Experiential Learning: Transitioning Students from Civility to Professionalism

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INTRODUCTION

The experiential component of a pharmacy curriculum includes both introductory and advanced practice experiences that occur as a continuum across the curriculum. The introductory pharmacy practice experiences (IPPEs) are expected to begin early in the curriculum and allow the student to progressively develop the ability to provide pharmaceutical care. Advanced pharmacy practice experiences (APPEs) are capstone experiences that provide students with in-depth practice in a

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variety of patient care settings. These final experiences allow students to "develop, in a graded fashion, the level of confidence and responsibility needed for independent and collaborative practice" (1).

Because these experiences occur in actual practice settings, students encounter situations where they are expected to demonstrate civil and professional behaviors. The goals of this paper are to:

1. Characterize the dimensions of civility most relevant to experiential practice settings and identify the types of incivility most commonly seen in experiential learning
2. Recommend strategies for responding to incivilities at both the programmatic and individual instructor levels
3. Recommend implementation of a code of professional conduct that can guide students in developing and demonstrating civility and other aspects of professional behavior as they progress from IPPEs through the APPE sequence.

FRAME OF REFERENCE

The recommendations provided in this paper are based on a review of the social sciences and health professions literature. The example cases are based on our experiences in conducting a longitudinal introductory practice experience and a ten-month advanced practice experience at Auburn University. One of the ten ability-based outcomes for the Auburn Pharm.D. program is "Professional Ethics and Identity," and students are expected to show developmental growth in achieving this outcome as they progress across both the IPPE and APPE experiences. This outcome includes criteria related to civility.

Our IPPE is unique in that students are assigned to a pharmacy team during orientation to pharmacy school. Throughout the first three years, students visit a patient on a weekly basis and report their progress to faculty mentors during weekly team meetings. One of the primary reasons for this continuous experience model is to promote the professional socialization of our pharmacy students (2).

Our advanced practice experience sequence is designed to document the final growth and achievement of the Pharm.D. program's ten ability-based outcomes by students. Because our students have had three years of patient care and team responsibilities by the time they begin their APPEs, they are accountable for demonstrating a higher level of ability for the "Professional Ethics and Identity" outcome as compared

to eight other program outcomes when they begin the APPE sequence. Unsatisfactory achievement in this single outcome can result in failure of a rotation even though the student has excelled in all other outcome areas. The following literature review and discussion will provide the reader a means for understanding the rationale for this continuous experiential learning model.

LITERATURE REVIEW

Civility and Today's Students

Civility is often interpreted as politeness. However, Carter has proposed that we define civility in broader terms (3). He specifically points out that living in society is like living in a household. Carter notes that in a household, moral people maintain relationships with other people according to standards of behavior and that, at times, these standards may limit an individual's freedom. A civil person follows standards of behavior even though the person may not agree with or like other individuals in the household (or society). This analogy illustrates that, in the past, rules of civility were instilled during childhood. Carter and others have pointed out that, in addition to a decreased emphasis in teaching children rules of civility, other factors, such as the introduction of technology, have contributed to an overall decline in civility in our society (3, 4).

Faculty need to be cognizant that many of the young adults entering pharmacy school, and thus IPPEs, have not been inculcated with standards of behavior prior to starting pharmacy school (3). Such students may not be prepared to "make sacrifices for the sake of living together in a community where their patients exist" and work in the "health professions household" (3). Experiential programs, therefore, need to clearly communicate expected standards of behavior when IPPEs begin, explain how these standards relate to professionalism, and hold students accountable for meeting a code of professional conduct throughout all practice experiences.

Incivility in the Practice Setting

In the practice setting, students may succumb to incivility as they interact with faculty, other health professionals/teams, and patients. However, the occurrence of incivilities is a two-way path; although we most

often think of students demonstrating incivility, they may also be recipients as they communicate with faculty, other health professionals/teams, and patients.

Students often will not discuss or disclose incidents of incivility involving faculty members because they fear that the faculty member will retaliate or that the administration will not believe them. Medical educators have documented that when medical students are subjected to abuse and exposed to unprofessional behaviors, the conflict may cause them to abandon the desired attitudes and behaviors they were initially taught to exhibit (5). Hundert has recommended that programs offer students opportunities, without faculty present, to discuss incidents that contradict the ideal attitudes and behaviors they have been taught (6).

