low academic performance, as discussed above, significant violations of behavioral norms were rarely sanctioned formally. Braxton & Baird (2001) have suggested that the graduate school socialization

process functions as a mechanism of deterrence of scientific misconduct. Bosk (1979) described formal actions and informal actions to change behavior. As the promotions committee is addressing formally the academic performance, this leaves the professional behaviors mostly in the informal socialization realm. For the most part the formal actions of the promotions committees rarely addressed professional behaviors. Other studies have looked at the socialization of the hidden curriculum and the informal messages that are transmitted to the students (Hafferty, 1998, Hafferty & Franks, 1994).

Freidson in *The Profession of Medicine* (1970) noted that for the most part, intra-professional conduct is governed by unwritten rules. When the decision for sanctions is made, Freidson (1970, 1975) described two criteria for sanctions, functional or symbolic. The first, functional criteria are when it is believed that the sanctions specifically will prevent future misconduct. On the other hand, symbolic criteria are when the sanctions serve to cause embarrassment to the individual and at times, by extension to his or her colleagues. The actions of the promotions committee were confidential and therefore did not rise to the level of public symbolic sanctions. The actions were meant to be functional and change the behavior of the students. Even when students were dismissed, it was done quietly and not announced publicly.

Promotions Committee Identification and Actions: Contributions to Theory

Freidson's work was looking at practicing physicians and not at the level of medical students. In practice, physicians are practicing mostly autonomously, therefore the criteria for sanctions are based on a violation of standards of practice. To extend the use of the criteria to medical school is to recognize that the criteria for sanctions have a

different role. We noted that symbolic criteria were not used by the promotions committee and so, will focus on functional criteria. Functional criteria recognized the goal that the sanction will change the future behavior of the student.

The students were in a setting of education, training, and socialization, and were not autonomous. Therefore, the criteria and the role of the sanctions were different compared to physicians in practice. There was the expectation in medical school that the students be guided to perform both academically and professionally. Thus, the sanctions provided guidance to change behavior. From the specific sanctions can be drawn 3 broad categories intended to change behavior- diagnostic, prescriptive and warning. The promotions committees were made up of physicians and basic science faculty. The physician influence was that the recommendations follow the practice of medicine- diagnosis, treatment (prescriptions) and then instructions of what to watch out for. The sanctions of the promotions committees followed a similar pattern. The first category is diagnostic. Committee actions indicated they needed more information about a student. An example would be to request that the student undergo psychiatric evaluation, be evaluated for a learning disability, or "...to be interviewed by the committee with respect to the advisability of continued enrollment." Each of these actions would provide the committee with further information. While this category of diagnostic functional criteria does not directly result in a change of behavior, it is a step towards better informed decisions by the committee regarding the student. The results of the actions, for example, discovering the student had depression or learning disability might ultimately lead to changes in behavior.

The second kind of action by a promotions committee is a prescriptive functional action. An example would be requiring psychiatric counseling, having the student follow a structured 4th year curriculum that addresses the weaknesses of the student, or to take study skills course. Each of these actions are to provide the students with a “treatment” that will help prevent further either academic or behavioral difficulty. Some of the prescriptions were detailed and included several prescriptions. For example, one student had substance abuse issues. His prescription included treatment for substance, monitoring after the treatment was completed and demonstration of satisfactory performance. Sometimes, the committee was very specific, while, at other times they were more general such as a sending letter to encourage the student to work harder.

The final category is a sanction that serves as a warning function. For example, “probation in this instance is to imply that significant absenteeism is cause to reconsider the desirability of continuation in the school of medicine.” The recommendation of promotion with probation also served as a warning because it does not provided additional recommendations. These served to warn the student that if there are further problems they would have further sanctions but did not provide them with specific instructions for conduct. The recommendation from the promotions committees could have included several of these categories. Whether the recommendation was diagnostic, prescriptive or warning, they all served to inform the student that their performance was problematic and prevent further behavior.

