

Virtual Mentor

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Medical Student Involvement in Patient Care: Report of the Council on Ethical and Judicial Affairs

AMA Council on Ethical and Judicial Affairs

Ask the Virtual Ethicist

Much to the benefit of patients and medical education, medical students are participating in patient care from the start of their medical education. Initially, students may be mere observers, but soon they assume more responsibilities, such as monitoring the condition of patients and even becoming involved directly in treatment. Patients and the public benefit from the integrated care that is provided by health care teams that include medical students and other trainees. Students' limited experience is counter-balanced by the supervisory structure of medical teams and patient care generally is enhanced by the involvement of medical students. Even so, some patients may prefer that students not be involved in their care. Others patients will value the opportunity to participate in the training of students in the context of receiving care in a teaching institution. This report elaborates on informing patients of medical students' training status and on ensuring patients' willingness to participate in student training.

Current practices in academic medical centers

In 1973, the Department of Health, Education and Welfare (DHEW) convened a Secretary's Commission on Medical Malpractice, which recommended that: "...the patient who is about to enter [a teaching hospital] should be told fully what to expect." Upon admission he should be given a statement explaining the educational aims and activities of the institution and told how students, interns, and residents will participate in his [or her] care." In support of the recommendation, the Joint Commission on Accreditation of Hospitals (now the JCAHO) promulgated the following guideline: "The patient has the right to know the identity and professional status of individuals providing service to him...this includes the patient's right to know of the existence of any professional relationship...to any...educational institutions involved in his care. Participation by patients in clinical training programs should be voluntary." Together, these statements make clear that it is inappropriate to assume that a patient is implicitly willing to participate in the training of medical students or other health professionals merely by being admitted to an academic medical center.

In the mid-1980s, investigators surveyed both medical schools and major teaching hospitals to determine whether policies had been implemented to comply with these guidelines. They found that a majority of hospitals did not specifically inform

patients of medical student involvement. A large proportion of medical schools' deans responded that their students received either verbal or written instructions on how they should introduce themselves. However, these instructions varied from students being required to introduce themselves explicitly as a "student," to encouraging students simply to clarify their status, to a small proportion that advised students to introduce themselves as "doctors."

The same researchers conducted a similar survey among third-year medical students to identify how they introduced themselves and obtained consent to treat patients. Results showed that a majority of students introduced themselves as medical students, without providing further clarification. A small proportion of students went further by stating that they were not yet physicians. In contrast, a similar proportion introduced themselves as "doctor." Finally, a considerable proportion of students alternated between these methods rather than using one method consistently.

In addition, the medical students were asked how they obtained specific consent to perform various procedures that were categorized in terms of their degree of invasiveness. These results showed that students were in fact reluctant to obtain consent for invasive interventions such as lumbar puncture or bone marrow aspiration. However, those students who were most forthright in introducing themselves and clarifying their status were more likely to obtain specific consent regardless of the level of invasiveness of the procedure. Some of the reasons students offered for not obtaining consent included that they considered themselves to be part of the medical team, that they did not want to be rejected by patients, or that they were concerned about the evaluation of their performance by house staff.

In a more recent study, results showed that although only a small proportion of medical students introduced themselves as "doctor," all had experienced being introduced by other members of the health care team as "doctor" and only 42% had corrected the information with patients. The authors explained that the deception may be due to the students' concerns that their clinical training would be compromised if the patient refused their care, but also because students were led to believe the practice was acceptable since staff responsible for their training perpetuated it.

Overall, these studies suggest that information that could be relevant to the patient receiving care from medical students often may be omitted. Some may be concerned that such disclosure may limit the opportunities students have to hone their clinical skills. This implies that the mission of the teaching hospital may be focused primarily on medical training, relegating other considerations such as respect for patient autonomy to a lesser role. Other explanations that have been put forward to explain this ethical lapse include: 1) the lack of coordination and the diffusion of responsibility between medical schools and teaching hospitals in implementing policies requiring students to obtain consent from patients to participate in their care; 2) relying on "blanket" consent to cover procedures performed by the medical team,

including students; and 3) medical educators' own reluctance to obtain informed consent in difficult circumstances, which sets a poor model for students.

