Fitness-to-practise policies in Australian medical schools — are they fit for purpose?

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ABSTRACT

Objectives: To describe current use and possible effects of Australian medical school fitness-to-practise policies (FTPPs), and to define and benchmark FTPP best practice.

Design, setting and participants: A questionnaire-based study of Australian medical schools was conducted in August 2009.

Main outcome measures: Use of FTPPs by medical schools; criteria used in FTPPs; remediation processes; numbers of students excluded for professional misconduct, reasons for exclusion, and year of study at time of exclusion.

Results: The questionnaire was completed by 15 of 19 medical schools to which it was sent, and 12 schools reported using an FTPP. There was wide variation in the FTPP criteria used by individual schools, and use of an FTPP appeared to be independent of medical student registration with state medical boards and type of course entry. There were no apparent differences in medical student exclusion rates between schools with FTPPs and those without. The most common reason for exclusion was persistent inappropriate attitude or behaviour, including poor attendance, and most exclusions occurred by the third year of study.

Conclusions: Most Australian medical schools use FTPPs, but these policies are variable and lack proven effectiveness. The variations in the numbers of students excluded by the different medical schools for unprofessional behaviour suggest discrepancies in the medical schools' abilities to detect and manage students with problems in this area. Previous calls to develop a nationally consistent approach to the management of poorly behaving students should be addressed.

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Students of medicine, unlike those of any other discipline, have certain privileges and responsibilities which necessitate different standards of conduct, behaviour and professionalism.[1] In academia, this presents a challenge as it raises the question of whether the rules governing students in other degree courses are sufficient to ensure that medical students have appropriate safeguards to protect both patients and the students themselves. It has been noted that "there is a strong consensus that medical schools must deal effectively with clearly identified extreme cases of poor professional behaviour".[1] This raises questions about how we define poor professional behaviour, how we assess it, and what processes are in place in medical schools to deal with these issues.[1,2]

Fitness to practise has been defined as encompassing clinical competence, acceptable professional behaviour, and freedom from impairment.[2] Given that there is debate about the definition and assessment of these areas in postgraduate education,[3] it is not surprising that there is a range of opinions on how to manage these areas in medical student education.[1-4]

Fitness-to-practise policies (FTPPs) are being increasingly used to address issues of unprofessional medical student conduct and behaviour. We performed an Australia-wide questionnaire-based study on the uptake and effectiveness of FTPPs, as these policies have not been evaluated on a national level before. We aimed to obtain an accurate picture of the current use of FTPPs, identify factors that might affect policies in Australian medical schools, and collect baseline data for future comparisons. We also aimed to define and benchmark FTPP best practice in Australian medical schools.

METHODS

A review of the national and international literature to define best practice regarding FTPPs for medical students found that the only country with national guidelines on medical student professional conduct was the United Kingdom.[5] Our survey questionnaire (available from the authors on request) consisted of sections on medical school demographics, FTPPs, remediation processes, and exclusion of students. It specified key areas of professional conduct and behaviour to reflect best practice in FTPPs, based on eight categories of concern outlined in the UK General Medical Council guidelines (Box 1).[5]

Details of currently accredited Australian medical schools were obtained from the Australian Medical Council website, and individual university websites were checked for information on their FTPPs or professionalism policies. It was apparent from the university websites that the people responsible for coordinating professional practice in each medical school have variable titles. As such, we selected the deans as the most appropriate staff members to coordinate the distribution of the questionnaire within their schools, as they were in a position to have access to the information requested or to know which member of staff would be privy to this.

The questionnaire was sent to the deans of the 19 Australian medical schools in August 2009, with a covering letter explaining the aims and methods of the study. All documents were standardised and anonymous. To maximise response rates, reminder letters and emails were sent 2 and 4 weeks later.

Descriptive analysis of the data was used to identify any apparent associations between medical school demographics, use of FTPPs (or lack thereof), remediation processes and numbers of medical students excluded. Formal statistical tests were not used because of the small numbers in the survey.

Ethics approval for the survey was provided by the University of Western Australia Human Research Ethics Committee.

RESULTS

Completed questionnaires were returned by 15 of the 19 medical schools that were contacted. The anomymised questionnaires were coded with a letter (A–O) to aid comparisons between medical schools.