Function and Process of the Promotions Committees

In 1989, with a new Dean of Students and new Associate Dean, the grading form and the promotions committees changed to reflect a more holistic assessment of the students to include both academic performance and professional behavior. Committee members expressed that this new committee was more able and willing to act on issues of professional behavior. Some of the changes of the process and decisions of the promotions committee actions included a decrease numbers of students in several areas: in students identified by the promotions committee in the later time period, dismissals and students with problems in the 2nd year. However, the study also found there was a trend towards more attention to behavioral problems in the 90's with increased identification of behavioral problems and more behavioral recommendations.

It is not clear why fewer students were identified by the promotions committee in the later time period. One would expect, based on the comments from members of the promotions committee, that more students would have been identified in the later time period since the committee was picking up both academic problems but also behavioral problems. It was possible that students in the 80's were different from students in the 90's. It would be interesting to see if the metrics of GPA and MCATs of incoming students or if the USMLE (national licensing exam) scores were different across the time periods; indicating a "better" student in the later time period so that fewer students were identified. There were 2 other explanations. The first was that the later promotions committees did not work closely with the students, did not specifically grade them or manage problems. Thus as a results, they had less commitment and maybe less deep understanding of the students particularly in the preclinical years. For example, several

of the committee members were first year course instructors and expressed during the interviews the seriousness with which they took the assessment of students. It is not known if the voting committee members in the later period had this degree of understanding of the students. A final possible explanation was that the Dean of Students in the 1990's and other measures were preventive. This Dean played a proactive role in the student issues and as a result resolved the problems and prevented the students from getting into trouble enough to cause them to be identified by the promotions committee. This explanation can be supported by looking more closely at the numbers. There was nearly the same percent of students identified in the first year for both time periods (4.4% vs. 4.1%) but the number of student in the early time period having difficulty stayed remained high at 3.3% but the later time period in the second year dropped. Indicating that perhaps the actions were effective. Thus, this role of the Dean of Students served as internal effective informal social control of students' behaviors.

While the number of students in the later time period was less than the earlier time period, there was more focus on behavioral issues. The increasing number of behavioral problems addressed and recommendations made reflects the underlying goal of the changes, to better address professionalism. Some committee members reflected that the types of issues addressed changed some, but really that it was the way that the issues were addressed was the big change. There was more willingness to look at professional behavior. Unfortunately, the promotions committees' documents lack much of the detail of the discussions.

While the promotions committee members note that the committee was more attentive to professional behaviors, there is not an increase in students with primarily

behavioral issues in the later period. While there are more behavioral recommendations, there remain few dismissals, and few recommendations only based on professional behavior. Thus, as the promotions committee serves to ensure professional regulation in medical school, it is not clear that the change in the committee, has increased the professional regulation of medical students by the committee.

Function and Process of the Promotions Committees: Contributions to Theory

Bosk's ethnographic study examined resident socialization (1979). He described a matrix of four methods of control and guidance: internal/ external and formal/ informal. His description delineated each as a separate area. I would propose that there is overlap between formal and informal actions for the same academic performance or behavioral problem in many of the students. First, when an issue brought the student to the attention of the promotions committee, it had been identified and likely addressed by the course director using informal means through individual meetings with the student but also through formal means (a letter to the students from the course director and possibly the Dean of Students). Then recommendations of the promotions committees were in the formal internal area; after the decisions were made students would receive a letter that was also placed in their files. However, once the recommendations were determined, there was again blurring of the formal and informal lines as the sanctions were carried out. If there were a psychological assessment there would be a written report that would go to the Dean of Students and the student's file. If the student was recommended for study skills training, it would likely be no formal report. When participation in a structured curriculum in the 4th year was recommended, the report of this would be

through clerkship directors informal contact with the Dean of Students and direct feedback to the student as well as through formal grading. Therefore, the management of any given student problem likely involved both informal and formal actions.

Moreover, the blurring of formal and informal at times would create role conflict for the Dean of Students. The formal role was to address student issues by bringing those issues to the promotions committees' attention and to document and follow through on the recommendations and sanctions. The informal role then became more complicated. At the same time the Dean of Students was considered the advocate for the students, and was responsible for protecting the privacy of the student. At times this advocacy role was in opposition to bringing issues to the attention of the promotions committee and ensuring the follow through on the committee recommendations. Thus, the clear delineation of informal and formal in the detection and sanctioning of medical students was often blurred.