Tiberius and Flak point out that in one-on-one teaching and learning situations, such as practice experiences, extreme forms of incivility like those occurring in the large classroom setting are rarely overtly displayed (7). For example, the loud talking, sarcastic remarks, or emotional outbursts that have been reported in the large classroom setting rarely occur in small group situations (8). Tiberius and Flak have noted that when students interact with a faculty member in a one-on-one or small group encounter, they are more likely to exhibit withdrawal and uncooperativeness or to hold out and express inappropriate negativity in a written end-of-course evaluation (7). Pharmacy students are, therefore, more likely to exhibit passive-aggressive behaviors in one-on-one or small group interactions with experiential faculty members.

The primary types of incivility most likely to occur in the experiential practice setting are listed in Table 1. These examples of incivility are categorized according to four dimensions of civility that are common themes in the current literature describing how to live a civil life in society (3). In the section below, we briefly define each dimension, provide examples of how faculty members and students may role model civility and/or exhibit incivility, and give suggestions for promoting civility or addressing incivility.

Tolerance. Given the number of people who enter the practice setting (e.g., patients, faculty, other health professionals, staff, and students), it should be anticipated that a variety of cultures will be represented. Each culture has a set of beliefs, values, and lifestyles that shapes how members of that culture perceive and experience life. Our pharmacy graduates must be culturally competent and effectively relate to patients, colleagues, and staff who are different from them. Experiential rotations take place in a real-world setting where students must interact with

TABLE 1. Civility and Incivility in the Practice Setting.

Dimensions of Civility	Examples of Incivilities
Tolerance	**Faculty Member** • Making derogatory comments to other students or faculty members about an upcoming student who has a different lifestyle or value (e.g., gender, race, sexual preference, religious preference, socioeconomic class) **Student** • Making derogatory comments to other team members or peers about a patient's lifestyle or value (e.g., gender, race, sexual preference, religious preference, socioeconomic class) • Intolerance for ambiguity and anxiety[30]
Respect	**Faculty Member** • Making derogatory comments to other students or faculty members about the role and value of those in another discipline (e.g., basic sciences, medical profession, nursing profession) • Not respecting the student as a learner even though he or she has made a sincere effort to learn • When providing feedback about performance, using derogatory or nasty language • Public belittlement and humiliation in the presence of others in the clinical setting • Not treating students as colleagues **Student** • Not following assignments or disobeying orders given by pharmacists, pharmacy residents, or fellows when the faculty member has designated the individual as a colleague faculty member during the rotation • Nonparticipative and uncooperative behavior in teaching sessions held by a pharmacist, pharmacy resident, or fellow (The experiential faculty member has designated the individual to be the instructor for the teaching session.) • Refusing to follow orders and accept constructive criticism from a faculty member who is young or inexperienced • Not seeking patient desires for how to be addressed (first name or Mr./Ms.) • Not using appropriate titles in the practice area (e.g., calling faculty members by first name and not using "Dr." or "Ms.") • Lack of courtesy
Conduct	**Faculty Member** • Telling the students to meet at a given time but showing up late or not showing up at all • Using foul language or referring to the student in a derogatory manner during a learning session

TABLE 1 (continued)

Dimensions of Civility	Examples of Incivilities
Conduct (continued)	**Student** • Poor grooming and/or not following the dress code established by the practice site • Using foul language in a patient care area • Sitting around and joking with peer students in a patient care area • Not following guidelines established by the faculty member or medical team (e.g., arriving late to the practice site or rounds, not wearing proper identification) • Not being an active participant on the medical team • Not being polite with patients and staff (e.g., not using please and thank you when talking or giving directions) • Complaining about a program policy to the experiential faculty member such that it interferes with patient care or disrupts the site
Diplomacy	**Faculty Member** • Reacting negatively when a student respectfully disagrees with a faculty member's viewpoint • Not giving a student the opportunity to express his or her viewpoint and/or not listening to the student's perspective • Assuming the faculty member is always right and the student is always wrong **Student** • Constantly argumentative about rotation activities and requirements • Inappropriate reactions to constructive feedback • Not informing the faculty member of concerns about the teaching approach or learning experience during the rotation and instead writing offensive and angry comments on the Teaching and Site Evaluation Form • Not resolving conflicts in a manner that respects the dignity of all people involved[24] • Not listening to others

people of various cultures, providing students with the best environment for learning and demonstrating cultural competency.

