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Case Study: A Midclerkship Crisis—Lessons Learned From Advising a Medical Student With Career Indecision

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Abstract

Advising medical students is a challenging task. Faculty who serve as advisors for students require specific skills and knowledge to do their jobs effectively. Career choice is one of the many complex issues about which medical students often seek assistance from a faculty advisor. The authors present a case of a third-year medical student with career indecision, with a focus on the various factors that may be influencing her thinking about career choice. Key advising principles are

provided as a framework for the discussion of the case and include reflection, self-disclosure, active listening, support and advocacy, confidentiality, and problem solving. These principles were developed as part of the Advising Case Conference series of the Johns Hopkins University School of Medicine Colleges Advisory Program. Emergent themes from the case included a student's evolving professional identity, a student's distress and burnout, lifestyle considerations, and advisor bias

and self-awareness. The authors propose reflective questions to enhance meaningful discussions between the advisor and student and assist in problem solving. Many of these questions, together with the key advising principles, are generalizable to a variety of advising scenarios between advisors and learners at all levels of training.

Acad Med. 2010; 85:000–000.

Medical students often experience uncertainty and apprehension around career planning, and many seek advice during the process. Specialty choice at the start of medical school often differs from that at graduation.¹ A student's final decision represents a complex cognitive and emotional process that takes into account multiple contributing factors.^{2,3} Patients, the public, and the medical profession have a vested interest in ensuring that students make appropriate decisions. Both students and institutional leaders at schools of medicine have recognized the importance of assisting

students in this process, and many schools have advising programs to accomplish this.^{4–8}

In response to students' requests for increased student–faculty interactions, in particular around career planning, the Johns Hopkins University School of Medicine Colleges Advisory Program (CAP) was created in 2005. The primary goal of this program is to enhance the personal and professional development of medical students. Twenty-four faculty members from nine clinical departments serve as longitudinal advisors. Each student is paired with an advisor and assigned to one of four colleges within the program.⁶ Students meet their advisor on the first day of medical school; thereafter, they meet quarterly and as needed. Faculty also precept their student advisees in the Introduction to Clinical Skills course. Students interact with their advisor regularly at medical school milestone events and social functions sponsored by the CAP.

efficacy, we and our CAP colleagues developed a set of advising principles that provide a systematic approach to cases. These principles focus on the responsibilities of both the advisor and advisee in the relationship (see Table 1). The table presents statements of key principles (left-hand column) that are generalizable to most advising scenarios, and it presents specific examples (right-hand column) from the case described below to illustrate the full meaning and application of the principles.

The following is a description of a medical student advising case as it was presented during a CAP advising case conference. After the case, we summarize the main emergent themes from the case discussion among faculty advisors and give examples of interventions that an advisor might employ. This particular conference began with an advisor presenting, in narrative format, the case of a deidentified third-year medical student who sought out the advisor for information on nontraditional careers after medical school.

The Student Case (as Presented by the Faculty Advisor)

M is a female, third-year medical student who contacted me to discuss a new challenge in her thinking about her career path. We have already met on several

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Table 1
Key Advising Principles and Their Applications in the Case Described in This Article*

Advising principle	Case-specific application of the advising principle
Advisee responsibility	
Personal responsibility	Advisee is committed to working with the advisor and thus seeks out her advisor to discuss her interest in pursuing a nontraditional career, and she comes to the meeting well prepared, having done substantial research into various career options.
Self-disclosure and honesty	Advisee shares her experiences on inpatient rotations and is honest about her feelings even in cases when they might be considered to fall short of professional values in medicine, such as not enjoying patient care as much as she had thought she would.
Advisor responsibility	
Advisee-centered	The advisor explores the student’s perspectives, needs, and concerns around nontraditional careers and forms a partnership with the student to address these issues together.
Active listening	The advisor listens intently, seeking to understand and connect to the advisee’s experience. She asks questions to deepen understanding and achieve clarity about the concerns raised, and she conveys empathy or support.
Respect for diversity, individual choices, and autonomy	The advisor expresses respect for the student’s career choices, responds nonjudgmentally to the student’s statements, and works to minimize any perceived hierarchy to enhance the student’s expression of personal choice.
Provide support and advocacy	The advisor offers recommendations and resources to explore clinical roles not represented in inpatient medicine and to explore other nontraditional careers that the student had not already considered. The advisor offers assistance in facilitating first contact with the desired resources.
Assist in problem solving	The advisor engages the student as a partner in addressing complexity and, when needed, works toward reframing questions to enhance understanding of the student’s concerns. This typically involves exploring the advisee’s interests, strengths, values, and career goals. The advisor redefines the initial request to identify better the student’s concerns about clinical medicine by asking the student to consider and compare the pros and cons of clinical and nonclinical careers.
Confidentiality	Confidentiality is implied based on an explicit advisor–advisee agreement at the beginning of the relationship and reviewed as the context requires. This ensures full disclosure on the part of the advisee.
Shared responsibility	
Reflection	The advisor poses reflective questions to better understand why the student does not want to pursue a residency and practice clinical medicine; the student responds honestly and thoughtfully.
Self-awareness/self-monitoring	The advisor is conscious of her own biases about this student’s choice and avoids stating what she thinks is “best for the student.” The advisor models self-awareness and self-monitoring by sharing her feelings with the student.
Relationship-centered	The advisor and student engage in the discussion in a way that demonstrates respect and care for each other as individuals; the advisor seeks to collaborate with the student to develop a plan to assist her; the student expresses appreciation for the advisor’s assistance and their relationship.