Failure of Promotions Committees to Identify Graduates who have Subsequent State Medical Board Actions

Medical schools serve as the gatekeeper for who can enter the profession. Through the formal processes of promotion and remediation, the faculty of schools of medicine have the responsibility to identify and take formal action when students have significant academic performance and problematic professional behavior. The promotions committees make recommendations about which students are sanctioned, remediated or promoted. The majority of students sanctioned by promotions committee, including those with significant professional behavior issues, did not go on to have sanctions by state

medical boards. Furthermore, students who had either academic or behavioral difficulty were not at risk for actions by state medical boards.

State medical boards are in the form of formal internal control for physicians in practice. These boards serve to regulate professional practice. There are two studies which categorized the types of violations that were the basis for sanctions by state medical boards. Wolf et al. (2000) found that for 18% of physicians the basis for sanction was substandard care, incompetence, or negligence. Combining categories that violate appropriate professional conduct (criminal conviction, professional misconduct, substance abuse, sexual abuse, sexual misconduct), this accounts for 43.2% of the basis for sanctions. Grand and Alfred (2007) found similar results with 19.2% failure to conform to minimal standards of acceptable medical practice or gross negligence, and 50% unprofessional conduct, substance abuse or sexual abuse. Both of these studies show that once in practice, the basis for state medical board actions are more commonly professional behavior and less likely the inability to practice good medicine. Both types of violations, incompetence and unprofessional behavior, demonstrate how the professional regulation is intended to take actions when the safety of the patient is at risk. However, violations of professional behavior are more common than those of a failure to practice competent medicine. This study did not look at malpractice litigation, which may indicated deviance from performance standards (academic performance).

Professional behavior violations are noted for state medical board actions, the opposite is true medical school. The major driver in medical school for sanctions is low academic performance, and less likely professional behavior. In medical school students are rarely sanctioned just on the basis of unprofessional behavior. Once in practice,

physicians are more likely to be sanctioned for lack of professional behavior. One question might be is this a failure of medical schools to socialize students (informal actions) adequately so that they maintain professional behavior or is it a failure of medical schools to take formal actions?

Most of the medical school issues are academic, but in practice, the state board actions are almost entirely about behavioral issues. Those that do not have the academic ability are weeded out during medical school, but those without the behavioral ability to practice professionally are not. One might propose that the interventions in medical school on the issues of low academic performance removes students from medical school who do not have the ability to perform academically as a physician. It is also possible, that the interventions in medical school are effective at improving the students so that, for the most part, they do not have difficulty with the body of knowledge while in practice. While Papadakis (2005) found that controlling for all variables unprofessional behavior was associated with a 3 fold increased risk of disciplinary action by state medical boards, and MCATs and low grades in the first 2 years has some risk of state medical board action but clearly less risk. In other words, unprofessional behavior in medical school was associated with subsequent state medical board sanctions.

It is interesting that the Dean of Students found that substance abuse behavior itself was not considered to be a violation of the professional behavior norms but instead was treated as a disease that had confidentiality protection. In contrast, state medical boards, clearly consider substance abuse to be a threat to patient care. Likely this difference is reflected in the differing amounts of responsibility. A student has minimal if any

responsibility for patients. It is uncertain, if other Deans of Students have the same protectionist view of substance abuse.

“The fundamental assumption in medical education is that professional students become professional doctors” (Papadakis, 2005, p2674). Papadakis and colleagues (2004, 2005) reviewed the medical students records including student course and clerkship assessment forms, deans’ letters of recommendation, and other documents. These studies found that problematic behavior in medical school was associated with subsequent disciplinary action by a state medical board. Physicians disciplined by state medical boards were more likely to have notes of unprofessional behavior while in medical school. The findings of this dissertation did not find that formal sanctions of students by promotions committees correlated with state medical board findings.

Papadakis (2005) and colleagues coded the written narrative from the medical students records into categories of unprofessional behavior including

- Irresponsibility
- Diminished capacity for self-improvement
- Poor initiative
- Impaired relationships with students, residents and faculty
- Impaired relationships with nurses
- Unprofessional behavior associated with being anxious, insecure or nervous

In unadjusted analysis, all of these behaviors, were more likely to be noted in disciplined physicians compared to controls. On multivariate analysis, irresponsibility and diminished capacity for self-improvement were associated with increased odds of disciplinary actions. Students with more severely unprofessional behavior had even higher odds. These behaviors reflect the unacceptable behaviors noted by committee members, and also some of the behavioral triggers of students identified by promotions committees.

