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Justice and Care: Decision Making of Medical School Student Promotions Committees

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JUSTICE AND CARE: DECISION MAKING OF MEDICAL SCHOOL STUDENT PROMOTIONS COMMITTEES

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ABSTRACT

Accreditation standards for allopathic medical schools in the United States require that each institution have in place a mechanism by which student progress through the curriculum is monitored. These entities, referred to here as promotions committees, make important decisions in a high stakes medical education environment. Yet little is currently known about how promotions committee members make decisions about students who experience academic failures and lapses in professional behavior. Using the work of Lawrence Kohlberg and Carol Gilligan on moral development as a theoretical basis, the purpose of this study was to elucidate committee members' perceptions of the role of promotions committees, the ethical orientations that guide individual decision making, and the influence of particular student characteristics and circumstances on that decision making process.

An electronic survey was sent to representatives at 143 accredited allopathic medical schools in the United States with a request to distribute the survey to all voting members of that institution's promotions committee. Survey questions were primarily quantitative in nature. A total of 241 surveys were completed by individuals at 55 medical schools. Data were examined by gender, age, participant role (medical student, faculty member, administrator), and years of committee experience.

Major findings included the concurrent orientations of both justice and care in individual decision making, with some prioritization of responsiveness to particular student characteristics and circumstances over consistency across student cases. Significant differences by age, role and gender were identified, but these were limited in number. The aspects of student cases that were most influential to committee member decision making concerned student characteristics and circumstances that could reasonably be considered as being within the students' control, in

particular lapses in professional behavior. Recommendations for future research and promotions committee member training were discussed.

Chapter 1: INTRODUCTION

The Medical Education Context

The structure and function of undergraduate medical education (UME) in the United States, the four years of allopathic medical school that precede residency training, is well-documented in the medical education literature. Accepted students proceed through two "preclinical" years that have traditionally consisted of primarily basic science-focused course work. They then enter the clinical years of their medical education (years three and four), that consist of rotations in hospitals and doctors' offices. Upon graduation, students earn their doctor of medicine (MD) degree and have generally passed the first two of three medical licensing exams (the third is taken during subsequent residency training). If they are successfully matched into a specialty training program (such as Internal Medicine, Pediatrics or Neurology, for example) during their fourth year, medical school graduates are well on their way to becoming practicing physicians.

The road to graduation however, is both long and expensive. Learners may have spent many years, and many tens of thousands of dollars, in the quest just to obtain acceptance to medical school. Competitive pre-medical grades, high standardized exam scores, and the successful completion of a post-baccalaureate program all increase an applicant's chance of being accepted to one of the 144 accredited medical schools in the United States. According to the Association of American Medical Colleges' (AAMC) 2015-2016 table A-1 on medical school applications and matriculants, there were 781,602 applications to medical schools in the United States submitted by 52,550 individuals, and only 20,631 (39%) applicants in that same year were successful in their efforts and ultimately matriculated to medical school (retrieved from https://www.aamc.org/data/facts/).

Adding to the high stakes nature of medical education is its price tag. Once admitted, medical school is very expensive. The AAMC's October 2015 Debt Fact Card reports that the median cost of attendance in 2015 was $57,821 per year for public medical schools, and $78,512 for private medical schools. Data from that same year indicate that the mean debt level for all medical school graduates was $180,723 (median of $183,000), with 45% of all graduates owing $200,000 or more and 12% owing $300,000 or more (retrieved from https://students-residents.aamc.org/financial-aid/).

Due at least in part to high academic standards and intense competition for admission, the vast majority of students who come to medical school are well prepared for the academic rigors of the medical education curriculum. Once accepted, most matriculated students complete their UME program. Attrition from medical school, permanent withdrawal from the educational program for whatever reason, is quite low. AAMC data from 2010 indicate that only 3% of matriculates will not graduate within eight years of matriculation (the eight-year time frame accounts for students who complete dual or additional degree programs as well) (retrieved from https://www.aamc.org/data/aib/archive/). However, an indeterminate number of students each year will fail preclinical courses or clinical rotations, and find themselves literally or figuratively in front of their institution's "promotions committee." It is the work of these committees that forms the basis of my research.

Medical School Promotions Committees

Standard 10.3 of the Liaison Committee on Medical Education's 2016-2017 Data Collection Instrument for Full Accreditation Visits requires that every accredited allopathic medical school have in place a process by which representatives of the institution determine the progression of students through the medical education program (retrieved from

http://lcme.org/publications/). No equivalent standard exists for osteopathic medical schools, so those institutions were not included in the current study. Commonly referred to as "student performance committees", or "academic progress committees", promotions committees are charged with monitoring student progress by reviewing and analyzing information about students' performance in medical school. This information is generally in the form of exam grades, and both quantitative and qualitative information about students' clinical skill acquisition. Some promotions committees also review documentation concerning students' professionalism.

Student performance data act as the basis for committee decisions regarding academic standing, the particulars of which vary by institution. These data may include informal information about students provided by advisors or by the students themselves, as well as formal grades and evaluation narratives. The majority of students who pass their courses and clerkships will retain some version of "good" academic standing, while students who experience failures may be moved from one level to another (from "warning" to "probation," for example) by that institution's promotions committee. Promotions committees are also generally charged with officially promoting students from one year to the next and, infrequently, dismissing students from the medical education program all together.

The work of promotions committees represents a significant intersection of education and administration. While it does not include explicit acts of instruction, promotions committee work is situated at the very heart of the medical education enterprise, and it relies on a vast array of educational activities and perspectives to inform and guide it. Committee members make important decisions about student progress based on information generated from institutional systems of instruction, assessment, feedback, and advising. An academic failure may well

reflect a student's inability to appropriately demonstrate and apply knowledge. However, the performance data under review by a promotions committee may also reflect a preceptor's ability to accurately observe, measure and document the student's performance, and other individuals' ability to communicate the particulars of the student's circumstances to the committee.

Within the competitive "high stakes" context of medical education, academic failures take on great personal and professional significance, and the ultimate attrition of medical students, even in small numbers, can have consequences for not only the individual learner but for the institution and for society as well. Depending on how far they have gotten in their medical education, students who appear before a promotions committee may have amassed large financial burdens as a result of that schooling. Committee decisions that may ultimately result in dismissal from medical school have the potential to have an enormous emotional, financial and professional impact on the lives of those students (Cohen, Clinchot, & Werman, 2013; Maher et al., 2013; O'Neill, Wallstedt, Eika, & Hartvigsen, 2011; Stegers-Jager, Cohen-Schotanus, Splinter, & Themmen, 2011; Stetto, Gackstetter, Cruess, & Hooper, 2004; Tulgan, Cohen, & Kinne, 2001; Yates, 2012). Additionally, when a medical student withdraws or is dismissed, medical schools experience a loss of financial investment (Maher et al., 2013; O'Neill et al., 2011; Stetto et al., 2004), and may experience lawsuits or other legal consequences (Cohen et al., 2013). Student attrition can have a negative impact on an institution's academic reputation, with subsequent negative consequences for research and teaching resources, and on future applicant recruitment (Maher et al., 2013; Stetto et al., 2004). The tax-funded nature of graduate medical training means that society is impacted by medical student attrition both financially (Maher et al., 2013; O'Neill et al., 2011; Stegers-Jager et al., 2011; Yates, 2012) and in terms of the loss of

"useful contribution" (O'Neill et al., 2011, p. 441) by students who do not complete their medical training (Maher et al., 2013).

Because of the central role that they play in medical student promotion and attrition, and the array of stakeholders impacted by their actions, one might assume that the structure and functioning of promotions committees has been examined in detail. However, the medical education literature is devoid of any systematic examination of the work of student promotions committees. As a result, the structure and function of entities that play a central role in our medical education institutions, and that have an enormous impact on the lives of a small number of students, remain largely unknown.

Research Problem

The problem addressed by my research concerns a gap in knowledge about medical school promotions committees. Little is currently known about how promotions committees function across medical schools, and how information about individual students gets communicated and considered. Particular conceptions of fairness and particular ethical orientations may guide committee members' deliberations, yet these conceptions have yet to be explored, and the variables that influence decision making processes are yet to be identified.

In order to form a more complete picture of committee work across institutions, I sent an electronic survey to representatives from 143 of 144 accredited allopathic medical schools in the United States (one school with preliminary accreditation status had no publicly available website and therefore no available contact information). The survey utilized a theoretical framework contrasting an ethic of justice (in which decisions prioritize consistency and policy), with an ethic of care (in which decisions prioritize holistic review of student cases and responsiveness to individual circumstances). It was designed to be completed by voting members of medical

school promotions committees, and to ascertain 1) individual participant perceptions of their committee, 2) the ethical orientation(s) used in their decision making as part of their participation on the committee, and 3) the particular student characteristics and circumstances that most influence their decision making.

A second part of my research involved the gathering of data about promotions committees that are descriptive in nature and that may not be explicitly known by voting members (such as total number of committee members, minimum number of meetings per year, etc.). To this end, an Excel spreadsheet was distributed to 139 individuals at 136 medical schools by the current Associate Dean for Medical Education at The Warren Alpert Medical School (AMS) of Brown University (Dr. Allan Tunkel), who agreed to be involved in this process. Medical school representatives were asked to either fill out the form, or provide contact information for someone who could.

Research Significance

This study represents the first known systematic inquiry into the decision making of medical school promotions committees and their members. It could have a profound impact on both medical education institutions, and on the learning and development of individual promotions committee members. On a very basic level, making public the descriptive data gathered as part of the second aspect of my research could facilitate examination of committee structure and function by individual institutions. This in turn might instigate a sharing of best practices across institutions. For example, institutions could share information about how the inclusion of medical students as voting members of promotions committees (which is the case at a number of medical schools) impacts committee processes and deliberations.

Institutions could also use the information collected via the survey to more clearly articulate the role and function of their promotions committee to their own constituents. Such information could better prepare students and their advisors for how failures will be viewed by the committee, and the extenuating factors that members will or will not consider as part of their deliberations. These actions would serve to make the work of promotions committees more transparent to the students who come before them. Because academic failure and attrition are issues that are fraught with personal and institutional meaning at many different levels, medical schools could use the data collected in this study to more clearly articulate a set of educational and professional values that will in turn guide promotions committee deliberations and inform decision making processes.

The data gathered in this survey could also be used by individual committee members as an impetus to examine their own decision making processes. Within this context, an examination of the assumptions and influences that underpin internal deliberations could lead to important learning and development. Busy faculty schedules and the intermittent nature of committee work means that committee members have not in all likelihood had the opportunity to examine their own thinking about failure, about the students who are experiencing failure, and about the multiplicity of their responsibilities as a medical educator- to students, to students' future patients, to their institution, and to the medical profession generally. My hope is that once made public, the results of this study will represent the beginning of a new conversation within medical education about medical students and how we deliberate about their academic and professional struggles.

The Researcher

I am currently the Director of Student and Faculty Development at AMS. As part of my student advising responsibilities, I serve as an ex-officio member of the AMS Medical Committee on Academic Standing and Professionalism (MCASP), and have done so since 2008. In a previous position I had intermittent exposure to the workings of a promotions committee at a second institution. The MCASP is the AMS version of a promotions committee, and it considers the academic performance and professionalism issues of students in all four years of medical school. As a non-voting member, my role is to provide the committee with information about students not included in formal transcripts or reports that might help to inform committee deliberations. I have been fascinated with committee members' perceptions of the work, and with the conversations about particular student characteristics and circumstances that occur regularly during committee meetings. Policy, precedent and perception all play out in a variety of ways each time the MCASP meets, and my personal experiences on the committee have spurred my interest in understanding these elements more fully and systematically. For reasons of access and concerns about privacy, this research focuses on individual decision making rather than on the complex group dynamics that also play an enormous role in the work of promotions committees.

The medical education context has influenced my research in a number of ways beyond my choice of promotions committees as a topic of study. I work in a field that values evidence-based practice and that is steeped in quantitative data. My choice of survey methodology and the use of mostly close-ended quantitative questions within that survey are due in part to a desire to have my research validated and valued by my professional colleagues. Again, my hope is that this inquiry ultimately results a national medical education conversation about this particular

intersection of education and administration, one which is common in some form to all allopathic medical schools in the United States.

Overview by Chapter

Chapter 1: Introduction. Chapter 1 provides information regarding the medical education context in which this study takes place. It provides a synopsis of the problem addressed by this research study, and attempts to identify the potential significance of the work to medical education and medical schools. Chapter 1 also provides background information about myself as the researcher, and the origins of my professional interest in promotions committee work. It concludes with an overview of each Chapter in this dissertation.

Chapter 2: Literature Review. Chapter 2 examines the literature available in three basic areas related to the work of promotions committees. First, the "failure to fail" literature is examined. The "failure to fail" literature concerns the specific barriers encountered by faculty in the assessment of underperforming students in the health professions, and documents faculty reluctance to submit failing grades. Particular attention will be paid to systemic, personal and student-centered barriers to failing underperforming students. Though these grading processes take place prior to any involvement of promotions committees, the literature speaks to the complexity of evaluating student progress.

Second, articles and commentaries that mention promotions committees specifically in the context of medical student dishonesty are examined. These commentaries tend to involve debate on the appropriateness of promotions committee decisions (generally the decision to dismiss a student) after the fact. However, they raise an essential dilemma that is at the core of my research regarding the need to balance the values of fairness and consistency with the

potentially competing values of contextualization and responsiveness when making decisions about students.

Finally, I will discuss perspectives on moral decision making that provide some insight into the ethical orientations that may guide promotions committee members' decisions about students. Ethics of justice and care are examined, and the implications of the two for promotions committee work are discussed. The extent to which committee members are guided by one ethical orientation or another, or by some combination of guiding principles, is one of the central questions addressed in my research.

Chapter 3: Methodology. Chapter 3 provides details regarding how data were gathered, and a rationale for the chosen methodology. The primary means for data collection was an electronic survey. Survey design, pilot testing and distribution are described, and information about survey participants is provided. The second component of my research was the collection of basic descriptive information regarding the structure and function of promotions committees across institutions. The distribution of a data collection spreadsheet is described.

Chapter 4: Data Analysis. Chapter 4 describes all statistical and qualitative analyses conducted on the survey data. Data analysis is presented by survey section. The descriptive data collected via other means are also presented.

Chapter 5: Discussion and Conclusions. Chapter 5 presents a synthesis of major findings from Chapter 4. The discussion makes the connection between the survey data back to the "failure to fail" literature and moral development theories presented in Chapter 2. Chapter 5 also presents a new possible developmental lens by which to view the findings in Robert Kegan's subject-object theory. The chapter concludes with a discussion of project limitations and recommendations for future work.

CHAPTER 2: LITERATURE REVIEW

Introduction

The work of promotions committees is, on a very basic level, a learning activity that involves a multitude of complex cognitive processes (Tennant, 2012). Committees analyze data relating to student performance in the form of formal grades and evaluation narratives. They are also typically provided with other relevant data that may include information about mental health issues, personal trauma or financial stressors. Committee members attend to the reasons behind a student's difficulties, and make judgments about the likelihood that s/he will overcome current challenges. They weigh a student's potential for future competence, and attempt to predict that individual's ability to be successful in subsequent phases of his or her medical education. Committee members are charged with applying institutional policy to particular student cases. They consider actions taken in the past in similar circumstances, come together to discuss and debate, and ultimately synthesize all of these data into a decision about an appropriate course of action.

However, examination of the literature regarding these particular decision making processes reveals very little. The large body of literature on decision making is only indirectly related to committee decision making processes such as this and tends to be within the fields of cognitive or organizational psychology (Bandyopadhyay, Pammi, & Srinivasan, 2013; Dawes, 1971; Gruenfeld, Mannix, Williams, & Neale, 1996; Huntley & Costanzo, 2003; Loewenstein & Lerner, 2003; Samuelson & Zeckhauser, 1988). Literature on decision making often concerns calculations of risk (Hogarth & Kunreuther, 1995; Rettinger & Hastie, 2001; Samuelson & Zeckhauser, 1988), and utilizes jury or gambling decision making processes as the context

(Hogarth & Kunreuther, 1995; Pennington & Hastie, 1981, 1986, 1988; Rettinger & Hastie, 2001; Winter & Greene, 2007), rather than educational or administrative decisions regarding learners in higher education. Discussions regarding the academic or professional struggles of medical students in the literature generally concern either the student evaluation that occurs prior to any involvement of a promotions committee, or a review of committee decisions after the fact. Absent is a systematic investigation of exactly how members perceive and approach the work of promotions committees, and the specific variables that influence their individual decision making processes.

The dearth of information pertaining to the structure and function of promotions committees has several likely explanations. Most pertinent are potential privacy concerns for the students who come under consideration by their institution's committee. It is essential that institutions protect the privacy of student records, particularly for students who experience academic difficulty while in medical school. It should be said that most of these students go on to successfully complete their medical education and become skilled physicians. However, there is some evidence that student behaviors related to dropout or dismissal, which include academic struggles and dishonest or unprofessional behavior, are consistent over time (Hunt, Scott, Phillips, Yergan, & Greig, 1987; Papadakis, Hodgson, Teherani, & Kohatsu, 2004; Sierles, Hendrickx, & Circle, 1980). Students who experience significant academic difficulties during medical school have been shown to have significantly lower ratings than did other residents on the quality of their interactions with patients (Hunt et al., 1987). And cheating behaviors exhibited in undergraduate studies may continue, albeit at a reduced rate, in medical school (Sierles et al., 1980). The authors found that there was in fact a correlation between cheating in traditional academic venues and in dishonesty in patient care. Problematic behavior in medical

school in the realm of professionalism is also significantly correlated with subsequent disciplinary action by a state medical board (Papadakis et al., 2004). The apparent longitudinal nature of the very issues considered by promotions committees provides a rationale for increased attention to committee decision making.

A second possible explanation for the lack of inquiry into promotions committees is that it represents a reluctance on the part of medical schools to make public the promotions committee processes that may be more or less formalized, and that may adhere to a greater or lesser extent to committee bylaws and policies. It may be thought that to discuss these policies and processes is to place an institution at risk for potential legal or accreditation consequences.

Finally, the lack of information about promotions committees in the literature may represent a more benign assumption that the committees simply enforce institutional policy in a straightforward manner, and thus inquiry into their work would reveal little of interest to the medical education community. Personal experience would indicate otherwise. My years as a non-voting member of a promotions committee at one institution, and intermittent exposure to the workings of a promotions committee at a second institution, support the idea that promotions committee work is a complex combination of contextual factors such as institutional policy and group dynamics, the personal and professional characteristics of the committee members themselves, and a myriad of variables related to particular students and their personal and academic circumstances. Due to the privacy concerns and potential issues of access mentioned previously, my research primarily concerns the variables that are personal to the voting members of promotions committees who make decisions about medical students, and secondarily attempts to identify the student-centered variables that influence those decisions.

In the sections below I will discuss two areas of the literature that involve processes related to promotions committee work, as well as a seminal debate regarding moral decision making and its application to my area of interest. The first body of literature I will discuss is the phenomenon commonly referred to as "failure to fail." The "failure to fail" literature concerns the specific barriers encountered by faculty in the assessment of underperforming students in the health professions, and documents faculty reluctance to submit failing grades. The second area I will discuss concerns academic dishonesty on the part of medical students. The literature on academic dishonesty in medical school tends to involve commentary and debate on the appropriateness of promotions committee decisions (generally the decision to dismiss a student) after the fact. Finally, I will discuss perspectives on moral decision making that provide some insight into the ethical orientations that may guide promotions committee members' decisions about students.

