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For better or worse: role models for New Zealand house officers

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Abstract

Role modelling is considered an important influence on emerging professional identity. However as a process it goes largely uninspected. In an effort to develop greater awareness of this important process, this study examines the positive and negative role modelling experiences of New Zealand house officers.

The Medical Council of New Zealand (MCNZ) Intern Handbook is distributed to senior clinicians who supervise house officers. It outlines the desired characteristics and influence of role models in New Zealand.

A growing body of academic literature suggests that role models are inescapable mediators of medical socialisation and professional development.[1–7] Research indicates their influence over specialty selection,[8–10] ethics,[10,11] professionalism,[12] and the patient-doctor relationship.[13,14] Theorists suggest that these influences can be moderated by awareness of role modelling process.[15] It is unclear whether the importance of role modelling is as well recognised in the wards where it occurs.

This research was conducted to establish the nature of role modelling experiences for New Zealand house officers over the last decades to the present day. Retrospective accounts were provided by current general practitioners, which limits generalisability to other specialties. However, details of contemporary role modelling were provided by PGY1 and PGY2 doctors without speciality bias.

Examining these formative working years is important; house surgery represents the first time that many young doctors have been outside formal, full-time education, and may be marked by a loss of the structure and support associated with the student years. The experiences of junior doctors are also an important barometer of the professional and medical culture in New Zealand hospitals.

Methods

In November 2004, interviews were held with a convenience sample of six male and six female general practitioners (GPs) from the urban Dunedin area who completed their house surgery years in New Zealand and were provisionally registered at least ten years ago (Group 1).[16]

GPs are in an ideal position to reflect on their house office years with limited subsequent exposure to hospital culture. After training and a practise interview with the second author, the medical student first author conducted the interviews. The semi-structured interview, lasting about half an hour, was conducted in person at practice rooms around the city. The interviews began with the volunteers providing an example of ‘an experience, person or incident’ that they considered represented positive, and then negative, role modelling during their house officer years.

The third part of the interview covered reflection and consciousness of role modelling during and after the events. In December 2005 a convenience sample of 3 male, and 10 female, current house officers at Dunedin Public Hospital (Group 2) participated in interviews using the same probes.[17] These participants were PGY1 and PGY2 doctors with standard house officer rotations in medicine, surgery, and specialties.

The interviews were held in person, most at the Dunedin Public Hospital while the house officers were on duty. In general, the second round of interviews was shorter and slightly less structured than the first. All interviews were taped, independently transcribed, and underwent multiple readings by the first author to identify key themes. These themes, and samples from the transcripts, were regularly discussed with the second author throughout coding and analysis. 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

Identity of role models

Participants were initially asked to identify a person or incident which they considered an instance of positive role modelling. Senior teaching clinicians, specifically registrars and consultants, were the vast majority of positive models. A small number of participants also identified nurses, and and/or their peers, as positive role models. Most volunteers identified a number of positive role models, although group two seemed more aware of having multiple models.

In the second part of the interview, participants were asked to describe a negative role model. Volunteers from Group 1 generally identified consultants as negative models. Participants from Group 2 seemed reluctant to clearly identify individuals that they did not want to emulate. Instead, they spoke about broad categories—superiors, consultants, and supervisors—not single clinicians. When the information was volunteered, consultants and registrars were the most frequent negative role models.

Characteristics of role models

Analysis revealed three relationships which house officers in this study seem to use for identifying role models:

- Relationship between house officer and their role model;
- Relationship between role model and patients; and
- Relationship between role model and medicine

Relationship between house officer and role model—Participants from both groups identified supportiveness as the most important trait of their positive role models. They also described senior clinicians who were ‘nice’, generous with their time, engaging, patient, accessible for questions, and easy to work with..

> His manner was kind and warm and uncritical and he was always very approachable, always very very helpful, never made you feel as a learning house surgeon as though you were stupid or you made a foolish error (Group 1, 1)

Poor support, or poor communication, typified the relationship with senior clinicians who were negative role models. The incidents reported by Group 1 participants were generally more serious.

> I had to ring someone at home one night and they were just really horrible and unhelpful and I just sort of found that quite negative (Group 2, 3)

> …I rang him up about a baby who had been sent in and I started doing the presentation as I’d been taught to do and he sort of interrupted me and said ‘What the f--k are you telling me this for?’ That is something that certainly stuck in my mind (Group 1, 2)

Relationship between role model and patients—Senior clinicians who demonstrated a good relationship with their patients were widely admired by participants from both groups. These doctors were described as being compassionate, caring, and engaging.