* These principles were developed as part of the Advising Case Conference series of the Johns Hopkins University School of Medicine Colleges Advisory Program. The responsibilities presented in the table should be generalizable to most advising scenarios. The case-specific applications shown in the table provide examples of how the advising principles can be implemented.

occasions to discuss career planning. As her advisor, I have come to know M well and enjoy our interactions. Like myself,

she entered medicine following an undergraduate concentration in the humanities. Before coming to medical

school, she was active in public health advocacy and human rights. Also to her credit, she had successfully completed research projects in a medical field. To this point in medical school, M appeared well adjusted, academically successful, and happy with her experiences. As her preceptor in the Introduction to Clinical Skills course, I observed her interactions with patients and colleagues. She demonstrated excellent interpersonal and communication skills. Overall, her academic performances in her preclinical courses and during clerkships have been above average.

M is now a late third-year student. She has completed most of her basic clerkships, and as of yet, no particular specialty has appealed to her. She has grown increasingly concerned and begins the meeting by stating that she is exploring “nontraditional” career paths. M explains this to mean that she does not intend to pursue postgraduate residency training in a clinical specialty. She asks for my input on this and also wants to know if I have specific suggestions for “nontraditional” careers that she has not considered. She has already researched opportunities in various consulting groups.

I invited M to share her career interests and goals in greater depth (this type of approach is described in Table 1 under “Reflection”). “What do you feel is missing from clinical medicine for you?” I asked. M responded, “So far, I just have not been pulled toward any particular field. I enjoy interacting with patients, but I don’t feel like this is the thing that is driving me to go to work each day.” M explained that her thinking was based primarily on her experiences during her inpatient clerkship rotations. “One of the big turn-offs for me,” she said, “was listening to residents talk about how much they regretted what they were doing.” She explained that based on these ward experiences, she is worried that residency training would be overwhelming, take over her entire life, and cause her much unhappiness. M continued, “I think that because my exposure has been limited to inpatient experiences so far, I have not seen many doctors who seem to feel like they have a lot of flexibility. It seems as doctors progress in their careers that they have less autonomy and more responsibility. It

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just seems that there's no light at the end of the tunnel."

I empathized with M and recognized the difficult endeavor of trying to understand the range of opportunities within medicine when primarily seeing it practiced on busy inpatient services. In particular, I acknowledged that specialty choice and residency applications are a major source of anxiety for third-year medical students (Table 1, "Active listening," "Advisee-centered"). I encouraged her to consider that her experience on the wards was not typical of how many physicians spend the majority of their time. To experience this firsthand, I suggested that she take advantage of opportunities to participate in an outpatient clinical rotation. I also urged her to talk with various physicians about their other professional roles beyond inpatient attending and possibly shadow them in their clinics (Table 1, "Advisee-centered," "Assist in problem solving").

M was asked to share what she perceived to be the benefits of a "nontraditional" career (Table 1, "Assist in problem solving"), and she explained, "being in a diverse field with very diverse people and projects; immediately starting to work; using the skills I thought I was good at but not currently using much in medicine such as project management, leadership, and communication; feeling appreciated; receiving good pay and benefits."