Medical school demographics

Three medical schools offered programs for undergraduate and postgraduate students, seven offered a postgraduate program only, and five offered an undergraduate program

1 Categories and examples of concern relating to medical student fitness to practise*

Criminal conviction or caution

Child pornography; theft; financial fraud; possession of illegal substances; child abuse or any other abuse; physical violence

Drug or alcohol misuse

Drunk driving; alcohol consumption that affects clinical work or work environment; dealing, possessing or using drugs, even if there are no legal proceedings

Aggressive, violent or threatening behaviour

Assault; physical violence; bullying; abuse

Persistent inappropriate attitude or behaviour

Uncommitted to work; neglect of administrative tasks; poor time management; non-attendance

Cheating or plagiarising

Cheating in examinations; passing off others' work as one's own

Dishonesty or fraud, including dishonesty outside the professional role

Falsifying research; financial fraud; fraudulent curricula vitae or other documents

Unprofessional behaviour or attitudes

Breach of confidentiality; misleading patients about their care or treatment; sexual harassment; inappropriate examinations or failure to keep appropriate boundaries in behaviour; persistent rudeness to patients, colleagues or others; unlawful discrimination

Health concerns and insight or management of these concerns

Failure to seek medical treatment; refusal to follow medical advice or care plans in relation to maintaining fitness to practise; failure to recognise limits and abilities or lack of insight into health concerns; treatment-resistant condition

* Adapted with permission from: General Medical Council (UK); Medical Schools Council (UK).[5] ◆

only (Box 2). Seven medical schools had been established since 2000.

Fitness-to-practise policies

Twelve medical schools used FTPPs (Box 2), all introduced since 2000. Nine of the schools that used an FTPP notified medical students of the policy during the application process, and the remainder informed students on entry to the course. All respondents thought that there should be registration with medical boards at student level. This was a requirement at nine of the schools (Box 2). Student registration with a state medical board did not appear to have any bearing on the use of FTPPs by medical schools.

There was wide variation in the FTPP criteria used by individual medical schools. Six medical schools had FTPPs with criteria similar to those in the UK guidelines[5] (Box 3), but there was no commonality between these schools in terms of demographics such as when the school was founded, the type of course (undergraduate, postgraduate or both), student registration with the state medical board or the numbers of students excluded.

The criterion least likely to be present in Australian medical school FTPPs was poor performance (ie, persistently poor performance in professional behaviour).

Remediation processes

Fourteen medical schools had a remediation process for dealing with instances of student misconduct or poor professional behaviour. Most commonly, remediation was tailored to the individual student rather than being predefined. Of the three schools without an FTPP, two had a formal remediation process.

Exclusion of students

Seven schools had excluded students for professional misconduct during the previous 5 years. A total of fewer than 19 students (one school did not give an exact number) were excluded (Box 2). Absolute numbers varied between one and four students per school; as a proportion of the total number of students at each school, this ranged from zero to 0.95%. The majority of students (at least 10) were excluded in Years 2 and 3, with no students excluded for professional misconduct in Years 5 or 6. The commonest reason for student exclusion was persistent inappropriate attitude or behaviour, including poor attendance. No students were excluded on the basis of drug or alcohol misuse.

DISCUSSION

In 2005, a strong association between poor professional behaviour in undergraduate education and subsequent disciplinary action by medical boards for "problem" doctors was shown in the United States.[6] In Australia, the New South Wales Medical Board reported that, in NSW (where medical students have been registered with the medical board since 1992), 20% of "impaired" students have drug or alcohol problems and 70% have a mental illness.[7] This has prompted medical schools to develop measures to address these issues in undergraduate education; however, a literature search that we performed found no convincing evidence to validate any particular approach. This is the first national study of the experiences of medical schools regarding student professionalism, and the policies and remediation processes that have been implemented in this area.

There were a number of limitations in this study. Not all Australian medical schools were represented. As the survey was anonymous, it was impossible to determine whether there were differences between respondents and non-respondents. Although the deans were the most appropriate staff members to coordinate completion of the questionnaires, this created the potential for observer bias.

The majority of the 15 Australian medical schools surveyed reported using FTPPs in the 5-year period ending August 2009. However, there was little consistency in the criteria used in the FTPPs, and the policies do not appear to be a prerequisite for medical schools having remediation processes. Seven schools had excluded students for professional misconduct over the 5-year period, and the use of an FTPP had no demonstrable association with the numbers of students excluded.

Although the number of students excluded may be a poor marker of FTPP performance, the finding that most students were excluded for FTPP reasons during Years 2 and 3 lends support to medical schools actively assessing students who have difficulties in these areas. The types of remediation processes and efforts to remediate students are also inherently difficult to assess, but, based on our data, most medical schools appear to put significant effort and resources into these processes regardless of whether they have a formal FTPP in place.

