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Justice and care: decision making by medical school student Promotions Committees

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Abstract

CONTEXT—The function of medical school entities that determine student advancement or dismissal has gone largely unexplored. Decision making of "academic progress" or student promotions committees is examined using a theoretical framework contrasting ethics of justice and care, with roots in the moral development work of theorists Kohlberg and Gilligan.

OBJECTIVES—To ascertain promotions committee members' conceptualization of the role of their committee, ethical orientations used in member decision making, and student characteristics most influential to that decision making.

METHODS—An electronic survey was distributed to voting members of promotions committees at 143 accredited allopathic medical schools in the U.S. Descriptive statistics were calculated and data were analyzed by gender, role, institution type and class size.

RESULTS—Respondents included 241 voting members of promotions committees at 55 medical schools. Respondents endorsed various promotions committee roles, including acting in the best interest of learners' future patients and graduating highly qualified learners. Implementing policy was assigned lower importance. The overall pattern of responses did not indicate a predominant orientation toward an ethic of justice or care. Respondents indicated that committees have discretion to take individual student characteristics into consideration during deliberations, and that they do so in practice. Among the student characteristics with the greatest influence on decision making, professionalism and academic performance were paramount. Eighty-five percent of participants indicated that they received no training.

CONCLUSIONS—Promotions committee members do not regard orientations of justice and care as being mutually exclusive, and endorse an array of statements regarding committee purpose that may conflict with one another. The considerable variance in the influence of student

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characteristics, and the general absence of committee member training, indicate a need for clear delineation of the medical profession's priorities in terms of justice and care, and of the specific student characteristics that should factor into deliberations.

INTRODUCTION

It is well established that attrition from medical school is low relative to other professional schools. American Bar Association 2015 data indicate that the average rate of successful completion of the first year of law school is 89% with some schools reporting first year completion rates as low as 52%.[1] Similarly, nursing schools have, in recent years, reported retention rates of approximately eighty percent.[2] In contrast, data provided by the Association of American Medical Colleges (AAMC) in 2014 indicate that 97% of medical students graduate within eight years of matriculation.[3] The vast majority of medical students who experience course or clerkship failures go on to successfully complete their undergraduate medical education. When students do experience course failure in medical school, they may find themselves in front of a medical student promotions committee, also sometimes known as an "academic progress" committee.

Promotions committees exist at every allopathic medical school accredited by the Liaison Committee on Medical Education (LCME). Standard 10.3 of the LCME's 2017–2018 standards for accreditation[4] requires that every medical school have in place a process by which representatives of the institution determine the progression of students through the medical education program. Promotions committees are generally charged with promoting students from one year to the next and with dismissing students from the medical education program, yet the LCME offers no specific guidance regarding how such committees should be structured, who should participate, or the criteria by which decisions about students should be made. This lack of specificity may be viewed as problematic given that, unlike other areas of medical education, information about best practices of promotions committees is not widely available. Few institutional websites contain detailed information about the composition of their promotions committees, and due to Family Educational Rights and Privacy Act (FERPA) regulations, no information about actual promotions committee decisions is publically available. There has been very limited scholarly inquiry into the structure and function of these committees across institutions.

Promotions committee decision-making takes place in a high-stakes environment. Acceptance to medical school is highly competitive, and applicants may spend a great deal of time and money securing admission to a medical school. Once admitted, medical school can be very expensive. The AAMC's October 2015 "Fact Card" summarizing student debt[5] 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. The mean student debt for that same year was $180,723. Given these circumstances, dismissal from medical school can have an enormous emotional, financial and professional impact on the lives of medical students.[6–12]

There is well-documented evidence that faculty in the health professions experience barriers to accurate evaluation of underperforming learners, and that these barriers influence faculty decisions about the submission of failing grades.[12–20] However, no study to date has

extended the issue of underperforming medical students to the administrative processes triggered when failing grades are submitted. The seriousness of the issue is magnified by evidence that student behaviors related to dropout or dismissal, which include academic struggles and dishonest or unprofessional behavior, are consistent over time.[21–24] The central problem addressed by this research is the unexamined yet high-stakes nature of promotions committee decisions.

