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A Strategy for the Detection and Evaluation of Unprofessional Behavior in Medical Students

ABSTRACT

The authors describe the first four years (1995–1998) in which the University of California, San Francisco School of Medicine operated an evaluation system to monitor students' professional behaviors longitudinally through their clinical rotations. The goals of this system are to help "turn around" students found to have behaved unprofessionally, to demonstrate the priority placed by the school on the attainment of professional behavior, and to give the school "muscle" to deal with issues of professionalism. A student whose professional skills are rated less than solid at the end of the clerkship receives a "physicianship report" of unprofessional behavior. If the student receives such a report from two or more clerkships, he or she is placed on academic probation that can lead to dismissal even if passing grades are attained in all rotations. Counseling services and mentoring by faculty are provided to such students to improve their professional behaviors.

From 1995 to 1998, 29 reports of unprofessional behavior on the part of 24 students were submitted to the dean's office; five students received two reports. The clerkship that submitted the most reports was obstetrics–gynecology. The most common complaint for the five students who received two reports was a poor relationship with the health care team. Four of these students had their difficulties cited in their dean's letters and went on to residency; the fifth voluntarily withdrew from medical school.

The authors describe the students' and faculty members' responses to the system, discus lessons learned, difficulties, and continuing issues, review future plans (e.g., the system will be expanded to the first two years of medical school), and reflect on dealing with issues of professionalism in medical school and the importance of a longitudinal (i.e., not course-by-course) approach to monitoring students' behaviors. The authors plan to compare the long-range performances of students identified by the evaluation system with those of their classmates.

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Attainment of appropriate professional behavior is a fundamental component of clinical competency.[1] Unprofessional behavior, rather than problems with clinical skills, is the most common reason cited by the Medical Board of California for physicians to receive disciplinary action.[2] Much has been written about how important professionalism is to the field of medicine and about the need for greater emphasis on the professional development of physicians in training. Yet strategies for the evaluation of professionalism in medical students have not received the attention that the evaluations of other aspects of clinical competency, fund of knowledge, and clinical skills have received.[3,4] There are several possible explanations for this phenomenon: (1) students in the clinical years are not seen in a continuum by one group of evaluators[5]; (2) individual clerkships do not take "ownership" of the professionalism competency realm; (3) transient interactions with faculty and housestaff are the norm as students have several short rotations at several locations[6]; (4) evaluation of professionalism is perceived as subjective—negative evaluations may be particularly likely to result in grievance procedures and other adversarial student responses; and (5) strategies to evaluate professional and unprofessional behaviors in medical school are not available.

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Yet the need for such strategies is sufficiently great that in 1990, the American Board of Internal Medicine established a project to enhance the evaluation of professionalism as a component of clinical competence and to promote the integrity of internal medicine.[1] And at our school, the University of California, San Francisco (UCSF) School of Medicine, the faculty embarked on a similar road a few years later, prompted by concerns about particular students who were not acting professionally but for whom there was no formal mechanism in place for professional disqualification. In the rest of this article, we describe the four-year period, 1994–1998, in which our school developed and began using an evaluation system to monitor students' professional behaviors.

ORIGIN OF THE SYSTEM

Historically, at our school, if a medical student's professional skills had been found to be somewhat lacking but the student had received passing grades in all courses and clerkships, he or she had been allowed to graduate, since competencies in interpersonal skills had not been evaluated as rigorously as more traditional competencies in the areas of clinical performance and medical knowledge. Each year, the faculty knew of one or two students with notable deficiencies in their professional behaviors who nevertheless graduated.

