Role modeling professional behavior as a dynamic application of the hidden curriculum

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Abstract

Aims: To investigate the characteristics of role models and the significance of consciousness and reflection in role modeling. **Method:** Semi-structured, in person, interviews with twelve General Practitioners. **Results:** Supportiveness and unsupportiveness were commonly reported traits of positive and negative role models. A significant number of respondents discussed registrars, as distinct from consultants, as role models. Many attempted to understand or explain poor behavior by negative role models. Practitioners indicated superficial awareness of their models during house surgery but were largely unconscious of the role modeling process. Few reported reflecting on their models during house surgery, though most discussed models with their peers to share practical information. **Discussion:** House surgeons identify with registrars more than consultants so registrars are frequent role models. Justifying the behavior of negative models is an unexpected response in need of a satisfactory explanation. Unconsciousness of role modeling is detrimental to learner and model. Calls for consciousness, reflection and recognition of role models should be considered in order to produce doctors who are highly skilled at managing vast amounts of information, clinically excellent, professional, ethical and humanist.

Medical educators seek to produce doctors who are highly skilled at managing vast amounts of information, clinically excellent, professional, ethical and humanist. However, there is concern from the medical, and wider, community that these traits are not consistently instilled into graduates (1, 2). Inspiring these characteristics in young doctors is not solely the domain of the formal curriculum; the hidden curriculum also permeates medical education and is highly influential in shaping professional identity (3).

One important component of the hidden curriculum is interaction with role models. A number of descriptive studies have attempted to define the traits of influential models. The characteristics of positive role models are now generally accepted: clinical excellence, good teaching, compassion, focus on the patient-doctor relationship, and certain elements of personality (4-8). There have been attempts to classify models according to their influence on learners (9, 10). However, the challenge to integrate socialization (11), and social learning theory (12), into an effective conceptual schema of role modeling remains largely unanswered. Despite this relatively poor theoretical understanding, positive role models are often perceived as a panacea for addressing shortcomings in medical education. They are frequently charged with fostering professional identity, idealism, ethics, and the patient doctor relationship in medical learners. Defining role model, as distinct from mentor, has also been problematic, though mentoring is generally more conscious, interactive and considered than role modeling (13). This study will integrate previous research into medical role models and investigate the importance of consciousness. Throughout this paper, ‘consciousness’ refers to personal understanding and awareness of role modeling. Finally, the implications for improved role modeling will be examined.

Methods

A convenience sample of six male and six female General Practitioners in the urban Dunedin area was interviewed. Subjects completed their house surgery years in New Zealand[*] and were provisionally registered at least ten years ago[†]. Practitioners gave one half hour, semi structured interview, conducted in person. These interviews covered examples of positive and negative role models with interviewer prompts regarding reflection and consciousness. Tape recordings were independently transcribed and underwent multiple readings to identify key themes. These themes are illustrated with verbatim quotes in the results section, numbers in parenthesis refer to individual respondents. Ethics approval was granted by the University of Otago Ethics Committee under the auspices of the Hidden Curriculum Project.

Results

The most frequently cited characteristic of positive role models was supportiveness. Support encompassed being uncritical, approachable, friendly and helpful. In descending order of frequency, clinical skills, teaching, enthusiasm, compassion and 'being a nice person' were also identified. Overwhelmingly, being unsupportive was the key characteristic of negative role models. Ethical concerns, low enthusiasm, lack of compassion and poor teaching also characterized negative models.

Most primary positive role models were consultants, the remainder were registrars. A number of respondents volunteered that they were based at a hospital without registrars during their house surgery. Practitioners obviously felt that this was significant information, reflecting a broader trend for residents to supersede consultants as models. Some respondents attempted to explain this trend;

> *"Consultants are always those sort of doddly figures when they are up they are slightly removed from reality, whereas a Registrar, they know what you are going through, they have just been through it." **(8)***

Senior nurses were mentioned as secondary positive models by a number of respondents, mainly women. Nurses were often described as supportive teachers, highly experienced in clinical work and support of junior doctors. The vast majority of negative role models were consultants. No registrars were nominated, although not all practitioners had been exposed to registrars. Fellow house surgeons were negative role models for two of the respondents.