Papadakis, extended her work to internal medicine residencies. She found that residents with low professionalism score and low scores on the internal medicine certification examination had nearly twice the chance of being subsequently disciplined by a state medical board. Again showing that unprofessional behaviors are important potential markers for later sanctions by state medical boards. The professionalism scores used for this study were a part of a formal grading program for internal medicine residents that leads to residents being permitted to take their board certification examination. As such they serve as Bosk's formal control (1979). The findings of Papadakis' study are contrary to this study which did not find a correlation with state medical board actions and unprofessional behavior noted by promotions committees.

Papadakis found that students subsequently sanctioned by state medical boards, had notes in their files about unprofessional behavior, however this study did not find that graduates with state medical board actions were identified by promotions committees for either academic performance or unprofessional behaviors. While these findings appear to be contradictory, in fact they may not be. When taken together, the likely conclusion is that unprofessional behavior *is* occurring in medical school and some of it is documented in the students' record. However, the behavior is not so egregious to cause the promotions committees to sanction the students. So while the promotions committees are mandated to determine which students merit promotion and ultimately conferral of the MD degree, for the most part students are sanctioned primarily on academic grounds and less commonly on professional behavior. The system is insensitive for distinguishing problematic behavior or the threshold for action on behavioral grounds is high.

Furthermore, the students who later go on to have state medical board actions did not have significant behavioral problems, while other students who did have significant issues of dishonesty, poor interpersonal skills, stalking, irresponsibility did not go on to have state medical board actions. There were a number of students with professional behavior deviations, that would have lead one to expect them to deviate once in practice and in a setting of less supervision. However, in their professional practice they have avoided state medical board sanctions. One explanation is that they may still have deviant behavior that remains under the radar for state medical board actions. Another explanation is that it is possible that these students were adequately remediated and thus state medical board sanctions prevented.

In each stage of medicine, from admissions to medical training to practice, as a profession, medicine is responsible for regulation of its members. This study might bring into question how well does the medical school, specifically the promotions committee fulfill its commitment to self regulate. At this point, I advance a perspective based on my interpretation of the data I collected. From review of the promotions committee files and student files of students who did have state medical board actions, it seems as though a handful of students could have been sanctioned by the promotions committee, but were not. This is based on the four students with state medical board actions and significant behavioral problems but who were not formally identified by the promotions committees. These students had issues with substance abuse, interpersonal problems and lack of responsibility. In retrospect, possibly these students should have been dismissed or at least identified by the committee for formal functional actions to possibly prevent subsequent problems. In addition, there were a few rare students who had significant

unprofessional behavior, and should have been dismissed. For example there is the student with problems throughout medical school with stalking and poor interpersonal skills. There is a note about another student who was stalking a classmate with the belief that the student believed God intended the classmate to be his wife. Regardless of the fact that these students were not sanctioned by state medical boards, their actions in medical school showed a lack of moral character that will likely reappear in practice. In these cases there was a failure of self-regulation.

However, for the most part, I was concerned with the lack of detail of assessment and documentation of professional behavior. The promotions committees, it seemed did not have access or did not document the details of unprofessional behavior of the medical students. This lack of information might be considered the blind eye of professional solidarity (Braxton & Bayer, 1994), not wanting to examine the behaviors of the trainees. Another explanation is that medicine does not have the tools or ability to measure professional behavior. However, there is a push in medical education to better assess professional behaviors of trainees (Stern, 2005, Papadakis 1999, Stern & Papadakis, 2006). There is the recognition that there is a paucity of tools and methods of assessment of professionalism.