Two events occurred early in the 1990s that propelled the faculty to begin the creation of the formal evaluation system for professionalism described in this article. The first involved a student who passed all his courses, earning honors in most of them. In January of his fourth year, after he received notification that he had received his first choice for residency in a highly competitive surgical subspecialty, his performance began to slide. On his required clerkship in family and community medicine, he came late to clinics, did not show up at all for some lectures, and asked for numerous days off. Throughout the spring quarter of the fourth year he continued to exhibit unprofessional behavior in courses that were not in his field. He did not show up for the first day of a course in problem solving and critical thinking that met only three times a week but that had required attendance. When he did attend, he contributed nothing to the discussions, and made it clear to his classmates and the faculty member that he did not want to be there, and did not need to be. He failed both this course and the family and community medicine clerkship. When he was confronted with these failures, he explained to the associate dean that he had been distracted by family illnesses and that family obligations had made him miss class. Despite counseling about how he could have asked for help or sought advice, he was defensive and angry. He blamed the faculty and administration for being "cold" and unavailable, and did not accept responsibility for his unprofessional behavior. He was required to write a paper for the course that he had failed, and to make up the clerkship in family and community medicine. A letter was sent to his residency director and his future department chair about the student's poor performance at the end of medical school. He received his MD degree, but his nomination for induction into the Alpha Omega Alpha medical society was withdrawn.

A second student received low but passable evaluations in his clerkships. However, there were real concerns about his ability to interact with patients. The student was also defensive in accepting feedback. The student's marginal performance persisted throughout the academic year without evidence of improvement in physicianship skills. Clerkship directors felt that even though the student has passed the individual clerkships, he should not pass the third year of medical school. The faculty wished for a process to evaluate students over a continuum, rather than only in the clerkships' blocks of time.

In response to the realization that there was a need to develop a process to address the unprofessional behaviors of such students, a committee of core clerkship directors met between 1994 and 1995. Their goal was to create a professionalism evaluation system that would give the school the "muscle" to deal with issues of professionalism. It was the committee's intent to create an evaluation process that would identify and monitor patterns of problematic behavior, as observed throughout the continuum of training, and not just within each rotation. It was also their intent to create a process that would identify students who were passing clerkships based on their knowledge and skills, but who were identified by evaluators as having deficiencies in the area of personal attributes and behavior. Most important, once these students were identified, remediation would be attempted, but if that failed, the student could be placed on academic probation and be subject to dismissal even if passing grades were attained in all clerkships.

DEVELOPMENT OF THE SYSTEM

Most UCSF students take their core clerkships in the third and fourth years of medical school.* The school of medicine has had a uniform clerkship evaluation form for all core and elective clerkships for over ten years. This form, which is filled out by the clerkship site director, covers three areas: fund of knowledge, clinical skills, and interpersonal skills.

*The required core clinical rotations for UCSF medical students, and the number of weeks in each, are family medicine (eight), medicine (eight), surgery (eight), obstetrics–gynecology (six), pediatrics (six), psychiatry (six), neurology (four), surgical subspecialties (four), and anesthesia (two). There is also a subinternship in medicine, lasting four weeks.

UCSF SCHOOL OF MEDICINE
PHYSICIANSHIP EVALUATION FORM

Student name (*type or print legibly*) _____ Course (*Dept. & Course No.*) _____

Site Director _____ Quarter, Block and Year _____

Site Director's Signature _____ Location _____

Date this form was discussed with the student _____

A student with a pattern of the following behavior has not sufficiently demonstrated professional and personal attributes for meeting the standards of professionalism inherent in being a physician:

Circle the appropriate category. Comments are required.

1. **Unmet professional responsibility:**
   a. The student needs continual reminders in the fulfillment of responsibilities to patients or to other health care professionals.
   b. The student cannot be relied upon to complete tasks.
   c. The student misrepresents or falsifies actions and/or information.

2. **Lack of effort toward self improvement and adaptability:**
   a. The student is resistant or defensive in accepting criticism.
   b. The student remains unaware of his/her own inadequacies.
   c. The student resists considering or making changes.
   d. The student does not accept blame for failure, or responsibility for errors.
   e. The student is abusive or critical during times of stress.
   f. The student demonstrates arrogance.

3. **Diminished relationships with patients and families:**
   a. The student inadequately establishes rapport with patients or families.
   b. The student is often insensitive to the patients' or families' feelings, needs, or wishes.
   c. The student uses his/her professional position to engage in romantic or sexual relationships with patients or members of their families.
   d. The student lacks empathy.
   e. The student has inadequate personal commitment to honoring the wishes of the patients.

4. **Diminished relationships with members of the health care team:**
   a. The student does not function within a health care team.
   b. The student is insensitive to the needs, feelings, and wishes of the health care team members.

