Taking Students as They Should Be: Restoring Trust in Undergraduate Medical Education

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Abstract

A recently published editorial focused on trust in the relationship between teacher and learner; in this Invited Commentary, the authors examine trust between administrators, course directors, curriculum committees, and medical students, exploring the ways that a lack of trust may be manifest, how this impacts students, and how trust can be built in undergraduate medical education (UME).

The hierarchical and paternalistic culture in medical education can skew curricular and policy decisions in the direction of distrust of students, leading to overscheduling and overprogramming of students through much of UME and to inflexible policies and procedures. Students may feel unheard or disrespected by some administrators and course directors when asking for changes, particularly when advocating for reductions in workload or increased flexibility. The collective impact of this lack of trust appears substantial, leaving many students with feelings of frustration, resentment, and cynicism.

Trust can be built, and efforts to do so have little associated cost. Administrators and course directors need to demonstrate respect, compassion, flexibility, and trust in students. Trust is built on relationships, and administrators should avoid isolation and engage meaningfully with students. Efforts should be made to reduce overscheduling of students so that they have more opportunity to pursue activities in which they can find meaning. Flexibility in scheduling of mandatory sessions and exams should be introduced wherever possible. If we take these collective steps, students will be more likely to find a path to becoming the doctors they are capable of becoming.

Editor's Note: This New Conversations contribution is part of the journal's ongoing conversation on trust in health care and health professions education.

Viktor Frankl, the eminent psychiatrist, Holocaust survivor, and author of *Man's Search for Meaning*, lectures to the Toronto Youth Corps in 1972—the film, black and white and grainy.[1] He tells the audience that he is taking flying lessons and his flight instructor has recently taught him the following: If you are heading for an airfield directly to the east and there is a cross-wind from the north, you will drift south of the field, so you have to head north of your target to reach it.

Frankl's intent becomes clear as he continues*:

> This holds also for [students] I would say. If we, if we take [students] as they really are, we make them worse. But, if we overestimate them . . . if we seem to be idealists and are overestimating, overrating [students] . . . you know what happens? We promote them to what they really can be. So, we have to be idealists in a way, because then we, we wind up as the true, the real, realists. And you know who has said this: "If we take [students] as they are, we make them worse, but if we take [students] as they should be, we make them capable of becoming what they can be"? This was not my flight instructor, this was not me, this was Goethe; he said this verbally. . . .

Frankl's and Goethe's precept—taking students as they should be and the inherent trust and faith at the core of doing so—too often seems to be lacking in our institutional practices in undergraduate medical education (UME). A recent editorial focused on trust in the relationship between teacher and learner[2]; in this essay, we will examine trust between administrators, course directors, curriculum committees, and medical students. We will explore the ways that a lack of trust is, at times, manifest; how this impacts students; and how we can build trust in UME. This Invited Commentary is informed by the experience of 1 author (S.S.) as an invited visiting professor to more than 25 medical schools in the last 3 years; the professional relationships built by the second author (G.S.) through a medical science educator organization; countless conversations we have had with students, faculty, and administrators; and finally, our experience over 13 years working together to create an environment of trust in 1 medical school.

The assertions we make may be viewed as being critical of administrators and course directors, but that is not our intent. Our descriptions are not meant to be all-encompassing; trusting and trustworthy leaders exist within the system, but, in our view, their opinions and views too rarely hold sway. In this essay, we seek to describe actions, not ascribe motive. The actions we have observed and describe were typically made with good intent. We believe that intent—and the accompanying goal of producing knowledgeable, competent, and trustworthy physicians—matches our own. The only question is how best to achieve that goal.

*To address the gender bias in Frankl's words and to make them more inclusive, we have substituted "students" for "man" and "them" for "him" in a way that we hope retains the spirit and intent of the original quote.