Failure to Fail

There exists a body of educational research regarding student "underperformance" (defined for these purposes as a failure to meet established criteria for knowledge acquisition or clinical performance), that focuses on the assessment and evaluation processes that *precede* the work of promotions committees. The phenomenon commonly known as "failure to fail" is well-documented in the health professions literature (Cleland, Knight, Rees, Tracey, & Bond, 2008; Dudek, 2005; Fontana, 2009; Hauer, Teherani, Kerr, Irby, & O'Sullivan, 2009; Irby, 1989; Luhanga, Yonge, & Myrick, 2008; McAdams, Foster, & Ward, 2007; Nash, Moore, & Andes, 1981; Tulgan et al., 2001). These studies identify specific barriers to accurate evaluation of underperforming students in the health professions by clinical supervisors, and document how these barriers influence faculty decisions about grading. Barriers to accurate evaluation and

grading of underperforming students include systemic issues related to the educational context (Cleland et al., 2008; Dudek, 2005; Hauer et al., 2009; Luhanga et al., 2008), issues that are personal to the educator (Cleland et al., 2008; Dudek, 2005; Fontana, 2009; Irby, 1989; Luhanga et al., 2008; McAdams et al., 2007; Nash et al., 1981; Tulgan et al., 2001), and issues that pertain to individual students and their particular personal and professional circumstances (Cleland et al., 2008; Luhanga et al., 2008).

Systemic barriers to accurate evaluation and grading. Systemic barriers to the submission of failing grades for underperforming students include lack of appropriate means of documentation, and lack of understanding of appropriate content of that documentation (i.e., those specific student behaviors that are considered serious enough to warrant documentation of failure) (Dudek, 2005). It is perhaps notable that these barriers are fairly easily removed with appropriate faculty development. However, some systemic barriers have no simple educational remedy. A lack of educationally appropriate remediation options for certain clinical deficits is a profound problem for health professions supervisors. A perceived lack of appropriate remediation options has been shown to decrease faculty willingness to document student performance, even when a determination of failure has been made (Hauer et al., 2009). Preceptors indicate that if they are unable to provide a student with an appropriate remediation option, for failures on a standardized-patient comprehensive assessment of clinical skills for example, then it is unfair for them to penalize the student by documenting or reporting that failure on the student's Medical School Performance Evaluation (a standard document that is part of all medical students' applications to residency training programs) or academic transcript. Another example of a systemic barrier to accurate evaluation concerns work force issues. Clinical nursing supervisors indicated that they experienced pressure to graduate students in the

context of a national nursing shortage, and that they perceived this pressure as a barrier to accurate evaluation of underperforming students (Luhanga et al., 2008).

Faculty reluctance to accurately evaluate students may extend to difficulty in providing underperforming students with honest, constructive feedback even when formal grading processes are not involved. A multi-method longitudinal study was undertaken that looked at attending physicians' responses to behaviors and attitudes on the part of medical students and residents that would indicate a negative view of patients (Burack, Irby, Carline, Root, & Larson, 1999). Methodology included observations of medical teams over time, in-depth semi-structured interviews, a structured task that asked physicians to voice their thought processes regarding a written case scenario, and a patient chart review. The major finding of the study was that physicians had no direct observable reaction to negative behaviors of learners, relying instead on self-described non-verbal cues that were in fact missed or misinterpreted by their learners.

Burack et al. (1999) went on to interview physicians about barriers to providing more direct feedback to learners about their problematic attitudes or behavior. The barriers identified by physicians included systemic issues of limited learner observation (such that faculty were unsure how to interpret single incidents), and the generally public nature of much of the interaction with learners (thus limiting physicians' ability to give feedback in a confidential manner). In addition, faculty expressed concern that feedback was generally hard to provide, potentially ineffective in eliciting change, and perhaps even inappropriate if it represented an imposing of his/her own values on learners. Thus, even short of submitting a failing grade for underperforming students as a final, summative evaluation, faculty may experience difficulty providing those students with honest, formative feedback about problematic behaviors. This lack

of direct feedback may deprive the student of a chance to learn from his or her experience, and of the opportunity to make corrections to his or her behavior.

Personal barriers to accurate evaluation and grading. A second type of barrier to accurate evaluation and grading of students in the health professions concerns issues that are personal to clinical preceptors themselves. Fear of personal consequences has been documented as impacting the reporting of academic misconduct of students by nursing faculty (Fontana, 2009). These personal consequences include the emotional toll exacted by confrontations with students over performance or behavior, and damaged relationships. Nursing faculty indicated that reporting misconduct had the potential to disrupt not only their relationship with the student in question, but relationships with that student's peers and with professional colleagues who may or may not agree with the decision to report.

Medical faculty relate feeling shame or guilt regarding their potential role in the student failure (failure as a reflection of poor teaching or inadequate supervision, for example), and they expressed a reluctance to incur an increased workload as a result of having to counsel and remediate students who receive a failing grade (Luhanga et al., 2008) Avoidance of legal repercussions, and the accompanying increase in workload, are also cited as barriers to the submission of failing grades, though the court system has traditionally upheld health profession training institutions' right to determine the competence of their learners as long as due process is in place (Cobb & Jordan, 1989; Irby, 1989; McAdams et al., 2007; Nash et al., 1981; Tulgan et al., 2001).

Student-centered barriers to accurate evaluation and grading. Student-centered variables, those related to an individual student's particular circumstances, are a third type of barrier to accurate evaluation. These variables influence grading decisions and contribute to

faculty members' "failure to fail." Medical faculty report that they consider the relative youth and background of underperforming learners, and express sympathy with learner stress and an unwillingness to add to it (Burack et al., 1999). Clinical supervisors of nurses indicated that they consider a student's proximity to graduation and potential debt when deciding whether or not to submit a failing grade (Luhanga et al., 2008).

> Preceptors acknowledged passing students because they did not want to jeopardize the students' future, especially when they were so close to graduating… Some preceptors were reluctant to assign failing grades to students because of the amount of money involved in the university education. (p. 7)

The grading of struggling students may also be influenced by a student's experience with mental health or addiction issues. A substance abuse policy at the University of Memphis School of Nursing explicitly states a goal of caring for and supporting struggling nursing students who are experiencing issues with addiction (Monroe, 2009). Monroe's discussion of an institutional substance abuse policy nicely illustrates the tension between faculty roles of evaluator and care-taker. He takes the view that clinical educators should embrace the care-taking role and advocates for a more supportive approach to students who are underperforming. Maher et al. (2013) conclude a study on medical school attrition with the admonition that institutions have a "duty of care" (p. 15) to provide support to their students even after those students have left the program.

Medical education places great value on the creation of caring physician-learner relationships. Both education and medicine are fields that attract highly empathetic individuals, and both have the establishment of nurturing relationships, with learners and patients respectively, at the heart of the profession. In fact, the creation of humanistic physician-*learner*

relationships is often cited as a means for engendering future humanistic physician-*patient* relationships once the learner becomes a physician (Haidet & Stein, 2006; Penney, 1989; Tiberius, Sinai, & Flak, 2002). In essence, the educational relationship is viewed as a model for future medical relationships. Within this context, deliberations about medical student performance or professionalism may be conducted in a manner that treats the learner as a patient would be treated—with respect and dignity, and with the particular circumstances and needs of the learner as paramount. However, the responsibility that physician-educators feel toward vulnerable or struggling students may blur real distinctions between students and patients, and faculty concern for learners' well-being may unintentionally contribute to an inaccurate picture of a student's actual knowledge and skills.

Failure to fail and promotions committee work. Systemic, personal and student-centered variables all influence grading decisions, and may increase faculty reluctance to document failures. The relationship-centered approach to students that caring faculty create in an instructional context, while essential for the learning process, may have unintentional consequences for the institution responsible for graduating competent physicians-in-training. One consequence is that the information considered by promotions committees may be incomplete or misleading. Promotions committees may only be able to consider academic performance or behavior that is documented and submitted via formal channels of reporting. A study done by Frellsen, Baker, Papp and Durning (2008) indicates that many student issues do not get reported such that a promotions committee would even become aware of them. The authors surveyed directors of internal medicine clerkships in the U.S. and Canada and found that clerkships reported handling struggling students in a variety of ways, and there was great variation in the extent to which promotions committees were involved. They found that when

students received grades that were less than satisfactory, only 77% of respondents indicated that those students were always presented to a promotions committee. Nineteen percent indicated that those students were presented to the committee 50% of the time or less. These results would seem to indicate that promotions committees may be acting without full access to relevant information.

The "failure to fail" literature also suggests that we should challenge any assumption that the work of promotions committees involves simple policy implementation. The individuals who struggle with systemic, personal and student-centered barriers to accurate evaluation and grading of medical students in clinical settings may be similar to those individuals who make up promotions committees. It seems highly likely that promotions committee members are influenced by many of the same psychological and interpersonal issues as are their clinical preceptor counterparts who are in charge of submitting final grades. Committee processes too may involve multiple chances, exceptions to rules, and lack of certainty about decisions. However, to date no study has extended the examination of deliberations around underperforming students into the administrative processes triggered when failing grades are in fact submitted.

Academic Dishonesty

Promotions committees make an explicit appearance in the medical education literature in published commentaries on the consequences that they enact. These articles tend to have as their focus the relative severity or leniency of promotions committee decisions in cases of academic dishonesty. Specifically, there are a number of articles that discuss whether or not automatic dismissal is an appropriate consequence for academic dishonesty or cheating (Anderson & Obenshain, 1994; Osborn, 2000; Petersdorf, 1989; Smith, 2000). On one hand,

committee members are tasked with upholding the standards of their institution, and graduating cohorts of ethical and competent physicians who will provide essential health care to the members of our society. Dishonest or immoral behavior can be considered incompatible with the values upheld by the medical profession, and dismissal from a medical education program can thus be viewed as an appropriate means by which to prevent individuals exhibiting those behaviors from entering the profession. On the other hand, an argument can and has been made that implementation of such a drastic consequence without consideration of the details of the particular circumstance does an injustice to our learners and to the relationships that many medical educators strive to create with their learners.

In what was originally presented as a part of a plenary session at the 1988 annual meeting of the AAMC, Petersdorf (1989) posits that dismissal from medical school is an appropriate and non-negotiable consequence for cheating, and one that is necessary to maintain the integrity of the profession. The faculty who responded to a survey administered by Anderson and Obenshain (1994) disagreed with Petersdorf and indicated that they thought the appropriate consequence for cheating was not dismissal but a more nuanced and situation-appropriate hearing process. Osborn (2000) relates a story regarding an episode of medical student cheating and the actions taken by the home institution of the students in question. The story involved a medical student who turned in a paper written by another student. Medical student representatives, participating on the committee that determined punishment, voted for lenient consequences. Faculty wanted harsher consequences. The author attempts to outline educational and generational factors to help elucidate the different views on the cheating incident by faculty and students. She indicates that the students viewed the particular written assignment as unrelated to the skills required for patient care. The students' response indicates a nuanced view in which cheating is not a single

action but rather a category of actions that encompasses a spectrum of severity. The author makes her own opinion about the incident explicit—she is in favor of practicing the kind of forgiveness that she sees as essential to a healing profession.

A different view is expressed in a 2000 editorial by Richard Smith in the British Medical Journal. The editorial concerned an anonymous letter received by the journal regarding an episode of cheating at a British medical school. Smith followed up on the letter by contacting the school and asking for additional details. His concern was that the committee that dealt with the incident had not only permitted the student in question to graduate, but that their actions had damaged other students' trust in the examination system, and damaged the reputation of the medical profession generally. According to Smith, "justice is not a private matter" (p. 398) and he made explicit his motivation to publish the letter to stimulate debate regarding the credibility of medical education and the medical profession as a whole.

Smith's (2000) editorial stimulated a number of letters to the British Medical Journal editor in response in February 2001. The letters varied in their opinion about how the incident was handled by the school. Interesting variables discussed in these letters included the extent to which historical and personal knowledge of the student in question did or should play into the committee's decision, and the extent to which the stress of examinations on students should be viewed as a cause of, and perhaps explanation for, cheating. One letter even implied that the school could be held responsible were the student in question to harm herself in response to a harsh punishment for cheating. Other letters discussed the extent to which the profession should practice forgiveness and compassion for its members, and the extent to which the student's methodology of cheating, one that was unlikely to provide her with any significant advantage, should play a role in determining appropriate consequences.

Discussions of promotions committee decisions are largely of the "Monday morning quarterback" variety and concern decisions that have already been made rather than an investigation of how individuals or groups came to a particular decision. The Osborn (2000) and Smith (2000) articles (and subsequent letters to the editor) are examples of a debate that appears within the literature about the leniency or severity of consequences enacted by promotions committees after the fact. However, these commentaries on academic dishonesty do raise an essential dilemma that is at the core of my research. A goal of my study is to better understand how promotions committee members balance the potentially competing values of fairness and consistency with the values of contextualization and responsiveness when making decisions about students. I explore this tension further in the section below.

Moral Decision Making

It is perhaps a stretch to classify the administrative work of promotions committees as "moral" decision making. However, considering the enormous impact their decisions can have on the personal and professional lives of students, I believe that most committee members would readily agree that their decisions are guided by a set of professional and personal ethics, and that their individual and group deliberations are undertaken with every intention to make thoughtful and appropriate decisions. The extent to which committee members are guided by one ethical orientation or another, or perhaps by some combination of guiding principles, is one of the central questions addressed in my research. There exists a classic debate in the philosophical and psychological literature concerning moral development and the guiding principles of human decision making that serves to provide a theoretical framework through which to examine promotions committee decision making (Botes, 2000a, 2000b; French & Weis, 2000; Gilligan, 1982; Kohlberg, 1981; Liddell, Halpin, & Halpin, 1992; Noddings, 2003; Tong, 1998).

Justice versus care. In the 1960s and '70s Lawrence Kohlberg developed a theory of moral development that included six progressive stages and three over-arching levels of achievement (Kohlberg, 1981). While the first two stages were considered the realm of child development, Kohlberg posits that adults proceed through the "conventional" level (stages three and four) in which interpersonal accord and regard for society's laws become paramount. They may then proceed to the highest degree of moral development in the "post-conventional" level (stages five and six) when moral decision making is seen as an autonomous process guided by rational and abstract thought (Gump, Baker, & Roll, 2000; Kohlberg, 1981; Liddell et al., 1992; Zhong, 2011). Moral development culminates in stage six in which the universal principles of justice and equity guide all decision making, and the concept of "fairness" is based on a set of unchanging rules and standards. According to Kohlberg's developmental hierarchy, an "ethic of justice" is the most evolved approach to moral decision making.

> The ethic of justice-rights is characterized by objectivity, rationality, and separation. One who demonstrates and ethic of justice-rights treats people fairly by identifying and fulfilling rules, principles, rights, and duties. There is an assumption of reciprocity and a concern for equality. (Liddell et al., 1992, p. 326)

The work of Kohlberg has been substantially challenged by Gilligan and others (Flanagan & Jackson, 1987; Gilligan, 1982; Noddings, 2003) who contend that such a view of morality is masculine in nature, and discounts the more relationship-centric experiences of women. Gilligan's research resulted in an alternate model of moral development in which females proceed through three consecutive stages, motivated initially by self-interest, then by concern for others, then by a more mature integration of the two (Gilligan, 1982; Gump et al., 2000). Gilligan ultimately provides a conception of morality and moral decision making that is oriented

toward the care of others, one that within Kohlberg's original model locates a feminine ethic only midway up the moral development hierarchy (at stage three of six). Within Gilligan's redefinition of morality the conception of "fairness" becomes less abstract and rule-oriented, and more individualized and situational in nature.

> The ethic of care is characterized by subjectiveness, intuition, and responsiveness. One who demonstrates an ethic of care responds to people in a way that ensures that the least harm will be done and that no one will be left alone. There is an assumption of connectedness and attachment and an understanding that everyone is different and may have a different reality. Decisions are contextual and relative to a particular situation. (Liddell et al., 1992, p. 326)

This classic two-sided debate regarding masculine and feminine ethics is currently being broadened and is becoming more nuanced. For example, a number of studies now indicate that culture, in addition to gender, plays a mediating role in ethical decision making (French & Weis, 2000; Gump et al., 2000), and the idea that we are limited to two ethical orientations may prove a false dichotomy (Flanagan & Jackson, 1987). There are also discussions about whether justice and care orientations represent distinct and incompatible ways of viewing the world, or whether there are conceptual overlaps between the two (Flanagan & Jackson, 1987; Held, 1995). For example, Held indicates that she previously conceived of justice as a minimum threshold for all moral decisions- that we should go beyond justice as a moral "floor of duty" (p. 131) but that justice at least provided a baseline for decision making. Now however she believes that care for others provides the moral framework within which concerns for justice must fit. Others posit that an individual may subscribe to more than one ethical orientation and be able to switch between the two, or use the two concurrently, depending on contextual variables and

requirements (Flanagan & Jackson, 1987). "There is no logical reason why both care and justice considerations cannot be introduced, where relevant, into one and the same reasoning episode" (p. 626).

Limitations of empathy and rationality. The ethical orientations of justice and care may each have limited applicability to different realms of functioning. For example, an ethic of care may be more appropriate for personal interactions rather than large-scale policy making (Bloom, 2013, 2014; Jenni & Loewenstein, 1997; Pizarro, Detweiler-Bedell, & Bloom, 2006; Tong, 1998). One argument is that empathy, an emotion rooted in an ethic of care, introduces a host of biases that may unduly influence a decision making process. Empathic responses are triggered by perspective taking, mimicry and perceived similarities between the self and the person in question (Pizarro et al., 2006). These perceived similarities can unfortunately lead to bias.

> Empathy is biased; we are more prone to feel empathy for attractive people and for those who look like us or share our ethnic or national background. And empathy is narrow; it connects us to particular individuals, real or imagined, but is insensitive to numerical differences and statistical data. (Bloom, 2014, p. 2)

Empathy is also malleable (Pizarro et al., 2006). Our emotions are easily co-opted and manipulated for particular purposes. "Because human cognition is flexible, it is fairly easy to construe individuals as similar or dissimilar and thus increase or decrease the probability that someone will experience empathy for any given target" (p. 87). Politicians exploit our empathetic nature in their attempts to make abstract policy personal. By putting a face to a particular issue, they introduce an "identifiable victim effect" whereby we are willing to give more to help an individual personalized victim than large numbers of unidentified victims with

what may be exponentially greater need (Bloom, 2013; Friedrich & McGuire, 2010; Jenni & Loewenstein, 1997). According to this view, empathy (as an aspect of care) would be an inappropriate moral guide for making political decisions that impact large numbers of people, but may be highly appropriate as a guide to close personal relationships.

On one hand, when it comes to individual decision making, empathy (care) can lead to bias, and may therefore be an inappropriate basis on which to make large-scale policy decisions. On the other hand, pure rationality can lead to dehumanization (Botes, 2000b) and a disruption of human intuition and emotion (Zhong, 2011). In many situations, wherein there are multiple ways to view a dilemma, moral clarity about what to actually *do*, may be lacking. When one path forward represents a particular ethical orientation and another represents its opposite, there may be no escaping the need to ultimately make a choice between the two (Flanagan & Jackson, 1987; Held, 1995). This dilemma may be ameliorated somewhat when individual decision making is only one part of a larger group process.

Botes (2000a, 2000b) calls for the integration of care and justice orientations in the group process of healthcare decision making. She contends that healthcare teams, and the patients they attend, would be better served by a decision making process that validates and combines both orientations. In order to make appropriate treatment decisions, and to also incorporate as much as possible that which is valued by a particular patient, members of the healthcare team must work together to integrate the two ethical perspectives. "Both the fair and equitable treatment of all people (from the ethics of justice) and the holistic, contextual and need-centered nature of such treatment (from the ethics of care), ought therefore to be retained in the integrated application of the ethics of justice and the ethics of care" (2000a, p. 1074). In order for groups to actually achieve this integration they must engage in a process of extended rationality in which

sound arguments are made, solid reasoning is presented, and each contribution has adequate justification to support it (2000b). They must also engage in discourse that is characterized by open and empathic attitudes, verification of evidence and consensus building. The processes outlined may provide a model for promotions committee deliberations, but are clearly time consuming and require buy-in and participation from all team members.