5. **Please comment on an appropriate plan of action to pursue when counseling the student.**

This section is to be completed by the student.

6. **I have read this evaluation and discussed it with the clerkship director.**

Student signature _____ Date _____

7. **My comments are: (optional)**

Interpersonal skills are described as (1) professional attributes and responsibilities; (2) self-improvement and adaptability; (3) relationships with patients; and (4) interpersonal relationships with other members of the health care team. Students are evaluated on a 1–4 scale of "excellent," "solid," "concern," or "problem." From the form's inception, the clerkship directors had recognized that students who had marginal professional skills were receiving less than "solid" grades on the interpersonal skills part of the form, but that these grades usually had minimal consequences.

This existing evaluation process was the logical place to begin expanding the evaluation of professionalism. In 1995, the committee proposed that a student receiving ratings of "concern" or "problem" in any one of the four categories of interpersonal skills during any of his or her clinical rotations should be further evaluated for professional behavior. Such a rating would automatically trigger the submission of the newly created Physicianship Evaluation Form (also called "a physicianship report") to the appropriate authority (who, at that early stage, was still to be determined). The form would be filled out by the core clerkship or site director. (The most recent version of the Physicianship Evaluation Form is presented in a "box" in this article.) The new form was designed to expand on the four areas of interpersonal skills in the clerkship evaluation form. Specific performances and behaviors were intentionally described negatively, such as "The student does not accept blame for failure or responsibility for errors," rather than "The student needs to improve in the area of accepting responsibility for errors." The language was chosen to define the minimum standard of behavior that the student had not attained. Narrative comments were required. The clerkship or site director was required to discuss the evaluation with the student before submission. When creating the physicianship form, the clerkship directors un-

derscored that it would be used only for the few students who received less than "solid" ratings on the established clerkship evaluation form.

An explanation of the proposed evaluation system was posted on the walls of the student lounge to solicit students' inputs. The students supported the evaluation system, a factor critical to its adoption. Some students even voiced pride in their institution for addressing the issue of how to deal with unprofessional behaviors. The new system gained approval from the Committee on Curriculum and Educational Policy (CCEP), which is the school of medicine's curriculum governance committee, and from the student–faculty liaison committee, composed of student representatives from each class, the faculty, and the associate deans of student and curricular affairs and admissions. Long before the new system, students had repeatedly raised concerns that they did not receive timely feedback. In an attempt to lessen that problem, students and faculty agreed that if a physicianship report is to be submitted, it must be done before the end of the clerkship involved.

Further input from students and the associate dean continued to define the process that occurs after a student receives a physicianship form. Once a form is submitted to the associate dean of students and curricular affairs, she brings the report to the screening and promotions committee, which meets quarterly to discuss students' academic progress. The committee decides whether the report has merit, and whether the student should be placed on probation. The associate dean then meets with the student to design the most appropriate method of remediation.

The professionalism evaluation system was re-reviewed by the student–faculty liaison committee and the faculty in 1996. Students had become concerned that the system had become arbitrary and unfair. Despite the original intent that only the clerkship or site directors fill out the form, other faculty had submitted physicianship reports. In response, the Physicianship Evaluation Form was redesigned to (1) make clear that it could be completed by the clerkship or site director only; (2) provide space for the student's signature and comments indicating agreement or disagreement with the clerkship or site director's assessment and narrative comments; and (3) document that the student had been counseled by the clerkship or site director.

In addition, the student–faculty liaison committee recommended a revision of the process so that a student who felt that he or she was being treated unfairly could go to an ombudsperson or to the student welfare committee. The faculty proposed an extension of the deadline for submission of a physicianship report to beyond the end of the clerkship, citing the need for more time to gather individual faculty members' and residents' assessments of students. Students and faculty agreed to a deadline extension of two weeks. Extension of the deadline into the subsequent academic block, rather than two weeks after the end of the clerkship, obviates difficulties of physicianship form submission that would occur if there were holiday breaks between clerkships. The faculty rejected the students' suggestion that the associate dean of student and curricular affairs (who wrote the dean's letters for application to residency programs) not be notified until the second report, asserting that the school had a duty to oversee student performance. The faculty did agree that a student who received only one physicianship report would not have the report placed in his or her file, or mentioned in the dean's letter of recommendation for residency. However, if two or more clerkships submitted a physicianship report, the student would be placed on academic probation and would be eligible for academic dismissal from the school of medicine. On receipt of the second report, the student could be referred to the academic standards committee for review of the alleged deficiencies. In addition, the associate dean was required to describe the physicianship problem and the results of remediation in the letter of recommendation for residency.