In developing our study, we used a theoretical framework contrasting an ethic of justice, in which decisions prioritize policy, consistency and objectivity, with an ethic of care, in which decisions prioritize empathy and responsiveness to individual circumstances.[25–29] Though it has its roots in the work of moral development theorists such as Kohlberg and Gilligan,[30] this theoretical framework is not new within medical education and healthcare. An ethic of care has been proposed as a model for physician-student relationships,[31] recognizing its role in engendering future humane physician-patient relationships on the part of their learners.[32–34] A justice-care framework has also been used as a model for ethical decision making by healthcare teams.[29, 35] The justice-care framework is a useful one for promotions committee deliberations as committee members are tasked with upholding the academic standards of the institution on one hand, and on the other hand ensuring that some of our most vulnerable students have ample time and opportunity to take advantage of available support, remediate failures and demonstrate improvement. The justice-care framework appropriately reflects this tension. An ethic of justice as applied to promotions committee work has as its priorities consistent implementation of policy, and fairness across students. An ethic of care prioritizes the support and development of individual learners and contextual review of student cases. Again, the LCME provides no guidance as to how an institution might balance these priorities, yet committee composition that favors one over the other could have a major impact on the kinds of decisions made. Additionally, if there are student-centered variables that elicit the use of one orientation over the other it would be important to identify those variables. At the very least, awareness of the moral issues inherent in promotions committee work is the first step toward making ethical decisions about students.[36]

We used justice and care framework components as the basis for a survey designed to be completed by voting members of student promotions committees. Due to issues of access and concerns about student privacy, this study has as its focus the internal reflection and decision making of individuals that informs the wider group interaction. The goals of the survey were to ascertain participants' view of the role of their promotions committee, the ethical orientations used in their individual decision making, and the particular student characteristics and circumstances most influential to that decision making.

METHOD

Survey Design

In order to form a more complete picture of committee work across institutions, we developed a survey targeted to voting members of medical school promotions committees. The survey was designed to elicit information about specific elements of a justice orientation (consistency, fairness, objectivity) and of a care orientation (empathy, humanism,

responsiveness), and their influence on committee member decision making regarding student cases.[26]

The first two sections of the survey were designed to obtain demographic information about the individual respondent, including gender, primary role (medical student, faculty or administrator), and highest degree(s) completed. Institutional demographic information included institution name, whether their institution is public or private, and if the promotions committee on which the participant 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. An additional question asked participants for the size of their institution's class of 2019 in increments of 50.

Subsequent sections of the survey included questions regarding participant perceptions of their promotions committee's role and processes, and of their own decision making. Survey questions were written to reflect either an ethic of justice or an ethic of care. For example, participants were asked how important it was to them that their deliberations about students were objective and fair (elements of justice) and humanistic and empathetic (elements of care). The survey design did not require participants to choose between justice and care as guiding principles, consistent with the one tool the authors found to measure ethical orientations of justice and care specifically in college students.[26] The justice-care dichotomy identified by early moral development theorists may be more flexible than originally proposed, and there may be conceptual overlaps between the two.[25, 27, 28, 37, 38] Indeed, this survey was designed to account for the idea 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.[37] For example, the survey included two questions regarding what constitutes a "good" committee process and asked participants the extent to which they agreed with each. One statement reflected an ethic of justice, one reflected an ethic of care. The survey design allowed for participants to indicate high levels of agreement with one, both or neither statement.

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" was calculated for each participant using the mean for answers provided on three questions that reflected elements of justice (consistency, fairness, objectivity). A composite "care score" was calculated for each participant using the mean for answers provided on three questions that reflected elements of care (responsiveness, humanism, empathy). 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. Three categories of ethical orientation (justice-dominant, care-dominant and composite-neutral) were created based on this difference in composite scores.

Participants were also provided a list of specific student characteristics and circumstances and asked to weigh the extent to which each was influential in their decision making. The list was developed from the personal experience of the researchers and represented common student characteristics and circumstances presented at the promotions committee at their

home institution. The final section of the survey was comprised of open- and close-ended questions regarding the training committee members received regarding promotions committee work. A separate section of the survey, not addressed in the present report, asked respondents to answer a series of questions pertaining to two theoretical student cases. The full survey (excluding the student case section) is provided as supplemental material in Appendix S1 online).

The survey was reviewed by members of the lead author's doctoral dissertation committee, and the research design consultant at The Warren Alpert Medical School (AMS) of Brown University. The survey was pilot tested with past members of the promotions committee at AMS, and revisions were made based on these respondents' comments.

