Virtual Mentor

ETHICS CASE
Advising the "Gunner": The Student with Noncognitive Learning Difficulties
Commentary by Kimberly A. Kilby, MD, MPH

You're barely one sip into your first cup of coffee of the day when the administrative assistant drops it on the desk with a thud: the looming stack of clerkship evaluations. It is going to be a very long day. When you became clerkship director of surgery, you expected the worst part of your job to be dealing with arrogant attending physicians. Little did you know that reviewing resident notes about medical students would be the bane of every rotation. The first file in the stack is flagged with a bright red sticky note. You grumble to yourself, knowing exactly what that means. You open the file.

Melanie, a third-year medical student, is currently in the middle of her surgery clerkship. You recall the chief resident saying she was "brilliantly talented" in a department meeting last week, a "future pioneering vascular surgeon, for sure." Perusing the scribbled notes, you see that one resident reports that Melanie is an "anatomy expert" in the operating room during every procedure and "knows exactly how long to cut sutures." An attending note states: "the most efficient presenter of patients I have ever known." There is even a note from a patient: "Melanie was considerate, compassionate, and went out of her way to make sure all of our questions were answered, even when other students and doctors couldn't answer them for us."

Puzzled, you wonder why this file had the infamous red note.

As you thumb through the file, you find one note from a resident: "intense, rubs me the wrong way, doesn't seem to know when to stop asking questions." Another resident note calls Melanie a "gunner" with the "typical gunner problem of being almost unprofessional." You start to find more negative notes, including one from an attending who was approached by Melanie's clerkmates, saying that Melanie's competitiveness made him and other students uncomfortable. According to that anecdotal report, Melanie subtly interrupts her peers to answer pimp questions and aggressively asks questions in front of students *and* residents to demonstrate her knowledge. Even in front of patients, she is continually competing with others to be the best. Another student reported that Melanie clearly treated the others as inferior students with her condescending demeanor and her hypercompetitive attitude. She was a gunner and her behavior was unprofessional, the student concludes.

As you spread all the notes out on your desk, you cannot find a description of a specific incident in which Melanie clearly stepped out of line to mistreat her fellow

students. The opinions on Melanie vary widely. On one hand, some of her colleagues feel attacked and mistreated by her. On the other, she is an excellent student with keen bedside manner and a promising career in surgery.

Commentary
This case addresses how medical educators should respond, if at all, to students like Melanie who present with behaviors representative of the "gunner." "Gunner" is a slang term describing medical students who are so competitive and driven to succeed that they exhibit unprofessional behaviors toward their peers intended to make themselves appear smarter [1].

In the Association of American Medical College's Medical School Graduation Questionnaire taken by graduating fourth-year medical students, the proportion of students who cited mistreatment from a fellow student was 14.6 percent in 2011 and decreased to around 6 percent in 2012 and 2013 [2-4]. In their commentary, medical students (at the time of writing) Brainard and Brislen proposed some possible reasons why students engage in unprofessional behavior [5]. They asserted that students are forced to bend their existing ethical principles in order to survive in the learning environment, adopting the explicit as well as the implied rules of the medical education hierarchy. They posit that "students become 'professional' and 'ethical' chameleons because it is the only way to navigate the minefield of an unprofessional medical school or hospital culture" [5]. In Melanie's case, several classmates have brought forth concerns about "gunner" behavior, and the clerkship director is obligated to act.

The Role of the Clerkship Director
Clerkship directors are responsible for defining the expectations for students on the clerkship and facilitating the clinical learning environments that will optimally support meeting those expectations [6]. They often must depend on evaluations provided by their faculty peers and more junior faculty to assess each student adequately. Frequent communication is an important avenue for assessing each student in the clerkship and gathering information about the dynamic of the clerkship group. A clerkship director who is open and respectful of students is far more likely to be approached with information from students that may not be obvious from the faculty or resident evaluations of a student. Students need to know that they are free to bring concerns of any type to their clerkship director and that those concerns will be accepted, respected, and appropriately addressed.

Part of the clerkship director's responsibility is to follow up on all less-than-favorable evaluations, whether they are given formally or informally. Optimally, this should be accomplished using formative feedback midway through the rotation, rather than right before the end because this allows learners sufficient time to take corrective action or redirect their behavior before any summative feedback [7].

The Difficult Student
Having a well-thought-out and -defined plan for how students are assessed is especially critical when the clerkship director is presented with a difficult student. These situations can consume a large amount of a clerkship director's time and can be draining, often diverting resources from the rest of the student group [6]. There is no doubt that Melanie is a difficult student and poses a problem for the surgery clerkship director. However, I would argue that Melanie's unprofessional and disrespectful behaviors toward her peers, regardless of setting, should not be framed by labeling her a "gunner"—using slang terms can imply a tacit acceptance of this dysfunctional behavior—but rather should be viewed as a "noncognitive difficulty," an educational concern that deserves attention [8].

These are perhaps the most challenging of the difficulties students may demonstrate. Pure cognitive difficulties, such as inadequate clinical reasoning, lack of organization, lack of clinical efficiency, and poor knowledge base can often be easier for the clerkship director to address because the supporting data and paths of intervention and re-assessment are clearer.

In Melanie's case, the clerkship director should begin by gathering more information about the situation, discussing the concerns with the students and residents who raised them to make clear they are being heard and probe the degree of the problem. As time-consuming as this may be, it is important to gather all firsthand information relevant to the situation prior to addressing Melanie directly, so the clerkship director understands all aspects of the issue and is prepared to address them with her [8].