PROFESSIONALISM CURRICULUM

The concept of professionalism is introduced and emphasized from the first days of medical school at UCSF with the White Coat Ceremony, where each beginning medical student receives a white coat while being reminded of physicians' unique responsibility to patients and of the social contracts that the student is making. This ceremony is a revision of one initiated at the College of Physicians and Surgeons at Columbia University. Further emphasis on professionalism and its assessment occurs primarily through Foundations of Patient Care, a six-quarter course in doctoring skills and in the social and ethical context of medical care, which is given in the first year and is required of all medical students. Under close observation, students learn in collaborative small groups and in clinical preceptorships. The evaluation of students' performances in both clinical and small-group settings emphasizes critical attributes of a developing physician. In the clinical preceptorship, six attributes are assessed every quarter, in addition to the objectives specific to that quarter. These "constants" are: (1) reliability and responsibility; (2) rapport with, and respect for, patients and families; (3) relations with preceptor and office staff; (4) motivation and maturity; (5) flexibility; and (6) initiative and self-directed learning. In small-group work, in addition to each quarter's content objectives, students are assessed with respect to three general behaviors, (1) participation; (2) preparation, and (3) self-directed learning, and four communication skills, (4) listening; (5) contributing constructively; (6) giving and receiving feedback; and (7) respectful engagement

with persons holding opinions different from those of the student. The items are scaled 1 (needs improvement) to 4 (outstanding). An evaluation of 1 or 2 on any of these items prompts remedial intervention by course faculty and may be grounds for failing the Foundations of Patent Care course.

EXPERIENCE WITH THE SYSTEM

The 24 Students

Between 1995 and 1998, a total of 29 Physician Evaluation Forms concerning 24 of the 765 students who were in their clinical years during that period were submitted to the associate dean for student and curricular affairs. Five of these were second reports; the most common complaint for these five was having a poor relationship with the health care team. For all 24 students, the problems most often cited were unmet professional responsibility (14 students) and diminished relationships with the members of the health care team (nine students). These behaviors were followed by resistance to change or criticism (seven), arrogance (four), and inadequate rapport with patients (four)—see Table 1. Four of the five students who received two physicianship reports had their difficulties cited in their dean's letters of recommendation for residency and graduated from medical school. The fifth student was a person who had passed all courses. Prompted by the submission of the first physicianship report on this student, a review was undertaken of the student's performance since the beginning of medical school. A pattern of difficulties with interpersonal skills was revealed. Following discussions with the faculty, the student decided that he or she was better suited to a different career and voluntarily withdrew from medical school.

The associate dean for student and curricular affairs met with each student at the time that a physicianship report was submitted. For most students, this meeting involved a counseling session to determine the student's perspective of the issues, and identification of strategies for improvement. In several cases, students were referred to the school's counseling service, the Medical Student Well-being Program.

Examples of Students' Unprofessional Behaviors

The examples below are more detailed descriptions of the behaviors of a few of the students listed in Table 1.