> He was a registrar and he was just really good with patients…he always used their name, always made a joke, or would take their hand, or he might just pop his hand on their knee or leg, or something, so he made patient contact really well. He really engaged the patient. (Group 2, 9)

Negative role models who had poor relationships with patients were described as uncaring and disinterested. Interviewees expressed frustration, anger, and disbelief at the treatment of some patients. A significant number of participants in Group 2 described their attempts to make up for poor communication by their consultants.

> … if my consultant had gone around in the morning and was being really rude to the patients, then I would often go back and clarify what was going on for patients… often they didn't realise what was happening, or understand what the consultant was saying (Group 2, 2)

> I do find myself as a house surgeon going back and doing a second ward round sometimes…and actually going through things [explanations to patients] in a bit more depth and detail (Group 2, 5)

Relationship between role model and medicine—Several participants described and admired their positive role models for enjoying their job or having maintained interests outside medicine. Recent graduates in Group 2 seemed particularly reassured that positive role models had retained an enthusiasm for medicine.

> …it can be done. They're happy. (Group 2, 1)

Contrastingly, doctors who were bitter or cynical in their relationship with medicine were identified as negative role models by both groups, particularly Group 1.

> I think in hindsight definitely the registrars and consultants I didn't like were basically the people who didn't enjoy the job and you did sort of wonder why they were in medicine actually (Group 1, 10)

Role models also demonstrated a relationship with their specialty. Participants from both groups felt that role models had been influential in their thinking about specialty selection, mainly in a negative sense.

> He was vitriolic of them in his condemnation of [the] GP and always about, you know, the crap and the dross that was referred…and why was this patient in, and why was that patient in…and stupid GP didn't see this, and stupid GP didn't notice that. And that was enormously destructive (Group 1, 1)

Invariably, surgery was identified as a specialty with many negative role models. Some participants described choosing runs to work with consultants they liked and avoiding supervisors who were difficult to work for. This may bias graduates towards experiences in certain specialties.

Consciousness—Most interviewees said that they were aware whether other clinicians were 'good' or 'bad' while watching them on rounds. The vast majority of Group 1 participants could discuss who, why, and how they had been influenced by their interaction with senior doctors. They described a superficial awareness of role models during their house officer years, but growing reflection and consciousness over time.

> But when you think back from… however many years later I am now, 12 or 13, I guess…I do remember individuals and they do start to stick out as a sort of positive role model (Group 1, 10)

In contrast, current house officers found it more difficult to single out individual doctors who had influenced them. They tended to identify a wide range of positive and negative models who had helped to shape their professional style.

Both groups confirmed that house officers talk about their colleagues and senior clinicians. These discussions rarely focused on the clinician as a role model. Instead, house officers shared information about the idiosyncrasies of senior clinicians, or informally debriefed after negative experiences.

A significant number of participants in Group 1 provided unprompted explanation for poor behaviour by negative models. They cited external stress, exhaustion, bureaucracy, and family pressures as factors contributing to unprofessional behaviour by their superiors.

> Looking back you can see that I am…perhaps a bit sort of softer on them than I perhaps was sometimes at the time…just because you understand that they were probably under a lot of stress from all sorts of different things and perhaps were completely unaware of this house surgeon (Group 1, 4)

In contrast, participants from Group 2 made only very rudimentary attempts to explain or understand the behaviour of their negative role models. They occasionally identified that negative models were very busy or stressed, but were less sympathetic to these demands than Group 1.

Discussion

The basic characteristics of positive role models have been described by a number of studies: clinical excellence, good teaching, compassion, focus on the patient-doctor relationship, and certain elements of personality. However it is an oversimplification to consider these traits as the sole criterion for professional excellence. It is rare for students and junior staff to have global role models who represent the endpoint of all their professional aspirations.[18] Rather, role modelling is an interactional, transactional process which occurs simultaneously with multiple models and changes over time.[7,10,19] How young doctors interact with their role models is better served by examining relationships than lists of adjectives.

The interviews revealed three broad relationships that house officers consider important for identifying their role models: the relationship between house officer and the model; the model's relationship with patients; and the model's relationship with medicine. Clinical skills are excluded from this discussion because they are generally a poor demarcation between positive and negative role models.

