Resolving Ethical Dilemmas
A Guide for clinicians
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CHAPTER 36

Ethical Dilemmas Students and House Staff Face

Every clinician in training has entered a patient's room to perform a procedure knowing that someone else could do it more skillfully.

CASE 36.1 Performing an invasive procedure.

Obviously tired after a 9-hour wait in the emergency room, a woman with an asthma exacerbation is finally admitted to the floor. "Oh no, not another needlestick!" she groans, as a medical student approaches to draw arterial blood gases. The medical student gulps silently, aware that his previous attempts at drawing blood gases have been unsuccessful or required multiple punctures.

Trainees' self-interest in learning might conflict with their patients' best interests. Learning clinical skills and taking responsibility might present inconvenience, discomfort, or even risk to patients. Ethical conflicts also arise when trainees observe unethical or substandard care by other physicians. Both trainees and patients benefit when these issues are addressed openly. Ideally, the patient's welfare should be paramount. However, trainees must also be realistic about the power that more senior physicians have over them.

LEARNING ON PATIENTS

In their training medical students might worry that they are taking unfair advantage of patients but hesitate to voice their concerns to their supervisors (1,2). They fear that their reputation or career might suffer if others believe they are reluctant to accept responsibility or are not competent.

INTRODUCING TRAINEES TO PATIENTS

CASE 36.2 Introducing students as physicians.

The attending physician introduces a medical student beginning a third-year clerkship to the patient as "Doctor." When the student raises concerns about this, the attending physician insists that students have to get over their "hang-ups" about taking responsibility. According to the attending physician, patients who seek care at a teaching hospital know that students will be taking care of them. If they did not agree, they would not come to a teaching hospital.

Introducing students as physicians is common (3). In fact, 27% of medical schools fail to identify students as medical students, student doctors, or student physicians on their name tags (4). Several reasons are offered for not introducing trainees as such (5). Patients might not trust trainees or might worry needlessly about provision of care. As in Case 36.2, some physicians believe that patients in a teaching hospital have given "implied consent" to trainees to care for them.

There are compelling reasons to introduce students truthfully. Patient trust cannot be built on misrepresentation. Patients who are misled about a health care provider's role might feel betrayed if they discover the trainee's status. Informed consent requires physicians to disclose pertinent information to patients (*see* Chapter 3). The identity of trainees who will provide care can be highly relevant to a patient's decisions. State laws and accreditation requirements can also require trainees to disclose their educational status to patients (5). The argument that patients who seek care at teaching hospitals have given implied consent to be "teaching material" is untenable. The concept of "implied consent" applies only to emergency situations in which delaying treatment would seriously harm a patient who is unable to give consent.

Protecting patients from unnecessary worry is also an unconvincing reason to withhold information. Most patients agree that trainees enhance the quality of their care and want to contribute to a trainee's education (6,7). Concerns that patients will worry inappropriately should be addressed with more information about teaching hospitals, not less. Trainees are accessible around the clock, often have more time to answer questions, and are closely supervised. Overall, primary teaching hospitals have a lower rate of adverse patient events due to negligence than nonteaching hospitals (8).

Some trainees resort to unfamiliar titles, such as "clinical clerk," that are literally true and avoid the adverse consequences of explicitly calling oneself a student. However, such titles are unacceptable because they are incomprehensible to patients and intended to mislead. "Student physician" is commonly used and emphasizes the special medical training that the student has received.

LEARNING BASIC CLINICAL SKILLS

To learn to take a history, perform a physical examination, draw blood, and start intravenous lines, medical students need to practice on patients. Although patients are not subjected to any serious medical risks, they might be inconvenienced, lose privacy, or experience some discomfort. Out of respect for patients, the attending physician or resident should ask permission first. When asked, almost all patients agree to have students listen to a heart murmur or perform a history and physical examination. Although it is reasonable to ask patients to spend an hour with a student, it is inappropriate to ask them to spend 3 hours for an exhaustive student examination, to miss their meals, or to lose sleep.

LEARNING INVASIVE PROCEDURES

Invasive procedures performed by trainees might raise ethical concerns. In Case 36.1 medical students need practice in order to learn how to perform arterial punctures skillfully. When trainees learn invasive procedures such as lumbar puncture or insertion of central lines, their first patients might experience increased discomfort or even risk. The trainee's self-interest in learning and long-term goal of benefiting future patients might therefore conflict with the short-term goal of providing the best care to current patients.