Applying the "SOAP" framework to learning situations, as suggested by Langlois and Thach, offers a nice approach to discussing such evaluations with their subject because it not only allows feedback to be given to the learner but also entails a plan for corrective action [9]. The framework recommends:
> **S**ubjective: Use your experience and opinion to gain an individualized impression of the student's difficulty.
> **O**bjective: Document specific examples of the problem.
> **A**ssessment: Diagnose the problem.
> **P**lan: Develop and implement a plan to address the problem [9].

The development of a plan for a behavioral concern can be a bit more challenging than it is for academic shortcomings. The clerkship director may consider some well-known behavioral change strategies employed with patients, such as the transtheoretical model of change, to assess Melanie's understanding of her own behaviors [10]. Doing so ensures that the planned intervention is appropriate. The clerkship director is unlikely to change Melanie's attitudes and beliefs, or even what ultimately motivates her, so he can and should focus on Melanie's behaviors [8]. Taking behavioral change theories into consideration also acknowledges that behavior change is difficult and does not occur overnight but takes practice and time. When communicated in such language, this should allow the learner to feel safer in

accepting and looking at the process not as a punishment but as mentorship and an opportunity to grow as a physician.

The most challenging situation would be one in which Melanie's reaction reveals she has little to no insight into the way she is perceived by her fellow learners. In this case, the intervention must start by opening her eyes to her behaviors and their repercussions, making clear that this behavior, if unchanged, will negatively affect evaluations. For example, the clerkship director may have Melanie try to "walk through" the possible consequences of her actions [8]. In these instances, it is critically important to document the advisement given to Melanie and alert the appropriate education faculty to the situation so they can monitor Melanie's behaviors on subsequent clerkship rotations.

Strategies for Reducing Noncognitive Difficulties
360-degree evaluation. 360-degree evaluation tools, long used in the business world, involve comparing self-evaluations to those of people above, people below, and peers of the evaluee. A version for medical learners was developed by a group of radiation oncology program directors [11]. It has been used increasingly in medicine over the past decade but is not necessarily widespread because it is labor-intensive and difficult to carry out in a timely fashion [12]. It is underutilized in undergraduate medical education most likely because of the relatively short time students spend in any one clinical learning environment.

If formal 360-degree evaluation—including both peer and self-evaluation—was the standard at the medical school or on the clerkships, the groundwork would already be in place for a more productive, open, and honest discussion with Melanie and would probably increase her acceptance of such feedback. If the system has made it clear from the very first day of medical school that learners will continually be assessed by their peers and that those assessments will matter to those who evaluate them formally, perhaps many of the competitive and self-promoting behaviors that arise in the clinical years could be prevented. Peer and self-evaluation are infrequently performed in most educational settings, and they would add much.

Peer evaluations seem to be less objective for colleagues with close personal ties, and may create a strong reaction when the student performing the evaluation is directly affected by a peer student's behavior [13]. But they tend to reflect extenuating circumstances, such as the impact of a resident's competency level on the student's growth and development, better than faculty evaluations [13, 14]. Self-evaluations often conflict with the evaluations of teachers and other team members; they are best used in a formative capacity to allow the students to compare their own assessments of their performance to the summative assessments they receive. This helps them develop the skill of self-evaluation to inform their own lifelong learning habits [13].

Curricular and cultural changes. Clerkship directors must assess the climate of professionalism in all of the clerkship environments and work with their faculty to

ensure it is conducive to students' internalizing desirable behaviors [15]. Cooperation with department chairs and residency program directors, who have the power to take punitive action when necessary [16], will send a consistent message that bad behavior by faculty will not be tolerated anywhere.

Clerkship directors should include professionalism in their formal learning objectives, communicate them to students at the start of the rotation, specify how professionalism will be defined and assessed, and make clear the ramifications of not meeting the objectives [15]. And, when it comes time to hand out grades, educators must hold firm to their standards. That way, students will understand that clinical knowledge and professionalism are being given equal weight.

Admissions. There is no national consensus about the qualities that make successful physicians. However, most organizations and academic medical schools agree on the importance of themes such as "compassion, coping capabilities, decision making, interprofessional relations, realistic self-appraisal, sensitivity in interpersonal relations, and staying power—physical and motivational" [17]. The wider adoption among American medical schools of the Multiple Mini Interview (MMI) process—in which students are rated on responses to hypothetical situations by a variety of interviewers, rather than on self-descriptions by one or two interviewers—indicates that more and more medical schools are prioritizing noncognitive factors when deciding which students to admit [18, 19]. The MMI has been shown to offer more information about the noncognitive qualities valued in students who will ultimately become physicians, and such techniques may be our most vital tool to help combat some of the less favorable behavioral tendencies and enroll more empathetic, humanistic, and kinder students in medical school from the outset [20]. In theory, this should produce a population of students who interact more respectfully with one another, if those values are properly reinforced in the curriculum.

Conclusion

One of the greatest challenges for clerkship directors is addressing the student who exhibits unfavorable behaviors toward anyone, including his or her peers. It is critical to take a thorough approach in investigating and addressing the student's behaviors directly and provide them the feedback as early in the clerkship as possible. Behavioral change theories such as those used to counsel patients may prove useful. Documenting advice and feeding information forward to academic administration allows clerkship directors to fulfill their responsibilities to the educational mission of their institution.

Working together with all levels of health care professionals has become the standard of care for the health care system. Being open to how we are perceived by others is extremely important to our professional development. There is skill in developing openness to feedback of all kinds, and not clinging too tightly to only the very good feedback, but accepting feedback in all its forms. This is something that all physicians should continue to practice and that students must learn early in their medical education.

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