Survey Distribution

Web searches were performed to identify points of contact at each of the 143 accredited medical schools in the United States. When possible, the faculty member serving as promotions committee chair was identified. When such information was not available, the name and contact information for an Associate Dean of Medical Education or Student Affairs was used. A link to the survey was distributed to institutional representatives via email. The email requested that the medical school representative pass along the survey link to all voting members of their institution's promotions committee.

Data Analysis—Data were analyzed using IBM SPSS Statistics 22 and GraphPad Prism 6.0. Confidence intervals were established at 95% ($p<0.05$) for inferential analyses.

RESULTS

Participants

A total of 241 promotions committee members from 55 institutions completed the survey for an institutional return rate of 38% and an estimated overall return rate of 13%, assuming an average promotions committee size of 13 (241/[143 × 13]). Participants included 126 men (52%) and 112 women (47%). One hundred and ninety-four participants identified as faculty members (80%), 20 as medical students (8%), and 28 as administrators (12%). Because this study represents the first known systematic data collection regarding student promotions committees, no information is available as to the representativeness of these figures across all medical schools. Participants indicated affiliation with medical schools from all four geographic regions as categorized by the AAMC Group on Educational Affairs. The greatest representation of individual participants was from the Central region (33%), and the least representation of individual participants was from the Northeastern region (20%). Nationally, the Central region represents 24% of medical schools and the Northeast region represents 28%.[39] One hundred and seventy participants (72%) indicated that they were from public institutions, and 65 (28%) from private institutions. Nationally, public institutions represent 60% of accredited allopathic medical schools and private institution represent 40%.[39] The average number of participants per institution was four individuals with a maximum number of participants from a single institution of 13 and a minimum of one.

Participants represented a variety of promotions committee models. The most common model was one that considers students in all four years of medical school (203, 86%). Other models included committees that consider students in the preclinical years only (14, 6%), or the clinical years only (9, 4%). The remaining participants were members of committees that consider students in the first year of medical school only or committees that consider students in all years of combined programs such as B.A. or B.S./M.D., M.D./Ph.D., and postbaccalaureate/M.D.

The Role of Promotions Committees

Participants indicated that they viewed the role of their promotions committee as multifaceted (Figure 1). The greatest degree of agreement was with the characterization of the committee's role as being "to act in the best interest of our learners' future patients," "to graduate highly qualified learners," and "to maintain our school's academic standards." Lowest levels of agreement were with characterization of the role as being "to nurture future colleagues" and "to implement policy." Participants disagreed with characterization of the role as being "to graduate all admitted students." The pattern of responses to questions that reflected either a justice or care orientation may have indicated a slight orientation toward the former given that the three top-ranked responses were all in this category. However, responses with lower agreement scores did not indicate a predominant orientation toward either. We found significant differences among committee member roles for the justice-based statement "enact consequences consistently over time," with medical students indicating lower levels of agreement (4.30 [0.73]; mean [SD]) than faculty (4.57 [0.76]) or administrators (4.91 [0.81]; $p = 0.032$).

Participants endorsed the notion that committee processes should be both responsive and consistent. Participants indicated a high level of agreement with the characterization of a "good" committee process as being one in which "institutional standards are applied in a manner that is responsive to the individual characteristics and circumstances of the student" (4.6 [0.80]; six-point Likert scale, [1] Completely Disagree to [6] Completely Agree). Agreement was lower regarding the characterization of a "good" process as being one in which "institutional standards are applied consistently across all students regardless of individual characteristics and circumstances" (3.26 [1.048]). There was a significant difference between the answers to these questions ($p < 0.001$).

Using the same six-point Likert scale, we found that participants indicated a high level of agreement with a statement regarding their committees having the discretion to take individual student characteristics and circumstances into consideration as part of their deliberations (5.16 [0.83]), and with a second statement regarding their committees actually doing so in practice (4.79 [1.29]). Participants from private schools had a higher level of agreement that their committees actually considered these details than did their counterparts from public institutions ($p = 0.037$).

Responses on the question regarding the discretion committees have in taking student characteristics and circumstances into consideration (Figure 2) differed significantly by class size ($F(4, 210) = 4.77$, $p = 0.001$) with the highest levels of agreement being reported for the 150–199 class size, and the lowest levels with the 300+ class size. A Bonferroni post hoc

analysis indicated significant differences among several of the class size categories. Also differing with class size was the response to the corollary question on actual committee practice ($F(4, 210) = 3.36$, $p = 0.011$). A Bonferroni post hoc analysis showed that participants from the 150–199 class size group indicated significantly greater agreement than did the 300+ class size group.