- One student was criticized for her lack of professionalism on the pediatrics clerkship: spending too much time with her patients, being late for rounds, and wearing unsuitable clothes. She observed that her problem was over-identification with her adolescent patients. She subsequently wrote a letter to the associate dean stating in part, "I know that there is a lot I can learn from this, so I take it as a pointer for positive growth." She received a university award for community service for her work with youth the following year.
- A student received a physicianship report from his psychiatry clerkship when the site director felt that the student was judgmental, condescending, and arrogant. The student, however, considered it "emotional prostitution" to ask questions about a patient's behavior or sexual orientation and considered the professionalism evaluation system a "tale of deep misunderstandings." In a meeting with the faculty from the psychiatry clerkship, the associate dean, and the student, the problem was identified as a culturally rooted difference of opinion about what is appropriate for a young physician in training to ask an older person. The student subsequently repeated the clerkship and performed very well.
- Another student had poor patient interactions that were perhaps due to a language deficiency. The student stated that although he had been born outside the United States, he had attended high school in the United States and had not had difficulty understanding or speaking English. He admitted, however, that his clinical skills were rusty due to a year spent in the laboratory, and he believed that the clerkship in which he had received the physicianship report was not well supervised. He had no further problem in subsequent clerkships.
- As mentioned earlier, only five students received two physicianship reports. The most common complaint for all five of these was poor relationship with the team. These students are exemplified by one of the five, a man with extensive laboratory research experience who was felt to be extremely bright by all his evaluators, but also appeared frustrated with the lack of hands-on clinical experience, and often wanted to take on the kinds of responsibilities appropriate for a resident. He had entered medical school in the same class as many of the senior residents on the team. His perceived arrogance and lack of self-awareness exacerbated the situation. He had similar difficulties on his medicine and obstetrics–gynecology core clerkships. However, once he had received counseling from the associate dean and from the students' psychiatrist, he had no further problem documented in his fourth year.

Lessons Learned and Continuing Issues

To date, the director of the obstetrics–gynecology clerkship has submitted the greatest number of physicianship reports. Four of the five students who received two reports received one of them from this clerkship. In contrast, in the first three years of implementation of the professionalism evaluation system, there was no submission of a physicianship report

Table 1

Descriptions of the 25 Students and Their Professionalism Deficiencies That Were Reported on Physicianship Evaluation Forms from 1995 to 1998, UCSF School of Medicine*

Student No.	Class Year	Gender	Clerkship	Problem	Comment*
1	1995	F	Obstetrics–gynecology	Lack of initiative	
				Unmet professional responsibility	Despite many reminders, student did not allow adequate time for prerounds and did not see adequate number of patients
1	1995	F	Family medicine	Poor relationship with team	
2	1995	M	Obstetrics–gynecology	Poor rapport with patients and families	
2	1996	M	Medicine	Poor relationship with team	
3	1996	M	Obstetrics–gynecology	Poor relationship with team	
				Arrogant	
3	1996	M	Medicine	Unmet professional responsibility	Did not follow through on patient care tasks
					Poor relationship with team
4	1996	M	Obstetrics–gynecology	Falsifies information	
4	1996	M	Pediatrics	Resistant to change	
				Poor relationships with team	
5	1998	M	Surgery	Poor relationship with team	Argumentative, unable to get along with non-physician team members
				Unaware of inadequacies	
5	1998	M	Medicine	Resistant to criticism	
				Unaware of inadequacies	
				Arrogant	
6	1995	M	Obstetrics–gynecology	Avoided patients	
				Arrogant	
				Disruptive with team	
7	1996	F	Obstetrics–gynecology	Unmet professional responsibility	Did not take initiative in patient care duties; needed frequent reminders to complete ward work; did not show up on time for operating room cases; student stated there was a resident conflict
8	1995	M	Obstetrics–gynecology	Unmet professional responsibility	Did not attend rounds and was late for other clinical responsibilities
9	1997	M	Obstetrics–gynecology	Unmet professional responsibility	Did not show up at scheduled clinics
10	1995	F	Pediatrics	Resistant to criticism	
				Lack of interest	Seemed disinterested in clinical pediatrics; when asked to take on the usual clerkship duties, at times felt duties were not worthwhile since was going into research
				Poor relationship with team	Lack of interest in the rotation hurt her relationship with the rest of the team, who did not feel invested in her education
11	1996	F	Pediatrics	Unmet professional responsibility	Needed frequent reminders from the housestaff regarding her duties as a clerk
				Inappropriate dress	
				Lack of timeliness	
12	1997	M	Pediatrics	Arrogant	
				Argumentative	
				Lack of effort towards self-improvement	Student did not accept blame for failure or responsibility for errors
13	1995	F	Psychiatry	English language difficulties?	