M and I then brainstormed possibilities, considering the spectrum of opportunities available to medical school graduates with or without clinical training that might allow M to fulfill her interests and meet her lifestyle needs. I encouraged M to research the ideas that interested her most and gave her contact information for potential faculty role models. She was also given suggestions and contacts for other nontraditional careers such as those in government agencies, international organizations, health policy, and medical journalism and writing. I offered to help initiate these contacts, should M desire (Table 1, "Provide support and advocacy").

Finally, I was aware of feeling conflicted during the conversation. On the one hand, I wanted to convey respect for her choices, but I also felt that M would make an outstanding clinician and had much to

contribute to patient care. I disclosed these thoughts and feelings with M (Table 1, "Respect for diversity, individual choices, and autonomy"; "Self-awareness/self-monitoring").

At the end of the meeting, I suggested that we meet again soon, after she had time to reflect on our conversation, and invited M to set an agenda for what she would like to do next and how I could help her (Table 1, "Advisee-centered," "Assist in problem solving").

Case Discussion Among CAP Faculty Advisors

The discussion following the case presentation focused on four main themes: (1) development of professional identity, (2) medical student burnout, (3) lifestyle issues and career choice, and (4) advisor bias, self-awareness, and self-monitoring.

Development of professional identity

Some advisors wondered if a familiar scenario was at play: The medical student is at a crossroads and wondering, "Is medicine right for me, and am I right for medicine?" The advisors initially focused on the context, taking into account the student's developmental stage of training. The student is in her third year of medical school, during which time she is experiencing increased responsibility and stress related to caring for patients. Further, she is at a stage in her training when she is beginning to feel pressure to make a career choice and may feel isolated when her classmates declare their career plans. During medical school and especially during the clinical years, students undergo a profound transformation from laypersons to physicians. Traditionally, this has involved a sense of complete commitment and dedication to the profession. Students may question their ability and desire to live up to this role, especially in situations where they see a potential for their core values to be threatened.⁹⁻¹² For some students, a measurable change in their attitudes away from altruism and humanism may occur as a result of these experiences.^{10,13-16} This major shift in self-image and identity may be accompanied by a crisis of confidence and self-esteem. Advisors recognized that M's request for advising around nontraditional careers may be symptomatic of a deeper issue, perhaps

related to a conflict about her evolving professional identity and loss of idealism about clinical medicine.

The advisors also considered the importance of exposure to role models (both positive and negative) on the development of professional identity and career choice.¹⁷⁻²⁰ Students frequently report that career choice is influenced by a role model's ability to dispel negative stereotypes about their intended career.² Because inpatient rotations are often quite stressful, with resident and faculty burnout highly visible in these settings, this student may have had limited experiences with engaged and satisfied physician role models at a time when she is making career decisions.

In the majority of U.S. medical schools, third-year medical students spend the bulk of their core clerkships in the inpatient setting, where their exposure to a spectrum of career options is limited, as seemed to be the case for this student. Some medical schools are addressing this issue through curricular innovations that provide early longitudinal, clinical exposure for students to the outpatient setting.²¹⁻²⁵ Another option that may be appropriate for some students is to take a "year off," during which students may pursue another degree, conduct research, or work in a community setting or abroad.

Advisors acknowledged the value of employing student- and relationship-centered paradigms, reflection, and active listening to explore this complex terrain (see Table 1). The following reflective questions might assist both the advisor and student in understanding the issue on a deeper level.

- What recent experiences have influenced your thinking about clinical medicine?
- How have these experiences helped to clarify your thoughts, feelings, and direction?
- What strengths do you feel you bring to medicine?
- Which aspects of working in medicine give you the most satisfaction? And which give you the least?
- How do you hope your personal values will align with your chosen career path? Before coming to medical school, how did you imagine your life in medicine?

Has that image changed for you, how and why?

- Think about a positive role model in medicine for you. Which characteristics of that role model do you wish to emulate?