Individual Decision Making

Participants characterized their individual decision making as multi-faceted. They indicated the highest levels of agreement with statements indicating that it is personally important that they be “fair” and “objective” in their consideration of student cases. Responses indicated a lower priority on being “empathetic” and “humanistic.” A paired sample t-test yielded significant differences between five of six possible value pairs (Table 1). Responses to the question regarding the importance of being objective differed significantly by role ($p = 0.023$), with both faculty members and administrators indicating greater agreement with the justice-based statement than did medical students.

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, $t(215) = 1.056$, $p = 0.292$. 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.”

In order to better understand the relative influence of particular student characteristics and circumstances on committee member decision making, the authors developed a list of 18 basic student characteristics and circumstances about which committees would reasonably be informed. Participants were asked how influential each would be to their decision making (Figure 3). Responses were recorded on a four-point Likert scale from “Not at all influential” (1) to “Highly influential” (4). Participants indicated that the most influential student characteristics and 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,” and “amount of time the student has until graduation.”

Gender and Committee Members’ Attitudes and Priorities

With regard to the gender of committee members, women indicated a significantly greater agreement with the care-based statement regarding the role of the committee to “act in the best interest of learners” ($p < 0.001$) than did men, and men indicated a significantly greater agreement with the justice-based statement regarding the role of the committee to “enact

consequences consistently over time" than did women ($p < 0.01$). However, 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), and 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. 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. Men and women differed significantly in their responses to only one of the 18 student characteristics/circumstances provided (men indicated that the "existence of a physical disability" was significantly more influential than did women).

Preparation and Training of Committee Members

Eighty-five percent (141) of participants indicated that they received no training to prepare them for their promotions committee role. The 15% (24) who reported receiving training indicated that it primarily entailed overviews on institutional policy and committee procedures. When asked what training might be useful to them, 33 open-ended responses indicated a need for information regarding policies and standards, and four 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. Twenty-four comments 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. It was suggested that 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. 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.

DISCUSSION

To the best of our knowledge, this study represents the first systematic inquiry into the decision making process of medical school promotions committees and their members. The concept of ethical orientations that prioritize justice or care provides a useful theoretical framework through which to examine committee members' perceptions of and approach to promotions committee work as they represent potentially very different consequences for institutions with a mandate to produce competent graduates and for individual students who come under consideration.

Analysis of our survey data leads us to conclude that in their characterizations of promotions committees' roles and their own decision making, promotions committee members do not regard orientations of justice and care as being mutually exclusive. The majority of

participants (70%) fell into the “composite neutral” category in which their composite justice and composite care scores were essentially equal, and they report 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 statements about it being important that their individual decision making be fair and objective (qualities that reflect an ethic of justice), as well as humanistic and empathetic (qualities that reflect an ethic of care). This finding is important because it points to the influence of contextual elements such as particular student circumstances or even the emotional state of the committee member[40, 41] in determining the dominant ethical orientation employed at a given time. Our capacity to operate from both a justice orientation and care orientation may also lead to conflicts when 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.[37, 38] This dilemma may be ameliorated somewhat when individual decision making is only one part of a larger group process. Further study of the complex group processes that take place as part of promotions committee work is warranted.

The data also indicate potential discrepancies between how participants view their own role versus the role of the committee. For example individuals strongly endorsed the qualities of fairness and objectivity in their own decision making, but prioritized responsiveness over consistency when characterizing a “good” committee process. Medical students in particular prioritized elements of care over elements of justice, perhaps reflecting identification with the students under committee consideration and a desire to be seen themselves as a unique individual. We did not anticipate the low priority that promotions committee members would assign “implementation of policy” relative to other committee roles. The observation that participants prioritized one ethical orientation (justice) for their own decision making and another (care) for the committee raises concerns about the lack of clarity regarding institutional priorities. This would seem to be an area that could be addressed by the development of training and training materials such that members had a clearer understanding of institutional values and priorities, and of the specific role(s) of their institution’s committee.