Continued on next page

Table 1 (Continued)

Student No.	Class Year	Gender	Clerkship	Problem	Comment*
14	1995	M	Psychiatry	Unmet professional responsibility	Student did not check in with supervisor as requested; on the final day of the rotation, student did not show up for his clinic assignment or his individual supervision and did not inform staff of his early departure
15	1996	M	Psychiatry	Unmet professional responsibility	Supervisor advised student to check frequently for new assignments; student did not do this and on at least two occasions did not see patients as promptly as requested; student seemed interested in performing at a minimally acceptable level only
16	1996	F	Psychiatry	Unmet professional responsibility	Poor patient interactions Record keeping inadequacies
17	1996	M	Psychiatry	Resistant to criticism Arrogant Critical Poor relationship with patients and team	 Cultural?
18	1995	M	Medicine	Poor relationship with team	
19	1997	F	Medicine	Unmet professional responsibility	Left uncompleted rotation without appropriate notification
20	1998	F	Medicine	Unmet professional responsibility	Student misrepresented an event
21	1998	M	Medicine	Unmet professional responsibility	Failed to show for start of clerkship
22	1995	F	Family medicine	Unmet professional responsibility	Did not understand the need for preceptors to review patient exams, histories, treatment plans; physical exams not always complete; student did not seek help or assistance
23	1998	F	Neurology	Unmet professional responsibility	Took unexcused time off from clerkship
24	1997	M	Dermatology elective	Lack of effort toward self-improvement	
25	1997	M	Otolaryngology elective	Unmet professional responsibility	Left uncompleted rotation without appropriate notification

*Although comments were made concerning every student cited, only the more interesting or instructive comments are shown.

from the surgery clerkship. In both the obstetrics–gynecology and the surgery clerkships, a student works closely with one faculty member over a six-week period. This similarity in the clerkships' structures makes it likely that the faculty in both were able to observe a student's communication skills. Then why there was such a difference between these clerkships regarding physicianship reports? More broadly, why are there differences between the frequencies of these reports among all clerkships? It is possible that unprofessional behavior is more likely to occur in certain clerkships than in others. More probable is that because clerkships have different cultures, different aspects of professionalism are valued in them. For example, communication skills may be more highly regarded in some clerkships. And we cannot ignore the possibility that students' apparent professionalism problems, particularly those dealing with the team, may sometimes be the result of a dysfunctional team or faculty member (we discuss this factor in the last section of this article). Finally, there may be a "threshold effect." For example, in the fourth year of the evaluation system, the surgery clerkship director submitted the first physicianship report from that clerkship. After the very next surgery rotation, the same director wanted to submit a physicianship report on another student, but the two-week deadline for submission had passed.

There have been other instances where a clerkship director has wanted to submit a physicianship report after the two-week deadline has passed. Some clerkship directors feel unduly constrained by this deadline, since they may not know of a student's difficulty or its extent until the individ-

ual evaluations of the student by faculty and housestaff are returned to the director, which often occurs after the deadline has passed. Yet delayed feedback to students and tardy evaluations are a continual problem. Since the goal of the physicianship evaluation system is remediation, prompt submission of the physicianship reports is essential. The deadline may also be an incentive to clerkship directors to further encourage that evaluations be submitted in a timely manner. Therefore, the submission deadline has not been extended beyond two weeks of the subsequent rotation.

Faculty Response to the System

The professional evaluation system has become part of our institution's culture. It fitted into the previous evaluation system relatively seamlessly because of the pervasive need for it, which was appreciated by both students and faculty. Even with the new system, inherent problems continue that discourage faculty from reporting problems in professionalism. First, faculty are unsure about whether their perceptions of unprofessional behavior are accurate. Second, it is difficult to confront students over issues of professionalism, and it is even more difficult to make a written report of unprofessional behavior and deal with the consequences of that report. However, we have no suspicion or evidence that clerkship directors are avoiding giving physicianship evaluation forms now that a program of consequences has been established. In fact, the opposite is true. Faculty finally have a mechanism to deal with issues of professionalism that have previously caused much frustration. This evaluation system also allows faculty to demonstrate how important professionalism is to them by their committing to the consequences of submitting a physicianship report. Most important, the faculty use this evaluation system because it has a series of graded (i.e., graduated) responses, with the goal being remediation.

