Ochsner Journal 16:11–13, 2016
© Academic Division of Ochsner Clinic Foundation

Futile Education: When Graduation Is Not the Best Option

Jennifer Schafer, MBBS, DRANZCOG, FRACGP, GCELead

Director, MBBS/MD Program, The University of Queensland School of Medicine, Brisbane, Queensland, Australia

The intrinsic rewards of medical education are enormous. As clinician teachers, we have the very great privilege to work with intelligent, enthusiastic, and highly motivated people who aspire to become doctors. In doing this work, we are honoring our commitment as outlined in the Hippocratic Oath "to gladly share such knowledge as is mine with those who are to follow."[1] What could be possibly more satisfying?

So why is it that conversations between clinician teachers so often gravitate toward discussions regarding a very small number of students who, despite all reasonable interventions, remain a source of distress for themselves and others? These students can be very difficult to manage, consuming time and emotional energy, and this difficulty is compounded by the frustration that this time and energy could be better invested in enhancing the experience of the majority.

For the purpose of this discussion, I am referring only to those students who—having expired all of the usual resources in terms of academic and pastoral care, teaching, feedback, and remediation—are finally recognized as lacking inherent suitability for medical practice. Once this understanding has been reached, how can we manage their transitions to alternative careers that better suit their personal attributes and skill sets with care, dignity, and respect?

The underlying diagnoses for this group vary. The problem may be as simple as a good person who has made an ill-informed career choice. Others include more serious concerns, such as physical or mental health issues that, despite adequate medical treatment, continue to pose a risk to personal or patient safety, as well as impaired cognition, communication, resilience, or professionalism. These students create a ripple effect around them, triggering notifications of concern or complaints from colleagues, academic and professional staff, and occasionally even patients. A common theme is lack of insight, as those who are capable of responding to feedback are usually able to be remediated or have the good sense to adjust their own career plans.

The management principles of medical education are not dissimilar to those of medical practice. The logical steps are prevention, early detection, routine management, and, if all else fails, the educational equivalent of palliative care. Therapeutic options include policies defining inherent requirements and fitness to practice, selection tools, curriculum, teaching and assessment, role modeling, feedback with remediation, career counseling, and, in the most extreme cases, misconduct processes.

PREVENTION

As in healthcare, prevention is the best medicine. A very clear definition of the inherent requirements for medical practice can communicate realistic expectations to potential students, inform selection processes, guide teaching and assessment, and provide a defendable consensus view in the face of the inevitable appeal process if students are not selected or are failed from a program.

One definition of inherent requirements is the "core activities, tasks or skills that are essential to a workplace in general, and to a specific position. They cannot be allocated elsewhere, are a major part of the job, and result in significant consequences if they are not performed."[2]

While many of us share a sweeping general view that the inherent requirements for medical studies and medical practice should be simple, logical, and commonsense, the reality is much more complex. It is critical to have a very precisely defined, agreed, and defensible policy. In Australia, the Disability Discrimination Act of 1992 makes it unlawful for an educational authority to discriminate against someone because that person has a disability.[3] The Act was tested in 2013, when a complaint made by a medical student alleging discrimination by the education provider on the grounds of disability was substantiated in the New South Wales Civil and Administrative Tribunal, resulting in much concern and debate in medical education circles.[4,5] Currently, a collaborative project involving multiple medical schools in Australia is underway with the aim of achieving a nationally agreed definition of inherent requirements for medical studies.

EARLY DETECTION

Selection processes in medical education are the equivalent of early detection. In a perfect world, selection tools should identify and prevent most of these at-risk students from even entering medical school. There are two components to selection—a minimum standard that must be met and a process for ranking the candidates. Inherent requirements are one component in the definition of the minimum hurdle, along with academic scores and other prerequisites. One could argue that ranking processes are less about selection and more about managing the discrepancy between the high volume of applications for the limited number of placements in a valid, feasible, and defensible way.

While the science underpinning selection processes is improving, we do not yet have the perfect tools for predicting at-risk students. Some physical and academic attributes can be measured, but others—such as lack of resilience or integrity—can be impossible to predict and are

likely to only be revealed over time in the study or work environment. The expectation that one or more measurement tools applied at a particular moment in time can predict future behavior, as well as take into account students' capacity for learning or remediation, is unrealistic, particularly across multiple soft variables.

ROUTINE MANAGEMENT

Students who fail in the areas of knowledge and skills are, in theory, relatively easy to manage. A clear and well-worn path exists for teaching and learning, assessment, standard setting, provision of feedback, remediation, and then further assessment. Most program rules define a finite number of attempts to pass, and once these have been expired, students are refused further enrollment. Experience attests that this management is often not as easy as it appears, as students will exert their right to appeal, a process that can prolong what is often a painful experience for all.

In contrast, the process for failing students who demonstrate persistently impaired professional behavior can be much more difficult. When planning the curriculum, we consider the integration of knowledge, skills, and attitudes, but traditional assessments have focused predominantly on knowledge and skills. Assessments of industry, engagement, teamwork, and professionalism are more difficult to define, do not map well to traditional assessments, and are subject to ongoing debate regarding standard setting. We can easily recognize poor performance when we see it, but it is much harder to predefine a rubric that includes the myriad of potential parameters. These difficult decisions can be improved and supported by the development of fitness-to-practice policies. We are very proud to set high standards for knowledge and skills but extremely cautious about failing students when it comes to professionalism.