The original debate regarding justice and care was a gendered one in which Kohlberg’s conclusions about moral development, which reflected his male subjects’ achievement of a justice-based morality, were challenged by feminist theorists who posited that women operated from a more care-based ethic.[25, 27, 28, 37] Indeed, for 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, while the data indicate consistency in orientation by gender, gender differences were limited in number. Recent discussions regarding justice and care orientations indicate that the gender binary is less clear than originally thought and that decision making context and other factors such as culture play important mediating roles in ethical decision making.[37, 42, 43] Nevertheless, committee composition in terms of gender and role may be an important consideration to those in charge of appointing members.

The “failure to fail” literature, a body of work exploring the perceived barriers to accurately grading learners who do not meet academic benchmarks, makes it clear that there are contextual, personal and student-centered variables that play a role in faculty decision making about students.[12–20] For example, Luhanga et al. found that preceptors considered learners’ debt and proximity to graduation when deciding whether or not to submit a failing grade.[16] One goal of this study was to explore which particular student-centered elements most inform and influence committee member decision making. Survey participants were provided a list of 18 student characteristics or circumstances and asked how influential each is to their decision making. It is notable that each of the 18 characteristics/circumstances provided was viewed as influential with the lowest mean responses close to 2 (“Somewhat Influential”). Promotions committees are charged with analyzing academic and non-academic student data as they make their decisions, thus it makes intuitive sense that these data regarding these student characteristics would all, to some degree, influence deliberations. More investigation both within and across institutions is needed to have a true understanding about the type of student information that is shared with promotions committees, how consistently different variables are discussed across student cases, the sources of student information, and the roles of the people sharing it. Additionally, committee members would benefit from training that directly addresses the specific student characteristics and circumstances that are and are not the purview of that committee’s deliberations.

Our data indicate that promotion committee members place considerable importance on professionalism. The two categories of student-centered variables 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, willingness to seek help, level of insight into his/her problem, and work ethic. It is notable that each of these, with the possible exception 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. The extent to which issues of professionalism have been shown to be consistent over time would seem to support participants’ focus on these issues as being highly influential.[21, 23, 24]

It is notable that the least influential characteristics/circumstances in the list provided included student debt and the student’s academic background and preparation for medical school. Given the high degree of student debt mentioned previously and the potential tension between the societal expectation that medical schools will graduate competent trainees and the goal of producing a work force that is diverse in elements that include socio-economic status, it may be viewed as surprising that a disadvantaged educational background would not be a more influential factor when academic struggles are under consideration. Again, appropriate training for committee participation could more clearly outline institutional goals and priorities relevant to certain student-centered variables, and how these variables should or should not influence that committee’s deliberation.

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, but lower degree of agreement that promotions committees actually do so in practice. The data indicate that both discretion in considering student characteristics and actual consideration of these factors in practice decline as class size grows beyond 250 students. Specific student-centered variables may be most salient for schools with smaller class sizes, and for private schools as they are under-represented among the larger class size categories. Medical schools with larger class sizes may not prioritize responsiveness to individual student characteristics and circumstances, or may simply be unequipped to do so because of the volume of student cases.

Limitations

One major limitation of this study is its reliance on self-report. It has long been known that a survey may not be able to accurately assess how individual participants will actually vote during promotions committee processes, nor does it capture the complex group dynamics present during committee meetings.[44, 45] A second limitation is the low response rate given the potential number of voting promotions committee members across all institutions. However, 241 participants across 55 institutions represents a robust enough response for this type of survey research that the authors feel comfortable drawing some important, if preliminary, conclusions, particularly considering that promotions committee work is thus far a relatively unexplored aspect of medical education.