Medical student burnout

An advisor questioned whether the student might be experiencing burnout, which led her to feel apathetic about her current work and disillusionment about her future career in clinical medicine. This was prompted by the student's statement that her clinical experiences were not motivating her to go to work each day. Distress (depression, anxiety, burnout, and related mental health problems) is common among medical students and occurs at higher rates than in age-matched peers in nonmedical fields.²⁶ Burnout may affect close to 50% of medical students.^{27,28} When students across all four years of medical school are compared, burnout and depressive symptoms are highest among third- and fourth-year medical students, a time when many medical students make career decisions.²⁸

Many factors threaten students' well-being, including stressful life events, sleep deprivation, and academic pressure. Students on inpatient ward rotations and those taking overnight call are significantly more likely to report burnout symptoms than will their peers who are not on those types of rotations.²⁹ One reason for this is illustrated by the findings of a cross-sectional study in which students who perceived their supervising resident or intern to be cynical were 1.35 times more likely to report burnout than students who did not.²⁹

Experience with the hidden curriculum may result in negative consequences for students' well-being and career choice.³⁰ The hidden curriculum encompasses the disconnect between what students encounter in practice and what they are taught in the formal curriculum.²⁰ For example, students are taught the value of taking time to build a relationship with patients, but on busy clinical services they are often rewarded for the speed with which they finish their work. In this way, what is done and witnessed in practice can conflict with students' core values. Emotional distress experienced by some

students in response to elements of the hidden curriculum may undermine the humanism and empathy they exhibit at the start of medical school training.^{10,13,20,31} Students may find it difficult to make a confident decision about a specialty if the negative experiences were especially profound or frequent. Such influences make the role of a trusted advisor, one who can offer a different perspective and provide support, critical in promoting reflection about the medical profession.

A conceptual model of medical students' well-being has been proposed.³² This model is described as a dynamic "coping reservoir." The reservoir has an internal structure, comprising the student's personal traits, temperament, and coping style, that influences how negative inputs (stress, internal conflict, and time/energy demands) drain the reservoir and positive inputs (psychosocial support, mentors, intellectual stimulation, and healthy/social activities) replenish it. This may be a useful concept for advisors to consider when working with students. Advisors may guide students in recognizing their own internal strengths by promoting reflection and self-awareness and may help them to identify other activities or support networks that can replenish their coping reservoirs. Negative emotional responses to aspects of medical training are common; however, students with considerable or prolonged distress should be referred to a confidential student assistance program that provides mental health services.

The following questions may help to identify students experiencing considerable distress.

- Can you share a story of a specific time or situation in medicine that has led to significant emotional distress for you?
- How have you dealt with those experiences? Have the experiences changed your behavior in any way?
- How often do you feel that you lack the emotional energy needed to get you through a day or to interact with patients or colleagues in a positive way?
- What supports (internal and external) do you rely on for coping with distress?

Lifestyle factors and career choice

Advisors also acknowledged that this student's career thinking may have been

influenced by lifestyle considerations. The discussion focused on her references to physician autonomy and flexibility when she was describing her concerns about clinical medicine. Trends in medical students' career choices have undergone significant changes over the past decade with an increasing number of graduates seeking nonclinical careers, based on data from the Association of American Medical Colleges (AAMC) Graduate Questionnaire. In 2004, 7.2% of graduates indicated plans to pursue "other, nonclinical practice," either after or instead of a residency program. Factors associated with this choice include reporting less debt, having dual degrees, and being an underrepresented minority.³³ Graduates planning to pursue nonclinical careers most commonly sought jobs in state or federal agencies, followed in descending order by "other" (details not provided), nonuniversity research, and health care administration.³⁴

This shift may be part of a larger societal change in attitudes about work that may be related to generational factors. Younger workers report wanting more time to pursue interests outside of work.³³ Controllable lifestyle, defined by control over weekly work hours and amount of time free from work responsibilities, explains most of the variability in the recent trend of increased applications to specialties with controllable lifestyles, such as anesthesiology, dermatology, emergency medicine, and radiology.³⁵

Student debt may also play a role in career choice. Students completing the 2008 AAMC Graduate Questionnaire reported an average debt load of about \$150,000, with the proportion of students with very high debt and the average debt increasing during the previous five years so that a third of the graduates reported debt over \$175,000.³⁶ The data on the effects of debt on career choices are conflicting; however, it seems likely that many students struggle with this issue in some way in relation to career choice.^{37,38}

Understanding what is driving these trends will help advisors to foster an open and supportive dialogue about lifestyle issues and career choice. Similarly, advisors should strive for self-awareness of their own biases and attitudes about work, which may have unique

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generational characteristics, and be aware of the potential impact of these on conversations with students.^{9,39} Advisors should be prepared to talk candidly and realistically with students about matters such as finances and what it is like to be a physician after training, including many of the difficulties of practicing medicine in the current health care system.