Moral decision making and promotions committee work. The classic philosophical debate regarding ethical orientations based on justice or care may well provide insight into the decision making processes of promotions committee members. For example, a committee member may employ an ethic of justice, in which his or her decisions prioritize institutional policy, consistency, and accepted principles of the medical profession. Alternately, a committee member may employ an ethic of care, in which his or her decisions prioritize the maintenance of relationships with learners, holistic review of student cases, and decisions that respond to individualized circumstances. There are, however, limitations and dangers inherent in each of these ethical approaches. Empathic responses are often induced through the use of stories (Pizarro et al., 2006). "Indeed, a well-told story with a sympathetic protagonist may serve as one of the most effective sources of moral persuasion" (p. 93). Thus when compelling information about a student case is shared with promotions committee members, either by an administrator or by the student him/herself, the empathy elicited by that "story" has the potential to perhaps unduly influence proceedings in the favor of the "identifiable victim" (the underperforming student), versus a greater number of unidentifiable potential "victims" (the student's future patients).

If empathy and bias are intertwined, committee members may need to think critically about with whom they empathize, and why. They may need to engage in an analysis of their

own decision making for potentially uncomfortable trends that may favor one group over another. And if a focus on justice and objectivity comes at the expense of compassion and support, committee members may need to temper absolute policies and provide occasional exceptions to the rules.

Implications for Current Research

Data from the "failure to fail" literature within health professions education seem to indicate that many underperforming students are never even considered by a promotions committee because faculty are reluctant to submit grades that reflect actual student performance. The "failure to fail" literature was very influential in the design of the survey tool used to collect data for this research project. Student-centered issues, such as debt level, proximity to graduation and experience of mental health issues that played a role in faculty members' "failure to fail" influenced the survey design. Personal experience indicates that when shared with committee members, students' individual characteristics and circumstances play an influential role in committee decision making. For example, if it is known that a student is experiencing depression or extenuating personal circumstances that could help explain an academic failure, committee members may be more likely to vote in favor of showing "leniency" toward the student (perhaps providing him or her an extra chance to pass a course or voting against moving the student from academic warning to academic probation, for example). If it is known and shared that a student is availing him or herself of all appropriate resources, committee members may look favorably upon that student and make decisions accordingly. What is not currently known, and what I attempt to assess through my survey, is which particular student characteristics or circumstances (from a predetermined list) are *most* influential. Section 5 of the survey asked participants to weigh the extent to which specific student characteristics or

circumstance are influential to their decision making using a four-point ordinal Likert scale from "not at all influential" to "highly influential."

The body of literature that most directly addresses the work of medical school promotions committees concerns an appraisal of committee decisions after the fact. The debate regarding dismissal of medical students for reasons of academic dishonesty speaks to the interest that exists in the work of promotions committees by members of the medical profession, and also begins to explicate the tension between the multiple roles of physician-educators. The calls for automatic dismissal of students for cheating represent the notion of physician-educators as "gate-keepers" of the profession whose primary responsibilities are to the students' future patients and to the medical profession itself. The calls for a humane and nuanced approach to dealing with students represent the care-based nature of both medicine and education and the need to model to our learners a holistic approach to human interaction.

While my research does not explicitly deal with issues of academic dishonesty, the descriptive data collection process included a question regarding whether or not participants' committees consider issues of professionalism as part of their charge. Additionally, the tension identified in the commentaries on student misconduct is closely related to the concept of ethical orientations which provides the theoretical framework for much of my survey. Section 3 of the survey consisted of two short fictional student cases and asked participants to decide whether or not to dismiss the fictional students. Participants also identified the extent to which they were influenced by the need to be consistent with previous decisions (exemplifying an ethic of equity and justice), and then the extent to which they were influenced by the need to be responsive to the student's particular circumstances (exemplifying and ethic of contextualization and care). It is worth noting that I designed the survey questions with the

assumption that participants would identify *both* ethical orientations as being influential. The survey purposefully did not require participants to choose between justice and care as guiding principles. Rather, my hope was that participant responses would provide data regarding the relative strength of two ethical orientations across a variety of demographic categories including, but not limited to, gender.

Section 4 of the survey was also designed using ethical orientations as a conceptual framework. Questions in this section concerned conceptions of fairness that contrast an egalitarian or justice-based approach (in which one set of standards is applied uniformly across all students) with a humanistic or care-based approach (in which students are considered as individuals with a unique set of personal circumstances). A series of questions about committee deliberations attempted to elicit information regarding participants' conceptions of a "good" committee process. Questions also addressed the values that guide individual decision making and the extent to which it is important to participants that their consideration of student cases is objective and fair (ethic of justice), and humanistic and empathetic (ethic of care). A final set of questions in Section 4 asked the extent to which participants agree with a variety of definitions of the role of their promotions committee. These definitions embodied elements of justice and care. Again, no questions required participants to choose one orientation exclusively, and my hypothesis is that both justice and care guide individual participant decision making to different extents under different circumstances.

Conclusions

A review of the literature related to promotions committees in health professions education reveals a scholarly jump from consideration of grading practices to post-hoc consideration of decisions to dismiss. Few studies are directly concerned with the decision

making processes that are at the heart of promotions committee work. As a result, there is inadequate information available to replicate successful models, document best practices, or create appropriate training materials. Only a small number of published articles provide any guidance in terms of actual promotions committee practices (Cohen et al., 2013; Teplitsky, 2002). While these few articles attend to the complex issues that surround student failure, none address the decision making of committee members from the perspective of moral or ethical orientations.

The ability of the medical education community to compile a complete picture of students' performance over time is made difficult by the disjointed nature of medical education. It is not uncommon for each course and clerkship to be directed by different individuals. Without a robust central administration and tracking system, individual instances of academic underperformance or unprofessionalism can be viewed in misleading isolation. Studies on the persistent nature of poor academic performance, cheating and unprofessionalism should give us pause. "Data suggest that questionable behaviors and academic performance displayed early in a career (often as early as college) may not disappear with age, maturity, or even intervention" (Arawi & Rosoff, 2012, p. 137). Additionally, "there may be a tendency by many medical schools to go to heroic lengths to enable students to pass their courses" (p. 142). In this researcher's opinion, while the cost of medical student attrition is high, the cost of inaccurate or incomplete assessment of the competence and integrity of our future physicians is potentially much higher.

Institutional promotions committees play an important role in that determination of student competence. Committee members balance the needs of society and the medical profession with the needs of individual students. They consider policy and consistency, while

also attempting to treat individual students in a manner befitting a healing profession. Committee members, and the institutional entities that facilitate their participation in this administrative process, may need to undertake a critical examination individual and group decision making processes. Committees may need to review their procedures to ensure that all voices, those that emanate from primarily an ethic of care, and those that emanate primarily from an ethic of justice, are heard. The current research represents a first step in the explication of this important and complex process.

CHAPTER 3: METHODOLOGY

Introduction

This chapter will provide details about the methodology used to collect data regarding promotions committee members' perceptions of their committee, the ethical orientation(s) used in their decision making as part of their participation on the committee, and the particular student characteristics and circumstances that influence their decision making. The primary means for data collection was an electronic survey. Survey methodology was chosen as the most appropriate for this inquiry because some version of a medical school promotions committee exists at every accredited allopathic medical school in the United States according to LCME accreditation requirements, and a goal for this project was to analyze these committees on a national level. A national survey allowed me to come to some generalizable conclusions about how committee members perceive the committee work, and how they consider student cases. Survey methodology allowed me to reach a large number of individuals and solicit information from them about their participation on their institution's version of a promotions committee. Primarily quantitative in nature, survey data can be analyzed to describe committee member decision making and reveal similarities and differences across individuals, institutions, and other demographic categories such as gender, size of the student body, and geographic region.

Survey methodology was also chosen because of the privacy it affords to participants, and because access to participants at other medical schools for qualitative research may have proved problematic. Within survey-based inquiry, participants are able to answer questions anonymously without fear of identification or judgement. Survey methodology allowed me to electronically access participants in a non-threatening manner that was thought to potentially

produce the least resistance on the part of medical education institutions that may be wary of making public their promotions committee processes.

Survey Design

The survey instrument was designed using Qualtrics software, a platform supported by the Brown University computing services department. The survey consisted of informed consent information and six subsequent sections of questions (please see Appendix A for a complete printed version of the survey). Section 1 was designed to elicit demographic information about the individual respondent. The five questions in this section asked participants to indicate gender, age (in 10-year increments), primary role (medical student, faculty or administrator), the number of years participated on their institution's promotions committee (in two-year increments) and highest degree(s) completed. One additional question regarding major teaching responsibilities (of medical students or of residents) was displayed if a respondent indicated that his/her primary role was as a faculty member. One additional question regarding clinical specialty area was also displayed if a respondent indicated having completed a medical doctor (MD) degree.

Section 2 of the survey was designed to elicit institutional demographic information. The questions in this section asked participants to identify their home-institution (from a drop-down list of accredited allopathic medical schools in the United States), and whether their institution is public or private. The third question asked the participant if the promotions committee on which he/she serves considers students in all four years of medical school, students in the preclinical years of medical school only, or students in the clinical years of medical school only. The final question asked participants for the size of their institution's class of 2019 in increments of 50.

Section 3 consisted of two short fictional student cases. Each case was followed by three questions that asked participants to engage in a hypothetical decision making process about the student(s) in question, to identify the influences on that decision making, and about their ultimate decision (to dismiss or not dismiss the student in question). I developed these cases and, although they are fictional in nature, they are representative of common situations considered by the medical school promotions committee in which I am involved. Case A concerned two male students, and Case B concerned two female students. Gender concordance within cases was purposeful to reduce the potential influence of student gender on participant decision making. No additional demographic details regarding student race/ethnicity, age, etc. were included.

Narrative responses to the open ended questions for each case ("Assuming that you have to make a choice, what action would you take regarding Bill/Shayla? Explain your choice.") were collected and coded for themes. Initial review of responses revealed 17 themes for Case A and 15 for Case B. For each of the cases there were strong repeated themes that emerged and that were consistent with whether or not the participant voted to dismiss the student. These major themes are discussed in detail in Chapter 4.

Section 4 was comprised of a series of questions about committee deliberations generally. These 17 questions elicited information regarding whether participants' committees have the discretion to take into consideration particular student characteristics and circumstances, whether participants' committees actually do take into consideration particular student characteristics and circumstances, and participants' conceptions of a "good" committee process in terms of responsiveness to particular student characteristics and circumstances. The questions also addressed how committee members perceive the values that influence their own decision making, and how they define the role of their promotions committee. More specifically,

questions in this section concerned conceptions of fairness that contrasted an egalitarian or justice-based approach (in which one set of standards is applied uniformly across all students) with a holistic or care-based approach (in which student cases are considered on an individual basis).

Section 5 of the survey made use of an existing list of specific student characteristics and circumstances that potentially inform the decision making process of promotions committee members. The list was developed through a previous pilot study, my experiences as an ex-officio member of one such committee and occasional participant in a second, and examination of the "failure to fail" literature. It asked participants to weigh the extent to which specific student characteristics or circumstances were influential in their decision making using an ordinal Likert scale.

The final section of the survey, Section 6, was comprised of open- and close-ended questions regarding the existence of committee processes to assist faculty with the emotional aspects of their work, and to describe any training received regarding committee work. Narrative responses to the open-ended questions were coded for themes. Major themes are discussed in detail in Chapter 4.

Survey Pilot Testing

The survey was pilot tested by seven individuals from The Warren Alpert Medical School of Brown University (AMS). Of the six faculty members, two were former members of the AMS promotions committee, and two had never participated on a promotions committee. Two faculty were current members of the AMS promotions committee, one in the role of committee Chair. The seventh individual to pilot test the survey was an administrator with no experience on a promotions committee. Each individual submitted written feedback on survey

length and on specific survey questions, and I made appropriate changes to the survey in response to their feedback.

Survey Participants

A list of 144 accredited medical schools in the United States was obtained from the Liaison Committee on Medical Education, the accrediting body for medical schools in the United States, on August 18, 2015 (retrieved from http://lcme.org/directory/accredited-u-s-programs/). One school with preliminary accreditation status had no publicly available website and was therefore excluded from the study. An Excel spreadsheet was created that contained each medical school's name and a link to the main institutional webpage. Additional web searches were performed to identify information regarding promotions committees using internal keyword searches of "promotion", "probation", "progress", "academic standing", "bylaws", "handbook" and "dismissal". The promotions committee name and URL with committee information was identified whenever possible and saved on the spreadsheet.

Web searches were also conducted to identify the appropriate contact person for each institution's promotions committee. When possible, the faculty member serving as committee Chair was identified by name and title, and an email address was located. When such information was not available, the name, title and contact information for an Associate Dean of Medical Education or Associate Dean of Student Affairs was added to the spreadsheet as an appropriate contact person instead. An email was distributed to each of these contact points on October 20, 2015. The email was addressed to each contact person by name, and included the institution's particular name for their version of a promotions committee in the subject line (when that information was unavailable, the subject line "Medical Student Promotions Committee" was used). The body of the email provided basic information about the research

project and requested that the point of contact pass along the survey link to all voting members of his/her institution's promotions committee. If an individual contact replied asking for more information about the research project, I responded appropriately with the requested information.

A reminder email designed to be easily forwarded to promotions committee members was sent on November 9, 2015. The email encouraged promotions committee members to complete the survey and reiterated the IRB-approved and anonymous nature of the survey. A total of 135 reminder emails were sent to the originally identified institutional contact people, or to a new contact person if a more appropriate individual had been identified via a response to the original email. The reminder email was not sent to any individuals from institutions who had responded to the original email in a way that indicated refusal to pass along the survey. The survey was officially closed on December 11, 2015 with 296 surveys started and 241 surveys completed.

Descriptive Data Collection

The second component of my research was the collection of basic descriptive information regarding the structure and function of promotions committees across institutions. While the survey attempted to explicate the decision making processes, and influences on those processes, of individual committee members, the goal of the descriptive data collection was to describe relevant aspects of the membership and logistics of promotions committees across a number of institutions.

On November 30, 2015, an Excel spreadsheet was distributed to 139 individuals at 136 medical schools by the current Associate Dean for Medical Education at AMS who agreed to be involved in this process (Dr. Allan Tunkel). The identified points of contact were asked to assist in the completion of the spreadsheet which asked for information regarding their institutional

promotions committee. The point of contact was asked to either provide the descriptive data for the institution him/herself, or to identify an appropriate administrator with whom I could communicate. These descriptive data focused on structure and function of promotions committees that may not be explicitly known by voting members (for example, total number of committee members, member term limits, minimum number of committee meetings per year, etc.).

CHAPTER 4: DATA ANALYSIS

Introduction

The primary means for data collection was an electronic survey (see Appendix A for complete survey questions). The survey was designed to be completed by voting members of medical schools' promotions committees. A total of 296 surveys were begun, and 241 were completed. Analyses were performed using IBM SPSS Statistics 22. Participant responses are analyzed by survey section below.

Survey Sections 1 and 2- Demographic Data

Sections 1 and 2 of the survey were designed to elicit demographic information about individual respondents and about their home institutions. Participants included more men than women, and three participants (1%) indicated "Other/Prefer not to identify."

Table 1
Survey Participants, by Gender

Gender Category	N	%
Men	126	52
Women	112	47
Other/Prefer not to identify	3	1
Total	241	

The highest percentage of participants were between 40 and 49 years of age, with the next highest percentage indicating that they were between 50 and 59 years of age. Fewest participants reported being in the two oldest age categories, 70-79 and 80+.

Table 2
Survey Participants, by Age

Age in Years	N	%
<30	15	6
30-39	34	14
40-49	73	30
50-59	68	28
60-69	45	18
70-79	4	2
80+	2	1
Total	241	

The three most frequently reported categories of experience on a promotions committee, three to four years, one to two years, and 7+ years, accounted for three quarters of the respondents.

Table 3
Survey Participants, by Committee Experience

Experience in Years	N	%
<1	29	12
1-2	60	25
3-4	62	26
5-6	33	14
7+	54	23
Total	238	

The majority of participants identified as faculty members, with smaller percentages of participants reporting a primary role as administrator or medical student.

Table 4
Survey Participants, by Role

Participants	N	%
Faculty Members	194	80
Medical Students	20	8
Administrators	28	12
Total	242	

Generally speaking, medical students were younger than faculty members and had fewer years of experience on their institutions' promotions committees. While medical students represented 8% of total participants, they were overrepresented in the younger age categories. They made up 100% of the <30 age category and 6% of the 30-39 age category. They were also over represented in the categories of participants with fewer years of experience on their institutions' promotions committees. Medical students made up 24% of the <1 year experience category, 12% of the 1-2 years of experience category, 10% of the 3-4 years of experience category, and 0% of the 5-6 and 7+ categories.

When asked to mark the highest degree(s) earned, most participants indicated having completed a graduate degree, though 16 (6%) participants (all of whom were medical students) indicated that a bachelor's degree was the highest degree earned. The most common degree earned was a Doctor of Medicine.

Table 5
Highest Degree(s) Earned

Degree	N	%
Bachelor's Degree	16	6
Master's Degree	9	3
MD	139	50
PhD/EdD	71	26
Other	10	4
Total	245	

Of the medical doctors, clinical practice areas were spread out across a number of specialty areas (from a drop-down list) with Internal Medicine, "Other" and Family Medicine being the most common choices, and Neurology, and Pathology being the least common choices.

Table 6
Clinical Specialties

Specialty Area	N	%
Internal Medicine	26	9
Family Medicine	24	9
Pediatrics	20	7
Psychiatry	14	5
Obstetrics/Gynecology	11	4
Emergency Medicine	9	3
Surgery	9	3
Neurology	5	2
Pathology	4	1
Other	25	9
Total	147	

The majority of primary teaching responsibilities involved medical student and resident learners. "Other" learners, such as fellows, graduate students, or an equal mix of medical students and residents, comprised a smaller percentage of teaching responsibilities.

Table 7
Primary Teaching Responsibility

Learner Type	N	%
Medical Students	101	52
Residents	61	32
Other	31	16
Total	193	

A total of 220 participants indicated their institutional affiliation from a drop-down list of all 143 accredited allopathic medical schools in the United States. The maximum number of participants from a single institution was 13, the minimum was one. The survey indicated that institution names would not be mentioned in any research reports. Participants indicated affiliation with 55 medical schools (38% of all medical schools) from all four geographic regions

as categorized by the Association of American Medical Colleges' Group on Educational Affairs. The greatest representation of individual participants was from the Central region, and the least representation of individual participants was from the Northeastern region.

Table 8
Participation by Geographic Region

Region	N Individuals (%)	N Institutions (%)
Central	73 (33)	19 (35)
Northeastern	44 (20)	10 (18)
Southern	53 (24)	13 (24)
Western	50 (23)	13 (24)
Total	220	55

One hundred and seventy participants (72%) indicated that they were from public institutions, and 65 (28%) were from private institutions. Participants reported a range of medical school sizes, as indicated by the size of the class scheduled to graduate in 2019. The most commonly reported class size was 100-149 and 150-199. For data entered regarding class size, public schools were overrepresented in the largest class size category (100% of 300+) while private schools were underrepresented in the largest category (0% of 300+) and over represented in the smallest category (34% of <100).