Although most individuals know better than to make derogatory statements about a person's gender, race, sexual preference, religious preference, or socioeconomic class in the practice setting with others present, incidents involving both medical residents and students have been reported in the medical education literature (9). Such cases have not been documented in the pharmacy education literature, but we should expect them to occur with pharmacy students, given the similarity of medical rotations and pharmacy rotations.

Experiential faculty members should be mindful that cultural insensitivities probably occur more often than we realize and may go unrecognized by a faculty member who has not been trained in cultural competency and is not sensitive to implicit messages that can sometimes be conveyed in daily life. Medical educators have cautioned that students can learn attitudes and values from incidents of incivility committed unwittingly by faculty members and that these incidents are often counter to what students are supposed to learn according to the formal curriculum. Medical educators have cautioned about the effects of this "hidden or informal curriculum" (5). For example, Finucane et al. have reported incidents where case reports included descriptions that promoted racial stereotyping (10). Experiential faculty should also carefully evaluate stories and jokes that are shared among the team during a rotation experience and assess whether they convey a cultural bias. These situations accentuate the importance of maintaining careful vigilance for cultural bias, which may be very subtle but still weaken the formal curriculum.

Uncivil statements may be made by peer students and other health professionals when the preceptor is not present, and these undermine the attitudes and behaviors that are taught in the formal curriculum. For example, as students travel together to practice sites and share their rotation experiences, they may make statements that are culturally inappropriate. Cultural sensitivity training programs can enable peer students to detect such inappropriate behaviors and help them address their peer's behaviors in an appropriate manner (11).

Respect. The American Board of Internal Medicine has noted that "respect for others (patients and their families, other physicians, and professional colleagues such as nurses, medical students, residents, and subspecialty fellows) is the essence of humanism" (12). The board further notes that humanism is a central characteristic of professionalism. Because pharmaceutical care calls for pharmacists to be patient "caring," pharmacy education needs to place greater emphasis on helping pharmacy students develop humanistic skills.

Reiser has pointed out that the student-teacher relationship molds the quality of the student-patient relationship and, eventually, the practitioner-patient relationship (13, 14). The Hippocratic Oath, which is the ethical foundation for medicine, emphasizes that the student and teacher should relate as "members of a family." Pharmacy faculty members who demonstrate caring to pharmacy students will better prepare students to provide pharmaceutical care. As noted in Table 1, faculty role model incivility when they make disparaging comments about other

pharmacy faculty members, the school administration, or other health professionals in the presence of students.

Students demonstrate incivility when they are disrespectful to the experiential faculty member or a designated instructor such as a pharmacy resident or fellow. Both the literature and our experience confirm that this occurs more frequently with new faculty members who set high standards (sometimes unrealistic for the learner) (15).

We have also encountered pharmacy students who show respect to the experiential faculty member but are disrespectful to a pharmacy resident or fellow designated by the faculty member to help instruct or supervise the student. Students should be told during orientation that residents and fellows must be given the same level of respect given to the experiential faculty member. Furthermore, if the residents and fellows are involved in providing instruction or supervision, they should provide input into the assessment of student professionalism.

Conduct. Carter has emphasized that living with others requires that we conform to an established set of behaviors (3). In the practice setting, these behaviors include using of appropriate language, wearing professional attire, grooming properly, and participating actively in team rounds rather than being a passive observer or displaying inappropriate behaviors such as joking or talking with peers about topics that are not patient related.

It is important for the experiential faculty member to communicate standards of behavior that are the culture of the team at the beginning of the rotation and also to role model the expected behaviors. For example, during orientation, students should be advised that they are expected to be on time and to have all patient data updated before rounds begin. They should be instructed to be attentive on rounds, and if two pharmacy students are on the same team, they should not converse with each other while another team member is talking. Students need to be reminded that cell phones are prohibited in hospitals and that it is absolutely unacceptable to have their cell phones on.

