

Commentary: **Accurate Medical Student Performance Evaluations and Professionalism Assessment: “Yes, We Can!”**

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Abstract

In this issue, Brenner and colleagues report a correlation between the frequency of negative comments in the “dean’s letter” and future problems during a psychiatry residency program. Their study makes an important contribution to the body of literature on factors that predict professionalism-related performance issues during residency and suggests the importance of dependable data that can be used to predict and hopefully intervene early in the training of future physicians across all specialties. As we think about the implications of this study, important issues involving the standardization of

medical student performance evaluations (MSPEs) and the assessment of professionalism are raised. Despite the Association of American Medical Colleges’ 2002 guidelines for MSPEs, subsequent studies have revealed that considerable inconsistencies among the evaluations still remain. To enhance the accuracy and usefulness of the MSPEs in predicting “problem residents,” improved standardization is necessary. Moreover, Brenner’s findings call for the development of more vigorous assessment of professionalism in undergraduate medical education, as well as more accurate reporting of these

assessments to residency programs. Longitudinal assessment of professionalism with robust tools allows for the identification and possible remediation of students early in their undergraduate training. Insofar as unprofessional behavior in medical school is predictive not only of problems during residency but also of later disciplinary action against the practicing physician by state medical boards, it is the obligation of the medical school to the residency program and to society to identify and report these behaviors.

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Editor’s Note: This is a commentary on Brenner AM, Mathai S, Jain S, Mohl PC. Can we predict “problem residents”? Acad Med. 2010;85:1147–1151.

In this issue of the journal, the article by Brenner and colleagues¹ studies predictors of residency performance. The authors report a correlation between the number of negative comments in the “dean’s letter” and future problems during residency in a psychiatry training program. Failed courses, letters of recommendation, and ratings from interviewers were not predictors of future

problems. In this study, “problems” included “acute psychiatric illness, character pathology, boundary violations with patients, recurrent conflicts with peers and faculty, and situational losses and stresses” that directly affected residents’ performance, causing them to drop beneath the minimum standards of the program. These problem areas clearly fall under the domain of professionalism. Although the authors refer to the impact of “problem residents” on the operational aspects of the graduate program as well as the morale and reputation of the program, the implications for patient care are even more concerning.

In our opinion, this report is a very important contribution to the extant literature on factors that predict performance during residency and has clear implications for practice beyond residency. Unfortunately, part of the problem with this body of literature is the lack of standardization of the predictive factors and their definitions. Indeed, studies examining the dean’s letter or medical student performance evaluation (MSPE) come to different conclusions regarding its usefulness.^{2–4} The MSPE is a complex document that comprises several categories. To compare studies about the MSPE, the category in question

must be clearly specified in all cases. Understanding and capturing the factors that are prognostic of future performance is extremely important at all levels of training. Although the study by Brenner and colleagues focuses on a single psychiatry residency program, it suggests the importance of dependable data that can be used to predict performance problems and hopefully intervene to prevent such problems early in the development of future physicians in all specialties. Brenner and colleagues raise specific issues which need to be addressed, including the composition and integrity of the MSPE and the need for robust assessment and reporting of professionalism in undergraduate medical education programs.

The Value of the MSPE

Collecting and organizing the information included in MSPEs requires considerable time and effort. Ideally, the MSPE is a unique, authoritative, and valuable source of information that can be used by residency programs to evaluate candidates. However, despite its potential, it often falls short. In 2002, the Association of American Medical Colleges (AAMC) published guidelines for the format and content of the MSPE in an attempt to improve

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standardization.⁵ Despite these guidelines, there is still considerable variability in the format and content of the MSPE. In a study by Shea et al,⁶ only 69% of MSPEs contained comments about student performance that were produced exactly as originally written instead of being summarized or condensed. Only 13% of MSPEs had specific professionalism sections; the majority of comments about professionalism were embedded in other areas of the document. There was relatively low mention of gaps in study, leaves of absence, or adverse action against the student. Moreover, despite the AAMC guidelines against including a final recommendation, 39% of MSPEs still did so.

