NOW AND THEN

The Enduring Role of Role Models, 2012

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Example is not the main thing in influencing others. It is the only thing.

—Albert Schweitzer

Having recently changed roles from resident to attending a couple years ago, I found myself thinking a lot about my role models, my mentors, and the changing dynamic of my own role. So it was easy to say "yes" when *Forum* Editor Priya Radhakrishnan asked me to pen my thoughts on the topic. Like many important things in medicine, the subject is a enduring and pervasive one, and as she explained, Scott Wright, MD, had written an article on role modeling in 1998.

Everyone would agree that much has changed in medicine (and life in general) over the past 14 years. So role modeling surely has as well, right?

It is important to state this explicitly: Mentors and role models are different. They serve different functions. Sure, one person might be both, but often they are not.

We all recall the history of the word *mentor*: the story of Mentor serving as a guide to Telemachus, son of Odysseus, while the mighty warrior was off fighting the Trojan War. Mentors are those people with experience and knowledge who provide guidance and advice to those in some way junior to them.

Mentorship is important in academic advancement, in successful careers, in employee retention, and often times in job satisfaction. The role of *mentor* has been embraced by the medical literature: Since Scott's SGIM *Forum* article, there have been at least 450 articles on mentoring in medical education. The concept of *role model* has been a bit less popular: There are far less than 100.

Why the difference? The first is because people do not receive "academic credit" as a role model. This is the cynical view, but I think there is some truth to it. I have had mentors in medical school and residency who helped me with research, clinical projects, and teaching endeavors. I actively sought them out for their wisdom and experience. They set aside time to guide me. This relationship ended (or continues) with measurable goals: presentations, abstracts, and manuscripts. Our CVs have grown as a result of our collective efforts.

The title of role model affords no such growth in one's CV, does not lead to academic advancement, and often does not even have an explicit defined relationship between teacher and learner. It's tough to measure. And it's usually about personality fit and may often even be unconscious. Indeed, in a 1997 *JGIM* article on role modeling,[2] when students selected role models, they "felt that personality was the greatest determinant. This was followed by clinical competence, clinical skills, and teaching ability…students placed minimal emphasis on the research career of potential role models, including the number of publications and academic position."

Indeed, excellent role models often possess an amalgam of five traits:[3]

1. Spending more than 25% of one's time teaching,
2. Spending 25 or more hours per week teaching and conducting rounds when serving as an attending physician,
3. Stressing the importance of the doctor-patient relationship in one's teaching,
4. Teaching the psychosocial aspects of medicine, and
5. Having served as a chief resident.

When I was a resident, I was guided by a role model I had when I was a third-year medical student: Greg Holt, now an ICU attending, was my attending physician and chief resident at the VA in Washington, DC. It seemed like he knew everything about everything, like he was always in the hospital, always talking to people, always thinking about patients and helping our team to do the same. He was sometimes unsure about what to do and shared that uncertainty with his team and patients, always encouraging us to take a chance, make a mistake, and admit our faults and deficiencies so that we may learn more. He created an ideal learning environment.

Greg recently wrote an article titled "On Being Observed"[4] and ended it with the sage line that sums up what he knew but never let on to with those around him when he was a chief resident: Always do your best because "you never know who might be watching."

After I re-read Greg's article, it became crystal clear what the difference between mentor and role model has been in my own life. Mentors have helped me advance in my career once I have *made* a decision. But it has been the role models who have helped me do the hard thing: actually *make* the decision. They have impacted my path in life. They have molded me. They have inspired me. And not a single CV has reflected the role they have played in my life.

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Like the holosystolic murmur of mitral regurgitation, role modeling is not something that changes year to year. The traits of a good role model are timeless—hence, the dearth of literature. But as someone who was just graduating college when Scott's *Forum* article appeared in 1998, I can attest that role models continue to influence people in ways they will never know. They likely influence medicine more than any randomized clinical trial ever will. Their example continues to inspire. And they are always being observed.

References

1. Wright SM. Role models and medical education. SGIM Forum 1998; 21(3):2.
2. Wright S, et al. The impact of role models on medical students. J Gen Intern Med 1997; 12:53-6.
3. Wright SM, et al. Attributes of excellent attending-physician role models. N Engl J Med 1998; 339:1986-93.
4. Holt GE. On being observed. Ann Intern Med 2011; 155(4):272.