Relationship between house officer and role model—Senior clinicians who were supportive towards junior staff were most often elevated to role model status. Elements of supportiveness have been described in other studies; senior clinicians who spend non-essential time with house officers, make an effort to build relationships with them, and have a positive attitude towards junior staff are most likely to be considered positive role models.[10,20]

Being supportive transcends the boundaries of positive role modelling, encompassing good teaching, and good supervision. In contrast, negative role models had poor relationships with house officers from both groups. Participants described senior clinicians who were terse when called for clinical advice, unreasonable in their expectations, and unsupportive of junior staff. Negative interactions with senior staff

have been identified as one of the most memorable, stressful, and influential experiences for junior doctors.[21–24] Although gross examples of student abuse may be becoming less common, it seems that a cycle of poor relationships between senior doctors and their junior staff still exists.

Relationship between patients and role model—Consultants who made time to give thorough explanations or provide reassurance to patients were singled out as role models. Participants from Group 2, who have been more exposed to the principles of biopsychosocial medicine, were particularly appreciative of this.

The importance of the patient-doctor relationship is widely reported in literature on role model selection. Negative role models who display poor patient-doctor relationships are an unfortunate constant for junior staff.[25]

In our study, negative role models who communicated poorly with patients were discussed by both groups. However, only participants of Group 2 described 'fixing' the communication of senior doctors after ward rounds. Completing a second ward round to clarify the communication of consultants is a significant investment of time for a house officer. It is heartening to think that junior doctors are taking positive action to address perceived deficiencies; however there are questions about the appropriateness and efficacy of this practice. Junior staff may lack the experience, knowledge, and insight, to undertake all the intricacies of communicating clinical issues. Learners need to observe excellent consultants display the subtleties of the patient-doctor relationship to fully develop their own skills. Understanding why young doctors seem to be taking on additional responsibility to compensate for the perceived inadequacies of their seniors should be carefully examined in a dedicated study.

Relationship between role model and medicine—Young doctors need reassurance that medicine is challenging, manageable, and satisfying. These needs are probably greatest in the midst of the high stress PGY1 year when house officers are vulnerable to doubts about their clinical abilities and career choices.

Participants from both groups identified positive role models who were enthusiastic about medicine. Participants from Group 2 also admired senior clinicians who had maintained outside interests and demonstrated a work/life balance. This probably represents a wider generational shift towards career flexibility. Negative role models who had become cynical, disillusioned, weary, or bored with medicine were also identified.

A poor relationship with medicine is thought to be an area of considerable unconscious influence of role models. This may contribute to the well documented decrease in idealism during student and early clinical years.[6]

Specialty selection is an important issue for house officers and is consciously and unconsciously influenced by role modelling. Volunteers were conscious of the explicit, personal advice which they had received from mentors or active role models. They also identified clinicians whose behaviour and attitudes had made their specialty unappealing. Some also referred to the influence of casual comments or remarks they had overheard during training.

This 'badmouthing' of specialties, by potential role models, is exceptionally common in medical school and can seriously undermine learners' confidence in their career

choices.[6,26] A yet more subtle influence occurs when students and house officers choose runs based on which consultants are 'nice to work with'. Biased run selection can limit exposure to an entire field based on negative behavior by a single senior clinician.

The number and constancy of subtle messages about a given specialty—especially the surgical specialties—could be expected to have a significant influence on house officers. Analysis of these interviews indicates that this continues to be the case for modern house officers.

Consciousness—There is significant misalignment between the qualities learners profess to admire, and the characteristics they ultimately develop. Junior doctors describe aspiring to professional ideals of compassion, idealism, and humanism, yet research reliably indicates that students and young doctors become progressively less compassionate, idealistic, humanistic and empathetic during their training.[24,27]

This change is clearly multifactorial but role models almost certainly play a part. It is possible that if junior staff were conscious of this paradox they would be better equipped to deal with the myriad negative influences which shunt them away from their stated ideal. It makes sense that students and house officers who can analyse the behaviour of role models are most likely to benefit from their interactions.

Being conscious of role modelling allows medical learners to selectively integrate multiple models, and facilitates reflection. This process can reduce the impact of negative role models, and strengthens the influence of positive models. In the absence of understanding and appreciation of role modelling, young doctors passively absorb a multitude of mixed messages about medicine, patients, communication, and professional values.[15,28]

A spectrum of role model consciousness was revealed during these interviews. All participants could recall encounters which they considered to be role modelling. Some volunteers displayed deeper insight and went on to discuss role modelling as an active process, occurring simultaneously with multiple models. A few identified that most of their colleagues had been influential in forming their professional style and identity.

For others, role modelling was a novel concept which they had not really considered prior to these interviews. Awareness of multiple models was more apparent in Group 2; this was reflected in their tendency to be vague when identifying or describing single individuals as role models.