FUTURE PLANS

We at UCSF are working to expand this professionalism evaluation system to the first two years of medical school, where students are in small-group settings and in preceptors' offices early in their training. Initial reluctance to expand the evaluation system came from some of the basic science faculty. For example, they felt they did not have adequate contact with students to evaluate their professionalism, that evaluation would be based on something other than content, and that basic science faculty were not qualified to evaluate students on physicianship skills. Faculty raised concerns that students would no longer "like them." The faculty also did not understand how to translate the reporting procedure to the first two years. Once the need for the system was better explained and examples were given, that there were occasions when students failed to show up in preceptors' offices, kept patients waiting, or were disruptive in small-group settings, the basic science faculty uniformly endorsed the adoption of a professionalism evaluation system for the first two years of medical school. The course directors are in the process of modifying the Physicianship Evaluation Form to fit the needs of students in the first two years of medical school. We need to determine the process for its use and the steps that will occur after its submission. At a minimum, the identification of students through this evaluation process will serve as an important "heads up" to the third-year clerkship directors. The identified students can be placed in clerkship sites that are more highly structured and work with selected faculty who will help the students with their particular professionalism problems.

OVERALL THOUGHTS

Our experience with the professionalism evaluation system described in this article has strengthened our belief that it is imperative for medical school faculty to take responsibility and accountability for the professional development of students and the evaluation of students' professionalism. If character faults, such as dishonesty, are identified and cannot be corrected, students should be dismissed from medical school rather than passed on to residency training.

Despite the formal curriculum on professionalism that each UCSF student receives in the first two years of medical school, much of what is learned about professionalism comes from the "hidden curriculum" that is transmitted by peers and housestaff.[7–9] A formal curriculum on professionalism can be negated by the improper actions and behaviors of residents and attending physicians in their treatment of students, each other, and above all, the patients. An American Board of Internal Medicine survey documented many experiences in medical school that undermined the optimum educational environment needed to teach professionalism.[10] Observations of inpatient ward teams document that statements concerning interprofessional relationships encourage antagonistic, rather than collaborative, relationships.[11] Given the likelihood of negative modeling and the presence of a hidden curriculum, it is especially important that students understand what is considered unprofessional behavior, such as that described in the Physicianship Evaluation Form. Also, with the implementation of a process that evaluates professionalism, some parts of the hidden curriculum become visible, and thus more open to purposeful change.

As trainees progress through residency and on to licensure, it becomes more difficult to help or to remove a physician who has recurrent problems.[6] All students at the UCSF School of Medicine who go on to postgraduate training take part in a tracking survey that the school has em-

ployed for over ten years. Residency directors are contacted at the end of the residents' first year, and in some cases they are queried a second time at the end of the residents' second or third year of postgraduate training. The questionnaire asks residency directors to rank our graduates in terms of their funds of knowledge and their attitudes and behaviors, and, in a yes-or-no format, whether the directors would select the house officers for residency again. In over ten years of tracking, we have found that a small proportion, less than 5% of graduates, would not be selected again.[12] We have also learned that the most common reasons that our graduates have failed their residencies have concerned skills, attitudes, and "fit" with the programs. In some cases, changing residencies to more suitable fields has solved the problem. In others, where honesty, integrity, or personality faults have been identified, no correction has been successful and the resident has been dismissed.[12]

Schools should set standards for the attainment of professionalism that are as high as those for the attainment of the cognitive skills. However, while cognitive areas are judged in blocks of time (clerkships), professionalism should be assessed over the continuum of the student's medical school education. This long view is necessary to compensate for the tendency of faculty to shy away from giving negative evaluations that they feel may be "subjective." Also, this approach allows one to identify students who have problems that may not surface on two- to four-week rotations or on longer rotations where a variety of sites and/or faculty are involved.[6] The importance of a longitudinal, cumulative assessment may become greater as longer clerkships, which have up to now played a central role in the identification of student problems, move increasing amounts of teaching to the outpatient settings, with consequent fragmentation of observation. This change, while educationally appropriate, may compromise the ability to detect problems in professionalism, because students may participate in many different clinics during one ambulatory care rotation. Managed care constrained may also shorten the time available for the interaction of faculty with students, increasing the possibility of students' slipping through the evaluation system.