Table 9
Survey Participants, by School Type and Class Size

Class Size	Public N (%)	Private N (%)	Total
<100	23 (66)	12 (34)	35
100-149	75 (84)	14 (16)	89
150-199	34 (55)	28 (45)	62
200-249	29 (74)	10 (26)	39
250-300	0 (0)	0 (0)	0
300+	8 (100)	0 (0)	8
Total	169	64	233

Survey Section 3- Student Cases Data

Section 3 of the survey consisted of two short fictional student cases. Each case described two students and was followed by three questions (see Appendix A for complete survey questions). Case A described two students with similar academic performance- one with no extenuating circumstances that might explain his failures and who was previously dismissed from the medical school by the committee, and one currently under consideration by the committee who is undergoing a contentious divorce.

Figure 1

Student Case A
Last month your committee voted to dismiss Andrew, a medical student in his third year of medical school. Andrew had experienced multiple academic failures and struggled clinically. To the committee's knowledge, there had been no extenuating circumstances contributing to his failures.

This month, the committee is considering the case of Bill. Bill is also in his third year of medical school, has experienced the same number of failures as Andrew, and has also struggled clinically. The committee is informed that Bill is in the midst of a contentious divorce.

Participants were asked to rate the extent to which they were influenced by the need to be consistent across the two students, and the extent to which they were influenced by the need to be responsive to particular student circumstances, on a four-point Likert scale from "Not at all influenced" (1) to "Highly influenced" (4). The average score regarding the need to be consistent was 2.65. The average score regarding the need to be responsive was 2.62. These scores are not significantly different, indicating that participants were not influenced by one value (consistency versus responsiveness) significantly more than the other. Ninety-eight (45%) participants voted to dismiss Bill, while 120 (55%) voted not to dismiss him.

Figure 2

Student Case B
Last month your committee voted not to dismiss Alice, a medical student in her second year of medical school. Alice had experienced multiple academic failures. The committee was informed that Alice had taken advantage of tutoring assistance and worked with advisors to remedy the situation.

This month, the committee is considering the case of Shayla. Shayla is also in her second year of medical school and has experienced the same number of failures as Alice. The committee is informed that Shayla has not taken advantage of tutoring assistance. She has demonstrated reluctance to change the way she prepares for exams, and has been resistant to advice on a number of levels.

Participants were asked to rate the extent to which they were influenced by the need to be consistent across the two students, and the extent to which they were influenced by the need to be responsive to particular student circumstances, on a four-point Likert scale from "Not at all influenced" (1) to "Highly influenced" (4). The average score regarding the need to be consistent was 2.65. The average score regarding the need to be responsive was 2.76. Similarly to Case A, these scores are not significantly different, indicating that participants were not influenced more by one value than the other (consistency versus responsiveness) for this case. One-hundred fifty-one (71%) participants voted to dismiss Shayla, while 63 (29%) voted not to dismiss her.

A paired-sample t-test comparing the influence of the need to be consistent and responsive across the two cases indicated two significant differences between how participants responded to one case versus the other. Participants were significantly more influenced by the need to be responsive for Case B, which involved a student with negative characteristics (resistance to help and advice), than they were for Case A, which involved a student undergoing a divorce, $t(213) = 2.141$, $p = 0.033$.

Table 10
Responsiveness, by Cases

Case	N	Mean	SD	Std. Error Mean
Case A (Bill)	214	2.64	0.717	0.049
Case B (Shayla)	214	2.76	0.797	0.054

Note. Responses were on a four-point Likert scale from "Not at all influenced" (1) to "Highly influenced" (4).

Participants also indicated a significantly greater willingness to dismiss the student in Case B than for Case A, $t(213) = 5.956$, $p < 0.001$. In Case A, only 98 (45%) participants indicated that they would dismiss the student in question and in Case B 151 (71%) participants indicated that they would dismiss the student in question.

Table 11
Decision to Dismiss, by Cases

Case	N	Mean	SD	Std. Error Mean
Case A (Bill)	214	1.55	0.499	0.034
Case B (Shayla)	214	1.29	0.457	0.031

Note. Response choices were "Dismiss" (1) or "Do Not Dismiss" (2).

While participants indicated that they were influenced equally by the values of consistency and responsiveness in each case, a closer examination of how they actually "voted" indicates the relative strength of responsiveness as a value. In Case A, a decision to dismiss Bill would be consistent with how Andrew was treated. Yet only 45% voted to dismiss. In Case B, a decision *not* to dismiss Shayla would be consistent with how Alice was treated. Yet 71% of participants voted to dismiss. In both cases, the participants voted in ways that demonstrated a lack of consistency with previous decisions.

One-way ANOVA was performed in order to analyze participant responses to the three questions in each case by gender (male, female, other), age in years (<30, 30-39, 40-49, 50-59,

60-69, 70-79, 80+), role (medical student, faculty or administrator), and years of committee experience (<1, 1-2, 3-4, 5-6, 7+). A t-test was performed to analyze participant responses by institution type (public, private). There were no significant differences in responses by gender for either case. Because only one case describing a male student and one case describing a female student were used, and because these cases described very different circumstances, the impact of gender concordance between participant and hypothetical student cannot be analyzed with any validity. There were no significant differences by years of committee experience on either case.

The extent to which participants indicated being influenced by the need to be responsive in Case B varied significantly by age, $F(6, 207) = 2.713$, $p = 0.015$. A post-hoc Bonferroni analysis of variance did not indicate any significant differences between particular age groups. Responses on this question did not vary significantly by role ($p = .068$), however the data were reanalyzed excluding the <30 age group, completely comprised of medical student respondents, in order to further clarify the influence of participant role. Upon reanalysis, the results were not significant by age, $F(5, 193) = 1.818$, $p = 0.111$, indicating that role may have been an influential, if not statistically significant, variable.

Table 12
Responsiveness, Case B (Shayla), by Age

Age	N	Mean	SD	Std. Error
<30	15	3.27	0.594	0.153
30-39	33	2.79	0.545	0.095
40-49	64	2.67	0.874	0.109
50-59	56	2.68	0.741	0.099
60-69	40	2.73	0.877	0.139
70-79	4	3.75	0.500	0.250
80+	2	2.00	1.414	1.000
Total	214	2.76	0.797	0.054

Note. Responses were on a four-point Likert scale from "Not at all influenced" (1) to "Highly influenced" (4).

The extent to which participants indicated being influenced by the need to be responsive in Case A varied significantly by role, $F(2, 217) = 3.076$, $p = 0.048$, though not by age. Medical students reported being more influenced by the need to be responsive than did administrators or faculty, though a post-hoc Bonferroni analysis of variance did not indicate any significant differences between particular roles.

Table 13
Responsiveness, Case A (Bill), by Role

Role	N	Mean	SD	Std. Error
Medical Student	20	2.90	0.553	0.124
Faculty Member	177	2.56	0.714	0.054
Administrator	23	2.83	0.887	0.185
Total	220	2.62	0.728	0.049

Note. Responses were on a four-point Likert scale from "Not at all influenced" (1) to "Highly influenced" (4).

The extent to which participants indicated being influenced by the need to be responsive in Case A varied significantly by institution type, $t(217) = 2.186$, $p = .030$, as did the extent to which they indicated being influenced by the need to be responsive in Case B, $t(212) = 2.308$, $p = .022$. Participants from private institutions indicated greater agreement with the statements regarding being influenced by the need to be responsive than did participants from public institutions for both Cases.

Table 14
Responsiveness, Case A and B, by Institution Type

	Case A (Bill)				Case B (Shayla)			
Institution Type	N	Mean	SD	Std. Error Mean	N	Mean	SD	Std. Error Mean
Public	160	2.56	0.759	0.060	156	2.69	0.794	0.064
Private	59	2.80	0.610	0.079	58	2.97	0.772	0.101
Total	219				214			

Note. Responses were on a four-point Likert scale from "Not at all influenced" (1) to "Highly influenced" (4).

For each case, participants were also asked to explain their decision to dismiss or not dismiss the student in question. Narrative responses for each case were coded for themes. Initial review of responses revealed 17 themes for Case A (Bill) and 15 themes for Case B (Shayla). For each of the cases strong repeated themes emerged that were consistent with whether or not the participant voted to dismiss the student. For Case A, five of the original 17 themes were collapsed and coded as having to do with "causation" - the causal connection between the extenuating circumstances (the divorce), and Bill's academic struggles. Those that inferred a causal connection, who attributed Bill's failures to his personal circumstances, voted *not* to dismiss him. Those that questioned that connection, who doubted whether Bill's protracted academic struggles could be explained by a divorce in his third year of medical school, tended to choose to dismiss him.

Table 15
Narrative Responses to the Question, "Assuming you have to make a choice, what action would you take regarding Bill? Explain your choice."

Decision	Representative Quote
Do Not Dismiss	"I am making this choice based on the assumption that Bill's divorce process is highly stressful and is taking up a lot of time that he would otherwise be dedicating to his clinical/academic work. I would also be interested in how long this divorce process has been going on- whether it may have been the cause for his previous failures or whether those preceded his divorce process."
Do Not Dismiss	"Divorces do not happen overnight and it is likely that these issues have been influencing his performance throughout his academic difficulties."
Dismiss	"Based on the scenario, it seems like his academic struggles preceded the divorce. If his struggles coincided with his divorce, I would have hoped that someone would have recommended personal leave and support counseling prior to getting to this point."
Dismiss	"It has been 3 years of consistent bad performance. A bad divorce now shouldn't explain all that."

Of those participants who chose *not* to dismiss Bill, many indicated that they would instead recommend a leave of absence to give him a chance to work out his personal issues. Interestingly, many participants who chose to dismiss Bill also mentioned a leave of absence. However, these latter participants mentioned a leave of absence in the context of Bill's personal responsibility to be fully engaged in his education. The fact that Bill did not initiate a leave of absence himself was interpreted as lack of insight or as a lapse in professionalism. "One of the hallmarks of professionalism is that if you show up for duty, you are ready to perform and your personal circumstances are never an excuse. Bill should have taken a leave of absence if he could not perform." The participant making this comment voted to dismiss Bill.

Professionalism was a theme in a number of the narrative responses that focused on the expectations of the medical profession. They indicated that Bill should be held to the same standards as practicing physicians in which personal circumstances are secondary to patient care. "Unfortunately life is hard and as a physician one would still need to handle life experiences and perform well in the clinical setting. A student should be held to the same expectations." The participant making this comment also voted to dismiss Bill. Other less frequent themes included comments about not having adequate information in order to make a decision, doubts about Bill's ability to obtain a residency, and needing to be consistent with how the committee dealt with Andrew, the student who was dismissed.

Professionalism was a very strong theme in the narrative responses for Case B as well. Eight of the original 15 themes were collapsed and coded as having to do with Shayla's lack of professionalism. Resistance to advice and to making changes to her behavior was viewed as a poor prognosis for success. "Being self-aware and willing to accept that your way is not always the best way is integral to patient care. I would see Shayla's stubbornness as a red flag of her

potential inability to work as part of a team." The participant making this comment voted to dismiss Shayla. Most participants seemed to interpret Shayla's behavior as a character flaw- one that is incompatible with physicianship. Others interpreted her behavior as reflecting a lack of dedication or motivation. A very small number (3) of responses concerned possible explanations for Shayla's resistance, including mental health and cultural factors, and two of the three participants making such comments chose not to dismiss her without more fully understanding her circumstances. Other less frequent themes included comments about not having adequate information in order to make a decision, and needing to be consistent with how the committee dealt with Alice, the student who was not dismissed.

Table 16
Narrative Responses to the Question, "Assuming you have to make a choice, what action would you take regarding Shayla? Explain your choice."

Decision	Representative Quote
Dismiss	"It is necessary to adapt throughout one's career and constantly learn in order to be successful as a physician and provide good care for one's patients. Refusing to adapt and learn is a fatal flaw for this profession."
Dismiss	"To not take advantage of assistance suggests that success in med school is not a huge priority."
Do Not Dismiss	"Some students are reluctant to seek help due to cultural issues, or depression. I'd want to rule out other causes for noncompliance before dismissing."

Survey Section 4- Promotions Committee Data

The vast majority of participants indicated that they were members of a promotions committee that considers students in all four years of medical school, versus committees that consider students in the preclinical years only, or the clinical years only. Other reported committee types included one that considers students in the first year of medical school only, and

ones that consider students in all years of combined programs such as BA or BS/MD, MD/PhD, and postbaccalaureate/MD.

Table 17
Promotions Committee Type

Committee Type	N	%
Considers students from all four years of medical school	203	86
Considers students in the preclinical years only	14	6
Considers students in the clinical years only	9	4
Other	9	4
Total	235	

Two survey questions attempted to elicit information about the extent to which participants agree that their promotions committee has the *discretion* to take into consideration individual student characteristics and circumstances, and the extent to which they agree that their committee actually *does* consider individual student characteristics and circumstances. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

A paired sample t-test indicated a significant difference between discretion and actual practice, $t(216) = 5.252$, $p < 0.001$. Participants indicated a high level of agreement that their committees have the discretion to take student factors into consideration, while their level of agreement was lower on the question regarding whether or not the committees actually did so.

Table 18
Committee Discretion and Practice

	N	Mean	SD	Std. Error Mean
Committee Discretion	217	5.16	0.826	0.056
Committee Practice	217	4.79	1.288	0.087

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

While the data show a significant difference overall between committee discretion and committee practice, there was a great deal of concordance between *individual participants'* answers to the two questions. Of the 217 participants who answered both questions, 195 (90%) had answers on the first question (discretion) that were within one point on the Likert scale to their answers on the second question (actual committee practice). Answers from four (2%) participants were within two points and answers from 12 (6%) participants were within three points. Answers from 1 (.5%) participant were highly discordant with a four point difference, and answers from three (1%) participants had the maximum difference of five points. Thus while there exists a significant difference between committee discretion and practice across all participants, the data suggest that individual participants do not experience a wide gap between discretion and practice for their particular committee. Of note, only 11 (5%) of the 217 responses indicated greater agreement with the statement about actual committee practice than with the statement about discretion, indicating that a small number of promotions committees consider individual student characteristics and circumstances to a greater degree than perhaps was intended in the committee charge. In each of these 11 responses the answers to the two questions were highly concordant and within one point of each other.

One-way ANOVA was performed in order to analyze participant responses on the two questions by gender, age, committee type (one that considers students from all four years, preclinical years only, or clinical years only), participant role, years of committee experience and class size. A t-test was performed in order to analyze participant responses by institution type. There were no significant differences in responses by gender, age, committee type or participant role. Participant responses on the question about committee *discretion* varied significantly by a participant's number of years on the promotions committee, $F(4, 209) = 2.409$, $p = 0.050$. With

a minor variation, agreement about their committee having the discretion to take into consideration individual student characteristics and circumstances increased with number of years served. However, a post-hoc Bonferroni analysis of variance did not indicate any significant differences between particular categories of years of experience.

Table 19
Committee Discretion, by Years Experience

Years Experience	N	Mean	SD	Std. Error
<1	24	4.79	0.977	0.199
1-2	56	5.07	0.759	0.101
3-4	56	5.30	0.851	0.114
5-6	27	5.11	0.698	0.134
7+	51	5.33	0.816	0.114
Total	214	5.17	0.828	0.057

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

Participants from public and private institutions agreed in equal amounts that their promotions committees had the discretion to take into consideration individual students' characteristics and circumstances. However, when equal variances were not assumed, results indicated that participants from private schools had a higher level of agreement that their committees actually *did* take into consideration individual students' characteristics and circumstances than their counterparts from public institutions, $t(125) = 2.111$, $p = 0.037$. Responses on the question regarding committee discretion differed significantly by class size, $F(4, 210) = 4.769$, $p = 0.001$, as did responses on the question regarding committee practice, $F(4, 210) = 3.357$, $p = 0.011$.

Table 20
Committee Discretion and Practice, by Class Size

	Committee Discretion				Committee Practice			
Class Size	N	Mean	SD	Std. Error	N	Mean	SD	Std. Error
<100	32	4.91	0.734	0.130	32	4.59	1.012	0.179
100-149	82	5.20	0.808	0.089	82	4.78	1.324	0.146
150-199	57	5.44	0.682	0.090	57	5.14	1.187	0.157
200-249	37	5.08	0.924	0.152	37	4.70	1.412	0.232
300+	7	4.29	1.113	0.421	7	3.43	1.397	0.528
Total	215	5.17	0.826	0.056	215	4.79	1.293	0.088

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

Agreement on both questions increased across class size groupings until it peaked for the class size of 150-199, then dropped for the largest two class size groupings of 200-249 and 300+. A Bonferroni post hoc analysis of variance indicated that for the first question (discretion), significant differences exist between the <100 class size group and the 150-199 class size group ($p = 0.029$), between the 100-149 class size group and the 300+ class size group ($p = 0.042$), and between the 150-199 class size group and the 300+ class size group ($p = 0.004$). A Bonferroni post hoc analysis of variance indicated that for the second question (actual committee practice), a significant difference exists between the 150-199 class size group and the 300+ class size group ($p = 0.009$).

Two survey questions attempted to elicit information regarding the issues of consistency and responsiveness. Participants were asked the extent to which they agreed with the statement, **"**When considering the performance of a student being reviewed by my promotions committee... A good process is one in which institutional standards are applied consistently across all students regardless of individual characteristics and circumstances," and with the statement, "A good process is one in which institutional standards are applied in a manner that is responsive to the individual characteristics and circumstances of the student." Responses to both questions were

on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6). Participants indicated a high level of agreement with the idea that a good process is responsive (mean = 4.6), while their level of agreement was lower regarding the idea that a good process is consistent (mean = 3.26)). A paired sample t-test indicated a significant difference between these two questions, $t(212) = 12.771$, $p < 0.001$. These results are somewhat inconsistent with participant responses to the two student cases in which participants indicated equal influence of the values of consistency and responsiveness. However, these results are consistent with the way in which participants prioritized responsiveness in their actual votes to dismiss or not dismiss the fictional students.

One-way ANOVA was performed in order to analyze participant responses on the two questions about a "good" committee process by gender, age, role, and years of committee experience. A t-test was performed in order to analyze participant responses by institution type. There were no significant differences in responses on either question by gender, role, years of committee experience or institution type.

Participant responses on the question about a "good" committee process being responsive varied significantly by a participant's age, $F(6, 206) = 2.153$, $p = 0.049$. A post-hoc Bonferroni analysis of variance did not indicate any significant differences between particular age groups. Responses on this question did not vary significantly by role ($p = .874$), however the data were reanalyzed excluding the <30 age group, completely comprised of medical student respondents, in order to further clarify the influence of participant role. The results were still significant, $F(5, 192) = 2.451$, $p = 0.035$, indicating that age, not role, was indeed the influential variable.

Table 21
Good Process as Responsive, by Age

Age	N	Mean	SD	Std. Error
<30	15	4.67	0.488	0.126
30-39	33	4.58	0.751	0.131
40-49	64	4.41	0.868	0.108
50-59	56	4.71	0.803	0.107
60-69	39	4.62	0.782	0.125
70-79	4	5.50	0.577	0.289
80+	2	5.50	0.707	0.500
Total	213	4.60	0.804	0.055

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

A series of four survey questions attempted to elicit information about the extent to which participants agree with statements regarding the nature of their individual consideration of student cases. "In my individual consideration of student cases is it important to me that I am...Humanistic (centered on an individual's values, capacities, and worth), Fair (free from prejudice), Empathetic (understanding of another's situation and feelings) and Objective (grounded in facts and policy)." Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6). Participants indicated high levels of agreement with all four statements, consistent with the notion that an ethic of justice and an ethic of care are not perceived as mutually exclusive. However, the highest levels of agreement were with statements regarding fair and objective, and lower levels of agreement with empathetic and humanistic.