Personal reflection on role models and professional socialization was generally limited. Some of the current house officers from Group 2 referred to formal team debriefings after traumatic cases; they valued these forays into a formal reflective process. A few participants described mulling over the events of their day. Most indicated that these thoughts were an effort to check that everything had been done, and elements of clinical care had not been overlooked.

Volunteers generally indicated that surviving the house surgery experience was a much higher priority than thinking about examples of good practice. Time and subsequent general practice training seemed to have increased the reflective abilities of participants from Group 1.

Self-reported discussions between house officers were also heavily influenced by the time and role demands of house surgery. Conversations were generally focused on

sharing practical information, or tips about working with a given consultant. Some discussions with peers also serve as an informal debrief after difficult events.

Discussing negative role models is generally more emotive than analytical; although recounting a story about what happened on the wards does force learners to identify and articulate their experiences. Participants from both groups consistently alluded to the time pressure and clinical demands which superseded discussion of role models.

In place of constructive, reflective analysis, it seems that past and present house officers rely on informal storytelling to peers and friends as a way of coping with the stresses of their role. This should be an area of consideration, and possible concern, in terms of the wellbeing of junior doctors.

Inter-group analysis—Decades of difference in age and experience between the two groups were evident but not overwhelming. Participants from Group 1 were distinguished by their greater life experience; they referred to overseas examples, personal research interests, empathy with consultants, and were generally more opinionated. This group also expressed a general view that the house surgery experience has changed and is now less traumatic. There was little evidence that this was the case.

A significant area of distinction was the willingness of Group 1 to explain, justify, or excuse, the behaviour of negative role models. This was an unexpected outcome with a number of potential explanations. One previous study has suggested that students become less critical of faculty as they gain experience.[29]

Alternately, their progression through the medical hierarchy may have provided insight into the pressures experienced by their role models. This 'insight' may be compounded by an alarming normalization of poor behaviour as house officers progress through medicine. Some participants identified that their general practice training had emphasised reflective skills; it is possible that their reflective development enhanced their empathy with role models.

Maturity and medical experience probably also influenced the recall of the general practitioners. These elements may explain why current house officers in Group 2 made little comment about the context of negative role modelling.

Volunteers from Group 2 seemed somewhat muted in comparison to Group 1; their interviews were considerably shorter and they were understandably more self absorbed by their own experiences. Participants who had had other careers before medicine and those who had been involved in student medico political activities were exceptions and displayed a wider perspective in their interviews.

Group 2 participants were more likely to want to 'fix' inadequate communication by their supervisors and were more focused on models with an effective work/life balance. Participants from Group 2 also indirectly displayed a greater awareness of the socialization process; they stressed that they had multiple models who they emulated to create their own personal style. It is difficult to know whether this indicates a genuine awareness of role modelling, or simply an inability to be definitive about the people and qualities that they admire.

Conclusion

This study adds to our understanding of role modelling for house officers in the New Zealand health system. It demonstrates the importance of providing multiple models who excel clinically and in the three relationship domains that house officers use to identify role models. Awareness, understanding, and reflection on role modelling was variable in both groups. However, the majority of participants had a limited appreciation of the influence of role models.

Methodological weaknesses stem from recall bias, potential gender selection bias in Group 2, geographic bias, and the single specialty represented in Group 1. However, qualitative analysis revealed consistent key themes, and correlates well with other research in role modelling.

A recent paper from the *New Zealand Medical Journal* calls for district health boards to take increased responsibility for providing mentorship for resident doctors.[30] A mentoring program for house officers began recently at Dunedin Public Hospital. This increasing awareness and support of mentoring is to be applauded. However, even the most talented of mentors can not hope to single-handedly outweigh the incidental influence of other clinicians.

Improving the learning environment for junior staff requires attention to both mentoring and to role modelling. If students and junior staff could have a greater understanding of socialisation, role modelling, and mentoring then they would be more equipped to analyse, and benefit, from the interactions they have with professional colleagues. Clearly this increased awareness needs to be parallel in senior clinicians.

All members of clinical teams need to view themselves as role models and appreciate the impact and influence they have on young doctors. Excellence in teaching, role modelling, and mentoring must be rewarded alongside research and clinical excellence as criteria for recruitment and promotion.

The values, skills, attitudes, and behaviours which role models imbue in learners are some of the most important elements of clinical training. Although this is increasingly recognised by medical councils and educators, it is not yet common knowledge in wards where role modelling occurs.

Addressing this lack of awareness should be a primary consideration in order to improve the teaching, socialisation, and professional development of junior staff in New Zealand hospitals.

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