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Culture: Hierarchy, Paternalism, and Distrust

In medical education, curriculum and policy decisions made within a largely hierarchical and paternalistic culture tend to skew in the direction of distrust of students. Those on the upper rungs of hierarchies—in this case, administrators and course directors—often feel they know what is best for those on the lower rungs. Those on the lower rungs—the medical students—often feel their voices are discounted and dismissed. Distrust is at the core of hierarchical systems. Paternalistic systems mimic strict approaches to "parenting." Paralleling the actions of a strict father of a teen who breaks curfew, educational leaders often tighten existing rules, add new ones, and reduce flexibility in procedures and policies when faced with student misbehavior or anticipation of future misbehavior.

Manifestations and Impact of a Lack of Trust in Students

In part because of the influence of hierarchy and paternalism, medical students tend to be overscheduled and overprogrammed through much of the UME continuum.

The preclerkship years

In the preclerkship years, students often find themselves with days that are full to brimming with lectures, small-group sessions, skills training, and clinical preceptorships, not to mention the studying required to master the material. Students often receive inadequate elective and free time to pursue personal interests. The time pressure that students face has intensified as more schools move to shortened preclerkship curricula in which cuts in curricular weeks have not been matched by proportionate cuts in curricular content.

In addition to the problem of overscheduling, inflexible policies and procedures appear fairly common. In some schools or courses, students may be granted little accommodation for absences from exams or required teaching sessions for important life events, such as weddings, presentations at professional conferences, personal illness, anguish over a breakup of a long-term relationship, or the serious illness of a family member. Students may also become frustrated when a class is scheduled with mandatory attendance on the first day after a holiday break and nothing is provided in that session that could not have been acquired from a video recording.

At their core, the overscheduling of students and the inflexibility in policies and procedures seem influenced by a lack of trust by some administrators and curricular leaders that students will use their time wisely and make ethical and professional choices. We need to remember that medical students are *adults*; they average 26 years of age, and most of their peers have been in the workforce for half a decade. Many educational leaders speak of the importance of professional identity formation, but won't we be more likely to see this formation if we treat students with the respect and trust that their age, history of accomplishment, and human potential deserve?

The clerkship year

Distrust of students in the core clerkship year manifests differently than in the preclerkship years. On some clinical rotations, students may feel ignored by faculty and residents and yet may be required to remain in the clinical setting for extended periods of time even when little clinical activity is going on. Students rarely have time to pursue personal interests and meaning because of clinical demands and the time needed to prepare for end-of-clerkship exams. Some clerkships directors are also reluctant to grant days off for important life events, claiming that students should adjust to making personal sacrifices if they are going to be good doctors.

Across the continuum

Students we have talked to often feel that they are not listened to or respected by some administrators and course directors when asking for curricular or policy changes, particularly when advocating for reductions in workload. The 2018 Association of American Medical Colleges Graduation Questionnaire asked students to rate their satisfaction with the office of the dean of educational programs'/curricular affairs' awareness of student concerns and responsiveness to student problems. On a 5-point Likert scale from very satisfied to very dissatisfied, only 29.8% chose very satisfied.[3] Despite the presence of administrators and course directors who are strong student advocates, paternalistic and dismissive attitudes among administrators and curricular committee members appear commonplace, and the arguments of those with more hardline orientations and "we know best" beliefs often prevail.

In these debates, the fairly commonly used term "millennial learner" can signal a lack of faith and trust in students and can be used as an attack on student character. The negative connotations associated with this label are multiform and can frame students as entitled, demanding, needy, fragile, trophy-expecting, concerned with work–life balance (i.e., lazy), and obsessed with social media. When medical students raise concerns—usually reasonable—about the curriculum or a particular policy, faculty and administrators may dismiss discussion by resorting to this attack on character rather than engaging in meaningful discourse about the concern itself. Negative generalizations and stereotypes are uniformly found to be offensive with other social groups; why should they be appropriate to use with an age group?

Policies and procedures may vary by institution, but what too often unites them is a tendency to assume the worst and set policies aimed at the few who may be inclined to act unprofessionally. For example, some course directors or faculty may require students who miss a mandatory class or an exam to provide evidence that they were truthful about their excuse—if they were ill, producing a doctor's note (even though with influenza, for example, going to a doctor would be inappropriate), or bringing in a receipt from a towing service if they say their car broke down. These approaches often discourage and demean the vast majority of students who are trustworthy.