Table 22
Participant Responses to the Question, "In my individual consideration of student cases it is important to me that I am…"

Decision Making Characteristic	N	Mean	SD
Fair (free from prejudice)	214	5.30	0.803
Objective (grounded in facts and policy)	214	5.02	0.813
Empathetic (understanding of another's situation and feelings)	214	4.62	0.823
Humanistic (centered on an individual's values, capacities, and worth)	213	4.57	0.842

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

The lower levels of agreement on statements regarding being "understanding of another's situation and feelings" (empathetic) and "centered on an individual's values, capacities, and worth" (humanistic) are somewhat surprising as they contain elements of responsiveness, which participants prioritized over consistency in their votes to dismiss or not dismiss students in the fictional cases. New here, however, are values that potentially define participants' decisions as "free from prejudice" (fair) and "grounded in facts and policy" (objective). As defined, these definitions, while part of an ethic of justice alongside consistency, are perhaps more emotionally laden with negative connotations of racial or cultural bias ("prejudice"), and positive connotations of scientific positivism ("grounded in facts"). From this perspective it is perhaps unsurprising that participants prioritized fairness and objectivity. A paired sample t-test indicated significant differences between five of the six possible value pairs. Humanistic differed significantly from fair, $t(212) = 11.533$, $p < 0.001$, and from objective, $t(212) = 6.379$, $p < 0.001$. There was a significant difference between fair and objective, $t(213) = 5.187$, $p < 0.001$, and fair and empathetic, $t(213) = 10.967$, $p < 0.001$. Empathetic also differed

significantly from objective, $t(213) = 5.766$, $p < 0.001$. There was no significant difference between empathetic and humanistic.

One-way ANOVA was performed in order to analyze participant responses on the four questions by gender, age, role, and years of committee experience. A t-test was performed in order to analyze participant responses by institution type. There were no significant differences on these questions by gender or institution type.

Agreement with the statement that it was important for them to be empathetic varied significantly with age, $F(6, 206) = 2.737$, $p = 0.014$. A post-hoc Bonferroni analysis of variance did not indicate any significant differences between particular age groups. Responses on this question did not vary significantly by role ($p = .752$), however the data were reanalyzed excluding the <30 age group, completely comprised of medical student respondents, in order to further clarify the influence of participant role. Upon reanalysis the results were still significant, $F(5, 192) = 3.283$, $p = 0.007$, indicating that age, not role, was indeed the influential variable.

Agreement on the importance of objectivity also varied significantly by age, $F(6, 206) = 2.309$, $p = 0.035$. It starts out relatively low for those under 30 years of age, then rises over age categories to a high for those in the 50-59 years of age category, then decreases again across the 60-69, 70-79, and 80+ age categories. A Bonferroni post-hoc analysis of variance indicates significant differences between the <30 age category with the 40-49 age category ($p = 0.037$) and the 50-59 age category ($p = 0.033$). When the data were reanalyzed excluding the <30 age group, which was completely comprised of medical student respondents, the results were not significant, $F(5, 192) = .773$, $p = 0.570$, indicating that role, not age, was the influential variable.

Table 23
Importance of Being Empathetic and Objective in Decision Making, by Age

	Empathetic				Objective			
Age	N	Mean	SD	Std. Error	N	Mean	SD	Std. Error
<30	15	4.67	0.816	0.211	15	4.40	0.828	0.214
30-39	33	4.36	0.783	0.136	33	4.91	0.678	0.118
40-49	63	4.46	0.800	0.101	63	5.13	0.729	0.092
50-59	56	4.71	0.825	0.110	56	5.14	0.773	0.103
60-69	40	4.83	0.813	0.129	40	5.10	0.744	0.118
70-79	4	5.50	0.577	0.289	4	4.75	2.500	1.250
80+	2	5.50	0.707	0.500	2	4.50	0.707	0.500
Total	213	4.62	0.824	0.056	213	5.03	0.812	0.056

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

Responses on the question of objectivity did differ significantly by role, $F(2, 211) = 3.844$, $p = 0.023$, with both faculty members and administrators indicating greater agreement with the statement that it was important for them to be objective than did medical students. A Bonferroni post hoc analysis of variance indicated significant differences between faculty members and medical students ($p = 0.020$).

Table 24
Importance of Objectivity in Decision Making, by Role

Role	N	Mean	SD	Std. Error
Medical Student	20	4.55	0.887	0.198
Faculty Member	172	5.07	0.722	0.055
Administrator	22	5.09	1.231	0.262
Total	214	5.02	0.813	0.056

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

Results indicated that agreement with the statement regarding the importance of being fair varied significantly by years of committee experience, $F(4, 206) = 2.808$, $p = 0.027$. With

the exception of the lowest group with less than one year of experience, levels of agreement rose as committee experience increased, from a mean of 5.05 for the group with one to two years of experience, to a peak of 5.54 for those with seven or more years of experience. A Bonferroni post-hoc analysis of variance indicates a significant difference between the 1-2 years of experience category and the 7+ years of experience category ($p = 0.018$).

Table 25
The Importance of Being Fair in Decision Making, by Years Experience

Years Experience	N	Mean	SD	Std. Error
<1	24	5.21	0.779	0.159
1-2	55	5.05	0.911	0.123
3-4	55	5.36	0.802	0.108
5-6	27	5.41	0.694	0.134
7+	50	5.54	0.646	0.091
Total	211	5.31	0.797	0.055

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

A series of nine survey questions attempted to elicit information about the extent to which participants agree with statements regarding the role of their promotions committee. "The role of the promotions committee is to...Graduate highly qualified learners; Act in the best interest of our learners; Act in the best interest of our learners' future patients; Maintain our school's academic standards; Graduate all admitted students; Implement policy; Nurture future colleagues; Consider learners in a holistic fashion; and Enact consequences consistently over time." Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6). Participants indicated high levels of agreement with all but two of the nine statements. The highest levels of agreement were with statements regarding acting in the best interest of our learners' future patients (mean = 5.54) and graduating highly qualified learners

(mean = 5.10). Participants indicated a lower level of agreement with the statement regarding implementation of policy (mean = 3.96). Participants disagreed with the statement regarding graduating all admitted students (mean = 1.89).

Table 26
Participant Responses to Survey Question, "The role of the promotions committee is to…"

Response Choice	N	Mean	SD
Act in the best interest of our learners' future patients.	212	5.54	0.656
Graduate highly qualified learners.	210	5.10	0.968
Maintain our school's academic standards.	209	4.98	0.840
Act in the best interest of our learners.	212	4.64	0.966
Enact consequences consistently over time.	210	4.58	0.774
Consider learners in a holistic fashion.	212	4.55	0.736
Nurture future colleagues.	212	4.10	1.037
Implement policy.	211	3.96	0.940
Graduate all admitted students.	211	1.89	0.934

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

One-way ANOVA was performed in order to analyze participant responses on the nine questions by gender, age, role, and years of committee experience. A t-test was performed in order to analyze participant responses by institution type. There were no significant differences in responses by years of committee experience or institution type.

The data indicate significant differences by gender regarding acting in the best interest of our learners, $F(2, 207) = 8.451$, $p < 0.001$, and enacting consequences consistently over time, $F(2, 205) = 4.543$, $p = 0.012$. A Bonferroni post-hoc analysis of variance showed that women indicated significantly greater agreement with the statement regarding acting in the best interest of our learners than did men ($p < .001$), and men indicated a significantly greater agreement with

the statement regarding enacting consequences consistently over time than did women (p = 0.009).

Table 27
Role of Committee as Acting in Best Interest of Learners, and Enacting Consequences Consistently, by Gender

	Act in Best Interest of Learners				Enact Consequences Consistently			
Gender	N	Mean	SD	Std. Error	N	Mean	SD	Std. Error
Male	111	4.40	1.003	0.095	110	4.73	0.777	0.074
Female	97	4.93	0.845	0.086	96	4.41	0.748	0.076
Other/ Prefer not to identify	2	4.50	0.707	0.500	2	4.50	0.707	0.500
Total	210	4.64	0.964	0.067	208	4.58	0.776	0.054

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

Level of agreement on the question regarding maintaining a school's academic standards varied significantly with age, F(6, 201) = 2.301, p = 0.036, with the lowest agreement indicated by participants under 30 years old (medical student respondents) and the highest agreement indicated by those over 80 years old, though a post-hoc Bonferroni analysis of variance did not indicate any significant differences between particular age groups. Responses on this question did not vary significantly by role, however the data were reanalyzed excluding the <30 age group, completely comprised of medical student respondents, in order to further clarify the influence of participant role. Upon reanalysis the results were not significant by age, F(5, 187) = 2.105, p = 0.067, indicating that role may have been an influential, if not statistically significant, variable.

Table 28
Role of Committee as Maintaining School's Academic Standards, by Age

Age	N	Mean	SD	Std. Error
<30	15	4.60	0.910	0.235
30-39	33	4.79	0.781	0.136
40-49	62	4.84	0.872	0.111
50-59	53	5.21	0.717	0.098
60-69	39	5.15	0.812	0.130
70-79	4	5.25	1.500	0.750
80+	2	5.50	0.707	0.500
Total	208	4.98	0.840	0.058

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

There was a significant difference in agreement on the statement regarding enacting consequences consistently over time by participant role, $F(2, 207) = 3.399$, $p = 0.035$, with medical students indicating lower levels of agreement than faculty or administrators. A Bonferroni post-hoc analysis of variance indicated a significant difference between medical students and administrators ($p = 0.032$).

Table 29
Role of Committee as Enacting Consequences Consistently, by Role

Role	N	Mean	SD	Std. Error
Medical Student	20	4.30	0.733	0.164
Faculty Member	168	4.57	0.763	0.059
Administrator	22	4.91	0.811	0.173
Total	210	4.58	0.774	0.053

Note. Responses were on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

Composite Scores

In order to further examine ethical orientations of justice and care, composite scores for each orientation were calculated for each participant. A composite "justice score," comprised of

elements of consistency, fairness and objectivity, was calculated for each participant using the mean for answers provided on the following three questions: "A good process is one in which institutional standards are applied consistently across all students, regardless of individual characteristics and circumstances," "In my individual consideration of student cases is it important to me that I am...Fair," and "In my individual consideration of student cases is it important to me that I am...Objective." A composite "care score," comprised of elements of responsiveness, humanism and empathy, was calculated for each participant using the mean for answers provided on the following three questions: "A good process is one in which institutional standards are applied in a manner that is responsive to the individual characteristics and circumstances of the student," "In my individual consideration of student cases is it important to me that I am...Humanistic," and "In my individual consideration of student cases is it important to me that I am...Empathetic." Responses to these questions were each on a six-point Likert scale from Completely Disagree (1) to Completely Agree (6).

The average composite justice score was 4.54 (n = 216; range of 2.67 to 6.0), slightly lower than the average composite care score of 4.60 (n= 216; range of 2.67 to 6.0). A paired sample t-test indicated that these means were not significantly different, $t(215) = 1.056$, $p = 0.292$.

Table 30
Average Justice and Care Composite Scores, Overall and by Gender

	All	Men			Women			Other/Prefer not to identify		
Composite Score	Mean	N	Mean	SD	N	Mean	SD	N	Mean	SD
Composite Justice Score	4.54	111	4.61	0.618	101	4.46	0.602	2	4.83	0.707
Composite Care Score	4.60	111	4.60	0.677	101	4.60	0.659	2	4.67	0.471

In order to differentiate participants with composite justice and care scores that are approximately equal from those with scores that are high in one category versus the other, composite justice scores were subtracted from composite care scores. The difference between composite scores ranged from -3.33 to 2.67. The average difference between composite scores was -0.065, very close to zero, indicating that most participants self-report justice and care orientations that are approximately the same.

Three categories of ethical orientation were created based on this difference in composite scores. One-hundred fifty-one (70%) participants who had a difference in composite justice and care scores that was within one standard deviation of the mean (-0.91 to 0.79) were considered "composite neutral" in that there was a high degree of concordance between their composite justice and care scores. Twenty-six (12%) participants whose composite justice score was greater than their composite care score by more than one standard deviation from the mean (< -0.91) were considered to be "justice dominant." Thirty-nine (18%) participants whose composite care score was greater than their composite justice score by more than one standard deviation from the mean (>0.79) were considered to be "care dominant."

Table 31
Ethical Orientation Categories, Overall and by Gender

Orientation Category	All N (%)	Male N (%)	Female N (%)	Other/Prefer not to identify N (%)
Justice Dominant	26 (12)	14 (54)	11 (42)	1 (4)
Composite Neutral	151 (70)	78 (52)	70 (46)	3 (2)
Care Dominant	39 (18)	19 (49)	20 (51)	0 (0)
Total	216 (100)	111 (51)	101 (47)	4 (2)

There were some differences in the representation of men and women in the ethical orientation categories. Men made up 51% of the total participants for whom composite scores were calculated, but 54% of the justice dominant group and only 49% of the care dominant group. Women made up 47% of the total participants for whom composite scores were calculated, but 51% of the care dominant group and only 42% of the justice dominant group.

Representation in composite score categories varies by age. While the <30 age group makes up 7% of the total participants for whom composite scores were calculated, they were over-represented in the care dominant group at 13% and under-represented in the justice dominant group at 0%. The 40-49 age group (30% overall) was under-represented in the care dominant group at 13%, and the 50-59 age group (26% overall) was over-represented in both the care and justice dominant groups at 33% for the care dominant group and 35% for the justice dominant group.

Table 32
Ethical Orientation Categories, by Age

Orientation Category	<30 N (%)	30-39 N (%)	40-49 N (%)	50-59 N (%)	60-69 N (%)	70-79 N (%)	80+ N (%)	Total N
Justice Dominant	0 (0)	4 (15)	9 (35)	9 (35)	4 (15)	0 (0)	0 (0)	26
Composite Neutral	10 (7)	24 (16)	50 (33)	34 (23)	29 (19)	2 (1)	1 (1)	150
Care Dominant	5 (13)	5 (13)	5 (13)	13 (33)	8 (21)	2 (5)	1 (3)	39
Total	15 (7)	33 (15)	64 (30)	56 (26)	41 (19)	4 (2)	2 (1)	215

Representation in composite score categories also appears to vary by role. While medical student make up 9% of the total participants for whom composite scores were calculated, they make up 13% of the care dominant group and only 4% of the justice dominant group. Similarly, administrators make up 10% of the total participants for whom composite scores were calculated,

yet they make up 15% of the care dominant group and only 8% of the justice dominant group. The opposite distribution pattern is true for faculty members. Faculty make up make up 81% of the total participants for whom composite scores were calculated, they make up 89% of the justice dominant group and only 72% of the care dominant group. For medical students and administrators, the maximum difference in representation from what would be expected by role distribution overall is five percentage points in either direction. However, for faculty members, the maximum difference is nine percentage points (81% total representation to 72% representation in the care dominant category), indicating that faculty are under-represented in the care dominant group.

Table 33
Ethical Orientation Categories, by Role

Orientation Category	Medical Student N (%)	Faculty N (%)	Administrator N (%)	Total N
Justice Dominant	1 (4)	23 (89)	2 (8)	26
Composite Neutral	14 (9)	123 (82)	14 (9)	151
Care Dominant	5 (13)	28 (72)	6 (15)	39
Total	20 (9)	174 (81)	22 (10)	216

Participant decisions regarding the two student cases were examined by ethical orientation category. While 45% of the total participants for whom composite scores were calculated voted to dismiss Bill, 72% from the justice dominant group voted to dismiss him, and only 26% from the care dominant group voted to dismiss him. These data indicate over-representation of decisions to dismiss him from the justice dominant group by 27 percentage points, and an under-representation of decision to dismiss Bill from the care dominant group by 19 percentage points. The opposite trend was present in the data regarding votes not to dismiss

Bill. While 55% of the total participants for whom composite scores were calculated voted not to dismiss Bill, 74% from the care dominant group voted not to dismiss him, and only 28% from the justice dominant group voted not to dismiss him. These data indicate an under-representation of decisions not to dismiss Bill by the justice dominant group and an over-representation of decisions not to dismiss Bill by the care dominant group.

The findings were slightly different for Case B. As mentioned previously, participants were far more willing to dismiss Shayla than Bill (70% compared with 45%). Participants in the justice dominant group were proportionally more willing to dismiss Shayla than participants overall (80% from the justice dominant group voted to dismiss her compared with 70% of the total participants for whom composite scores were calculated). However, participants in the care dominant group were also more willing to dismiss Shayla than were participants overall (76% from the care dominant group voted to dismiss her compared with 70% of the total participants for whom composite scores were calculated). The data regarding votes *not* to dismiss Shayla was also somewhat different from that of Bill. While 30% of the total participants for whom composite scores were calculated voted not to dismiss Shayla, only 20% from the justice dominant group voted not to dismiss her, and 24% from the care dominant group voted not to dismiss her.

Table 34
Ethical Orientation Categories, by Decision to Dismiss

	Case A (Bill)			Case B (Shayla)		
Orientation Category	Dismiss N (%)	Do Not Dismiss N (%)	Total	Dismiss N (%)	Do Not Dismiss N (%)	Total N
Justice Dominant	18 (72)	7 (28)	25	20 (80)	5 (20)	25
Composite Neutral	68 (45)	82 (55)	150	101 (67)	49 (33)	150
Care Dominant	10 (26)	28 (74)	38	29 (76)	9 (24)	38
Total	96 (45)	117 (55)	213	150 (70)	63 (30)	213

In order to further examine the role of responsiveness (which includes responsiveness to negative characteristics and behavior as in the case of Shayla) as a component of care, composite care scores were recalculated, eliminating responsiveness from the calculation. New composite care scores were calculated using participant responses to only two of the three original questions ("In my individual consideration of student cases is it important to me that I am... Humanistic," and "In my individual consideration of student cases is it important to me that I am... Empathetic."), leaving out the question regarding a "good" committee process being responsive to individual student characteristics and circumstances. Reconfiguration of composite care scores did not significantly change average composite scores overall or by gender.

Table 35
Average Justice and Care Composite Scores, Original and Reconfigured, Overall and by Gender

	All	Men			Women			Other/Prefer not to identify		
Composite Score	Mean	N	Mean	SD	N	Mean	SD	N	Mean	SD
Composite Justice Score	4.54	111	4.61	0.618	101	4.46	0.602	2	4.83	0.707
Composite Care Score	4.60	111	4.60	0.677	101	4.60	0.659	2	4.67	0.471
Reconfigured Composite Care Score	*4.59*	*111*	*4.60*	*0.730*	*99*	*4.58*	*0.765*	*2*	*4.75*	*0.354*

New ethical orientation categories were created using the same methodology as previously. In order to differentiate participants with composite justice and care scores that are approximately equal from those with scores that are high in one category versus the other, new composite justice scores were subtracted from new composite care scores, and three revised categories of ethical orientation were created based on this difference in composite scores.

Participants who had a difference in composite justice and care scores that was within one standard deviation of the mean were again considered "composite neutral" in that there was a high degree of concordance between their composite justice and care scores. Participants whose composite justice score was greater than their composite care score by more than one standard deviation from the mean were again considered to be "justice dominant." Participants whose composite care score was greater than their composite justice score by more than one standard deviation from the mean were again considered to be "care dominant."