As stated earlier, a poor relationship with the health care team was the second most frequently reported professional deficiency of our medical students since our professionalism evaluation system began. In reviewing the Physicianship Evaluation Form with the student, the associate dean must determine whether unprofessional behavior is the student's fault or whether a "dysfunctional" team is to blame. Despite this potential pitfall of the evaluation process, the team criterion is important. With the change in health care delivery created by managed care, physicians are being given "report cards" that identify not only their clinical expertise and relationships with patients but also their abilities to work with a team. This approach is just one more sign that it is incumbent on the medical schools to produce physicians who are morally responsible and are effective health care team members.

Some students have criticized the professionalism standards used in the evaluation system by saying they are culturally insensitive. This criticism may have merit, especially in a school such as the UCSF School of Medicine, where only about half of the medical students and more than 90% of the faculty are Caucasian. Our school prides itself on its students' cultural diversity and the rich ethnicity of the university community. Nonetheless, we believe that the ethical and moral values evaluated in our professionalism system are basic and transcend most cultural differences. We also feel that, on balance, it is more detrimental to patients to avoid defining professional standards than to remain on the sidelines of this issue because of cultural complexities.

Dr. Jack Stobo recently pointed out that the 1910 Flexner Report called attention to the fact that the medical profession was not consistently exemplifying professional behavior. The report urged the leaders of the profession to promote a high level of professional behavior and acceptability.[12] Flexner stated that "those who represent the higher ideals of the medical profession must take a stand for that form of education calculated to advance the true interests of society and to better the ideals of medicine itself."[13] Our professionalism evaluation system underscores the importance our institution places on the development of professionalism of our students. Many educators say that the curriculum is evaluation-driven. By requiring focused evaluation in four areas, we have facilitated the identification of problems in students' professionalism, most of which were in the realm of accepting responsibility or in collegial professional relations. As stated earlier, we plan to extend this professionalism evaluation strategy to all four years of our medical school. It will be of interest to observe the long-range performances of students who have been identified by this professionalism evaluation system and compare their performances with those of their classmates.

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REFERENCES

1. Project Professionalism. Philadelphia, PA: American Board of Internal Medicine, 1995.
2. David Thornton, supervisor, enforcement, Medical Board of California, Sacramento. March 1998, personal communication.
3. Phelan S, Obenshain SS, Galey WR. Evaluation of the noncognitive professional traits of medical students. Acad Med. 1993;68:799–803.
4. Reynolds PP. Reaffirming professionalism through the education community. Ann Intern Med. 1994;120:609–14.
5. Christakis DA, Feudtner C. Temporary matters: the ethical consequences of transient social relationships in medical training. JAMA. 1997;278:739–43.
6. Hunt DD. Functional and dysfunctional characteristics of the prevailing model of clinical evaluation systems in North American medical schools. Acad Med. 1992;67:254–9.
7. Ludmerer KM. What will the education of internists be like in 2011? In: American Board of Internal Medicine. Professional Responsibility, Professional Accountability: What is the ABIM's Role? Report of the 1996 ABIM Summer Conference. Philadelphia, PA: ABIM Communications, 1997.
8. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. Acad Med. 1994;69:861–71.
9. Papadakis MA. Do as I say, not as I do. Am J Med. 1998;104:605–6.
10. Arnold EL, Blank LL, Race KE, Cipparone N. Can professionalism be measured? The development of a scale for use in the medical environment. Acad Med. 1998;73:1119–21.
11. Stern DT. Values on call: a method for assessing the teaching of professionalism. Acad Med. 1996;71(10 suppl):S37–S39.
12. McArdle P, Osborn E, Doyle J. Teaching methods and residency performance: match or mismatch? Poster presentation at the Association of American Medical Colleges (AAMC) annual meeting, Boston, MA, November 1994.
13. Stobo JD. The Board's evolving role in professional responsibility and public accountability. In: American Board of Internal Medicine. Professional Responsibility, Professional Accountability: What is the ABIM's Role? Report of the 1996 ABIM Summer Conference. Philadelphia, PA: ABIM Communications, 1997.