State Medical Board Actions: Contributions to Theory

Since a profession holds the responsibility for self-regulation, the state medical boards in part serve that function. They detect and sanction physicians not practicing acceptably. The sanctions by state medical boards are formal and internal using Bosk's framework (1979). While Freidson (1975) described functional and symbolic criteria for

sanctions in practicing physicians, the lines are not so clearly delineated for state medical board action. The medical boards function under state legislation, and their actions are public. The specific sanctions include restrictions on licenses, suspension of licenses, or monitoring for impaired physicians. Rarely is the license completely removed. Thus the actions have to some degree functional criteria, the intent to prevent further misbehavior. Using the previously developed categories of functional criteria, the actions are not diagnostic, but can be prescriptive such as mandating entering impaired or disruptive physicians program. In addition, the sanctions serve as a warning, that further behavior will result in continued restrictions on the license. However, because the boards are part of the state, and serve to protect the community, the names of the physicians and sanctions of many state medical boards are published and distributed. Thus, the actions have public, in other words, symbolic criteria as well.

Disjunction Between Values Placed on Professional Behavior and the Actions of Promotions Committee.

This research identified two major areas where there was a lack of consistency between actions and values. Specifically the actions by promotions committee specifically addressed issues of academic performance and rarely of professional behaviors. Academics are important because unacceptable performance translates to incompetent medical practice. However, there was a disconnect between the importance placed on professional behaviors both by the promotions committee members and state medical boards that were not demonstrated in the actions of the promotions committees.

First, the promotions committees expressed that professional behaviors were important. Their descriptions of “unacceptable” mirrored deviance from acceptable

professional behaviors for practicing physicians. Yet, it was rare that unprofessional behavior was the sole basis for identification by the promotions committee. Moreover the identification and actions of the promotions committees did not specifically address these behaviors. Thus the commitment that promotions committee members expressed to identify unprofessional behavior was not translated into real actions. The disjuncture may have occurred in part because detection of behaviors is problematic and also the difficulty determining the threshold for actions on behavioral misconduct. Nonetheless, this demonstrates a disjuncture between expressed values and actions.

The second disjuncture was along the same line. The majority of state medical board actions are in response to unprofessional behaviors, yet the majority of the medical school actions are on the basis of academic performance. Papadakis' work demonstrated through the comments extracted from medical student files, that irresponsibility and diminished capacity for self-improvement were behaviors that were of concern for medical students who had subsequent state medical board actions. One can make the connection how these two behaviors translate into unprofessional behavior in medical practice. This disjuncture of actions and values by promotions committees and the relationship between academic and professional performance will need to be addressed in order reduce the probability of state medical board actions.

Limitations

There are several limitations to this study. The major one is the limitation of a retrospective study at a single institution. The promotions committee notes do not have all of the details occurring at the time. The memories of the committee members was

limited to what they remember and much of what was asked of them was from over 20 years ago. Therefore their responses may more accurately reflect what they perceive today rather than 20 years ago.

While the students who had significantly problematic behavior in medical school did not go on to have state medical board actions, it is unknown if they were nonetheless successful in practice, or whether they had issues in residency, with malpractice claims or credentialing. In other words, the outcome of state medical board actions was feasible but does not show the entire picture of successful practice of medicine. Review of student files of students with state medical board sanctions was not blinded, so reading of those files was subject to interpretation and potential bias.

The list from the state medical board of graduates included 2 students the registrar had no record of their attending the school of medicine. Therefore, the data may contain errors. In addition, the information from the state medical board included actions from a limited time period, so some of the older state medical board actions may be missed. Finally, it is unknown how generalizable the results of this study to other schools since this was performed at a single institution.

Implications for Policy

This study has identified three areas where better policy and practices may be useful. First, although, the promotions committees were effective in identifying and remediating problems with academic performance, they did not frequently address professional behaviors. The school of medicine has the responsibility to ensure professional behavior and thus has a responsibility to assure adequate opportunity for assessment and

documentation of the expected professional behavior. Thus the goal of medical schools should be for better assessment and documentation of unprofessional behaviors in students. Then, once identified, the promotions committees will need to take action and remediate or dismiss students with unprofessional behaviors.

Second, the change in the promotions committee had some minimal effect to increase attention on professional behaviors. Regardless, promotions committees rarely dismiss students, and most students go on to become physicians. While the committee members expressed that the change in the committee format changed the issues addressed and increased attention to professional behaviors, the evidence that this occurred is not consistent, nor strong. Therefore before the recommendation can be made for all schools to change their promotions committees, further study is required.