The lack of standardization among MSPEs has important implications for residency program selection. A study by Lurie et al³ found that an applicant's ranking as expressed in the dean's letter is a significant predictor of program director evaluations of residents. However, regardless of AAMC guidelines, only 17% of MSPEs provided comparative class data. In a study of performance predictors in an anesthesia residency program, Swide and colleagues⁴ reported that program directors do not view the MSPE to be a reliable source of information regarding students' professional conduct. In fact, their study found that program directors frequently question the accuracy of the professional behaviors reported in the majority of MSPEs and maintain the belief that "the MSPE, in general, avoids 'negative' comments, rendering a section on professionalism inherently unreliable." The perception is that medical schools do not have a reliable tool to measure professional behavior.

The Need for Reliable and Accurate Reporting of Professionalism

Brenner and colleagues' findings call for the development of mechanisms for more robust assessment of professionalism in undergraduate medical education programs and in the accurate reporting of these assessments to residency programs. If relatively innocuous comments such as "very nervous" and "displayed little curiosity" were identified as negative enough to predict poor performance outcomes, it is clear that we

must identify even more reliable standard behavioral definitions of professionalism that would allow for more precise predictions of problematic behavior. Such definitions may serve to decrease the false-positives that were reported in the article by Brenner and colleagues. In a control group containing no problem residents, 28% had "negative" comments in the dean's letter.

Reporting students' performance against common behavioral standards may result in comparable data from every school; however, even if we were able to agree on standard behavioral definitions, factors contributing to the underreporting of negative behaviors would still need to be addressed. Faculty are often reluctant to report poor professional behavior. They worry that the witnessed events are anecdotal and may represent anomalies that are not reflective of the overall performance of the student. Faculty often do not experience enough direct observation of or exposure to students to feel confident in their assessments. The "halo effect" might result in faculty dismissing unprofessional behavior in an otherwise high-performing student. As a result, clerkship narratives may only include the "tip of the iceberg" in revealing negative professional behaviors.

Additional methods of identifying and monitoring students who exhibit unprofessional conduct are necessary. Professionalism forms have become fairly widely accepted as one such method. This process allows faculty members to submit a form describing a professional lapse for an individual student to the dean's office, allowing for the longitudinal collection of data on a student's professional behavior. The collection of this information is important for the remediation of the student, but the reporting of this information to residency programs is imperative and should be part of the MSPE. Only then might the section on professionalism become reliable.

Recommendations

Every medical school seeks to provide students with the knowledge, skills, values, and attitudes to become competent and compassionate physicians. Medical school faculty must take responsibility for the professional development and evaluation of their students. Longitudinal assessment with

robust tools allows for the identification and possible remediation of students early in their undergraduate training. But medical schools also have the unique opportunity to observe closely a learner's behavior and performance in clinical settings in a manner that may be more rigorous than what will be possible in the learner's residency program. We know that unprofessional behavior in medical school is predictive of later disciplinary action against the practicing physician by state medical boards.⁷ It is the obligation of the medical school to the residency program and to society to identify and report these behaviors. For the MSPE to be valuable, it should serve as an objective and unabridged summary of the student's performance. For medical schools, the MSPE is the only vehicle by which longitudinal information about professionalism can be shared with residency programs. It is critical that we first agree on definitions of professionalism and that we find tools that will measure this competency more accurately. Behaviorally anchored assessments from peers, patients, and other members of the health care team may provide useful information. Perhaps a 360-degree evaluation of professionalism should be required of every medical student. We also need to develop and use a standard method of reporting that all will understand. For this to become a reality, all medical schools would have to agree to report unprofessional behavior both in principle and practice. Schools would legitimately be concerned that accurately portraying their students who had professional lapses would disadvantage these students if other schools were sanitizing the records of their students with identical issues. Finally, given the fact that some of the components of the MSPE are not predictive of performance, perhaps the MSPE could be streamlined to provide only the information that is predictive. Further identification of these predictors in other specialties is essential, but this report by Brenner and colleagues is a valuable contribution.

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