Most interviewees recalled being aware of their role models during house surgery. Some reported superficial awareness which subsequently developed into a deeper appreciation of the model's influence. Others had only retrospectively identified a positive role model. Very few respondents recalled reflecting on, or analyzing, the values or behavior of their

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[*] With the exception of one participant who left New Zealand after their Trainee Intern year to complete house surgery in Australia.
[†] With the exception of one participant provisionally registered five years ago.

role model during house surgery. Half reported discussing their positive role models with peers, primarily to transfer practical information.

> *"Yes, yeah, I mean, "this guy's a good – it's a good run, he's a good person to work with, he treats the patients nicely', or, you know, that sort of thing"* ***(2)***

> *"Oh I think we would talk about your next house surgeon run who you would go on with, and say 'oh he's good, he's bad'. Well, not really bad, but, you know, you'd comment for sure"* ***(12)***

A minority recalled analytical discussions with their peers about the significance or influence of their models. Practitioners were generally more aware of their negative role models and developing increased awareness over time was common. Informal discussions with peers were primarily to transfer practical information or as a coping strategy for sharing negative experiences. Only one respondent recalled deeper analysis with peers. The response below typifies learner consciousness of role modeling;

> *"Not if it's necessarily a conscious thing, it was just an unconscious – I mean, there are some – there are some elements of it that you do consciously, like if somebody asks a question in a particular – if you are with somebody and they ask a question in a particular way and you think 'oh, when I tried to ask that question I didn't get a very useful answer, but when you asked that way, the patient knew what you meant more and so I'll try and ask it that way next time'. But I think a lot of the other stuff is more intuitive in that, you know, oh this person sat on the bed and shouted at that person and I don't think I'd like to do it that way. I mean, as a house surgeon too the patients often talk to you about consultants, you know, 'oh, so and so is grumpy', or 'I'm scared of this consultant', or 'I've found this consultant really nice', and I think of that information gets distilled in a more subconscious way"* ***(2)***

When prompted, a majority of the respondents felt that formal reflection activities would have been beneficial. However, discussing reflection invariably prompted the practitioners to outline the demands they faced as house surgeons and the comparatively low priority of role modeling awareness. They clearly felt that the practical demands of surviving house surgery was more important than analysis of role models.

> *"I mean, we were very busy, we work really hard, and, you know, we kind of talked about the patients, and there were good clinicians and bad clinicians, and you knew which they were. And, you might tell stories to each other about bad things that happened but not in the sense of analyzing that person's behavior as much"* ***(3)***

Most found it difficult to know whether their role models had been conscious of being role models. Many felt that positive role models were aware of their status. Two thought that their positive models were unaware of modeling and were simply being themselves. Most suspected that their negative models were entirely ignorant of being role models.

None of the practitioners reported any opportunity to discuss role modeling with senior doctors. Providing feedback to superiors seemed entirely alien to the practitioners. Questions about feedback were generally interpreted as reporting negative role models. None of the negative role models for this cohort were formally reported; generally there was no reporting procedure. The majority of respondents did not feel that having the opportunity to provide feedback to models would have been useful. They suggested that it would have been difficult to provide negative comments to supervisors, that everybody knew there was a problem anyway and that feedback wouldn't have created any meaningful change.

Surprisingly, half the interviewees provided unprompted explanations for the behavior of negative models. They suggested that external stress, exhaustion, and family pressures contributed to unprofessional behavior by their superiors.

