

Virtual Mentor

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“Trust Me. I’m a Doctor.”

by William Martinez

You are a third-year medical student on the last day of a clinical rotation. You have seen a total of 2 lumbar punctures. Just before you enter a patient's room and leaving you no time to respond, your attending physician says, “I’m going to introduce you as ‘doctor.’ It makes it easier for the patient and you need to do a spinal tap before you finish your rotation.” As you enter the room, the attending physician tells the patient, “This is Dr [Smith], who will be doing your lumbar puncture.” The attending physician and the patient both look at you expectantly. What do you do? What are the ethical and professional considerations that would guide your response?

In their study of third- and fourth-year medical students, Beatty and Lewis found that 100 percent of students surveyed had experienced being introduced to patients as “doctor” by members of the medical team [1]. When attending physicians introduce medical students as “doctors” to facilitate their gaining experience with procedures such as spinal taps, medical students must quickly determine if this deception is justified and if not, whether, how, and when to correct it.

The requirement of obtaining a patient’s informed consent prior to any substantial intervention is intended to respect patient autonomy, minimize risk, and prevent exploitation and injustice [2]. To this end, most legal jurisdictions require that physicians disclose what a *reasonable person* in similar circumstances would find relevant to the decision at hand [2]. Presumably, novices have a higher rate of complications when performing new procedures than do more experienced clinicians. Therefore, most, if not all, *reasonable persons* would wish to know the true status and qualifications of individuals involved in their care and, in particular, of those individuals who wish to perform fairly risky interventions for the first time. With regard to spinal taps specifically, 2 separate studies found that more than 80 percent of patients would want to know the experience level of the person doing the tap [3, 4]. Since reasonable patients clearly find this information material to their decision, true informed consent cannot be obtained without disclosing the true status of medical students as students, not doctors.

Circumventing informed consent requires strong justification, and few exemptions exist. Nevertheless, 3 common justifications are given for deceiving or not otherwise disclosing to patients the status and experience levels of medical students performing

procedures [3]. They are: (1) consent to be treated by medical students is implied by allowing oneself to be admitted to an academic medical center, (2) knowing the status of medical students performing procedures would cause patients unnecessary stress and nervousness, and (3) societal necessity; ie, if patients were told and refused treatment from students, future patients would suffer at the hands of inadequately trained physicians [3]. Let's look at each of these.

Consent to admission into a teaching hospital does *not* imply consent to the involvement of medical students in the provision of care to all patients. Most patients, and particularly poor or uninsured patients, have little choice about which hospitals they are admitted to. Some patients are not even aware they are in a teaching hospital [5]. Moreover, if patients truly consented to receive care from medical students upon admission to a teaching hospital, there would be no need to deceptively refer to medical students as "doctors."

While it is true that informing patients that medical students are performing procedures for the first time may make patients anxious, it is also true that most patients who later discover that they were not told or were deceived about a medical student's involvement, become upset [3]. The stress and distrust that results when this is revealed may be worse than the stress caused by the disclosure of a student's role prior to a procedure [3]. Furthermore, full disclosure is necessary for patients to exercise their right, as recognized in the American Medical Association's *Code of Medical Ethics* [6], to determine whether or not to participate in a student's medical education. If a student's role is disclosed prior to a procedure, some patients may refuse the student's participation. To some degree this is desirable and would serve to demonstrate that medicine is meeting its obligation to foster patient autonomy by allowing patients to make informed decisions about their care.