Finally, identification of students by promotions committee did not predict for subsequent state medical board sanctions, nor were the promotions committee effective in identifying students who later went on to have state medical board sanctions. There were important discrepancies between the findings Papadakis et al (2004, 2005) and this study that need further investigation. This study did not find the strong association between unprofessional behaviors in medical school and future sanctions by state medical boards. At one medical school, most students reviewed by promotions committees did not receive sanctions in practice, while others who were not identified by promotions committees were sanctioned by state medical boards. In practice, promotions committees need to be aware of the Papadakis findings and seriously consider the professional behavior of students when determining sanctions. They need to recognize that the professional

behavior in medical school may have serious implications for those students once they are in practice.

What should be done with the findings of this study? Together with Papadakis' work, we can say that problematic behavior is occurring in medical school, but it may not be acted upon by faculty and thus, the promotions committees. The major issue is the ability of the medical schools to socialize the students to professional behavior, and then accurately assess the behavior. There is an adage, "assessment drives learning and behavior". Therefore, if students are assessed on professional behaviors, it will encourage them to develop more professional behaviors. However, professional socialization and assessment are problematic.

Over the past 10 years a number of schools have instituted new professionalism curricula and others have new professionalism assessments. In addition, the letter of recommendation all students receive from the school for their application to residency (The Medical Student Performance Evaluation-MSPE) more often includes statements about professionalism. These are culture changes that indicate that schools are taking seriously their responsibility to ensure professionalism.

It is important that standardized instruments and strict mandates to report unprofessional behavior be implemented to increase the documentation of unprofessional behavior during medical school. Additionally, medical schools could improve systems of evaluation to monitor the development of professional behavior and guard against lapses. Schools might consider, increasing expectations for student evaluators, both faculty and residents, to identify and document unprofessional behaviors and then passing that information on to the promotions committee. With these changes, there needs to be

support from the administration in all of these steps. While the Dean of Students frequently manages many student behavioral problems, care needs to be taken that the role does not become protectionist rather than supportive. Further, studies might look at trends in other medical schools and their ability to identify and act upon unprofessional behaviors.

Directions for Future Research

This study looked only at promotions committees in a single elite medical school. Some schools have higher attrition rates and the question becomes, how does the professional regulation and review of student performance vary at different medical schools? In addition, do elite schools have more or less incentive to retain their students? The incentive to retain students is multi-factorial. When students are dismissed, there is the underlying question of did the admissions committee make a mistake? Another issue may be the image that the school is not an excellent school because some students do not succeed. In other words, is the school a failure because the student failed? Further, the elite schools are more costly to the students, so dismissal usually leaves the student with a large bill or loan, which can be over \$100,000 depending on how many years they have been in school. These are incentives, as well, to dismiss students. The school does not want substandard graduates representing the school. Likewise, the school is embarrassed by students not obtaining the specialty match they desire or students failing their licensing boards. All of these are incentives to dismiss students. It is not known to what effect these play in the decisions of the committee and how they might differ by institution. Further studies might try to unpack these influences.

As the practice of medicine is life long process from medical school on to practice, examination of self-regulation along the spectrum is important. While Papadakis (2008) has continued her work and found that poor performance on behavioral and cognitive measures for internal medicine residents were associated with state board sanctions, it would be useful to examine the relationship between professionalism problems in residency and those in medical schools. Do students who have behavioral problems in medical school go on to have problems in residency and then in practice. Ensuring that we police our own is the essence of professionalism and must be adequately done to ensure we maintain this privilege.

A further study might seek to better understand professional regulation in medical school. This study focused only on the promotions committees. The promotions committee recommendations for the most part, addressed issues of low academic performance, rather than professional behaviors. Further studies might look for other forms of professional regulation, administered by other entities, such as the faculty directly or the Dean of students. In addition, an ethnographic look at promotions committee discussions may find that unprofessional behaviors are discussed but not acted on and not documented or sanctioned.

Concluding Thoughts

In conclusion, for one school, academic performance is the major reason for identification and recommendations from the promotions committee. The change in the promotions committee had some minimal effect to increase attention on professional behaviors. Finally, the majority of graduates who were disciplined by state medical

boards, were not identified or sanctioned by the medical school promotions committee. However, there are a number of students who have sanctions by promotions committees who do not later have disciplinary actions.

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