Table 36
Ethical Orientation Categories Overall and by Gender

	Responsiveness Included				Responsiveness Excluded			
Orientation Category	All N (%)	Male N (%)	Female N (%)	Other/Prefer not to identify N (%)	All N (%)	Male N (%)	Female N (%)	Other/Prefer not to Identify N (%)
Justice Dominant	26 (12)	14 (54)	11 (42)	1 (4)	29 (14)	18 (62)	11 (38)	0 (0)
Composite Neutral	151 (70)	78 (52)	70 (46)	3 (2)	153 (72)	74 (48)	75 (49)	2 (1)
Care Dominant	39 (18)	19 (49)	20 (51)	0 (0)	32 (15)	19 (59)	13 (41)	0 (0)
Total	216 (100)	111 (51)	101 (47)	4 (2)	214	111 (52)	99 (46)	2 (1)

In this reconfiguration, the total number of composite neutral participants rose from 151 (70%) to 153 (72%), the total number of justice dominant participants went from 26 (12%) to 29 (14%), and the total number of participants classified as care dominant went from 39 (18%) to 32 (15%). Participant decisions regarding decisions to dismiss or not dismiss Shayla were examined again using the new ethical orientation categories in which the care composite scores did *not* include an element of responsiveness. The original calculation indicated that 76% of the

care dominant group voted to dismiss Shayla compared with 80% of the justice dominant group and 70% of the total participants for whom composite scores were calculated. The calculation using the new ethical orientation categories indicated an increased gap between responses from care dominant and justice dominant individuals. Seventy-one percent of the care dominant group (minus the element of responsiveness) voted to dismiss Shayla compared with 86% of the new justice dominant group and 71% of the total participants for whom new composite scores were calculated.

It is worth noting that the recalculation of composite score categories decreased the over-representation of women in the care dominant group and actually increased the over-representation of men in both the care dominant and justice dominant groups. Previously, women made up 47% of the total participants for whom composite scores were calculated, but 51% of the care dominant group and only 42% of the justice dominant group. Upon recalculation women made up 46% of the total participants for whom new composite scores were calculated, and went from 51% to 41% of the care dominant group, and from 42% to 38% of the justice dominant group. Previously, men made up 51% of the total participants for whom composite scores were calculated, but 54% of the justice dominant group and only 49% of the care dominant group. Upon recalculation (removal of the responsive element from the care composite score) men made up 52% of the total participants for whom new composite scores were calculated, and went from 54% to 62% of the justice dominant group, and from 49% to 59% of the care dominant group.

Survey Section 5- Student Characteristics Data

Section five of the survey consisted of 18 questions regarding how influential certain student characteristics and circumstances are to participant decision making. Responses were

recorded on a four-point Likert scale from "Not at all influential" (1) to "Highly influential" (4). Every student characteristic/circumstance was deemed influential to some degree. Participant responses indicated that the *most* influential characteristics/circumstances were the "nature of the lapse in professionalism," "total number of lapses in professionalism," "total number of academic failures," "poor clinical skill acquisition," and "level of reliability." The *least* influential characteristics/circumstances were "amount of financial debt," "academic background/preparation for medical school," "amount of time the student has until graduation," and "existence of a physical disability."

Table 37

Participant Responses to Survey Question, "For each of the following student characteristics or circumstances, please indicate how influential it would be to your decision making."

Rank	Student Characteristic/Circumstance	N	Mean	SD
1	Nature of the lapse in professionalism	211	3.83	0.457
2	Total number of lapses in professionalism	211	3.81	0.460
3	Total number of academic failures	211	3.58	0.667
4	Poor clinical skill acquisition	210	3.51	0.605
5	Level of reliability	210	3.46	0.634
6	Willingness to seek help	211	3.38	0.646
7	Level of insight into his/her problem	211	3.24	0.704
8	Work ethic	211	3.24	0.739
9	Existence of severe mental illness	211	3.23	0.848
10	Existence of an appropriate remediation option	211	3.13	0.767
11	Poor standardized exam performance	210	2.90	0.692
12	Existence of physical health problems	209	2.74	0.816
13	Existence of documented learning disability	211	2.65	0.774
14	Existence of mild mental illness	211	2.60	0.770
15	Existence of physical disability	211	2.43	0.861
16	Amount of time the student has until graduation	211	2.14	0.870
17	Academic background/preparation for medical school	211	1.88	0.730
18	Amount of financial debt	211	1.55	0.711

Note. Responses were recorded on a four-point Likert scale from "Not at all influential" (1) to "Highly influential" (4).

One-way ANOVA was performed in order to analyze participant responses on the 18 questions by gender, age, role, and years of committee experience. A t-test was performed in order to analyze participant responses by institution type. There were no significant differences in responses by years of committee experience.

Men and women differed significantly on only one of the 18 dimensions, $F(2, 206) = 4.042$, $p = 0.019$. A Bonferroni post-hoc analysis of variance indicated that men reported that the "existence of a physical disability" was significantly more influential than did women ($p = 0.024$).

Table 38
Existence of Physical Disability, by Gender

Gender	N	Mean	SD	Std. Error
Male	111	2.57	0.849	0.081
Female	96	2.25	0.858	0.088
Other/Prefer not to identify	2	3.00	0.000	0.000
Total	209	2.43	0.864	0.060

Note. Responses were recorded on a four-point Likert scale from "Not at all influential" (1) to "Highly influential" (4).

Responses on the question regarding "level of reliability" varied significantly by age, $F(6, 202) = 2.764$, $p = 0.013$. A Bonferroni post-hoc analysis of variance indicated that for "level of reliability" there was a significant difference between the 30-39 age group and the 60-69 age group ($p = 0.007$), with the 60-69 age group indicating a greater degree of influence. Responses on this question did not vary significantly by role ($p = .214$), however the data were reanalyzed excluding the <30 age group, completely comprised of medical student respondents, in order to further clarify the influence of participant role. The results were still significant, $F(5, 189) = 2.966$, $p = 0.013$, indicating that age, not role, was indeed the influential variable.

Responses on the question regarding "existence of severe mental illness" also varied significantly by age, $F(6, 203) = 3.725$, $p = 0.002$. A Bonferroni post-hoc analysis of variance indicated that for "existence of severe mental illness" there was a significant difference between the <30 age group and the 50-59 age group ($p = 0.003$) and between the <30 age group and the 70-79 age group ($p = 0.035$), with the <30 age group indicating less agreement than the other two. When the data were reanalyzed excluding the <30 age group, which was completely comprised of medical student respondents, the results were not significant, $F(5, 189) = 2.253$, $p = 0.051$, indicating that role, not age, was the influential variable.

Table 39
Level of Reliability and Existence of Severe Mental Illness, by Age

	Level of Reliability				Existence of Severe Mental Illness			
Age	N	Mean	SD	Std. Error	N	Mean	SD	Std. Error
<30	14	3.64	0.497	0.133	15	2.53	1.060	0.274
30-39	33	3.18	0.727	0.127	33	3.03	0.728	0.127
40-49	62	3.35	0.655	0.083	62	3.21	0.813	0.103
50-59	55	3.49	0.635	0.086	55	3.45	0.765	0.103
60-69	39	3.72	0.456	0.073	39	3.26	0.910	0.146
70-79	4	3.50	0.577	0.289	4	4.00	0.000	0.000
80+	2	3.50	0.707	0.500	2	4.00	0.000	0.000
Total	209	3.45	0.635	0.044	210	3.23	0.850	0.059

Note. Responses were recorded on a four-point Likert scale from "Not at all influential" (1) to "Highly influential" (4).

Responses to the question regarding "existence of severe mental illness" did vary significantly by participant role, $F(2, 208) = 3.905$, $p = 0.022$, with administrators and faculty members indicating the factor as more influential than did medical students. A Bonferroni post-hoc analysis of variance indicated that for "existence of severe mental illness" there was a significant difference between medical students and faculty ($p = 0.032$), and medical students and administrators ($p = 0.035$).

Table 40
Existence of Severe Mental Illness, by Role

Role	N	Mean	SD	Std. Error Mean
Medical Student	20	2.75	1.070	0.239
Faculty Member	169	3.26	0.804	0.062
Administrator	22	3.41	0.854	0.183
Total	211	3.23	0.848	0.058

Note. Responses were recorded on a four-point Likert scale from "Not at all influential" (1) to "Highly influential" (4).

Responses varied significantly by institution type on only one question regarding "existence of an appropriate remediation option," $t(208) = 1.998$, $p = 0.047$, with participants from private schools indicating the factor as more influential than did participants from public schools.

Table 41
Existence of Appropriate Remediation Option, by Institution Type

Institution Type	N	Mean	SD	Std. Error Mean
Public	155	3.07	0.774	0.062
Private	55	3.31	0.717	0.097
Total	210			

Note. Responses were recorded on a four-point Likert scale from "Not at all influential" (1) to "Highly influential" (4).

Participant responses on the 18 questions were also analyzed by the original ethical orientation categories. A Bonferroni post-hoc analysis of variance indicated that there were significant differences between ethical orientation categories on four student characteristics/circumstances, "total number of academic failures," "academic background/ preparation for medical school," "existence of an appropriate remediation option," and "willingness to seek help." For "total number of academic failures" the justice dominant group

indicated a significantly higher degree of influence than did the composite neutral group ($p = 0.017$). For "academic background/preparation for medical school" the composite neutral group indicated a significantly higher degree of influence than did the justice dominant group ($p = 0.038$). For "existence of an appropriate remediation option" the care dominant group indicated a significantly higher degree of influence than did the composite neutral group ($p = 0.036$). For "willingness to seek help" the care dominant group indicated a higher degree of influence than did the justice dominant group ($p < 0.001$), and the composite neutral group indicated a higher degree of influence than did the justice dominant group ($p = 0.001$).

Survey Section 6- Training Data

Section 6 of the survey asked questions regarding the training received by promotions committee members. Only 15% (24) of respondents indicated that they received training as part of their committee participation. Training was described as entailing primarily overviews on institutional policy and committee procedures. Eighty-five percent (141) indicated that they received no training. When asked what training might be useful to them, 33 comments indicated a need for information regarding policies and standards, 4 indicated a need for more information regarding the medical education curriculum and grading. Participants also indicated a desire for training on legal issues. Seven comments indicated a need for information about disability law, Title IX, the Family Educational Rights and Privacy Act, and on the array of institutional resources available to students. A large number of comments (24) indicated that the use of case examples, with information about common scenarios, what was decided and why, would be useful to help guide current deliberations. These cases could also provide committee members with follow up information about the impact of their decisions, and about the ultimate success (or lack thereof) of the students considered by the committee in the past. Other interesting, but

infrequently mentioned, suggestions included training on becoming more objective in their deliberations, on breaking bad news, on active listening, on processing emotional decisions, and on ethical decision making. However, 20 comments indicated that they were either unsure what would be helpful or that formal training was unnecessary, and that only by actually participating in the committee could members learn what they need to know.

Another series of questions acknowledged the often emotional aspects of committee work and asked participants how they process those emotional aspects. Forty-seven comments indicated that they primarily engaged in discussions of student cases with professional peers or other members of the committee. Seventeen comments indicated that they process emotional cases with their spouse or partner. Participants reported a number of ways of thinking that helped them process the tough student cases considered by their committees. Three reported that knowing they had acted with empathy helped them to come to terms with their decisions. Eight reported that knowing they had been objective in their consideration helped them come to terms with their decisions. One participant's comments captured the multiplicity of factors that influence his decision making process, and the responsibility he feels to both the students and to the institution as a promotions committee member:

> I try to be empathetic, but in the end I fall back on the balance of: "Will this student succeed if given another chance?", "How likely is the student to be an good physician if given another chance?", Is it worth the continued investment of time, money, resources, and effort on the part of both the student and the institution to allow this student to continue?", and "Have we (the institution) offered the student a fair chance to remediate or otherwise address the difficulties they are facing so that they can be effective as a student and as a physician if they are allowed to continue?" If the answer to those

questions is negative on balance, then I think the standard for allowing the student to continue isn't met and the student must be dismissed. These decisions are hard but they are part of my responsibilities as a faculty member and a member of the promotions committee. My basic approach is to accept that I have that responsibility even if it is unpleasant.

Twelve comments indicated that keeping the good of patients and society in mind helped them to come to terms with decisions. Eight comments indicated that committee members came to terms with their decisions with the thought that they were acting in the good of the student in the long run. Interestingly, even though amount of time until graduation and amount of financial debt were rated as two of the least influential student characteristics/circumstances from the list of 18, three comments specifically included students' investment of time and money in their thoughts about acting in the students' best interest. "I focus on the overall goal which is to do what is right for future patients and to do what is right for the student, which in some cases is to dismiss before they get too far along in their education and into deep financial debt."

Ten percent (17) of respondents indicated that their committee had processes in place to assist committee members. These processes were described in seven comments as discussions among the committee members, and six comments mentioned the availability of counseling support. Sixty-one percent (101) of respondents indicated that their committee did not have processes in place to assist them, and 29% (49) were not sure.

The final survey question asked participants if they had any additional comments about the work of their promotions committee or about the survey itself. Ten responses indicated a high degree of satisfaction with doing important work, and a high degree of respect for their colleagues who engage in the work in a serious and thoughtful manner. "I am really proud of the

thoughtful work our committee does. We take it very seriously and always strive to have the best interests of the students in mind." Six participants took the opportunity to share frustrations with the process. Three comments expressed frustration with what participants viewed as the leniency of committee decisions. Two comments expressed frustration with school leadership who overturn committee decisions, possibly for fear of lawsuits. One participant took the opportunity to express that s/he does not believe that fairness (justice) and responsiveness (care) are mutually exclusive notions, a sentiment consistent with many of the survey results analyzed here.

> Our goal is to apply uniform standards of achievement but with recognition that the path to graduation is not identical for every student. I don't believe fairness and recognition of individual circumstances is an either/or consideration. That is why you need a promotions committee made up of people who can make complex decisions rather than using some sort of 'objective' algorithm.

Descriptive Data Collection Results

The second component of my research was the collection of basic descriptive information regarding the structure and function of promotions committees across institutions. A total of 22 medical schools responded to a request for information about their promotions committees that was distributed separately from the electronic survey. Due to a number of problems with the design and distribution of the Excel sheet by which information was to be collected (including distribution of an older version of the data collection sheet and inaccessible explanations for the information needed), data from these 22 schools are difficult to interpret and contain missing or unclear information. The following information represents the data points for which there were the clearest and most complete responses.

Seven private and 15 public medical schools from 18 states shared their information. Class sizes (MD19) range from 70 to 211 with an average size of 132. Ten schools indicated that their promotions committees did not include any student representatives, while 12 indicated that their committees included student representatives. Of those 12, two responded that students did not participate as voting members, one indicated that the students abstained when the student being considered was a member of the representative's class, and one indicated that the representatives voted, but not on "matters affecting student status" (it is unclear what other votes the student representative(s) do vote on). All but two institutions indicated that their committees also include non-physician (basic science) faculty as voting members. The size of promotions committees ranged from eight members to 26 with an average of 15. The minimum number of meetings per year of promotions committees ranged from two to 26. While the responses are somewhat unclear regarding the sharing of student information with the committee, it appears that most committees are provided with information about students, and that those individuals presenting the information generally do not vote. Nineteen out of the 20 institutions that provided information on professionalism indicated that their promotions committees do consider students' professionalism as part of their charge.

CHAPTER 5: DISCUSSION AND CONCLUSIONS

Introduction

In this chapter I will discuss the major findings of the electronic survey regarding medical school promotions committees. First I will consider the overarching concepts of justice and care as ethical orientations for decision making about medical students. Specifically I will consider major findings regarding ethical orientations and the variability of participant responses by age and role. A new possible developmental perspective will be introduced to help make sense of the survey data in the form of Robert Kegan's subject-object theory (1982). I will then address major findings regarding ethical orientations and gender, as well as findings regarding the specific student characteristics and circumstances that influence committee member decision making as related to the "failure to fail" literature discussed previously. Finally I will discuss limitations of the current study and possible directions for future research.

Justice and Care

For the purposes of this study and using the definitions provided by Liddell, et al. (1992), an ethic of justice was defined as being comprised of elements concerning consistency, fairness and objectivity. An ethic of care was defined as being comprised of elements concerning responsiveness, empathy and humanism (being centered on an individual's capacities and worth). One of the major ideas supported by data analysis is that participants do not perceive orientations of justice and care as being mutually exclusive. They report a high level of agreement with statements that reflect an ethic of justice *and* with statements that reflect an ethic of care. For example, participants indicated high levels of agreement with all four statements about it being important that their individual decision making be fair, objective, humanistic and

empathetic. Within each hypothetical student case, participants indicated being equally influenced by the need to be both responsive and consistent, and when composite care and justice scores were calculated, both were high. When composite justice and care scores were calculated, the majority (70%) of participants actually fell into the "neutral" category in which their composite care and justice scores were approximately the same. Survey questions were purposefully designed so that participants were not required to choose between justice and care as guiding principles, and clearly participants perceived elements of both of these ethics to be relevant to their decision making about students.

The data however do reveal some prioritization of responsiveness (to particular student characteristics and circumstances) over consistency (across student cases). Participants indicated significantly greater agreement with the question regarding a "good" committee process being responsive than they did with the question regarding a "good" process being consistent. Responsiveness was also prioritized over consistency in participants' decisions to dismiss or not dismiss the fictional students presented. In Case A, a decision to dismiss Bill would have been consistent with how the student with equivalent academic performance was treated previously. Yet only 45% voted to dismiss Bill. In Case B, a decision *not* to dismiss Shayla would have been consistent with how the student with equivalent academic performance was treated previously. Yet only 29% of participants voted to not dismiss Shayla.

The details provided regarding Bill and Shayla's situations may have been influential factors in participant "voting." Bill's "contentious divorce" provided a concrete explanation for his struggles that helped participants make sense of his situation, and perhaps elicited sympathy for him in a way that influenced participants' decisions to give him an additional chance. Indeed, narrative explanations for participants' decisions to dismiss or not dismiss Bill indicated

the influence of inferred "causation" in decision making. Those who perceived Bill's divorce as a cause of his failures tended to vote against dismissing him. Those who rejected such a causal inference tended to vote to dismiss him. The details regarding Shayla's "reluctance to change" and "resistance to advice" provided some explanation for her academic difficulties, but proved to be powerful influences in the opposite direction. According to participants' narrative comments, Shayla's circumstances were perceived as being a result of character flaws or highly negative choices, and participants responded to these negative aspects of her case in their willingness to dismiss her. In Case A, participants responded to Bill's sympathetic circumstances with fewer decisions to dismiss him than would be expected based on self-reports of equally influential values of responsiveness and consistency. In Case B, participants responded to Shayla's particular circumstances, which were perhaps less sympathetic than Bill's, with a greater number of decisions to dismiss her than would be expected based on self-reports of equally influential values of responsiveness and consistency. While participants indicated in each case that they were influenced equally by the values of consistency and responsiveness, the nature of the particulars of each case elicited a response that clearly overrode the need for consistent application of policy.

Decisions to dismiss or not dismiss were also analyzed by composite justice and care scores. As mentioned above, the majority of participants had composite justice and care scores that were essentially the same. However, 30% of participants had composite scores that indicated a high degree of orientation towards either justice or care, and of this group, a greater number of participants (39; 18%) qualified for the care dominant ethical orientation category than for the justice dominant category (26; 12%). When participant decisions to dismiss or not dismiss in the two student cases were examined by ethical orientation category the data indicated

that, as would be expected, the justice dominant group was over-represented in decisions to dismiss Bill, and the care dominant group was over-represented in decisions *not* to dismiss him. One might have assumed a similar result for Shayla with care dominant participants being over-represented in decisions *not* to dismiss. However, responsiveness as defined here encompasses responsiveness to *negative* characteristics and behaviors as well as responsiveness to more sympathetic circumstances. Participants who fell into the care dominant category, based on a definition of care that includes a high degree of responsiveness, actually voted to dismiss Shayla in numbers proportionally similar to the justice dominant group.