Ethical considerations in the patient-medical student relationship The first encounters between medical students and patients are important moments in the progression of the students' ethical education. They should serve to integrate the theoretical foundation of medical ethics learned during pre-clinical education into the clinical setting and to promote the development of interpersonal skills, which students will rely upon throughout their career as physicians. In essence, medical students engage in a simple form of truth-telling that constitutes a first step in establishing trust when they introduce themselves as students and verify that patients agree to student participation in their care.

Clearly students will benefit from the experience they gain by practicing skills on patients. In return, it is believed that patients in academic medical centers also benefit from focused attention. The medical students' involvement provides patients an additional opportunity both to discuss problems and to receive information. For example, students have much more time to spend with patients when taking a medical history. However, some patients may feel uneasy about student involvement, a choice that ought to be respected. , Some patients may feel hesitant to state this reluctance to the medical student or another physician, particularly if they worry that such a refusal would adversely affect the care they receive. As a result, students and physicians should be especially sensitive to patient preferences in this area.

In one study, patient willingness to be involved in student training was measured by comparing one group of patients who were provided information about the program by non-physician patient-advocate-interviewers (PAIs) to another group informed by residents. Patients in both groups were told about the students' training level, the scope of the intervention to be performed by the students, the opportunity for patients to refuse to participate, and an expression of appreciation for the patient's cooperation. Overall, the patients informed by PAIs were more likely to understand that they were among the first patients to be seen by the students, to feel comfortable about being seen by students, and to appreciate the importance of their own role in medical education.

However, non-physician patient-advocates are uncommon and the task of informing patients about the role of medical students often is fulfilled by regular members of the medical team, or perhaps students themselves. As in many aspects of medical education, teachers and supervisors should lead by their example and, therefore, should be mindful of correctly introducing students to patients. Also, it is important to reassure patients that the quality of care they receive is independent of their willingness to participate in training. Ultimately, in an environment where patients are informed of the role of medical students, and where reassurances are given that student involvement is supervised, patients may find satisfaction by participating in training of medical students, similar to the satisfaction gained through participation in research.

In cases of emergency care, when the requirement for consent is waived and decisions are based on the patient's best interests, the participation of medical students should be evaluated judiciously. In situations where the patient will be temporarily incapacitated (e.g., anesthetized) and where student involvement is anticipated, involvement should be discussed prior to undertaking the procedure whenever possible. Similarly, in instances where a patient may not have the capacity to make decisions, consent should be obtained from the surrogate decision-maker involved in the care of the patient. Finally, state courts have censured physicians who have deceived patients in terms of their level of expertise, and liability has been imposed on undisclosed substitutions of surgeons.

Conclusion

This report focuses on the balance between the educational needs of medical students and benefits to society of medical training, and the obligation to protect the integrity of patients, to obtain patients' consent (oral or written) to student involvement in their care, and to refrain from using terms that may be confusing when describing the training status of the students. The report considers that medical students greatly benefit from clinical training and that their involvement can enhance patient care when undertaken with proper supervision. The important role that patients play in medical training is reflected in section 9 of amended Opinion 10.02, "Patient Responsibilities." However, the benefits of medical education should not undermine the obligation all medical providers share to respect patients and their right to understand and determine the manner in which they receive care. It follows that all health care professionals should identify themselves, their training status, and the purpose of their involvement. This obligation requires that medical students not deceive patients as to their qualifications.

Recommendations

The Council recommends that the following be adopted and the remainder of the report be filed:

1. Patients and the public benefit from the integrated care that is provided by health care teams that include medical students. Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility for properly identifying themselves. Students and their supervisors should refrain from using terms that may be confusing when describing the training status of students.
2. Patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients and should ensure that they are willing to permit such participation. Generally, attending physicians are best suited to fulfill this responsibility.
3. In instances where the patient will be temporarily incapacitated (e.g., anesthetized) and where student involvement is anticipated, involvement should be discussed before the procedure is undertaken whenever possible. Similarly, in instances where a patient may not have the capacity to make

decisions, student involvement should be discussed with the surrogate decision-maker involved in the care of the patient whenever possible.

AMA Council on Ethical and Judicial Affairs is comprised of seven physicians, one resident physician, and one medical student. This report's consensus recommendation were adopted by the AMA House of Delegates.

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