> *"I think you also have to put that into context with the revolving door syndrome of junior staff, but also the exhaustion and frustration that consultants presumably also share in a hospital system where they are dealing with lack of resources, battling to get resources for their particular area, and doing rosters that most of us probably don't want to do"* ***(9)***

Some of the practitioners noted that their role models had a degree of influence over their specialty selection. Respondents also mentioned the effect of models on the idealism of junior doctors,

> *"I think burnt out, tired uncaring doctors are very poor role models for young doctors because you start of with all this lovely shiny starry eyed idealism, and it's very toxic to be around people who don't care any more"* ***(3)***

The majority of respondents felt that role modeling had a significant impact on house surgeons. Some also noted the value and influence of mentors, over and above role models. The respondents generally felt that 'things' had changed since they were house surgeons, particularly positive changes to training and support of junior doctors.

Discussion

The characteristic traits of role models described in this study were essentially congruent with other literature. Beyond pure description of models, three interesting themes emerged from the data: identity of role models, explanation of negative models, and consciousness of role modeling.

Respondents frequently identified registrars as positive role models, or volunteered that they hadn't had contact with registrars during house surgery. This may reflect the tendency of learners to choose role models who are similar in ethnicity, gender, age or role (6, 14, 15). Interviewees outlined why residents were regarded as important models in comparison to consultants. According to the General Practitioners, they had had more direct contact with residents, were less intimidated by them, felt closer in age and experience and could imagine taking on their role in future. This is a good example of 'stage modeling' described by Bucher and Stelling as learners anticipate moving on to the role of registrar (10). However, Registrars are often stressed, extremely busy and untrained in teaching or role modeling. This may make them susceptible to being negative models (15). This was not the case in this study; negative role models were predominantly consultants. However, not all practitioners had interacted with residents in their house surgeon years and this may limit the generalisability of consultants as negative role models.

Respondents repeatedly attempted to explain and understand the negative behavior of their senior colleagues. This unpredicted outcome provides an intriguing area for future research. Currently, it is possible only to hazard potential explanations for this unexpected trend. One previous study has suggested students become less critical of faculty as they become more experienced (16). Perhaps respondents in this study grew less critical throughout their career. Alternately, their progression through the medical hierarchy may have provided insight into pressures experienced by their role models, and the psychological effects of complaints. Some respondents mentioned having undergone general practice training which emphasized reflective skills; perhaps increased reflection created heightened empathy. Normal personal growth and increased maturity probably also influenced the recall of the general practitioners. Although it is heartening to think that most of these practitioners are retrospectively forgiving of their superiors, it is difficult to assess the long term consequences of frequent exposure to negative models.

The medical profession is intuitively aware that role modeling occurs and that it is important. However, awareness of role modeling as a concept does not directly translate into consciousness of the process. Investigating the influence of consciousness, understanding, and reflection in role modeling was of particular interest in this study.

The results indicate that most house surgeons only had a superficial awareness of their models. All respondents could recall positive models and describe some of their characteristics. However, there was little evidence that they had thought much about role models as house surgeons or engaged in any deeper analysis of their influence. As Kenny et al writes 'Although students can often express the characteristics of positive and negative role models, it may be difficult to appreciate how embedded the influence is in the learning.'(17). Unconscious modeling may be instrumental in subtle changes to learners' values, such as decline in idealism. There is divergence between the values learners profess to admire and the changes which actually occur during medical training and socialization (13). This anomaly may indicate the power of unconscious, unexamined role modeling.

Respondents found it difficult to know whether their models had been conscious of being role models. In general, most felt that positive role models were aware of their influence, and that negative models were not. This is consistent with other research indicating a spectrum of awareness by role models (4, 5, 18-20). It seems that there is a baseline level of role modeling awareness. Good role models, nominated by learners, appear to have enhanced awareness of the process. Doctors who learners do not identify as role models are generally less aware of role modeling.

This mutual role modeling unconsciousness is detrimental to role models and to learners. Role models who are unaware of their influence are limited to 'silent modeling' without discussion of their actions (21). This leaves learners adrift to infer a rationale for the behavior of the model. Likewise, unconscious role models are unaware of the embedded values and behavior they are demonstrating. Tacit approval of inappropriate behavior occurs when a model is ignorant of their impact on learners and behaves unprofessionally. The apparent increased consciousness of positive role models may be a function of their increased awareness and reflection more generally. For learners, role modeling unconsciousness makes it difficult to reflect on critical experiences. Self reflection has been identified as a poorly utilized tool in medical practice despite its reported benefits (22, 23). As Bowen and Carline identify, 'encouraging learners to reflect upon what they have observed can help make implicit norms and values explicit and understandable'(24).