As defined initially, and as demonstrated in the case of Shayla, an ethical orientation of care did not automatically indicate decision making characterized by "leniency." When the data were reexamined using a new definition of care that *excluded* the element of responsiveness, and had as its basis empathy and humanism only, the gap between the justice dominant and care dominant votes to dismiss Shayla grew substantially. Votes to dismiss her from the justice dominant group went up (80% to 86%), and votes to dismiss her from the care dominant group went down (76% to 71%). Essentially, participants who fell into the new care dominant category no longer voted to dismiss Shayla in numbers proportionally similar to the justice dominant group. These data would seem to indicate that "care" and "leniency" are conceptually different aspects of decision making. Liddell, et al. (1992) include responsiveness in their definition of an ethic of care, and contend that within an ethic of care "decisions are contextual and relative to a particular situation." This would seem to include responding in a strict or harsh way to a negative situation. Can an individual operate from an ethic of care while enacting harsh consequences or imposing strict rules? As discussed in Chapter 1, dismissal from medical school can have enormous personal and financial repercussions for students who have spent

years of their lives and many tens of thousands of dollars on their medical education. The distinction between "care" and "leniency" is an important one, especially for promotions committee members who struggle to make decisions that are in the best interest of a variety of invested parties. At times, decisions that are on the surface the most "harsh" in nature, are the ones that demonstrate real care- for the learner, for patients, and for the profession. As one participant said about his/her work on a promotions committee, "it is frequently hard, but letting them through so that they can continue to struggle and even leave later on is not a solution for them personally or financially or for our community."

An ethic of care based primarily on empathy has its own limitations. As discussed previously, empathy has the potential to lead to bias that favors those who look like us, or that favors "identifiable victims" over others (Bloom, 2013, 2014; Friedrich & McGuire, 2010; Jenni & Loewenstein, 1997; Pizarro et al., 2006). Additionally, empathy and indeed ethical orientations of care or justice generally, may or may not be stable over time. Empathy has been shown to decrease over the course of medical training although some studies focus on a decline during medical school (Hojat et al., 2009; Neumann et al., 2011; Newton, Barber, Clardy, Cleveland, & O'Sullivan, 2008), and others on a decline during residency training (Bellini & Shea, 2005; McFarland, Malone, & Roth, 2016; Rosen, Gimotty, Shea, & Bellini, 2006). Physician burnout and empathy deficits across career trajectories remain a widespread concern (Firth-Cozens, 2001; Jauhar, 2014; Peisah, Latif, Wilhelm, & Williams, 2009; Shanafelt et al., 2012).

Ethical Orientations and Age/Role

The survey data indicated a number of areas in which participant responses varied with age and/or role. The twenty medical students included in this study made up only eight percent

of the total number of survey participants, but 100% of the <30 age category. Not every medical school includes students as voting members of their promotions committee, and students are likely to make up only a small portion of committees that do. Twelve of the 22 schools that responded to the descriptive data collection portion of the project indicated that their promotions committee includes student representatives, though in three of those cases students were non-voting members. The fact that medical students made up 100% of the <30 age category in these results meant that the interaction between age and role required additional attention. All of the statistical analyses regarding age were performed a second time excluding the <30 age group in order to further clarify the influence of role on the findings.

Eliminating the <30 age group clarified in some instances that age, not role was indeed the significant factor. For example, responses to the question regarding the importance to participants that a "good" committee process be responsive varied significantly by age even once the <30 age group was eliminated. The same held true for responses to the question regarding the importance to participants that their decision making be empathetic. Responses regarding how influential students' level of reliability is to participant decision making also varied significantly by age, even once the <30 group was eliminated from analysis. The importance of age to these cases, rather than role, was confirmed by the fact that the data did not vary significantly by role in any of them.

On the other hand, there were also instances in which the elimination of the youngest age group made it clear that role, not age, was the influential factor. For example, responses to the question regarding the importance to participants that their decision making be objective no longer varied significantly by age once the <30 age group was eliminated from analysis. The influential nature of role was confirmed when the data were analyzed by role and the variation

was significant between medical students and faculty members. Responses regarding how influential the existence of severe mental illness is to participant decision making also varied significantly by age only until the <30 age group was eliminated. Again, the influential nature of role was confirmed when the data were analyzed by role and the variation was significant between medical students and faculty members, and between medical students and administrators.

Even on questions for which analyses did not reveal statistically significant differences between *particular* age groups, it seems conceptually significant that when the data varied significantly by age, responses from the <30 age category tended to be numerically more similar to those from older age groups than they were to the closest chronological age groups. As mentioned above, some of this may be due to the influential nature of the medical student role, and the differences between it and faculty or administrative roles. While there were no significant differences between particular age groups or by role, participant levels of agreement with a statement regarding being influenced by the need to be responsive in Case B were lowest for the 40-49, 50-59, and 60-69 age groups, and highest for the <30, 30-39, 70-79, and 80+ age groups. Responses from the <30 group (medical student respondents) were closest numerically to the 60-69 age group. For the question regarding a "good" committee process being responsive to individual student characteristics and circumstances there were no significant differences between particular age groups or by role, but the responses from the <30 group were closest numerically to the 50-59 age group.

For participants *over* 30 years old, agreement with the statement that it was important for them to be empathetic rose with every age category. However, participants in the <30 years old category (medical student respondents) indicated greater agreement than did their counterparts in

the two age groups above them. Responses for the <30 age group were closest numerically with the average score for the 50-59 age group. These results suggest that the importance placed on being empathetic is high in medical school, reduces in importance in early career, and then increases again with age and experience.

Agreement regarding the importance of objectivity starts out relatively low for medical students, then rises over age categories to a high for those in the 50-59 years of age category, then decreases again across the 60-69, 70-79, and 80+ age categories. Responses for the <30 age group (medical students) were closest numerically with the average score for the small numbers of individuals in the 80+ and 70-79 age groups. These results suggest that the importance of objectivity is lowest while in medical school, increases as individuals become physicians, peaking at the mid-career level, then drops again with age and experience.

Overall, while there are certain trends in the data that increase or decrease with age, responses from the <30 age group, comprised of all medical students, tend to be somewhat dissimilar numerically to the younger age groups and more similar numerically to the older age groups. These results suggest that the dimensions of care and justice may rise and fall across the aging process, with elements of care taking priority at a younger age, especially while in the role of medical student, elements of justice increasing in priority across middle age and career development, and care reemerging as a priority as individuals enter their older years and later career stages. This conclusion is somewhat supported by an examination of the representation of age groups within ethical orientation categories.

The <30 age group is under-represented the in the justice dominant ethical orientation category and over-represented in the care dominant category. While the <30 group represents seven percent of all the individuals for whom composite categories were calculated, they

represented 0% of the justice dominant category, and 13% of the care dominant category. The 30-39 age group is slightly under-represented in the care dominant category (13% compared with 15% overall). The 40-49 age group was under-represented in the care dominant category (13% compared with 30% overall) and slightly over-represented in the justice dominant category (35% compared with 30% overall). Though their overall numbers were low, the two highest age groups were also over-represented in the care dominant category and under-represented in the justice dominant category. The 70-79 group represented 2% overall, but 5% of the care dominant category and 0% of the justice dominant category. The 80+ group represented 1% overall but 3% of the care dominant category and 0% of the justice dominant category. While the differences are most consistent for the lowest and two highest age categories, the pre- and late-career groups do appear to lean toward an orientation of care rather than justice.

One exception to these findings concerns responses to the question regarding the committee's role being to maintain a school's academic standards. While there were no significant differences between particular age groups on the question, the <30 age group (medical student respondents) indicated the lowest agreement and those over 80 years old indicated the highest agreement. Responses from the <30 group were closest numerically to the 30-39 age group. These data suggest that loyalty to an academic institution, and investment in maintaining its academic standards, increases with age and experience.

Even with the small number of medical student survey participants, their responses differed significantly from faculty and administrators in a number of ways. As mentioned above, in terms of the list of 18 particular student characteristics and circumstances, medical students indicated that "existence of severe mental illness" was significantly less influential than did faculty or administrators. The extent to which participants indicated being influenced by the

need to be responsive in Case A (Bill) varied significantly by role with medical students reporting being more influenced by the need to be responsive than did administrators or faculty. On the question regarding the importance of being objective, medical students indicated significantly less agreement than did faculty. On the question regarding it being the committee's role to enact consequences consistently over time, medical students indicated significantly less agreement than did administrators.

Representation in original composite categories also varied by role. While medical students made up nine percent of the total participants for whom composite scores were calculated, they were proportionally over-represented (13%) in the care dominant group and proportionally under-represented (4%) in the justice dominant group. Though there were many survey elements in which there were no significant differences between medical students, faculty and administrators, on the elements that did vary by role medical students' responses were uniformly consistent with a care orientation (there were no instances when medical students indicated significantly greater agreement with statements that reflected consistency or objectivity than did faculty, for example). There are data that support medical students operating from one ethical orientation (care) over the other, but these data are limited in number.

Alternate Developmental Perspective

For an additional perspective on how individuals approach promotions committee work we may need to look beyond the moral development literature to a more general conception of how adults make meaning of their lives. Robert Kegan's subject-object theory describes adult development as a series of developmental stages that are progressive in nature, though not necessarily tied to specific ages (Eriksen, 2006, 2008; Kegan, 1982). Kegan views adult development as a series of transitions in which an individual moves from being embedded in and

defined by something (subjectivity), to a state in which that same thing is external to the self and can be acted upon or related to (objectivity). For example, Kegan's interpersonal stage is characterized by an embeddedness in relationships in which those relationships define the self, and loss of those relationships is perceived as a loss of self. There are clear similarities between Kegan's interpersonal stage and Kohlberg's ethic of care (Conn, 1986; Kegan, 1982). In both, relationships are of primary importance, and for both, Gilligan's (1982) critique regarding the devaluation of feminine development may hold true. Kegan attempts to address this by indicating that perhaps men and women experience the transitions between stages in different ways, with women experiencing more difficulty moving out of relational stages and men experiencing difficulty moving out of more autonomous stages. "Women can be expected to have more difficulty emerging from embeddedness in the interpersonal, men more difficulty emerging from the embeddedness in the institutional (Kegan, 1982, p. 210).

In Kegan's theory, development beyond the interpersonal stage involves increasing autonomy and an ability to reflect upon relationships as external from the self (Eriksen, 2006, 2008; Kegan, 1982). In the institutional stage subsequent to the interpersonal stage, the systems of work and family become of primary importance. What Kegan may offer to our consideration of promotions committees is his explicit discussion of the theories and rules that govern work. Kegan conceptualizes adults in the institutional stage as being committed to an organization and understanding their role in maintaining that organization. Institutional knowers are "embedded in or subject to the institutions of which their roles are a part, to their jobs, and to the values or theories about how to regulate their roles and relationships" (Eriksen, 2006, p. 294). Here we may begin to make connections with the balance promotions committee members must strike between their responsibilities to individual learners, and their responsibilities to the medical

school, to patients, and to the medical profession as a whole. Committee members' work is subject to not only the institutional standards to which learners are held, but to the standards and values of the profession, of which the members are part. It would be reasonable to assume that committee members who are in the institutional stage of development may respond to the survey questions from this "embedded" perspective.

However, the real balancing act is reflected in Kegan's fifth and final stage, interindividualism (Eriksen, 2006, 2008; Kegan, 1982). This stage is characterized by movement away from single governing theories, and toward a more fluid conception of reality. Interindividual people place an increased value on contradiction and paradox as a means for improvement, and as an opportunity to co-construct a reality with others. In their attempt to balance varied, and perhaps competing, responsibilities, a person in the interindividual stage may be best suited to deal with the complexity and ambiguity of student stories. No longer subject to a particular system, the interindividual person is a creator of systems, and is oriented toward process rather than product. Instead of, or perhaps in addition to, ethical orientations of care and justice, it is possible that responses to the survey questions about committee work reflect participants' achievement of different stages of meaning making. Developmental stage, versus gender, age or even role, may provide some explanation for the variation in participant responses. A person who has reached Kegan's final developmental stage seems particularly well suited for promotions committee work, if only medical schools were only equipped to screen for such developmental achievement, and guaranteed a cohort of interindividualized individuals from which to choose.

Ethical Orientations and Gender

Given that two major schools of thought concerning moral development and decision making broke down at least originally along gender lines (Flanagan & Jackson, 1987; Gilligan, 1982; Kohlberg, 1981; Noddings, 2003), it would be reasonable to assume that the data regarding promotions committees work might reveal consistent differences between how men and women approach decisions about struggling medical students. In fact, the data indicated only a small number of significant differences by gender. Women indicated a significantly greater agreement with the statement regarding the role of the committee to act in the best interest of our learners than did men, and men indicated a significantly greater agreement with the statement regarding the role of the committee to enact consequences consistently over time than did women. Men were proportionally over-represented in the original justice dominant group (54% compared with 51% overall), and women were proportionally over-represented in the original care dominant group (51% compared with 47% overall).

On the survey elements in which responses differed significantly by gender, men's responses were uniformly consistent with a justice orientation and women's with a care orientation (there were no instances in which men prioritized care more than women, or women prioritized justice more than men). However there were many dimensions on which there were no significant differences between the responses of male and female participants. There were no significant differences between men and women on either question regarding what constitutes a "good" committee process (responsiveness or consistent application of standards). There were no significant differences between men and women regarding how important it was to them that their decisions are fair, objective, empathetic and humanistic. Men and women differed significantly in their responses to only one of the 18 student characteristics/ circumstances (men

indicated that the "existence of a physical disability" was significantly more influential than did women), and there were no significant differences between men and women on any of the three questions about the two student cases, including their decisions to dismiss or not dismiss the students in question. Thus while the data indicate that on several measures women operated from an ethic of care and men from an ethic of justice rather than the opposite, gender differences were limited in number.

The reconfiguration of composite care scores by eliminating the element of responsiveness served to decrease the over-representation of women in the care dominant group and actually increased the over-representation of men in both the care dominant and justice dominant groups. In the initial configuration, one that included the element of responsiveness as part of a care orientation, men and women were proportionally represented in the composite neutral category. Post-reconfiguration, women were proportionally over-represented in this large category of participants for whom justice and care are equally important. Upon reconfiguration, women's composite care scores went down and became more equal to their justice scores, effectively moving them toward the composite neutral category. However, average composite scores across all men and women stayed approximately the same in both care configurations so the number of individual participants affected was very small. Post-reconfiguration, men were proportionally under-represented in the central composite neutral category and proportionally over-represented at the ends of the spectrum- in both the justice dominant category *and* in the care dominant category. For men who were highly responsive, elimination of the element of responsiveness lowered their composite care scores, moving small numbers of them toward the justice dominant group. For men who scored lower on the responsiveness question, the elimination of this element raised their composite care scores and moved small numbers of them

toward the care dominant category. Responsiveness as an element of care, its impact on decision making, and differences in responsiveness by gender, is an area ripe for future study.

Influential Student Characteristics and Circumstances

The "failure to fail" literature makes it clear that there are contextual, personal and student-centered variables that play a role in faculty decision making about students (Cleland et al., 2008; Dudek, 2005; Fontana, 2009; Hauer et al., 2009; Irby, 1989; Luhanga et al., 2008; McAdams et al., 2007; Nash et al., 1981; Tulgan et al., 2001). We have taken a look at ethical orientations as one type of *personal* variable that may influence faculty members' decisions. An additional goal of this study was to explore which particular *student-centered* elements most inform and influence committee member decision making. To do so, survey participants were provided a list of 18 student characteristics or circumstances and asked how influential each is to their decision making. Each of the 18 characteristics/circumstances was influential with the lowest mean responses close to two ("Somewhat Influential"). Promotions committees are charged with reviewing and analyzing academic and non-academic student data as they make their decisions. It makes intuitive sense that these data would all, to some degree, be influential in deliberations regarding a student and his or her performance.

Participant responses in this section of the survey reveal the influential nature of issues related to student professionalism. The two categories that were rated as being *most* influential were "nature of the lapse in professionalism" and "total number of lapses in professionalism." Other characteristics that could reasonably be considered aspects of professionalism were all rated in the top half of the list in terms of extent of influence- "level of reliability" (#5), "willingness to seek help" (#6), "level of insight into his/her problem" (#7), and "work ethic" (#8). It is notable that each of these, with the exception perhaps of "insight," could reasonably

be considered to be within the control of the student. It may be that committee members are more influenced by aspects of a student case in which a student demonstrates positive or negative choices or behavior, and that circumstances that are deemed outside the student's control are less influential. This was certainly true in the case of Shayla, whose behaviors led to participant willingness to dismiss her. The *least* influential characteristics/circumstances in the list provided included "amount of financial debt" (#18), "academic background/preparation for medical school" (#17), and "amount of time the student has until graduation" (#16). None of these could reasonably be deemed under direct control of the student. Indeed, one participant wrote in response to an open-ended question about how committee members process the emotional aspects of their decision making:

> I try to separate components that are under the student's control (willingness to improve, accepts suggestions) vs those that are not under student's control (mental health issues, family situations). This helps me be somewhat more objective in making decisions and helps remove some emotional aspects.

It may also be the case that committee members are reluctant to admit that certain student characteristics or circumstances are influential to their decisions, and that self-report is not the most accurate way to gather data about their actual influence. All four participants in a small qualitative pilot study on promotions committees identified student debt level and time until graduation as influential to their decision making, but expressed some ambivalence regarding whether these particular student circumstances should really be part of deliberations. In answer to a question about whether students' financial investment influenced decision making one pilot study participant indicated:

> Yeah, I think it did. I think, you know we had those discussions occasionally and sort of felt like it shouldn't… I certainly remember some cases where the financial implications seemed pretty tragic for the student, but I think it probably was a piece.

A real-time study of actual promotions committee decisions regarding students in their fourth year with high degrees of debt, for example, may be a more valid way to determine the influence of certain student-centered variables than self-report.

The existence of mental and physical disabilities were rated as being in the bottom half of the list in terms of extent of influence, though "existence of severe mental illness" (#9) was rated as more influential than were "existence of mild mental illness" (#14), "existence of physical health problems" (#12) and "existence of a physical disability" (#15). One participant used the final open-ended question of the survey as an opportunity to inform me that "psychiatric health problems ARE physical health problems," yet as potential explanations for students' academic difficulties, they tend to present very differently to a promotions committee. Again, none of these could reasonably be deemed under the direct control of the student unless the difficulty was caused by non-compliance with a medication regiment for example, in which case perhaps "level of insight" or "willingness to seek help" might become the more relevant characteristics.

Other interesting findings include the extent to which characteristics/circumstances that involve *patterns* of behavior are influential, and the greater influence of clinical skills acquisition versus standardized exam performance. "Total number of lapses in professionalism" (#2) and "total number of academic failures" (#3) were both rated as highly influential. It makes intuitive sense that a committee member will consider a case involving a single lapse in professionalism or a single academic failure differently than they would cases with multiples of either. The identification of patterns of behavior or performance was a theme for participants in the pilot

study mentioned above as well. Faculty want their evaluative impressions corroborated by other faculty, and the existence of a pattern of behavior or series of failures is a powerful influence. As one participant wrote in the open-ended section regarding student Case A (Bill), "the pattern of failure is the most notable issue." Finally, the data indicate that "poor clinical skill acquisition" (#4) is more influential than "poor standardized exam performance" (#11). These data reflect the priority placed by the medical profession on the skills acquired primarily in years three and four of UME versus the knowledge base assessed by traditional standardized multiple choice exams that characterize the preclinical years and are administered into the clinical years.

Finally, the survey data indicate that there was a high degree of agreement that promotions committees have the discretion to consider particular student characteristics and circumstances in their decision making, and that promotions committees actually do so in practice. The highest levels of agreement on both of these elements were for schools with class sizes of 150-199. Although numbers are relatively low in the larger class size categories, the data suggest that both discretion and actual consideration go down as class size grows beyond the 150-199 category. Thus specific information about the influential nature of student characteristics and circumstances may be most salient for private schools (as they are under-represented in these larger class size categories) and schools with smaller class sizes as they are potentially more likely to consider student characteristics and circumstances in their deliberations.