Conclusions

Even with the most rigorous medical school admissions processes in place, there will always be medical students who experience academic failures or exhibit unprofessional behaviors, and medical schools must have in place robust mechanisms to address those issues. Additional attention should be paid to promotions committee composition and factors that influence committee decision making. On-the-job experience with promotions committee work is inadequate preparation for faculty making such high-stakes decisions. We interpret the variability and inconsistencies in our survey findings as indicating that promotions committee members would benefit from a clear delineation of our profession’s priorities in terms of how we treat struggling students, and of the specific student characteristics and circumstances that should or should not factor into deliberations. Fair and unbiased student promotions committee deliberation does not require blind application of policy across all student cases in order to uphold institutional standards. Instead, consistent reference to explicit institutional values and priorities, provided to members as part of comprehensive training and self-study, may allow promotions committees to achieve a flexible approach to students in a manner befitting a healing profession. We propose that our medical education institutions should strive to create greater transparency about how we achieve the balance between justice and care, and that we begin to establish a set of best practices for medical schools around promotions committee deliberations.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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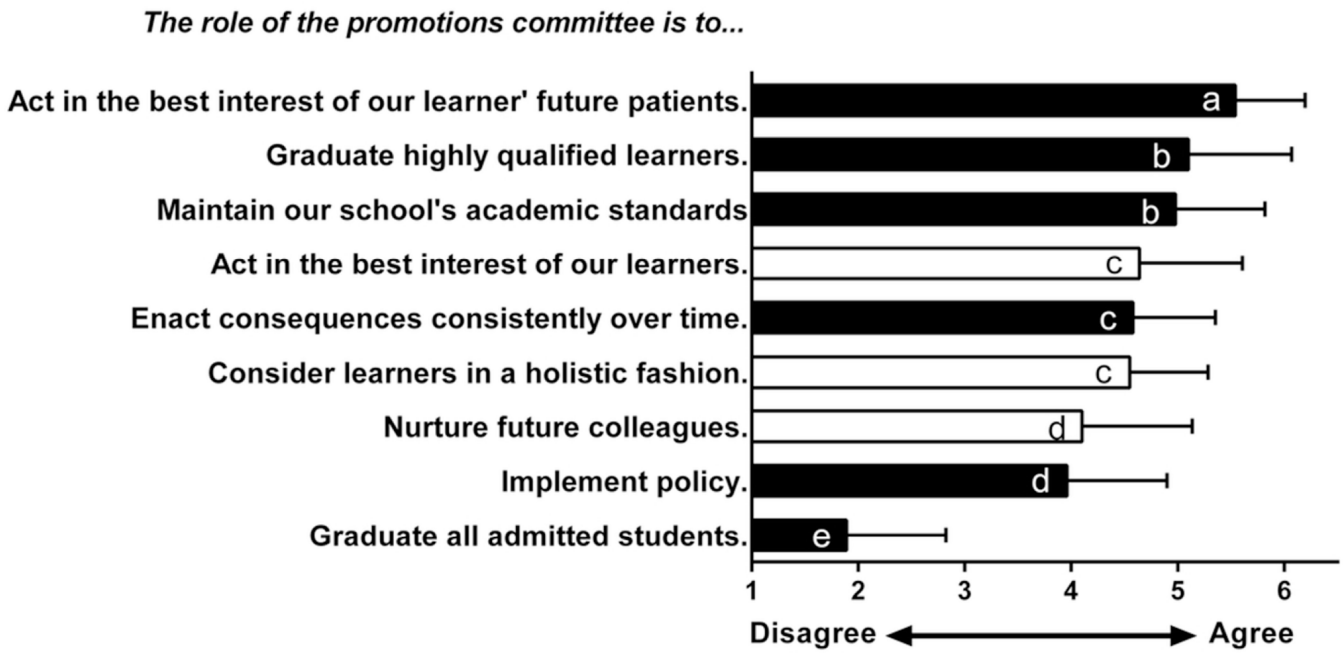

Figure 1. Survey participants' responses to the survey question, "The role of the promotions committee is to…"

Responses were on a 6-point Likert scale ranging from "completely disagree" (1) to "completely agree" (6). Data, shown as the mean + 1SD, are ordered from the highest degree of agreement to the lowest. Specific responses are designated as reflecting a justice orientation (black bars) or a care orientation (white bars). Significance of differences between responses was assessed using one-way ANOVA with a Tukey post-hoc test. Significantly different groups are indicated by the letters within the bars (e.g., a is not different than a, but is different than b; b is different than c; etc.).