With pharmacy education's greater emphasis on ambulatory rotations, students spend less time participating in formal inpatient rounds and therefore have only a limited time to learn how to be an integral member of an inpatient team. Students need specific orientation to the standards of behavior expected during team rounds. Faculty members should also round with the team so they can serve as role models, observe the students' behaviors, and provide feedback about this performance.

Diplomacy. Civility does not imply that an individual should always conform and agree with others. Carter emphasizes that criticism is appropriate and valuable as long as it is civil (3). Faculty members can role model this by encouraging students to express their viewpoints and by promoting civil debate of controversial topics. Diplomacy is also role modeled when the faculty member constructively criticizes a student's performance. For example, when providing feedback about performance, the faculty member should describe the inappropriate behaviors (e.g., your plans for solving medication-related problems are often incorrect) rather than labeling the student by using a demeaning term such as "dumb" or "lazy." Furthermore, the student should not be belittled in the presence of others, especially patients, when a task is performed inappropriately.

Students should be encouraged to share their concerns about the quality of the learning experience during the rotation rather than letting emotions build up and writing offensive comments about the faculty member on the Student Evaluation of Teaching form. Students tend to resist providing negative feedback about the instruction during a rotation for fear of retaliation or negative impact on their final rotation grade. The faculty member can minimize this by establishing a teacher-student bond at the beginning of the rotation and encouraging constructive feedback for the purpose of maximizing the student's learning. This point is discussed in more detail below.

STRATEGIES FOR PREVENTING AND MANAGING INCIVILITY

As described by Tiberius and Flak, it has been our experience that students fear faculty retaliation and are hesitant to openly express even appropriate emotions (7). Recent incidents that have occurred with graduate students, another form of one-on-one interaction, suggest that these relationships have the potential for culminating in explosive and catastrophic situations (4). Experiential faculty and administrators need skills for addressing even the most subtle occurrences of incivility. The following discussion outlines strategies that can be implemented at the programmatic and individual faculty levels to prevent and manage incidents of incivility.

Programmatic Strategies

As noted in the ACPE accreditation standards, the experiential component of the curriculum should occur as a continuum across the curric-

ulum and allow students to progressively develop the ability to provide pharmaceutical care (16). Most pharmacy schools have adopted a set of learning outcomes, and one of these outcomes should communicate that ethics and professionalism must be demonstrated by the successful graduate. Because practice experiences are intended to be a continuum across the curriculum, they provide the most appropriate venue for enabling students to grow and to demonstrate civility and professionalism in the practice setting. The formal experiential curriculum should provide students with opportunities to demonstrate achievement of civility, other virtues, and professionalism in a graded fashion over time.

As described below, pharmacy students must learn that virtues are the foundation for professionalism. Students need more than just knowledge about virtues and other aspects of professionalism. We must help them make use of virtues and professionalism a daily habit as they progress across the entire experiential sequence. This can be promoted by allowing students to reflect on their patient care experiences and to discuss the ethical and professional dilemmas they have encountered.

Virtues such as civility have been cited by various health professions faculty members as important foundations for understanding ethics and demonstrating professionalism (17-20). Pellegrino and Thomasma state that "virtue makes us function well as humans to achieve our purposes" (17). A virtue defines human excellence, and adherence to virtues makes good humans. Other virtues that are particularly germane to the health professions include fidelity to trust, compassion, phronesis (prudence), justice, fortitude, temperance, integrity, and altruism (17).

We recommend that pharmacy students be introduced to virtues by the time they begin their first IPPE. Specifically, students should be taught about the virtues that are essential for excellent pharmacy practice, how these enable one to develop a sense of morals or ethics, and that morals are a prelude for effectively interacting with others (3). As noted by Anderson, it is probably unrealistic to expect students to begin a professional program such as medical school or pharmacy school with an understanding of all of the virtues that relate to their career (18). Students need to be nurtured as they learn about virtues and need to be provided with opportunities to make use of virtues a habit. All experiential faculty members need to role model these virtues and to encourage students to apply them each day and to reflect on their experiences (19). For example, during orientation to the first IPPE, students should be provided guidance in how to interact with others in a civil manner and told that civility is the foundation for professionalism.