The following questions may help to identify what factors are influencing a student’s career choice.

- What do you feel most passionate about, and what factors are motivating you in relation to your work and future career in medicine?
- What role is educational debt playing in your decision-making process?
- What questions do you have about financial aspects and the business of medicine?
- What lifestyle issues are you most concerned about?
- Who are some of your role models in medicine with regard to career and lifestyle? Why?

Advisor bias, self-awareness, and self-monitoring

We ended the discussion with a focus on advisor bias, self-awareness, and self-monitoring. It is only natural that one interprets others’ thoughts and actions through the lens of his or her own belief system and accumulated experiences. In the case, the advisor was aware of her conflicted feelings during the meeting, and she attempted to identify her own biases and be explicit with the student about them.

The concept of the physician as an “instrument of diagnosis and therapy” rests on the physician’s self-awareness.⁴⁰ Physicians who have insight into how and why they react to certain experiences (self-awareness) are more likely to engage in self-monitoring practices. The ability to regulate one’s attention in real time and react with curiosity and flexibility to those actions exemplifies self-monitoring. Patient care may be improved through physicians’ self-awareness and self-monitoring by enhancing doctor–patient communication and avoiding medical errors.⁴¹ Physicians’ well-being may be enhanced by better recognition and management of stress.⁴⁰ We posit that

self-awareness and self-monitoring are critical skills and behaviors for providing more effective and student-centered advising. Advisors may also serve as role models for these valuable professional behaviors explicitly by encouraging reflection and by sharing their own experiences related to personal awareness openly with students.

Mindful practice represents a practical means to achieving greater self-awareness and self-monitoring. Epstein⁴² describes the “mindful practitioner” as someone who “attends ... to his or her own physical and mental processes during ordinary everyday tasks to act with clarity and insight.” Key to this concept is the ability to observe oneself in the moment, adopt multiple perspectives, process information in a nonjudgmental fashion, and lower one’s reactivity to internal responses.⁴¹

Advisors may foster mindfulness by striving to achieve insight into their beliefs, motivations, and responses and how these might have an impact on their advisees. Addressing these processes through in-the-moment reflection promotes mindful self-awareness and self-monitoring.⁴¹ Examples of questions the advisor might have asked herself during this scenario include

- What about this situation is unexpected? How am I responding to that?
- What assumptions am I making? How can I verify these?
- Is there another way to understand and interpret the student’s perspective?
- What thoughts or feelings are arising in the moment for me? What prior experiences may be coloring my responsiveness?
- If I am feeling the need to fix or correct this student’s perception, why is that? Is it because of my own biases as a clinician–educator or my lack of comfort with an area I know less about?

Summing Up

This case highlights the complexity of issues that medical students face around career choice as well as the many opportunities for meaningful advising. Adopting a narrative case presentation method allowed for a more contextual

discussion of specific advising topics, skills, and behaviors. Discussing the case with multiple advisors ensured that varied perspectives would emerge; also, the richness of the case expanded. In this case, themes were proposed that the primary advisor had not initially considered, and sample questions were developed to guide future conversations with students. In particular, these themes demonstrate the need for advisors to remain up-to-date with seemingly timeless issues in medical education such as developing professional identity and career choice, the impact of the hidden curriculum, and an evolving understanding and conceptual framework for student distress. The case presentation format lent itself to a review of the relevant literature and sharing of this information with fellow educators. The setting also provided an opportunity to emphasize and amend key advising principles employed by our group of faculty advisors. Finally, faculty advisors were provided with the space to share and reflect on challenging advising experiences, further promoting the principles of reflection, self-awareness, encouraging self-monitoring behavior, and emphasizing the importance of role modeling these professional behaviors for advisees.

Funding/Support: None.

Other disclosures: None.

Ethical approval: Not applicable.

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AUTHOR QUERIES

AUTHOR PLEASE ANSWER ALL QUERIES

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A—AU: In the article title, the hyphen has been removed from the term “midclerkship”; please confirm that this change is acceptable.

B—AU: There is a verb tense shift from this paragraph to the next (present to past). Please check whether some verb tenses should be modified for consistency.

C—AU: Please clarify whether the phrase “impact of these” refers to “biases and attitudes” or “generational characteristics.”
