Dealing with "rogue" medical students: we need a nationally consistent approach based on "case law"

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ABSTRACT

- There is strong agreement in the medical profession and among academic commentators about why professionalism has become an important focus of medical regulation and education, and about the need to respond to serious instances of unprofessional behaviour among doctors and medical students.
- Admission processes which include interviews do not prevent the entry of a small number of students who behave extremely poorly.
- Fair, reliable assessment of students' attitudes and behaviour is achievable, but the challenge of preventing the progress of students who behave poorly through academic assessment remains.
- A nationally consistent approach to the management of poorly behaved students within the academic program is vital in the interests of equity across programs and protection of the public.

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Recently, the Editor of the Journal suggested that the fabled Martian, visiting us today, would ask "Why all this intense preoccupation with professionalism in the face of medicine's stupendous advances?"[1] There is a strong consensus among medical practitioners and academic commentators about the importance of professionalism in response to the erosion of authority in general, the demands of a more highly educated, articulate public,[2] recent prominent failures in clinical care and self-regulation (Bristol, Bundaberg and others), and the slow pace of medical cultural change from defending professional solidarity to emphasising public accountability.[3]

The medical boards and councils have developed statements about fitness to practise (eg, the New South Wales Medical Board[4]), codes of professional conduct (eg, the Medical Board of Queensland[5]), and better investigative processes, in attempts to make their role in self-regulation of the profession more effective and reassuring to the public and government in the areas of impairment, clinical competence and professional conduct. Medical schools are paying considerably more attention to teaching and assessing safety, professionalism and fitness to practise, although the definitions and scope of these terms vary widely. But what should be done about the small number of "rogue" medical students who almost certainly should not become doctors?

Professionalism in medical students

Part of the motivation for introducing graduate entry and for including admission interviews in medical programs was to enrol reflective students who communicate effectively and behave appropriately. We have recently shown that interviews are weak predictors of performance in written and oral ethics examinations,[6] but, more significantly, our experience is that they do not prevent the entry of the worst-behaved students. We suspect that, despite preventive strategies, other medical school programs also experience this, and that all schools continue to face the challenge of students who, it is strongly agreed, are unfit to practise, but who satisfy traditional program academic requirements.

Little has been published about characteristics of unprofessional behaviour among medical students, although some programs have reported the development of processes with the potential for academic failure on the basis of attitudes and behaviour.[7,8]

Since 1999 at the University of Queensland (UQ) School of Medicine, we have integrated the teaching of professionalism and professional issues with a personal and professional development (PPD) process that is primarily supportive, but also includes an assessment arm. A recent study of several UQ cohorts shows that over a 7-year period almost 20% of some 2630 enrolled students came into contact with the PPD committee for a range of issues including (but not restricted to) behavioural ones.[9] However, only four students were referred to the Board of Examiners, and two students failed a year for persistent unprofessional behaviour. In 2008, two further students have been failed on the basis of this process, one in relation to a persistent pattern of inadequacy across a wide range of behavioural parameters, and the other in relation to a criminal matter with serious practice implications.

Invoking university conduct rules is not necessarily appropriate in relation to the needs of professional courses, but the alternative of making professionalism part of the educational program and its assessment has raised apparent issues, including reliability, fairness, subjectivity and the possibility of value judgements, that have impeded progress. We believe these concerns have been significantly overstated. For the area of professional behaviour, the equivalent to the use of a sufficient number of questions in a written or oral examination is the identification of an established *pattern* of conduct.[10] Reliability can be based first on the identification of poor conduct by independent individuals, including tutors, clinical teachers and student peers, and then on a second-level consensus among a different group, established for the purpose of examining and assessing the prima facie pattern.

Does medical student behaviour predict future practice behaviours?

Recently, an association between poor behaviour during the medical school years and subsequent clinical practice has been demonstrated.[11] However, the predictive value of this association is low. Most doctors who demonstrate poor professionalism will have behaved appropriately as medical students, and most medical students with behaviour problems will not become professional miscreants. Nevertheless, educators, registration bodies and the public are justifiably concerned with the potential of those few students who demonstrate recalcitrant, unacceptable behaviours in the face of instruction, support and feedback.