SGIM

Role Models and Medical Education, 1998

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Social learning theories indicate that role modeling exerts major influences, both positive and negative, on the performance of social behaviors.[1] After observing how others behave (and observing the consequences), we may later choose to imitate their behavior.[2] Society's discussions about role modeling often relate to professional sports—specifically, which athletes are fine role models for our children and which are not. Role models have also been shown to be important in most jobs and professions. This is felt to be particularly true in medicine.[3-5]

My first experience with role modeling occurred while working at a summer camp in Ontario as a "counselor in training" (CIT) coordinator. My job entailed helping 50 17-year-old boys and girls make the transition from camper to counselor (and keeping them out of trouble). The camp director stressed that the CITs should be role models for the campers (enthusiastic, energetic, and positive) and that I should be a role model to the CITs. When I told him that I wasn't sure how to be a role model, he said, "Sure you do, but it's not easy, and it's a full time job!" While in medical school, through one-month encounters with many different attending physicians, I was exposed to skills and attitudes that I wanted to emulate as well as those that I did not. During my internal medicine residency training, I met the physician who would become and has remained my role model. He represented much of what I hoped to attain, and he served as the example after which I have tried to pattern my behavior. In his role as a general internist, he showed me that he was a great diagnostician, had wonderful bedside manner, and taught clearly and effectively. As a program director, he was fair, respected, well organized, thoughtful, and caring. As a person, he seemed to be a family man, had a great sense of humor, was well liked by all, and was healthful (finding time for himself to exercise regularly). For all of the above reasons, he serves as my primary role model. Having recently made the transition from medical trainee (fellow) to attending, I have thought about being perceived as a role model. When I was attending on the wards last month and interacting with the medical students and house officers, I had visions of being back at summer camp, but instead of working with CITs, I was working with DITs (doctors in training). Here, once again (just like 10 summers earlier), being a role model, especially at the bedside, was probably a very important aspect of my teaching.

The research that has been done on role modeling in medicine is scant but does indicate several points. Positive and negative role models encountered during medical training influence the career choice of medical trainees.[6-8] In one study, medical students reported that the relation-

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ship with their role models had resulted in personal growth and development.[9] Medical students, house officers, and attendings are all in agreement that clinical skills, personality, and teaching ability are the most important factors in identifying and selecting role models in medicine.[9-11] A case-control study comparing physicians who are perceived as excellent role models with those who are not perceived as such has found that many of the factors associated with being an excellent role model relate to acquirable skills and modifiable behaviors (e.g. formal training in teaching, stressing the importance of the doctor-patient relationship when teaching).[11] Detailed results of this study have been submitted for publication at the time of this article's printing.

The importance of role modeling in medical education is underscored by the fact that trainees need not only to acquire knowledge and skills but also values, attitudes, behaviors, and a personal code of ethics.[12] For the core competencies encompassed by professionalism and humanism, role modeling (or teaching by example) appears to be the process most likely to facilitate the trainee's learning and growth.[13]

References

1. Bandura A. Social learning theory. Englewood Cliffs, NJ: Prentice Hall, 1977.
2. Mazur J. Learning and behavior, 3rd ed. Englewood Cliffs, NJ: Prentice Hall, 1994.
3. Linzer M, Slavin T, Mutha S, Takayama JI, Branda L, VanEyck S, McMurray JE, Rabinowitz HK. Admission, recruitment, and retention: finding and keeping the generalist-oriented student. J Gen Intern Med 1994; 9(Suppl 1):S14-23.
4. Ficklin F, Browne V, Powell R, Carter J. Faculty and house staff members as role models. J Med Educ 1988; 63:392-6.
5. Shuval J, Adler I. The role of models in professional socialization. Soc Sci Med 1980; 14A:5-14.
6. Mutha S, Takayama J, O'Neil E. Insights into medical students' career choices based on third and fourth-year students' focus-group discussions. Acad Med 1997; 72:635-40.
7. Lieu T, Schroder S, Altman D. Specialty choices at one medical school: recent trends and analysis of predictive factors. Acad Med 1989; 64:622-9.
8. Babbott D, Levey G, Weaver S, Killian C. Medical student attitudes about internal medicine: a study of US medical school seniors in 1988. Ann Intern Med 1991; 114:16-22.
9. Wright S, Wong A, Newill C. The impact of role models on medical students. J Gen Intern Med 1997; 12:53-6.
10. Wright S. Examining what residents look for in their role models. Acad Med 1996; 71:290-2.
11. Wright S, Kern D, Kolodner K, Howard D, Brancati F. Attributes of excellent role models: a case-control study. J Gen Intern Med 1997; 12 (suppl):100 (abstract).
12. Guide to evaluation of residents in internal medicine, 2nd ed. American Board of Internal Medicine, 1992.
13. Barondess J. The GPEP report: III. Faculty involvement. Ann Intern Med 1985; 103:454-5.

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