

Ethical Dilemmas in Clerkship Rotations

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Abstract

A sound clinical education should include the opportunity for medical students to engage in a spirited and informed discussion with faculty about the ethical challenges they will undoubtedly face. Unfortunately, in many medical schools today this goal is thwarted by many factors, including denial that a problem exists, relentless system overload, unprofessional behavior, breakdown in communication, and inertia. What is worse is that this problem is not new, and the fallout is not insignificant. Another potential

contributing factor is burnout, which is well documented in a high percentage of medical students, residents, and faculty, and two of its most serious consequences are patient dissatisfaction and medical error.

The authors draw on hundreds of student reflections on ethical dilemmas submitted during classroom exercises to examine persistent themes. They posit that classroom and didactic teaching is not enough to enable students to face ethical dilemmas. The authors

call for a major culture change in medical education: “buy in” from top administration, especially the dean (and associate/assistant deans), chairs of all departments, and clerkship and residency training directors; the appointing of an ombudsperson and/or ethicist to oversee and resolve issues as they arise; instructional workshops and materials to enhance and impart skills for all teachers; remediation or retiring of errant faculty; and ongoing research and dialogue between and among medical centers about novel solutions.

Incident: Student was told to obtain a blood culture from a patient although he had never done one before. He was told to say to anyone who asked that he was experienced and had performed many. Student wanted to do the procedure but felt torn between telling the truth and being a team member and not subject to a bad evaluation.

Incident: An elderly surgeon with a tremor accidentally nicked the patient’s uterus while performing surgery and caused some bleeding. The student noticed, but didn’t say anything. When the resident came to suture the patient, she inquired what had happened. The surgeon told her he didn’t know. The student did not speak up about the surgeon’s “slip.”

Incident: Patient 28 weeks pregnant presented with spontaneous rupture

of membranes. Student was aware that under these circumstances, vaginal exams should only be performed when necessary. The resident performed an internal exam and then asked the student if she wanted to perform one also. Student was torn between wanting to perform the exam or pointing out that she might do harm.

These incidents of lying, poor teamwork, conflicted silence, medical error, and unprofessional behavior are examples from some 500 reports submitted during a four-year period beginning in 2008 as an assignment in a class on ethics, truth telling, and communication for third-year medical students. We had asked students to write down and share their own experiences in response to case scenarios in an article published in *Academic Medicine* more than a dozen years earlier by Christakis and Feudtner,¹ who were then medical students.

As we listened to the students’ visceral reactions, it was apparent that nothing much had changed over time and that these unethical, untoward situations were not confined to our medical school. We were also concerned about the effects of burnout on our medical students’ ability to handle ethical dilemmas. Dyrbye and colleagues,² in a survey of more than 2,500 medical students, noted that distressed students admitted to cheating, lying, and diminished altruism. More

recently, Shanafelt and his coauthors³ have found significant burnout in fully trained physicians, which can manifest itself in the workplace as proneness to errors, compromised empathy, and objectification of patients.

By the end of that academic year (2008), our informal findings had turned into collection of qualitative data. We continued collecting, evaluating, and analyzing student submissions for another three years.

By reading and analyzing the students’ papers we were able to categorize the ethical dilemmas or violations into several groups, although many reports fell into more than one category: lying, poor team playing, medical error, powerlessness, violation of confidentiality or poor communication, shaming, missed teaching moments by attending physicians, uncertainty of student responsibility, and a category called “other” that included a potpourri of lapses in professionalism.* The students’ papers tended to show more insight as the year progressed. It was evident that the students were learning, absorbing, and were more aware of what they were observing. But the categories never changed.

* Abusive behavior towards students has lessened but has not been eradicated as annual Association of American Medical Colleges surveys demonstrate, and new efforts are called for in this area as well. But that is beyond our purview in this paper.

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By sharing our findings in this commentary, we hope to draw attention to this pervasive issue in medical training. We first examine some of the themes that emerged during our years of collecting students' experiences and then consider the issue from the perspective of the culture of medicine. Finally, we offer some recommendations to begin to change our culture to address the ethical dilemmas that are now all too common.

Looking for Answers in the Data

We found that the categories of ethical dilemmas students described were consistent over time, but what were the major factors that continued these practices? Certainly, student apathy contributed to the persistent record of unethical or unprofessional occurrences, but the students' cynicism was most disturbing—students who had been so idealistic and excited when interviewed for admission to medical school less than three years earlier were now more likely “to go along to get along.” Asking them to explain what had happened to them in that short period of time to turn their attitude 180 degrees was both enlightening and discouraging.

Fear was the most prominent factor in this shift. Students expressed fear of reprisal from the attending physician or resident, fear that grades and evaluations would be at risk if they reported the actions of a superior (i.e., a resident or attending physician). Even the knowledge that they could reach out to us as the ombudsman and ethicist was not an option that students trusted. This fear of reprisal extended as well to what could be called “bad team playing”—for example, not speaking up when an ethical dilemma occurs, to avoid being perceived as disloyal to the team or to one's superiors.