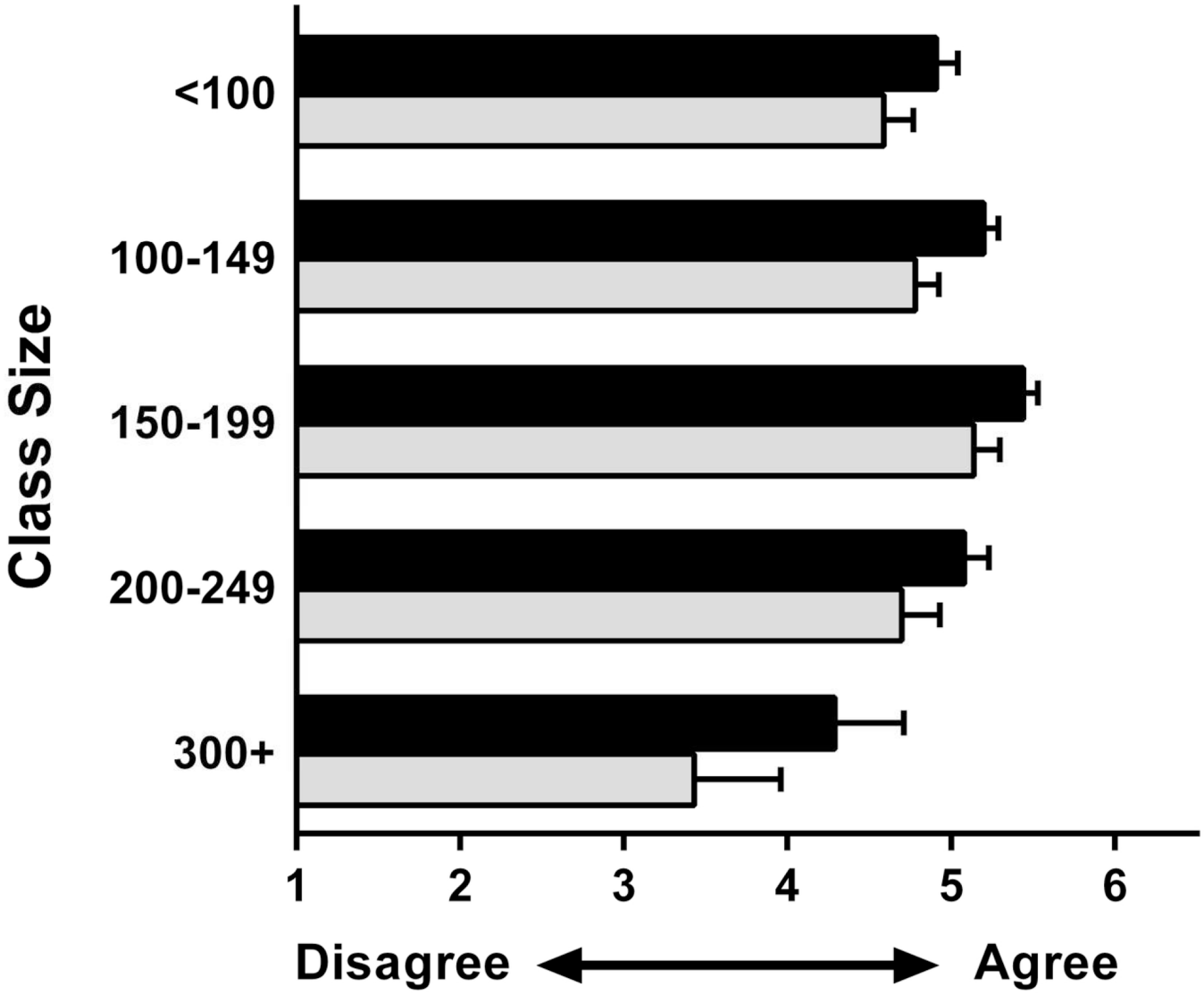

Figure 2. Relationship between medical school class size and survey participants' perceptions regarding the ability of their promotion committees to take student characteristics and circumstances into consideration when making decisions

Survey participants were asked to agree or disagree that their institution's promotions committee has the discretion to take particular student characteristics and circumstances into consideration when making decisions (black bars) or that their committee does so in practice (gray bars). Data are shown as the mean and standard error of the mean.