While we agree that professionalism — like any other area — must be modelled, taught and assessed for all students, and that no student or doctor is immune to lapses in behaviour, there is a strong consensus that medical schools must deal effectively with clearly identified extreme cases of poor professional behaviour. This is supported by evidence of a strong association between professional disciplinary action and the more severe cases of irresponsibility and diminished capacity for self-improvement.[12] Even if the small number of students with extreme behaviours makes their future risk somewhat difficult to study and hence predict, our considered collective professional judgement should be responsive to community expectations. We believe more is needed, in the form of our proposal below.

Frameworks for a response

Building on earlier publications concerning appropriate training and practice, the United Kingdom's General Medical Council (GMC) has recently published *Medical students: professional behaviour and fitness to practise*.[13] According to this guidance, behaviour that jeopardises the trust that is placed in both doctors and students, and/or puts patients at risk, and/or affects public confidence in the profession should be potentially subject to sanction. Student involvement with the university's general discipline procedures should not prevent assessment under the medical school's fitness-to-practise procedures. The investigative and adjudicative roles should be distinct. Sanctions are graded according to seriousness of conduct, ranging from warnings, undertakings and conditions, up to suspension or expulsion from the program as the most severe, and corresponding to the same actions in relation to registrants of the GMC. Expulsion is recommended in cases where students' behaviour is considered to have been "fundamentally incompatible with them continuing on a medical course or eventually practising as a doctor". Supervision, monitoring, remediation and pastoral support are urged for students who are disciplined.

It is worth comparing the UQ system with that of the GMC's guidance. There are several similarities of principle and process, including guiding principles, distinction from broader university disciplinary procedures, and the separation of investigative and adjudicative functions. Nevertheless, the GMC's model remains essentially a disciplinary one rather than an educational one. No explicit mention is made of integrating aspects of professionalism into the curriculum, or with assessing that curriculum. Support and remediation *follow* a sanction, whereas the UQ process is primarily supportive, and sanctions only follow recalcitrance in the face of considerable support and feedback. While we have instituted conditions and monitoring in a small number of cases, the sanction applied has been academic (ie, failure of a year), with continuing monitoring and support. On the one hand, this educational approach may be more appropriate to students who are meeting the professional regulatory environment for the first time, with exclusion from the program being possible only according to program rules (eg, where failure of 2 years requires it). Furthermore, if fitness to practise, broadly conceived, includes appropriate attitudes and behaviour, these aspects should fall within the purview of professional education, rather than remaining exclusively in the university's administrative jurisdiction. On the other hand, the educational approach may also be limited by such rules if it fails to prevent ultimate progression in some of the serious cases, such as where a canny miscreant stays beneath the radar.

Dealing with the small number of Australian medical students who exhibit extreme behavioural problems

The GMC's guidance is advisory, and individual medical schools in the UK must decide on their own specific procedures. It is thought that it will contribute to consistency across the schools in relation to fitness to practise, although it is less likely to ensure consistency in the judgements concerning degree of risk and appropriate penalties.[12] We strongly believe that a nationally consistent process is essential for Australian medical schools.

While particular rules and implementation processes for individual schools are both inevitable and important, there needs to be a distinct and strong consensus on the categories, principles and standards applicable to more serious examples of unacceptable professional conduct. These parameters should be established in pursuit of fairness to students across programs, and in congruence with moves towards national registration of medical practitioners. While we support registration of students with medical boards, we see our proposal occurring within medical schools, but with the same broad uniformity as is being pursued by moves towards national registration. Developing nationally consistent standards for students would help restore trust in the profession, which has been eroded in recent years because of perceived failures in self-regulation.

The first step would be to collate data on the serious cases all schools have collectively experienced over the past several years, and that have resulted in significant academic penalty or exclusion (or at least the wish to apply such sanctions) to form a "case law" collection.[14] This collection could be de-identified (both students and schools) for the purposes of analysis and report, and the project could be managed by a steering group under the oversight of the Medical Deans Australia and New Zealand. The collection would then inform the development of a framework within which specific policy could be developed. Individual universities would need to retain control of their processes within this context. While we have suggested that the development of such a framework should be an education matter, rather than one concerning university disciplinary and administrative procedures, we also think that the emerging themes and principles would inevitably and appropriately inform those procedures.

If those of us leading Australia's medical schools don't know what the others are doing about the few cases of extreme unprofessional behaviour among our students, how can we do our part in protecting the community and the profession in the future?

Competing interests

None identified.

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