As pharmacy students continue in their early practice experiences, they should be held accountable for behaving in a civil manner. Students should then be held accountable for demonstrating professional behaviors, including civility, during their APPE sequence.

Many incidents of incivility can be prevented if a code of professional conduct is established at the programmatic level and clearly communicated when students begin the IPPE sequence. Many programs have policies that mandate attendance, dress, and standards of behavior that in reality relate to civility and professionalism. However, students often view these policies as "course rules" and do not realize that they represent behaviors of professionalism.

Based on several recent incidents, we believe our students may better understand the rationale for our program policies related to attendance, dress, and use of professional language if we incorporate them into a code of professional conduct. To establish such a code, readers are encouraged to review the work of Hammer and the recent Charter of Professionalism that physicians developed during the Medical Professionalism Project (12, 21-23). Pharmacy schools are also encouraged to consider a system for longitudinally detecting professionalism problems as students progress across the curriculum (24). Furthermore, there should be severe consequences if this code is breeched so that students get the message that attitudes and values are as important as knowledge and skills in pharmacy practice. For example, as noted in the introduction, Auburn students must achieve a higher level of performance on the ratings related to the Professional Ethics and Identity outcome because they participate in a longitudinal practice experience that enables their growth as professionals. If students fail to achieve a minimum standard of performance on the Professional Ethics and Identity outcome at the end of an APPE rotation, they fail the rotation even though they have excelled in all other outcome areas. This performance criterion sends students the message that pharmacy practice involves more than just knowledge and skills; professional attitudes and values are essential in providing pharmaceutical care.

In addition to individual faculty member ratings that assess performance related to the Professional Ethics and Identity outcome at the end of each rotation, the Auburn Experiential Program faculty meets to review the progress of each student at the midpoint and end of the year. These discussions enable the faculty to assess the strengths and weaknesses of each individual student and recommend strategies for improvement. By having faculty members share their insights about a student's performance with other faculty members, we have been able

to detect problems faculty members were hesitant to document in writing. These sessions have also enabled the faculty to confirm whether a student's weakness or performance problem has been consistent across rotations and whether improvement and growth have occurred. These faculty evaluation sessions review the progress of students in accomplishing all ten of the program outcomes. They also allow the faculty to collaboratively develop a plan for helping the student improve. The information is then provided to students for use in personal improvement.

Hemmer et al. have shown that faculty evaluation sessions such as this are more likely to detect medical student behavior and professionalism problems than standard checklists (e.g., ratings) or written comments (25). These researchers also found that professionalism deficiencies were more likely to be detected in the inpatient setting than in the ambulatory care setting. Because of the increased emphasis on ambulatory care, students are spending less time in the formal inpatient setting and pharmacy educators should be aware that this may make detection of professionalism problems more difficult.

The faculty evaluation sessions also enable faculty development because the more inexperienced faculty members gain insight from those more experienced about how they observe students, the level of performance they expect, and their interpretation of the findings. These faculty reviews of student progress have been successful, and some faculty members have encouraged us to perform reviews more frequently than twice a year.

Some readers may be questioning the legal ramifications of failing or even expelling a student based on performance in the areas of civility and professionalism and whether it is appropriate to share student performance data with other experiential faculty members during faculty review sessions. In both situations, the courts have upheld the faculty member's activities and decisions (26-28).

Routine site visits and meetings with students provide opportunities for the program director to assess the frequency of incidents where faculty members are exhibiting incivility in their daily practice or treating students in an uncivil manner. The director can also determine whether patients have been uncivil to students. Each of these situations has been detected in our program as a result of routine site visits. Fortunately, during a 15-year period, only one incident has occurred where the experiential faculty member was exhibiting incivility in daily practice. This individual and site were subsequently dropped from the program. Although there have been some incidents where an experiential faculty member demonstrated incivility related to tolerance and conduct, inci-

dents related to treating the student with respect or humanism and using diplomacy when interacting with the student have been more frequent.

Students do encounter situations where patients are uncivil because they are frustrated with the pharmacy operations (e.g., perceived slow service). We have also encountered situations where patients insisted on talking to a "male pharmacist" because the student was a female. In one incident, it was very traumatic for the female student because it had occurred multiple times in a single rotation. The program director provided a reflective session with the student to help the student understand that some patients are accustomed to interacting with a male pharmacist or may feel more comfortable talking about health care issues with a pharmacist of the same gender. During the discussion, it was emphasized that once the student is in daily practice, she will have opportunity to gain the confidence of such patients over time.