Limitations and Future Directions

One major limitation of this study is its reliance on self-report. A survey may not be able to accurately assess how individual participants will actually vote during promotions committee processes. Participant responses to the two hypothetical student cases indicated some

inconsistency between reported influences (consistency and responsiveness) and actual votes to dismiss or not dismiss. Participants indicated being equally influenced by the need to be consistent and responsive, and yet their "votes" appeared to prioritize responsiveness. As mentioned previously, there may also be some reluctance for promotions committee members to report being influenced by certain student characteristics/circumstances. One goal for future research would be to better capture any discrepancies between self-reported values and actual decisions by better approximating actual committee decisions through the inclusion of additional hypothetical student cases on a survey tool. Through manipulation of case elements and additional opportunities to commit to a variety of decisions it may be possible to gain a clearer picture of participants' decision making and the influences exerted upon it. It may also be possible to gain a clearer understanding of the relationship between empathy and bias. Additional hypothetical cases would allow us to examine the relative power of different student "stories" to elicit empathy, and the impact of gender and racial concordance between participant and student could be examined.

While surveys or interviews may be the best way to better understand individual decision making, individual decision making is only one part of a larger committee process. The only way to fully understand how promotions committees operate as a whole would be to conduct systematic observations of actual meetings. For while a survey participant may indicate a particular ethical orientation, or even a particular hypothetical "vote," a survey cannot capture the nuances of a group discussion, the potential power dynamics inherent in group composition, or the impact of previous decisions or past student cases on current group decision making. A survey cannot adequately capture consensus building, persuasive discourse, or the impact of processes by which votes are displayed and tallied. A medical school promotions committee

would make a fascinating case study. Unfortunately the ability to conduct such research may be hindered by the sensitive nature of student performance data, and by concerns for student privacy and institutional anonymity.

A third major limitation of the current study concerns the list of student characteristics and circumstances. The list, as provided in the survey, is limited in nature and may not capture all of the potentially influential student-centered elements of a case. As mentioned in Chapter 2, stories can be highly persuasive (Pizarro et al., 2006) and there are innumerable personal details and circumstances that may serve to influence committee members in a variety of ways as they consider students' "stories." Additionally, while some of the elements are clearly influential, it remains unclear in which direction they may influence a participant's decision making. For example, the existence of mental illness may influence one participant to vote in such a way as to provide the student in question with additional opportunities to succeed. That committee member may conceive of mental illness as easily treated and temporary in nature. For another committee member, existence of mental illness may be equally influential, but in the opposite direction. That individual may conceive of mental illness as likely to be exacerbated by the continuation of medical training, and incompatible with the practice of medicine. Future research into promotions committee work should explore the "directionality," not just the level, of the influence of particular student characteristics and circumstances. Again, a survey that provides participants with additional opportunities to commit to a variety of decisions may better capture exactly how particular influences play out.

Ultimately, it may be difficult to measure ethical orientations via agreement with a small number of values statements. "Justice" and "care" are complex concepts that may include a multitude of elements beyond what were considered here (Bloom, 2013, 2014; Botes, 2000a;

Flanagan & Jackson, 1987; French & Weis, 2000; Gump et al., 2000; Held, 1995; Jenni & Loewenstein, 1997; Pizarro et al., 2006; Tong, 1998). The role of leniency and its relationship to care is an important avenue for exploration, and as discussed above alternate developmental constructs may also be at play (Kegan, 1982). The data indicated that the inclusion or exclusion of "responsiveness" impacted gender differences in votes to dismiss a hypothetical student. The development and validation of an assessment tool to measure ethical orientations, one that is sensitive enough to capture a multitude of ethical and moral elements, would be an appropriate and exciting next step.

In addition to there being an opportunity for future research and for the development of measurement tools, there are also administrative opportunities to better support promotions committees across medical schools. Participant responses to questions regarding training indicated that there is a need for training materials development. These materials could include overviews of relevant policies and grading practices. Committee members may benefit from sample "cases" that outline appropriate application of policy. In order to better guide committee work, the administrators who support their institution's promotions committee may also want to provide follow-up information about students considered by the committee in the past. Did the students who struggled in the preclinical years continue to struggle in the clinical years? Did the students with professionalism issues manage to maintain substantive changes to their behavior over the course of medical school? Were students ultimately successful in graduating? Did they successfully match into a residency program? These "real life" examples may provide committee members with a sense of how their decisions have impacted students and whether or not their impressions of students' chances for success proved accurate. Finally, schools may want to consider sponsoring regular debriefing sessions to provide committee members with the

opportunity to discuss and process the emotional impact of committee work. Such sessions could potentially assist participants in feeling supported and, if skillfully facilitated, help address any issues with committee processes or tensions among committee members.

Summary

The majority of participants in this study self-report a decision making framework that does not prioritize one ethical orientation over the other. They appear to acknowledge the importance of both justice and care and may alternate between the two depending on the context and student-centered elements of the problem at hand. In practice they may prioritize responsiveness over consistency, though additional research is needed in this area. While women may have a tendency to operate from an ethic of care, and men from an ethic of justice, the results of this study do not support broad generalizations regarding ethical orientations and gender differences. Other factors such as committee member role (medical student versus faculty), age, and career stage, may be equally or more important than gender in terms of decision making.

As mentioned in Chapter 2, Held (1995) proposes several ethical models that integrate justice and care. She indicates that she has moved from conceiving of justice as a minimum criterion for ethical decision making, to a conceptual model in which care provides an overarching framework for ethical decision making, within which concerns of justice must fit. Perhaps most relevant to promotions committee work however may be the model of integration put forth by Botes (2000a, 2000b) that focuses on integration of justice and care within a group rather than within an individual. Group decision making has the potential to provide appropriate checks and balances to individual ways of knowing the accompanying biases. It has the potential to integrate the voices of individuals who come embedded in "conventional," "post-

conventional," "interpersonal," "institutional," or "interindividual" developmental stages (Kegan, 1982; Kohlberg, 1981). The votes of a committee member who employs an ethic of justice to address a particular problem, may balance out the votes of a committee member who employs an ethic of care to that same problem. According to Botes (2000b), members of a group must work together to integrate perspectives, and engage in discourse that is characterized by open and empathic attitudes, verification of evidence, and consensus building. Only then can the group make important and appropriate decisions, ones that are both just and caring, to the benefit of all those involved.

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APPENDIX A: Survey Questions

Default Question Block

Consent for Participation: *Perceptions of the Decision Making Processes of Medical Student Promotions Committees*

Research Purpose:

To examine perceptions regarding the decision making processes of medical student promotions committees, and the contextual and case-based factors that impact those processes. This research is part of a doctoral dissertation project.

Research Process:

An electronic survey that will take approximately 15-20 minutes to complete. *The survey contains NO questions about actual students, student cases, or actual decisions made by your committee.*

Research Participation:

Participation in this study is entirely voluntary. You may decline to answer any survey question. You may stop the survey at any point. All of the data collected as part of the research process will be kept confidential. Survey answers are completely anonymous. Potential risk to participants of this research is very minimal.

For further information, please contact:
Primary Investigator: Emily Green; Emily_Green@brown.edu; (401) 863-9139
IRB Co-Chair: Terry Keeney (tkeeney@lesley.edu).

Medical school promotions committees (also commonly known as "academic progress committees" or "student performance committees") are tasked with making decisions about medical students' academic standing and promotion from year to year. These survey questions concern your participation as a voting member of your institution's version of a promotions committee.

I have read and understood the above consent form and agree to participate.

- ○ Yes
- ○ No

Demographics
Section 1 of 6: DEMOGRAPHIC INFORMATION

Gender:

- ○ Male
- ○ Female
- ○ Other/Prefer not to identify

Age:

- ○ <30
- ○ 30-39
- ○ 40-49
- ○ 50-59
- ○ 60-69
- ○ 70-79
- ○ 80+

My primary role is as a:

- ○ Medical student
- ○ Faculty member
- ○ Administrator (voting members only)

The majority of my teaching responsibilities involve:

- ○ Medical students
- ○ Residents
- ○ Other

How many years have you been a voting member of your institution's promotions committee?

- ○ <1
- ○ 1-2
- ○ 3-4
- ○ 5-6
- ○ 7+

Highest degree(s) obtained:

- ☐ BA/BS
- ☐ Masters (MA, MS, MPH, MPP, MBA, Med, etc.)
- ☐ PhD/EdD
- ☐ MD
- ☐ Other: _____

Clinical specialty area:

- ☐ Emergency Medicine
- ☐ Family Medicine
- ☐ Internal Medicine
- ☐ Neurology
- ☐ Obstetrics/Gynecology
- ☐ Pathology
- ☐ Pediatrics
- ☐ Psychiatry
- ☐ Surgery
- ☐ Other: _____

Institution Demographics
Section 2 of 6: HOME INSTITUTION DEMOGRAPHIC INFORMATION

Please select your home-institution from the list provided. (Note: We ask for the name of your institution to track completion and in order to group participant responses

appropriately for analysis. However, all institutional identifiers will be removed during the coding process. No institution names will be used in any research reports.)

Medical school type:

- Public
- Private

Some institutions have one promotions committee that considers all students. Others have one promotions committee for the preclinical years, and one for the clinical years.

Of which kind of promotions committee are you a voting member?

- One that considers students from all four years of medical school.
- One that considers students in the preclinical years of medical school only.
- One that considers students in the clinical years of medical school only.
- Other (please describe)

Approximate size of your medical school's current first year MD Class of 2019:

- <100
- 100-149
- 150-199
- 200-249
- 250-299
- 300+

Student Cases
Section 3 of 6: STUDENT CASES (fictional)

Student Case #1 (of 2)

Last month your committee voted to dismiss Andrew, a medical student in his third year of medical school. Andrew had experienced multiple academic failures and struggled clinically. To the committee's knowledge, there had been no extenuating circumstances contributing to his failures.

This month, the committee is considering the case of Bill. Bill is also in his third year of medical school, has experienced the same number of failures as Andrew, and has also struggled clinically. The committee is informed that Bill is in the midst of a contentious divorce.

To what extent are you influenced by the need to be consistent in your decisions across these two student cases?

Not at all Influenced Somewhat Influenced Influenced Highly Influenced

To what extent are you influenced by the need to be responsive to Bill's particular circumstances in your decision making?

Not at all Influenced Somewhat Influenced Influenced Highly Influenced

Assuming that you have to make a choice, what action would you take regarding Bill? Explain your choice.

- Dismiss
- Do Not Dismiss

Student Case #2 (of 2)

Last month your committee voted not to dismiss Alice, a medical student in her second year of medical school. Alice had experienced multiple academic failures. The committee was informed that Alice had taken advantage of tutoring assistance and worked with advisors to remedy the situation.

This month, the committee is considering the case of Shayla. Shayla is also in her second year of medical school and has experienced the same number of failures as Alice. The committee is informed that Shayla has not taken advantage of tutoring assistance. She has demonstrated reluctance to change the way she prepares for exams, and has been resistant to advice on a number of levels.

To what extent are you influenced by the need to be consistent in your decisions across these two student cases?

Not at all Influenced Somewhat Influenced Influenced Highly Influenced

To what extent are you influenced by the need to be responsive to Shayla's particular characteristics and circumstances in your decision making?

Not at all Influenced	Somewhat Influenced	Influenced	Highly Influenced
○	○	○	○

Assuming that you have to make a choice, what action would you take regarding Shayla? Explain your choice.

- ○ Dismiss
- ○ Do Not Dismiss

Committee Deliberations

Section 4 of 6: COMMITTEE DELIBERATIONS

For the questions below, please indicate the extent to which you agree with the statement.

My institution's promotions committee *has the discretion* to take particular student characteristics and circumstances into consideration when making decisions .

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

My institution's promotions committee *does* take into consideration particular student characteristics and circumstances when making decisions.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

For the questions below, please indicate the extent to which you agree with the statement.

When considering the performance of a student being reviewed by my promotions committee...

A good process is one in which institutional standards are applied consistently across all students, regardless of individual characteristics and circumstances.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

A good process is one in which institutional standards are applied in a manner that is responsive to the individual characteristics and circumstances of the student.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

For the questions below, please indicate the extent to which you agree with the statement.

In my individual consideration of student cases is it important to me that I am...

Humanistic (centered on an individual's values, capacities, and worth).

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

Fair (free from prejudice).

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

Empathetic (understanding of an other's situation and feelings).

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

Objective (grounded in facts and policy).

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

For the questions below, please indicate the extent to which you agree with the statement.

The role of the promotions committee is to...

Graduate highly qualified learners.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree
○	○	○	○	○	○

Act in the best interest of our learners.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Act in the best interest of our learners' future patients.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Maintain our school's academic standards.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Graduate all admitted students.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Implement policy.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Nurture future colleagues.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Consider learners in a holistic fashion.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Enact consequences consistently over time.

Completely Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Completely Agree

Student Characteristics and Circumstances

Section 5 of 6: STUDENT CHARACTERISTICS & CIRCUMSTANCES

For each of the following student characteristics or circumstances, please indicate how influential it would be to your decision making.

	Not At All Influential	Somewhat Influential	Influential	Highly Influential
Total number of academic failures	Total number of academic failures Not At All Influential	Total number of academic failures Somewhat Influential	Total number of academic failures Influential	Total number of academic failures Highly Influential
Poor standardized exam performance	Poor standardized exam performance Not At All Influential	Poor standardized exam performance Somewhat Influential	Poor standardized exam performance Influential	Poor standardized exam performance Highly Influential
Poor clinical skill acquisition	Poor clinical skill acquisition Not At All Influential	Poor clinical skill acquisition Somewhat Influential	Poor clinical skill acquisition Influential	Poor clinical skill acquisition Highly Influential
Academic background/preparation for medical school	Academic background/preparation for medical school Not At All Influential	Academic background/preparation for medical school Somewhat Influential	Academic background/preparation for medical school Influential	Academic background/preparation for medical school Highly Influential
Existence of documented learning disability	Existence of documented learning disability Not At All Influential	Existence of documented learning disability Somewhat Influential	Existence of documented learning disability Influential	Existence of documented learning disability Highly Influential
Existence of physical disability	Existence of physical disability Not At All Influential	Existence of physical disability Somewhat Influential	Existence of physical disability Influential	Existence of physical disability Highly Influential
Total number of lapses in professionalism	Total number of lapses in professionalism Not At All Influential	Total number of lapses in professionalism Somewhat Influential	Total number of lapses in professionalism Influential	Total number of lapses in professionalism Highly Influential

	Not At All Influential	Somewhat Influential	Influential	Highly Influential
Nature of the lapse in professionalism	Nature of the lapse in professionalism Not At All Influential	Nature of the lapse in professionalism Somewhat Influential	Nature of the lapse in professionalism Influential	Nature of the lapse in professionalism Highly Influential
Level of reliability	Level of reliability Not At All Influential	Level of reliability Somewhat Influential	Level of reliability Influential	Level of reliability Highly Influential
Existence of an appropriate remediation option	Existence of an appropriate remediation option Not At All Influential	Existence of an appropriate remediation option Somewhat Influential	Existence of an appropriate remediation option Influential	Existence of an appropriate remediation option Highly Influential
Amount of time the student has until graduation	Amount of time the student has until graduation Not At All Influential	Amount of time the student has until graduation Somewhat Influential	Amount of time the student has until graduation Influential	Amount of time the student has until graduation Highly Influential
Amount of financial debt	Amount of financial debt Not At All Influential	Amount of financial debt Somewhat Influential	Amount of financial debt Influential	Amount of financial debt Highly Influential
Level of insight into his/her problem	Level of insight into his/her problem Not At All Influential	Level of insight into his/her problem Somewhat Influential	Level of insight into his/her problem Influential	Level of insight into his/her problem Highly Influential
Willingness to seek help	Willingness to seek help Not At All Influential	Willingness to seek help Somewhat Influential	Willingness to seek help Influential	Willingness to seek help Highly Influential
Work ethic	Work ethic Not At All Influential	Work ethic Somewhat Influential	Work ethic Influential	Work ethic Highly Influential
Existence of mild mental illness	Existence of mild mental illness Not At All Influential	Existence of mild mental illness Somewhat Influential	Existence of mild mental illness Influential	Existence of mild mental illness Highly Influential

	Not At All Influential	Somewhat Influential	Influential	Highly Influential
Existence of severe mental illness	Existence of severe mental illness Not At All Influential	Existence of severe mental illness Somewhat Influential	Existence of severe mental illness Influential	Existence of severe mental illness Highly Influential
Existence of physical health problems	Existence of physical health problems Not At All Influential	Existence of physical health problems Somewhat Influential	Existence of physical health problems Influential	Existence of physical health problems Highly Influential
Committee Processes & Training				

Thank you so much for completing Sections 1-5 of the survey! I would very much appreciate if you would also complete the following final section. However, if you are running short of time, please submit your answers by selecting "Finish and submit" and clicking the arrow below.

- Finish and submit.
- I will keep going for one more section!

Section 6 of 6: COMMITTEE PROCESSES & TRAINING

Often, the work of promotions committees is emotional in nature because students' stories can be very moving, and the stakes for their future can be quite high.

Does your committee have processes in place to help members deal with the emotional components of promotions committee work?

- Yes
- No
- Not Sure

Please describe:

How do you personally process the emotional components of the work? What do you do? What helps?

Did you receive training as part of your promotions committee participation?

- Yes
- No
- Not Sure

Please describe:

What kind of training do you think would be useful?

If you have any additional comments about the work of your promotions committee or about this survey, please feel free to include them here:

APPENDIX B: Key Terms and Definitions

Association of American Medical Colleges (AAMC)- A non-profit educational organization that serves all accredited allopathic medical schools in the United States, facilitates services for medical students and medical schools, conducts medical education research and acts as a central repository for data on medical education and medical schools, and hosts national medical education and leadership conferences.

Attrition- Permanent withdrawal or dismissal from a medical education program.

Clinical Medical Education- Generally refers to the second two years of a four-year medical education program in which medical students complete clinical rotations in hospitals and doctors' offices.

Ethic of Care- An ethical orientation in which moral decisions are made based on relationships and in which the needs of others are paramount, identified primarily with the writings of Carol Gilligan and Nel Noddings.

Ethic of Justice- A moral orientation in which decisions are made based on a set of rules and principles, identified primarily with the writings of Lawrence Kohlberg.

Graduate Medical Education (GME)- Residency training that takes place after graduation from medical school.

Health Professions Education- Generally refers to educational programs and institutions that prepare students for careers in medicine, nursing, therapeutic or other care-based fields.

Liaison Committee on Medical Education (LCME)- The accrediting body for all medical schools in the United States and Canada.

Medical School Performance Evaluation (MSPE)- A standardized letter of evaluation used by US medical schools. The MSPE summarizes each student's performance and is sent to residency programs as part of each student's application.

Preclinical Medical Education- Generally refers to the first two years of a four-year medical education program in which medical students complete basic science coursework.

Promotions Committees- Entities tasked with making decisions about medical students' academic standing and promotion from year to year of medical school. Also commonly known as "academic progress committees" or "student performance committees".

Social Contract- Originally used to describe the tension between state control and individual freedoms, used in this context to describe the relationship between the medical profession and society in which the profession is expected to be devoted to the public good, and have patients' welfare as its primary concern.

Undergraduate Medical Education (UME)- Pre-residency training medical education.

Underperformance- Failure to meet established criteria for knowledge acquisition or clinical performance that may or may not result in submission of an actual failing grade.