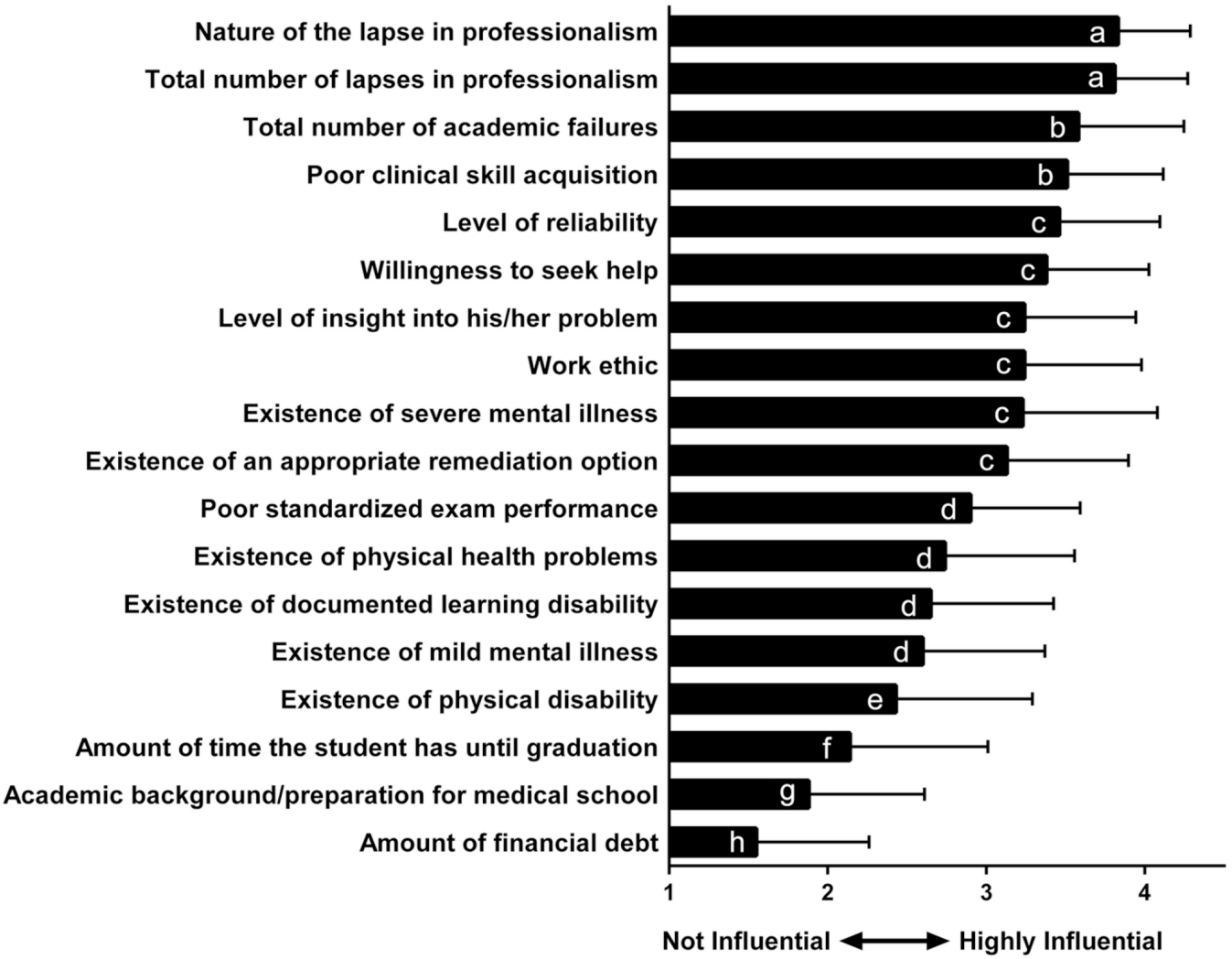

Figure 3. Influence of specific student characteristics on committee members' decision making

Shown are the survey participants' responses to an item that stated, "For each of the following student characteristics or circumstances, please indicate how influential it would be to your decision making. Responses on a 6-point Likert scale are shown as the mean + 1SD and are ordered from most to least influential. Significance of differences between responses was assessed using one-way ANOVA with a Tukey post-hoc test. Significantly different groups are indicated by the letters within the bars (e.g., a is not different than a, but is different than b; b is different than c; etc.).

Table 1

Participant responses to the question, “In my individual consideration of student cases, it is important to me that I am…”

Decision-Making Characteristic	Mean	SD
Fair (free from prejudice) [a]	5.30	0.80
Objective (grounded in facts and policy) [b]	5.02	0.81
Empathetic (understanding another’s situation and feelings) [c]	4.62	0.82
Humanistic (centered on an individual’s values, capacities, and worth) [c]	4.57	0.84

Responses were on a six-point Likert scale that ranged from Completely Disagree (1) to Completely Agree (6). Letters in square brackets denote whether or not groups were significantly different from one another. All differences (a versus b, a versus c, b versus c) were significant at the level of $p<0.001$.