Trainees frequently do not discuss their participation in invasive procedures with patients (3). One reason for avoiding the issue is the fear that patients will request more experienced physicians (9). Such requests would be understandable. Physicians might consider whether they would be willing to have a trainee perform the procedure on a close relative or whether they would request a more experienced physician.

In the spirit of informed consent, patients need to understand who will be performing invasive procedures and what additional risk, if any, can be attributed to trainees. Such information might be highly pertinent to the patient's decision to undergo a procedure at that institution. For surgical procedures, almost all patients want the attending surgeon to tell them what the resident will do during the operation (6). In one study all obstetric patients believed that student participation should be requested rather than assigned (10). Another study found that patients considered it very important to know that a medical student is going to make the incision, hold retractors, perform rectal or pelvic examinations under anesthesia, suture incisions, or intubate them (9). Patients consider such disclosure more important than medical students do (9).

Attending physicians should tell patients about the participation of students and residents in their care and introduce trainees (6). Patient concerns about unskilled trainees are best resolved by providing more information, not less. When informed and given a choice, most patients allow trainees to do procedures. In one study 80% of patients said they would want to know the experience of the person performing a lumbar puncture (11), but 52% would allow closely supervised medical students to attempt their first lumbar puncture on them and 66% would allow a resident to do so. Patient requests to have a more experienced physician perform the procedure should be honored if possible.

Trainees should carry out procedures only under adequate supervision, except in dire emergencies. Without supervision, the patient might be placed at unnecessary risk and the trainee will not have a good learning experience. The hospital has a responsibility to provide such supervision, and the trainee also has a responsibility to obtain it before starting the procedure. The senior physician should take over the procedure if needed.

LEARNING ON UNCONSCIOUS OR DEAD PATIENTS

Trainees might face further dilemmas when they are asked to learn on unconscious or newly dead patients without explicit consent to do so (12). For example, an attending physician might tell the medical student and intern that they should perform pelvic examinations on a patient under general anesthesia. He says that such examinations provide important learning opportunities because it is easier to palpate the ovaries when the patient is anesthetized. However, pelvic examinations performed under anesthesia without explicit permission violate patient privacy and autonomy (*see* Chapter 41).

Learning invasive procedures on newly dead patients without the next of kin's consent creates similar ethical dilemmas. For instance, after a patient on an intern and student's service dies, the resident might instruct them to practice intubation and insertion of a central venous catheter. "The patient is dead. You can't hurt her, but you might hurt a live patient if you don't practice." Such practice increases skill and thereby benefits future patients (13). However, invasive procedures might be regarded as disfiguring, offensive, or a violation of the corpse's dignity (14). Dead patients are not "teaching material." They deserve to be treated with respect.

Some physicians suggest that practicing invasive procedures should be permitted unless relatives specifically object. However, unless family members are informed that such a practice occurs, they might not know to raise objections (13). A better policy would be to obtain consent from survivors for practicing invasive procedures on newly dead patients (14–16). When consent is sought candidly and compassionately, most family members give permission (17,18). Permission from survivors also helps trainees resolve their own ambivalence or anguish over learning on patients and to appreciate that their training depends on other people's altruism (17).

TAKING TOO MUCH CLINICAL RESPONSIBILITY

Trainees sometimes assume too much decision-making responsibility without adequate supervision (1,2). For instance, a resident on a busy service might tell a subintern to sign his or her name on the physicians' order sheet, saying "You're a good student, and you can page me if you have a real question." However, it is unrealistic to expect the student to distinguish routine orders from serious management decisions. Errors in judgment or dosage can occur even in "routine" orders. Furthermore, the resident is giving the student a mixed message: "Call me for serious problems, but if you're a good student you won't bother me." Discouraging trainees' questions also reduces opportunities for learning. Students who request adequate supervision implicitly criticize the resident and might experience retaliation in grades and evaluations. They might be labeled as "not a team player," "insecure," "incompetent," or "reluctant to assume responsibility."