Even when fear was not a factor, apathy was. Students described just “getting through” medical school, avoiding confrontations and uncomfortable encounters. The thinking was that all one needs to do is get past this hurdle and the next until ultimately graduation is around the corner, and that this should remain the most important goal.

Some students' cynicism was based in large part on feeling blindsided about what practicing medicine was all about. Instead of learning to be healers, they began to

realize how much remains unknown and that medicine is not a cure-all. They seemed disillusioned. They complained that no one had prepared them for the harsh realities of the medical profession.

When we suggested to the students that we could not improve or correct matters if we did not know about them, one student burst out and said that he did not have enough time in the day to go to school *and* report on all the improprieties he saw or experienced. Reporting improprieties, students felt, was pointless because nothing ever came of doing so. They claimed that they were told to stop complaining, that faculty dismissed their complaints as without merit. In all, they felt that they were hearing a message “to stop whining and get on with things.” Again, they emphasized that they did not report unethical behavior for fear of reprisals. They simply wanted to get through and put it all behind them. They were quite skittish about anything that required any kind of boldness or candor. It wasn't worth jeopardizing what they had worked so hard to attain.

Our information is admittedly incomplete. We have been collecting only the students' side of the stories. Residents and attending physicians have had no opportunity to respond, amend, correct, or refute any of these incidents. What makes the reports ring true, however, is that most scenarios are repeated in virtually each cycle of teaching and in each year. Yet, fixing what is broken requires that all parties be able to respond to each complaint with an explicit commitment to bar any retaliation.

A literature search confirmed that we were certainly not alone in the observations we were gathering. Studies from New York, Pennsylvania, North Carolina, as well as Canada and The Netherlands indicated similar experiences.⁴⁻⁸ It was dismaying that no matter what students were taught, there seemed to be an abiding culture that allowed these practices to continue.

Changing the Culture of Medicine

Over the years, we have presented our findings to the dean of the medical school and the dean of students, to clerkship directors, to department chairpersons, and to the students. Some felt that these experiences were no different from

what they had experienced as students themselves. They saw the stories not as extraordinary situations but, rather, just as part of medical school apocrypha. While most agreed that they too had experienced similar scenes, some were clearly troubled. Senior faculty, including the deans, were not only disturbed by these findings but wanted to explore ways of changing the culture.

Culture change was what we needed to pursue. Clearly, a more pragmatic approach beyond the classroom was necessary. What would change such seemingly ingrained behavior? What recommendations could we make that would begin to make inroads in medical school culture? Finally, how could we reach out beyond our institution to call others to join in addressing the issue as a serious lapse in professionalism?

As professionals and educators, we must take note of serious dysfunction and direct our energies toward finding a better way. In the end, what is lost in not addressing these students' complaints may be valuable teaching moments for both faculty and students. This is a compelling enough reason not only to intensify the educational component but also to implement a procedure that encourages reporting—a procedure that ensures both due process to all persons involved and a method for mediation and resolution of problems that ensures that all participants are heard and that there will be no reprisals. The ultimate goal would be to eradicate the harmful cultural relic of such reprisals and replace it with an interactive collegiality. We hope the by-product will be a more energized student population and greater satisfaction among attending physicians, residents, and students.

Recommended Actions

We recommend a number of proactive steps to begin the process of cultural change to encourage open dialogue about and resolution of the ethical dilemmas students face:

1. A firm commitment from top administrators, including the deans, chairs of departments, clerkship directors, and directors of resident training to recognize the seriousness of students' ethical concerns and support resolution of them.

2. A faculty member, such as an ethicist or ombudsman, to meet with medical students during their rotations on “rounds” or at debriefing sessions to untangle situations and guide students into a more interactive, constructive, yet respectful experience.
3. Mandatory faculty and resident education aimed at changing the status quo and exploring the realities of what happens in the clinical setting.
4. Educational research into additional meaningful ways to address the issues, presentations at national/international conferences, and publication of the results.
5. An acknowledgment that not all professionals have the talent to teach. Those who can be remediated should be. Those who clearly do not like teaching need to be taken off the teaching roster and assigned to areas in which they excel.

Conclusion

In this brief communication, we have presented some case examples of ethical

dilemmas in clerkship, including thematic findings arising from data gathered during a four-year period in one medical school. These same conflicts exist in other medical schools in the United States and beyond—and have been continuing for many years. Irrespective of the seeming paralysis and apathy of many of today’s medical students, we believe that the culture of medicine can change and that our recommended actions are doable and will make a difference. We welcome a dialogue with colleagues and a combined effort toward creative solutions.

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