But what if all patients refused and medical education could not proceed? While this is a legitimate concern, evidence suggests that, when asked, many patients are willing to allow medical students to participate in aspects of their care. In their survey of 100 internal medicine outpatients, Ubel and Silver-Isenstadt found that less than half of the patients would "probably" or "definitely" refuse to allow students to perform even the more sensitive exams (eg, rectal or pelvic exams). They found that the majority of patients were willing to interact with students in a wide variety of clinical settings [7]. With regard to spinal taps, specifically, Williams and Fost found that 52 percent of those surveyed would be willing to be the subject of a student's first tap [3], while Ubel and Silver-Isenstadt report that 66 percent would definitely *not* allow a medical student to perform a spinal tap [7]. The consent rate was considerably lower in an emergency department setting where direct faculty supervision was not guaranteed [8]. Taking these studies into account, approximately one-third or more of patients may be willing to allow students to perform spinal taps in non-emergency settings. Although this rate of patient participation may hinder training, it is not unmanageable [3, 7]. Moreover, some of the patients' apprehension regarding spinal taps, may be due to a commonly held, but false, belief that spinal taps carry a high risk of paralysis [3]. Education about the procedure may result in greater patient willingness to participate. Still, more research is needed. All 3 studies involved hypothetical situations and no

study has looked at patients who actually need spinal taps to determine the impact of full disclosure on whether or not patients ultimately allow medical students to perform spinal taps.

Furthermore, medical students are not the only novices in hospitals. Residents, fellows, and even attending physicians must inevitably perform procedures for the first time as new technologies and interventions are developed. If research showed that the number of patients willing to receive care from novices, at any professional level, was too few to adequately and efficiently train physicians, then the “social necessity” justification would have to be revisited and the burden of medical education would have to be distributed to all members of society. Poor and uninsured patients in public hospitals, where students and residents supply a greater proportion of patient care, should not unwillingly be subject to greater risk and discomfort from first-time procedures than private patients.

What then is a medical student to do when an attending physician introduces her as a “doctor” in order to secure her an opportunity to perform an important yet moderately risky procedure? To resolve this question the medical student must examine her role and obligations within 2 complex relationships: the mentor-student relationship and the doctor-patient relationship.

The Hippocratic Oath helps illustrate the duties inherent in these 2 relationships. The oath calls on students “to hold [their] teacher in this art equal to [their] own parents” [9]. By equating preceptors to parents, the oath reminds us of the authority of preceptors over their students and of students’ responsibility to respect this authority. More generally, the oath is used to remind students and physicians of their responsibility, within the doctor-patient relationship, to act in their patients’ best interests and above all do no harm.

In the case of a spinal tap or other procedure of moderate risk, the student’s responsibilities and allegiances are in conflict. To show concern and respect for the patient’s welfare and autonomy, the student ought to reveal her true status and allow the patient to make an informed decision about the student’s participation. The greater the potential for harm, the greater the responsibility to be completely forthright. However, if the student is to respect the authority of the attending physician, then she should not correct the attending physician. Complicating matters, the student’s evaluation may depend, at least in part, on how well the student meets this latter responsibility. The student must also consider the consequences her actions may have on the relationship between the patient and the attending physician.

The central element of all these relationships is trust, and honesty is a critical part of developing trusting relationships. To preserve these vital partnerships, the student must act in a way that maximizes or preserves the trust between all parties to the greatest degree. This will depend heavily on the particular circumstances of the situation.

One way for the medical student to preserve or maximize trust is to excuse herself from the room and ask the attending physician to step out with her. Privately the student may begin by thanking the attending for helping to create learning opportunities for her and express her desire to learn new procedures. This helps demonstrate from the start that the student values this relationship, is eager to learn, and respects and appreciates the attending physician. The student should then express her concern that, should the patient later learn, say by noting it on the student's name badge, that the "doctor" is really a student, the patient may lose trust in them. This allies the student and the attending physician over a shared concern in securing the trust of the patient. Not passing judgment on the attending physician's actions maximizes the likelihood that the attending physician will respond positively and minimizes the risk to the student. It sets the stage for a discussion in which the student and attending physician can negotiate how to approach future patients and ethically learn new procedures. Although the medical student may lose out on the opportunity to perform a spinal tap on this particular patient, she may lessen the moral burden all medical students carry as they attempt to learn new procedures on unsuspecting patients.

Granted not all physicians will respond positively, and just how far a student must push the issue depends on the potential harms to the patient. Certainly students are not required to sacrifice their careers to prevent minimal harms. Although the approach I have proposed may be uncomfortable for some students, it poses minimal risk and therefore, the students owe it to their patients, attending physicians, and themselves to attempt to clarify their student status.

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