It would be appealing to measure a medical school's FTPP performance based on the number of students excluded. Unfortunately, surrogate outcomes such as this are meaningless. For example, a medical school with a "good" FTPP could have a low rate of student exclusion, reflecting good surveillance and effective remediation for students with difficulties. Conversely, a medical school with a "bad" FTPP might also have a low rate of student exclusion, as there may be no mechanisms in place to detect students with problems, with no onus on the medical school to exclude "rogue" students.

2 Demographics of medical schools that responded to the national survey on fitness-to-practise policies (FTPPs), August 2009

	Medical school														
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Course type (P, U or both)	P	P	P	P	P	P	P	U	U	U	U	U	Both	Both	Both
No. of students	100	600	1400	248	1089	321	230	420	na	726	560	na	1736 U, 127 P	996 U, 226 P	270 U, 30 P
Length of program (years)	4	4	4	4	4	4	4	4.7	6	5	5	6	5 U, 4 P	6 U, 4.5 P	5 U, 5 P
Use of FTPP	y	y	y	y	y	y	n	y	y	y	y	n	y	n	y
Year FTPP implemented	2009	2005	na	2008	2007	2005	na	2006	2006	2008	2001	na	2002	na	2007
Student registration*	n	n	n	y	y	y	y	n	y	y	n	y	y	n	y
No. of students excluded†	0	0	1	0	1	0	2	4	0	2	0	< 5	4	0	0

P = postgraduate entry. U = undergraduate entry. na = not answered. y = yes. n = no. * Registration by state medical board. † During the previous 5 years. ◆

3 Criteria used by medical schools in fitness-to-practise policies*

	Medical school											
	A	B	C	D	E	F	H	I	J	K	M	O
Criminal conviction or caution	n	n	y	y	y	y	y	y	y	y	y	y
Aggressive behaviour	y	y	y	y	y	y	y	n	y	n	y	y
Poor performance	y	y	y	n	y	y	y	n	n	n	y	y
Inappropriate attitude or behaviour	y	y	y	y	y	y	y	n	n	n	y	y
Drug or alcohol misuse	y	y	y	y	y	y	y	n	y	y	y	y
Cheating or plagiarism	y	y	y	y	y	y	y	n	y	y	y	y
Health or mental health issues	y	y	y	y	y	y	y	y	y	y	y	y
Dishonesty or fraud	y	y	y	n	y	y	y	y	n	n	y	y
Total number of criteria	7	7	8	6	8	8	8	3	5	4	8	8

y = yes. n = no. * Medical schools G, L and N are not shown as they did not use an FTPP. ◆

The commonest reason for student exclusion in our study was persistent inappropriate attitude or behaviour. Ironically, persistent poor performance in professional behaviour was the criterion least likely to be used in Australian medical school FTPPs.

At present, individual medical schools leave themselves open to challenge on their FTPPs, remediation processes and exclusion decisions, owing to a lack of evidence that any one process works. As recently noted:

> If those of us leading Australia's medical schools don't know what the others are doing about the few cases of extreme unprofessional behaviour among our students, how can we do our part in protecting the community and the profession in the future?[1]

Can these variable policies that lack proven effectiveness be improved by using a nationally consistent framework similar to that in the UK? With no published data to guide practice, the answer is as yet unknown, although a move towards better collaboration and a more consistent approach between medical schools in this area has been given new impetus by the recent National Forum: Assessment of Professional Behaviour of Medical Students (Malcolm Parker, Associate Professor of Medical Ethics, University of Queensland, personal communication). However, it is imperative to evaluate the possible effects of these processes on outcomes if a national approach is to be implemented.

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COMPETING INTERESTS

None identified.

AUTHOR DETAILS

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REFERENCES

1 Parker MH, Wilkinson D. Dealing with "rogue" medical students: we need a nationally consistent approach based on "case law". *Med J Aust* 2008; 189: 626-628.
2 Parker M. Assessing professionalism: theory and practice. *Med Teach* 2006; 28: 399-403.
3 Medical professionalism in the new millennium: a physicians' charter. *Lancet* 2002; 359: 520-522.
4 Medical education towards 2010: shared visions and common goals. Proceedings of the Medical Education Conference; 2005 Mar 7–9; Canberra, ACT. Sydney: Committee of Deans of Australian Medical Schools and Australian Medical Council, 2005.
5 General Medical Council (UK); Medical Schools Council (UK). Medical students: professional behaviour and fitness to practise. http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp (accessed Oct 2010).
6 Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behaviour in medical school. *N Engl J Med* 2005; 353: 2673-2682.
7 Reid AM. Overview: the experience of the New South Wales Medical Board. *Med J Aust* 2002; 177 (1 Suppl): S25-S26.

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