Traditionally, lapses in professional behavior have been managed under misconduct policies, but these do not cover the full spectrum of behavior that can be problematic in medicine. For example, a student who is unable to work collaboratively in a team is not guilty of misconduct but is unsuitable for the profession of medicine. Misconduct processes work best for incidents of significantly aberrant behavior (some of which may be remediable) rather than the broader "area under the curve" of repeated behavioral concerns that have proven resistant to feedback and remediation and which may only be evident in a longitudinal view.

At The University of Queensland School of Medicine, we have used a formal assessment of professional behavior as part of a clinical participation assessment for each clinical rotation since 2012 and have now extended this assessment to the earlier years of the medical program. This formal assessment provides the power to academically fail students in a course or clinical rotation, with repeated fails falling under the same progression rules as fails in knowledge or skills. In our experience, this assessment has proven to be much more effective and efficient in the management of unprofessional behavior than the misconduct process.

PALLIATIVE CARE

The experience of transitioning those irremediable students to alternative careers is analogous to end-of-life care. We know that for people approaching the end of life, there comes a time when further active intervention is not in the best interest of the persons or their families. Unnecessary and futile interventions fuel false expectations, prolong suffering, and generate inappropriate expenses without any hope of changing an inevitable outcome. Best interests are often better served by transition to palliative care, which promotes acceptance, provides symptomatic care to minimize pain and suffering, and enhances dignity.

Similar words could be used to describe futile education. Prolonging enrollment without any hope of achieving graduation is futile, harmful, and expensive. We are already dealing with a vulnerable group, so the potential for further damage by negatively impacting students' reputation and self-esteem is great.

Our fear of failing students, which also infers that we have failed as teachers, can trigger denial and questioning of our decisions. We may second-guess ourselves, filter information that we do not want to see or hear, try to rationalize away our observations, justify why the students are "not that bad," and question the standards.

Another natural response is to work harder, increasing our efforts to improve the students' knowledge, skills, or behavior. Despite our best efforts, they may continue to fail, negatively impacting their self-esteem and challenging our views of ourselves as good teachers. On the other hand, this approach also carries the real risk that our efforts may just get the students over the finish line to graduate, which can be an even worse outcome if they are not competent.

In an ideal world, honest feedback and a well-worded conversation at this stage should encourage the students to take action and find alternative paths. Unfortunately, in the real world these conversations may not land well. A common trait in poorly performing students is lack of insight. The unwanted message may trigger a grief reaction including denial, resistance, bargaining, and even anger at the person trying to help. It is wise to ensure that you have a witness and a support person in place for these conversations. Students can easily misinterpret the message and make false, inaccurate, or even vexatious allegations of bullying, harassment, discrimination, and victimization that are difficult to defend without an independent witness.

To fail students—even when based on the documented criteria—takes courage. I recall a number of conversations with preceptors who said, "I don't want to fail them, but they are really not fit to graduate." It is not uncommon to note a significant level of distress for the preceptors when making these difficult decisions. Our core values of promoting good teaching and good medicine while simultaneously caring for our students, patients, and community are normally perfectly aligned and therefore rewarding. Encountering students who (we believe) should never be doctors—for whatever reason—creates conflicting and mutually incompatible drivers at odds with our values, triggering distress in ourselves.

When counseling these students, we can still do much to assist them in the same way that palliative care ensures patients are not abandoned by the medical profession. Consideration should be given to referral for academic, medical, or pastoral care as needed, as well as career counseling. In some cases, students may need support to break bad news to parents or mentors.

By reframing the decision to fail unfit-for-practice students as a positive rather than a negative outcome, clinician teachers are fulfilling their duty of care not only to these students, but also to colleagues and the community. Like square pegs in round holes, students who don't fit the profession may experience more distress by staying than by being given permission to leave. Assisting these students to find alternative satisfying careers more suited to their skill sets, with care, dignity, and respect in a manner not dissimilar to good palliative care, is a demonstration of academic and pastoral support far exceeding that shown in most university programs. Providing compassionate end-of-program care in an empathic and nonjudgmental manner reconciles and realigns the core values of clinical teachers, medical schools, and tertiary institutions.

REFERENCES

1. Lasagna L. Hippocratic oath, modern version. Sheridan Libraries of John Hopkins University. http://guides.library.jhu.edu/c.php?g=202502&p=1335759. Accessed September 25, 2015.
2. Disability Employment Australia. Employers guide to partnering with disability employment services: inherent requirements. http://guide.disabilityemployment.org.au/proposing/inherent_requirements. Accessed September 25, 2015.
3. Australian Human Rights Commission. D.D.A. guide: getting an education. http://www.humanrights.gov.au/dda-guide-getting-education. Accessed September 25, 2015.
4. Walsh G. Educational institutions and the prohibition on disability discrimination. *Law Soc J*. 2014;1(5):76-77.
5. New South Wales Civil and Administrative Tribunal. BKY v The University of Newcastle [2014] NSWCATAD 39. http://www.caselaw.nsw.gov.au/decision/54a63cdb3004de94513dbafb. Accessed September 25, 2015.