The collective impact of this lack of trust appears substantial, leaving many students with feelings of frustration, resentment, and cynicism. Distrust and its effects also likely contribute to the ongoing problem of poor mental health of medical students.

Students' Loss of Trust in Faculty and Administrators

The distrust in UME is bidirectional. One of us (S.S.), in meetings and informal conversations with students during visits to medical schools, found that significant numbers had lost some degree of trust in medical school leadership. Years of inaction or ineffective action by administrators in dealing with chronically problematic courses were often cited by students, most often manifest in the preclerkship curriculum by the inability to change the behavior of course directors who lead courses with excessive volume of

information and level of detail, often harsh grading practices, and, in some cases, large numbers of failing grades compared with other courses at the same school. Many of these course directors may be well meaning and feel they have high expectations for students and are upholding academic standards, but too often they mistakenly equate the volume of material taught and learned by students with intellectual rigor. Many also view failing large numbers of students as further evidence of the rigor of their courses when, in actuality, given the intelligence and work ethic of the vast majority of medical students, we believe this practice represents their own failure as educators rather than the students' failure. Problematic and toxic courses also exist in the clerkship year, usually manifest by faculty and/or resident mistreatment of students. Curricular deans and committees are often unable (because of inadequate status within the medical education hierarchy) or unwilling (for a multitude of reasons including conflict avoidance) to adequately address and ameliorate these problem courses.

Finally, students at many schools have also spoken to us of their worry that, if they raise too many concerns, faculty will view them as complainers and produce negative performance evaluations of them, and administrators will produce weaker medical student performance evaluations. Some feel it is wiser to not take that risk, to keep their heads down and remain silent rather than potentially jeopardize their competitiveness for residency.

Proposed Approaches to Build Trust

Administrators and faculty who are responsible for overseeing the curriculum and policies need to demonstrate respect, compassion, flexibility, and trust in students. Our experience in an educational system that took this approach was that professionalism lapses among students became less common—not more.

Efforts should be made to reduce overscheduling of students so that they have ample opportunity to pursue activities in which they can find purpose and meaning—whether in research, service, or other relevant areas, such as medical humanities and narrative medicine. Flexibility in scheduling and taking of exams should be introduced wherever possible so that students feel a greater sense of autonomy. Importantly, these efforts should not be viewed as "coddling of students" or "lowering of standards."

Trust is built on relationship. Medical school administrators should try to avoid isolating themselves from students and should engage in some teaching capacity if possible. We directed or codirected an average of 8 required courses that spanned all 4 curricular years, and we also led additional elective courses. In that context, relationships and trust were built that served us very well in our administrative roles. In the clinical years, clerkship directors should be given protected time to spend with students to strengthen relationships and trust with them.

We do not believe student recommendations for curricular changes should be followed if they are illogical, but students deserve an explanation regarding why desired actions are not taken rather than having their concerns summarily dismissed out of hand. Course directors or faculty who teach an excessive volume of material, who have unnecessarily harsh grading systems that are out of step with other courses, who are inappropriately and unprofessionally dismissive of student concerns, or who demean students should be counseled and given resources to change their behavior. If their behavior fails to adapt, they should not continue to be granted teaching privileges.

Finally, as administrators and faculty begin to demonstrate trust of and respect for students, the students themselves—who may well have lost *their own* trust in medical school leadership and faculty—will need to strive to make sure that their requests are not unreasonable or unrealistic and to have their hearts open enough for mutual trust to grow.

The strategies and institutional approaches to build trust described above cost no money at all and were successfully implemented—at least for a period of time—at 1 medical school with very positive academic and mental health outcomes.[4] We originally thought that these outcomes stemmed from a comprehensive student well-being initiative, but in retrospect, we believe that student well-being was built on a foundation of mutual trust and that the outcomes we achieved would not have been possible without it. That trust took time to flourish. In our experience, several years were needed for student trust in us to develop, and it then continued to grow. This development and growth required not just words of trust but also concrete actions—expanding elective and free time, reducing curricular overload, and creating more flexibility in policies—that demonstrated our trust and belief in our students.