The training system might place the student in an untenable situation by exerting pressure to take too much responsibility or failing to set clear expectations or provide sufficient supervision. The institution should clarify expectations for supervision of trainees and establish a mechanism for students as well as residents to ask for help. A satisfactory resolution might require system-wide changes, such as more involvement from the attending physician or transfer of some patients to another team.

Trainees are ultimately accountable for taking too much responsibility and placing patients at increased risk. Ethically, trainees need to know their own limitations and should not exceed them.

LIMITS ON WORK HOURS

Residency accreditation bodies have enacted limits on house staff work hours in order to prevent fatigue and burnout and reduce medical errors. However, strictly observing such limits might raise ethical dilemmas.

CASE 36.3 House staff work hours.

During an on-call night, an intern has admitted only two patients. After rounding, he has finished his 30-hour tour-of-duty and is checking out when he gets paged. A 78-year-old woman that you admitted with pyelonephritis now has a temperature of 39 C, a blood pressure of 100/60, a pulse of 110, and seems confused. The cross-covering intern appears stressed. She exclaims, "Look, I've already had four admissions. How can you dump a patient like this?"

In Case 36.3 the harried cross-cover intern accuses her colleague of "dumping" a patient. This term highlights the way in which stressed physicians might focus their attention on their own well-being rather than the patient's interests. Ironically, restrictions on house staff work hours were intended to reduce stress on physicians. The intern signing out might feel that he should help his colleague by staying longer. After all, he might be overwhelmed some day and need similar help. In this case he does not feel tired. Moreover, the patient in early septic shock needs timely attention. It is commendable to help colleagues during unexpected emergencies. However, the on-call systems should anticipate that house officers on call might be overwhelmed. The interns should be able to call on the resident, the attending physician, or a "float" for help. In the long run, asking busy interns to stay additional hours to help others only leads to more stress and fatigue and ultimately greater risk for patients. In this case the intern at the end of shift might say, "Boy, you are really getting hit. Let me try to help. I can sign her out to the resident, who can start antibiotics and stabilize her. I sure hope it lightens up later for you." In this way the outgoing intern need only spend a few extra minutes, the cross-cover physician will feel less stressed, and, most important, the patient will receive care promptly.

In other cases a resident can provide an irreplaceable benefit to a patient or family by working a little longer than the scheduled hours. For example, a resident might be in the middle of a discussion about withdrawing life-sustaining interventions or comforting a family member over a patient's death. It would be desirable for the resident to stay to finish the conversation before signing out to the covering physician. In this situation the rapport and understanding that the physician has developed with the patient or family is not readily transferred to another doctor. Moreover, such rapport is the essential component of care in these end-of-life situations. Under such circumstances strict adherence to the time clock would undermine the ideals of benefiting patients and acting with compassion. However, such situations should remain exceptions and should not create any expectation that trainees should routinely exceed limits of working hours.

RELATIONSHIPS WITH COLLEAGUES

Case 36.3 illustrates how helping stressed colleagues is altruistic and helps create mutual expectations of reciprocity. Ultimately patient care is also enhanced when physicians support and help each other.

CASE 36.4 Lying or equivocating on rounds.

A 54-year-old man is admitted with severe pancreatitis. Overnight he required large volumes of fluid in order to maintain his blood pressure. While the intern is presenting the patient on rounds, the attending physician asks, "So what happened to his calcium?" The intern remembers that calcium is an important prognostic factor that should be followed in pancreatitis. Although he checked the patient's laboratory tests, the intern cannot remember whether he specifically reviewed the calcium. He thinks he would have noticed if the calcium had not been normal.

In Case 36.4 the intern feels a tension between making a good impression on the attending physician and acting for the patient's good. If the intern says that the calcium was normal when

it was not, the subsequent plan of care might be inappropriate. Hence, the ethical analysis is clear: The intern should say exactly what he did and offer to verify the value at the nearest computer terminal.

However, it would be simplistic to view this situation only as a clash between self-interest and beneficence. The hospital and team's culture is important. If the attending physician tends to criticize trainees sharply, the intern will be deterred from telling the truth. Conversely, if a resident and attending physician can reinforce the value of truth-telling by stopping rounds to look up the value and by discussing why the calcium level is important in this case, it will encourage the intern to tell the truth.