Faculty Member Strategies

Experiential faculty members should be prepared to both prevent incivility and manage a situation if it occurs. Tiberius and Flak emphasize that building a strong teacher-learner alliance provides an atmosphere where the faculty member and the student can have an effective relationship, one where they feel comfortable sharing concerns with each other in an open manner (7). The following recommendations for building a strong teacher-learner alliance are supported by their research and expertise.

At the beginning of a rotation, the teacher-learner alliance can be achieved by establishing an atmosphere where both commit to working together to help the student achieve the rotation goals and take a shared responsibility in helping the student learn and improve. Both the student and the faculty member should agree to hold weekly sessions to provide feedback to each other about the student's progress and how learning can be enhanced. The student should be particularly encouraged to share ways that the experiential faculty member can enhance the learning environment. The faculty member can role model humility by emphasizing that he or she is also an imperfect human being and desires feedback so he or she can improve learning during the rotation. Although a faculty member usually has more expertise and may have superior understanding of a topic, the student should be encouraged to express his or her perspectives on a topic or issue. By listening carefully and providing civil feedback, the instructor has an opportunity to cor-

rect or clarify misinterpretations that may otherwise go undetected. Students can learn significantly from these new understandings.

The faculty member should also be prepared to intervene and address issues or incidents where incivility is likely to result. Table 2 outlines seven steps recommended by Tiberius and Flak for communicating effectively when issues arise (7).

EXAMPLE STUDENT CASES AND DISCUSSION

The following example student cases highlight some of the issues and recommendations we have discussed in this article and provide further thought on issues related to incivility in the experiential learning setting.

IPPE Student Case

Shortly after being assigned to visit a patient in a nearby community, a female student contacted the experiential program director (JLK) and requested reassignment to another patient in Auburn. The nearby com-

TABLE 2. Steps for Resolving an Experiential Faculty Member-Student Issue and Preventing Incivility [recommendations cited by Tiberius and Flak (7)].

Steps	Description
Step 1	Detect early warning signs and symptoms: (irritability, loss of motivation, insomnia, and headaches)
Step 2	Schedule a mutually agreeable time to meet (allow sufficient time and privacy)
Step 3	Use active listening techniques (e.g., paraphrasing what the student has told you and checking for accuracy)
Step 4	Confirm and validate the student's statement of the problem (Clearly indicate you agree or differ)
Step 5	Express empathy for the student (use verbal and nonverbal techniques)
Step 6	Explain your viewpoint to each other (each should use the pronoun “I” instead of “you”)
Step 7	Establish solutions (Initially, both individuals should brainstorm and then narrow down to the best option.)

munity, twenty miles from campus, has a high percentage of both impoverished and minority residents. The student expressed concerns about having to drive a distance to visit the patient and further shared that visiting patients in that community did not seem "safe" to her (even though she had never visited the community). The coordinator assured the student that the patient did not live in a "dangerous" area and detected that the problem more likely related to student misperceptions about the patient's culture and neighborhood. She encouraged the student to talk with her individual faculty member (DEB) and express these concerns.

When the student approached the faculty member about her concerns, the faculty member detected that the student was equating poor living conditions with danger. The student also shared that she had discussed the assignment with her parents and that they did not want her going to that community. The faculty member clarified the difference between "poor" and "dangerous" and then shared her experiences in visiting the patient and neighborhood. She then arranged for the student to visit the patient with a senior student who had experience in caring for the patient. Both students were encouraged to give the patient the same level of care they would give to their parents, who are from a traditional middle-class background. Following the visit, the faculty member had both students share their experiences and assess the difference between living in a senior living facility that has poor citizens and walking down a street that is known for violence and therefore, "dangerous." The student later admitted that her initial perceptions of the community were formed by the opinions of other students.