In Closing

We believe that the critically important goal of producing outstanding, trustworthy physicians is most likely to be achieved through the approaches and strategies described above. The barriers to change in culture are strong, but we have found that they can yield to persistence and commitment.

If we take medical students as they should be, if we give them the trust, space, time, and support to develop as professionals and as people, we will help them become the doctors "they are, in principle, capable of becoming."[1] And in that process, our own lives as faculty, course directors, and administrators will be enriched immeasurably. To do otherwise seems unimaginable.

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Teaching and Learning Moments
Lost to Follow-up

My high school English teacher used to mark up any assignment that relied too heavily on the passive voice. I often took umbrage, and likely still would if she graded my clinical notes these days because every few weeks I find myself typing out the phrase "The patient was lost to follow-up."

As I began my final year of medical school, a chance encounter with a more recent educator offered a remedial lesson to improve both my diction and my clinical practice.

Jaime was in his late 40s when he suffered an unprovoked venous thromboembolism, leading to bilateral pulmonary emboli and his first-ever hospitalization. I met him at his follow-up hematology visit, where he described the events of the previous summer as the scariest days of his life. In addition to reinforcing my understanding of Virchow's triad, caring for Jaime would teach me why physicians' commitments to our patients cannot end at the clinic door.

At the end of the appointment, our team recommended that Jaime continue the direct oral anticoagulant that he had been taking—indefinitely, in fact. I soon transitioned to another rotation but looked up his chart after the date of his next clinic visit to see that he had canceled it. I didn't make much of this, assuming that Jaime would reschedule.

Fifteen months later, I walked out of the same building and hastily took out my phone to request a ride. An Uber driver pulled right up, and as he began to skillfully navigate Boston's tortuous rush-hour streets, I asked how his day had been going.

"Honestly, not great," he said. From his tone, I believed him. "You just can't get ahead in this job. And with all this sitting in the car, I keep worrying that I'm going to get another blood clot."

I looked at the rearview mirror and caught the driver's eye. It was, of course, Jaime, and I reintroduced myself. After a flash of recognition, he shared his story.

Shortly after our first meeting, Jaime lost his job and his insurance. Proud and independent, he sought new work while purchasing his rivaroxaban out of pocket for as long as he could. He attempted to self-enroll in Medicaid but gave up after learning of an application fee and canceled his appointment due to fear of co-payments.

As the job search dragged on, he started driving for Uber, but those earnings barely covered expenses, and he described impossible choices between meeting basic needs and investing in his health. Jaime hadn't taken a dose of anticoagulant medication in more than 6 months. He felt trapped.

"The patient was lost to follow-up," I might have documented in his record had I been seated at my hospital workstation. Although Jaime still had every intention of trying to reengage in care, his efforts to do so came to feel more and more like navigating a maze, with new structural barriers at every turn.

My intervention, enabled only by luck, was a small one. I validated his frustrations and reassured him that his doctors would not allow co-payments to keep him from essential care. With his permission, I reconnected him with his care team, and one phone call with a practice social worker would set Jaime on his way to regaining health insurance, with his coagulation cascade dammed up once again.

There is plenty of discussion these days about the need to ensure that doctors are practicing at the top of our licenses, yet ordering an Uber that day may have been the single most useful thing I did for a patient during my final year of medical school.

Jaime taught me that missed visits are important data points, rather than the lack thereof. They suggest that a patient could be struggling to contend with poverty, housing insecurity, immigration status concerns, domestic violence, immobility, untreated mental illness, or prior experiences facing racism when seeking care. While these forces may not be visible through the electronic medical record, they pose powerful threats to good health. Their effects warrant prompt diagnosis and an effective assessment and plan.

In addition to his eponymous triad, Virchow also wrote that "physicians are the natural attorneys of the poor, and social problems fall largely within their jurisdiction."[1] The next time one of my patients misses an appointment, I hope I'll pick up the phone and follow up.

Author's Note: The name and identifying information in this essay have been changed to protect the identity of the individual described.

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