In its most basic form reflection can occur in private conversations between friends and colleagues. Respondents in this study recalled superficial 'swapping notes' conversations as the main discussions about superiors and role models. Most inferred that the time pressure and the struggle required to survive house surgery compromised their ability and willingness to reflect on their experiences. These demands tend to limit even informal conversations to areas of perceived practical use, such as warning colleagues about the idiosyncrasies of a given consultant. This limits the value of conversations between medical learners as a form of analytical reflection. Attempts have been made to integrate reflective training into undergraduate education and have shown early promise (25).

This study, and other literature, indicates that role modeling is a pervasive form of teaching and socialization for doctors. The challenge for educators is to ensure that good role models are available to help foster development of learners. Currently, role modeling is ad hoc and largely unconscious. Calls for change focus on two main areas: curriculum design to maximize learner contact with excellent role models and recognition of role modeling as a valid professional skill (26).

Learners should be exposed to positive role models throughout medical training and house surgery (6). Currently, most role modeling occurs during the clinical years amongst the melee of patient care and clinical teaching. Problem based learning curricula and community attachments with General Practitioners both have potential to increase meaningful learner interaction with positive role models. Community attachment represents a renaissance of traditional one-on-one apprenticeship, once the foundation of

medical education. Working closely with general practitioners can facilitate mentoring and reflection removed from the hubris and hierarchy of tertiary care centers (17). Increased role modeling awareness may also help models and learner critically appraise the values and behaviors they are demonstrating or replicating.

Regardless of curriculum design, positive role models themselves must be identified, recruited, supported and rewarded. In contemporary academic medicine, research output has increasingly defined the key measure of success at the expense of clinical focus and teaching (2, 6, 7, 27). Reduced teaching time often results in a narrow focus as clinical teachers try to pass on immediately important clinical skills. The first casualties of time pressure tend to be intangible skills like reflection and role model debriefing. Recognition of teaching and role modeling as a valid, and important, professional skill is long overdue. It is unrealistic and unfair to expect altruism and personal satisfaction to be the sole reward for exemplary role models. Explicit financial and institutional recognition should be provided for exceptional teachers and role models (28). Teaching awards provide some form of recognition but without financial rewards effective teaching and role modeling will always be the poor cousin of research output.

Weaknesses of this study stem from the extended lag between house surgery and interview, and a sample comprised entirely of general practitioners. Respondents seemed to believe that support and role modeling for learners has improved since their house surgery. It would be interesting to address this perception through a similar study of current junior doctors. House surgeons who admire or reject particular traits in their role models may be more or less likely to enter a given specialty field. Investigating the retrospective role models for specialties other than General Practice may produce different responses.

However, consistent with other literature this study indicates that learners are aware of supportive, clinically competent, enthusiastic and personable doctors as positive role models. Conversely, unsupportive, unethical and unenthusiastic seniors are negative role models. Registrars and clinical teachers are the two groups most likely to act as role models. Models and learners are superficially aware of each other and the dynamic process of role modeling, however analysis and reflection on modeling are largely sporadic. Positive role models tend to be more aware and reflective than negative role models. Incomplete awareness often results in role modeling unconsciousness for both model and learner. Mutual unconsciousness is detrimental for both parties. Models can not articulate the rationale for their behaviors nor can they critically examine what they demonstrate to learners. Unconscious learners can not analyze their experience of models and may internalize different values to the ones they profess to admire in conscious role models. Consciousness of role modeling may alleviate some of these problems and facilitate reflection. Reflective practice is increasingly viewed as an important tool for continued improvement as a medical professional. Whether the model or learner is conscious of it, role modeling plays a significant role in the development of young doctors. This significant influence should be considered in curriculum design and better reflected in recognition and reward of positive role models.

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