Moreover, a teaching style that leads interns to feel stressed might be counterproductive. Slips in which a person forgets something are to be expected. Usually they are due to the limits of human cognition, not carelessness. Exhorting interns to be more careful or by shaming them to teach them a lesson cannot remedy slips; instead, interns need help in developing a routine for keeping track of labs or a checklist to ensure that essential tasks are carried out.

UNETHICAL BEHAVIOR OR SUBSTANDARD CARE BY OTHER PHYSICIANS

Trainees might be involved in cases in which senior physicians appear to violate ethical guidelines (19).

CASE 36.5 Failure to obtain informed consent for sterilization.

An attending obstetrician performs a tubal ligation on a 32-year-old Latina woman on Medicaid who has just delivered her sixth child by cesarean section. According to the chart the patient refused sterilization at her last prenatal visit. The resident who delivered the baby and served as the translator for the patient is outraged. The delivery room nurse confirms that no informed consent was obtained but cautions, "Don't ruin your career over this."

Some disagreements reflect reasonable differences of clinical judgment or misunderstanding by the trainee. In Case 36.5, however, the attending physician is violating the ethical guideline of respecting patient autonomy as well as laws on informed consent. The resident felt outraged at the event, frustrated at being powerless, guilty that she did not intervene, and ashamed that she had become an accomplice in an unethical deed. She believed that the attending physician's action was both sexist and racist.

Trainees who are involved in a patient's case might also observe grossly substandard care by senior physicians, as when they fail to round on patients, write progress notes, or answer pages. In cases of clearly inadequate care, the trainee has an ethical obligation to protect patients and to not mislead them. In addition, there is an ethical obligation to try to prevent harm to future patients if a pattern of impairment exists (*see* Chapter 35). However, there are also strong countervailing pragmatic considerations, as we discuss next.

RISKS TO WHISTLEBLOWERS

Fear of retaliation is a legitimate practical concern for trainees (20). The obstetrics resident in Case 36.5 might receive a bad evaluation or unfavorable treatment during the rest of her training. As in all occupations, whistleblowers might suffer harm even if their accusations prove valid. Ideally, the patient's well-being should take priority over the trainee's self-interest. Individual trainees need to decide how much personal risk as a whistleblower they are willing to accept relative to the harm they might prevent.

SUGGESTIONS FOR TRAINEES

Involve Other Physicians

Trainees often feel that they have to resolve these troubling situations by themselves. However, they should discuss the situation with trusted colleagues and senior physicians. These discussions allow trainees to verify that they have observed unethical misconduct or markedly substandard care and not that they merely have a reasonable difference of clinical judgment. Such reality testing is often

crucial for their peace of mind and sense of integrity. In addition, other people might provide emotional support, give advice, and intervene constructively. The chief resident, clerkship or residency director, and chief of service have an obligation to address issues of unethical or incompetent behavior (20). Furthermore, every hospital should have procedures, such as quality assurance programs or a patient ombudsperson, for investigating such cases (20).

Decide What to Tell the Patient

In addition to informing appropriate senior physicians, the trainee needs to consider what to tell patients, if anything. There are strong reasons why patients should have truthful information about events that will affect their future medical care and life plans. The sterilized woman in Case 36.5 cannot make informed decisions about reproduction if she does not know that a tubal ligation was performed.

Trainees do not need to inform the patient personally if they inform some responsible senior physician, such as the chief of service. However, trainees need to answer truthfully if the patient asks the trainee directly what happened.

Protect Their Own Interests

If the harm to patients is serious, the ethical ideal is for trainees to fulfill their obligations to patients, even at some risk to their careers. However, trainees should also minimize risks to themselves. Measures such as writing an angry note in the chart or directly accusing the attending physician of being unethical are likely to inflame the situation. Involving more senior physicians can reduce the risk of reprisals. Trainees who are unwilling to be identified as accusers can still discuss episodes with the quality assurance committee or chief of staff. In this way, if other people are willing to come forward there will be corroborating evidence. In addition, trainees should keep records of how they raised their concerns.

In summary, medical students, house officers, and fellows face unique clinical dilemmas. Trainees' interests in learning clinical medicine and invasive procedures might conflict with patients' interests. In addition, the ethical guideline of preventing harm to patients might conflict with trainees' career advancement. The ethical ideal is for all trainees to act in patients' best interests, even at some personal risk or disadvantage.

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