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VIEWPOINT

Should We Think of Early Career Cheaters as Capable of Stewardship?

Christy A. Rentmeester, PhD

Abstract

Resistance to acknowledging and curbing cheating should be seen as expressing academic organizations' dereliction of their tacit early career health professional self-regulatory duties. Cheating among students and trainees deserves ethical attention, scrutiny, and self-regulatory responses because cheating behaviors express characterological vices that undermine trust and trustworthiness, which, among other virtues, are key to good stewardship and other duties of health professionals.

Cheating as Early Career Self-Regulatory Failure

Cheating is not new in the index of human experience. It is not new in health professions education, and it happens all over the world.[1,2,3,4] Cheating students and trainees grow into cheating clinicians and researchers,[5,6,7] and that is a problem for all of us who rely on the integrity of health professions and health professionals.

As a philosopher who has taught for many years in academic settings, I've learned, directly and indirectly, of what some cheaters are characterologically capable. One student generated a fake death certificate for a member of their family. Another student exclaimed, upon learning that content in their assignment was found *verbatim* on a website, "I can't believe someone would put my case on their website!" Despite how outrageous these instances sound, some academic health organizations fail to use these and similar instances of cheating or kindred offences to enforce professional ethics standards, admonish or penalize offenders, or, in some cases, even wonder whether cheaters are characterologically worthy of public trust or able to execute their duties as clinicians, stewards of community health goods, and self-regulators of their professions.

These failures of academic health organizations are, what I will call herein, failures of early career health professional self-regulation, which tend to take the following forms: willful ignorance and naivete (eg, we do not need text replication detection programs because cheating has never been a problem here); denial that offences warrant serious concern (eg, these are minor offences); and overreliance on the ethical sufficiency of delayed self-regulatory response (eg, cheaters will be dealt with in good time and appropriately by their state licensure boards or professional societies).

Public Reliance and Professional Self-Regulation

There is little documented about what academic health organizations do or should be required to do about cheating. Even less seems to be documented about what is *not* done about cheating when these organizations fail to support faculty trying to pursue due diligence in response to suspected or verified cheating. What's been going on in practice for a long time has not, as far as I can tell, been tracked well by health professions education, health policy, health humanities, or health care ethics literatures.

How academic health organizations respond or fail to respond to early career cheating on examinations and assignments, falsification of information in applications, or other misconduct should get more ethical and self-regulatory attention. One reason for this is our tacit reliance upon and fiduciary trust in academic health organizations, for better or worse, to vet, select, teach, and train people whom we will, usually in 4 years, ask our states to license and credential as our clinicians. This is the same reason why academic health organizations have *de facto* early career self-regulatory obligations to health professions and to the public.

State boards are a more well-known species of health professional self-regulators, typically composed of professionals in the fields they self-regulate and members of the public. During my service on one of these boards, we deliberated on and made decisions about how to best protect members of the public from harms posed by licensees or their practices. Expressions of ethics concerns our board fielded were most frequently articulated as scope of practice questions (eg, *This clinician did or does X; is that appropriate?*) and as questions about clinicians' characters and behaviors (eg, *Is it appropriate for someone who did, does, said, or says X to practice this profession?* or *This clinician should have done X and they didn't; I'm reporting it and something needs to be done about it*). Sometimes queries we received generated our recommendations to the state attorney general's office or generated our responses (a range of disciplinary or nondisciplinary actions) to findings of the state attorney general's office's investigations into licensees' behaviors. For example, boards' self-regulatory functions can range from restricting clinicians' licenses, recommending issuance of cease-and-desist orders, recommending investigations, imposing practice supervision, requiring education and documentation of education on key topics, or levying a range of penalties or issuing a range of practice limitations in the interest of protecting the public from risk or harm posed by a licensee.

Prelicensure Vices and Virtues

But state boards have no authority to regulate health professions school graduates who are not yet licensed, other than to not grant a license to an applicant. One question to ask here is *When persons not yet licensed to practice their professions cheat, who or which bodies are better positioned than academic health organizations to do the jobs of early career professional self-regulation?*

Postlicensure self-regulatory bodies are not in the business of selecting who will have educational and training opportunities to become applicants for licensure. Nor are they in the business of professional or characterological formation. But academic health organizations are. When academic health organizations award degrees to cheaters, health professions' and health professionals' responsibilities to safeguard public trust and to self-regulate in the interest of public protection are not met. Instead, these responsibilities get passed along to public agencies, and at costs borne by all of us.

One way to understand cheating as professional malformation is in terms of the characterological vices cheating behaviors tend to express: insufficient self-governance, poor judgment, and lack of humility, which is, specifically, a failure to try to reckon honestly with the limits of one's content knowledge and to take ownership of limits in the scope of one's competence. Articulating cheating in ethical terms—that is, in terms of characterological vices—offers us opportunities to think, by contrast, about the kinds of virtues that good self-regulation, stewardship, and other key tasks of health professionalism require: self-governance, good judgment, and humility about the scope of one's knowledge and practice. If we generally accept that these vices and virtues have the kind of significance in health professional formation and malformation that I suggest here, then it's reasonable for us to think of conferral of a health professional degree and graduation as key early career self-regulatory functions that express academic health organizations' endorsement of an early career clinician's entry into a health profession.

Trustworthiness is Prior to Stewardship

It is certainly possible for the vicious to become virtuous and for the virtuous to become vicious. It is possible for cheaters to regret their behaviors and reform, and I remain hopeful that some of them can. An upshot of this essay, however, is that we should regard early career professional self-regulation as an explicit, not tacit, job of academic health professions education organizations. We rely upon these organizations to care about characterological transformations, for better or worse, of students and trainees because these educational and training organizations have key roles in recommending entire professions' and individual professionals' trustworthiness to the public. Trustworthiness should be regarded as prior to being trusted,[8] and being trusted should be regarded as prior to being entrusted with key duties, such as stewardship . . . of antimicrobials, scarce resources and commodities, inpatient bed space, or anything else patients and communities need.

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Christy A. Rentmeester, PhD spent several years as a tenured professor of health policy and ethics and is now managing editor of the *AMA Journal of Ethics*. She works with a team of stellar colleagues who work daily with students and clinicians to generate journal-based and multimedia content about cross-disciplinary, ethically complex clinical and health policy questions. Dr Rentmeester is a philosopher by background whose fellowship training is in clinical ethics and health humanities. She has published numerous peer-reviewed articles, most exploring some feature of moral psychology; served on ethics consultation call teams, ethics committees, human subject review boards, health professional licensure boards; and holds a faculty appointment in the Neiswanger Institute at the Loyola University Chicago Stritch School of Medicine.

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