Case Commentary

Students often will not express overt intolerance for people of another culture or social status. Instead, they try to avoid the rotation assignment or situation. When students make such requests, faculty should use open-ended questions and active listening to assess whether the underlying etiology is related to fears or biases about the patient's culture. This case had the potential for escalating to a point where the student refused to accept the rotation assignment and pulled her parents into the issue. Through active listening and giving both students an opportunity to reflect on their experiences, both the program coordinator and the individual faculty member provided an environment that allowed the student to realize her preconceived biases and to learn about a patient from another culture who was poor, but living in a safe neighborhood.

The student's statement that her initial opinions were based on the opinions of other students suggests the presence of a "hidden curriculum." Because similar incidents have occurred with prior students, the program director recommended that the school train faculty to detect and address cultural issues and implement a series of seminars to enhance the culture competency of students.

APPE Student Case

Early in the rotation sequence, a student was reported to have missed some rotation days and to be habitually tardy during several rotations. During an internal medicine rotation, she was late for rounds several times and it was disruptive to the team. Because the problem had not improved during the rotation, the faculty member contacted the program director for assistance. The experiential director (DEB) met with the student to discuss the problem, and the student revealed that she had been dealing with some personal family problems since the APPE rotations had started. She further shared that during the last several months she had found herself having difficulty getting out of bed in the morning and feeling depressed. She revealed that, through self-referral, she had sought psychiatric treatment for depression and had been taking an antidepressant for about one month. Although her depression could account for her absences and tardiness in earlier rotations, she acknowledged that she had always had difficulty being on time.

Knowing that her upcoming experiential faculty member (DCB) had heard through the "grapevine" that the student had attendance problems, the program director encouraged her to share her situation with the upcoming preceptor so that the upcoming experiential faculty member could assist her in overcoming the problem. Prior to meeting with the student, this experiential faculty member (DCB) developed a clearly written attendance policy that was added to her syllabus, and she began requiring that students sign an affidavit indicating that they understood the policy. The student met with the faculty member prior to the rotation, and they openly discussed the student's past problems and the expectation of arriving to rounds on time and ready to make patient care recommendations. The experiential faculty member conveyed the standards of behavior that the medical team expected and emphasized that arriving late was disruptive to the team. During the rotation, the experiential faculty member had to address one tardiness issue. She was very firm about the issue and pointed out that one more incident would result in failure of the rotation. The student did successfully complete the rota-

tion and after graduation contacted the experiential faculty member and thanked her for helping her overcome habitual tardiness.

Case Commentary

When a student does not follow the established standards of behavior, the faculty member needs to openly discuss the situation with the student and assess the possible etiologies. Although tardiness may seem to be a minor incivility, it continued in spite of directions from earlier faculty members to be on time for rounds. The etiology of the student's attendance problem was most likely a combination of both her depressive illness and a habit she had developed during her early college years of not arriving to class on time.

This student had already sought treatment for her depression, and the faculty were not presented with the challenge of detecting that the incivility was due to a psychiatric problem that needed to be addressed to solve the problem. We have encountered instances where students have exhibited performance problems that called for mandatory psychotherapy. Amada has noted that psychiatric problems are a frequent cause of incivility in college students today (29). However, when such treatment is mandated by the school and the student is not open to it, treatment is unlikely to be successful. Furthermore, Amada notes that this is probably a violation of Section 504 of the Rehabilitation Act of 1973 (29). When readers encounter such a situation, they are encouraged to read the article by Amada and seek assistance from an individual at the university who is familiar with the legal ramifications of any proposed action.

SUMMARY

Incivility during experiential practice rotations usually presents differently from incivility in the large classroom setting. Since incivility and other virtues provide the foundation for professionalism, it is essential that students learn established standards of behavior early in their IPPEs and learn how to live in the "patient care household." They should also be aware of other virtues that serve as the foundation for professionalism and be encouraged to make them daily habits. As Pharm.D. students progress to their APPEs, they will be better prepared to effectively care for patients, interact with others from different cultures, demonstrate respect for others, follow the standards of behavior

established by medical teams, and disagree in a diplomatic manner. Experiential programs should evaluate their established policies. If the policies really convey a code of professional conduct, rename the document so that students learn they are following these rules because they are "professionals" and not just students in an educational program with rules and regulations. Finally, as students progress across their APPE sequence, they should be accountable for demonstrating professionalism as outlined in a code of professional conduct that has been adopted by the experiential program.

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