Draw The Line II:

Professionalism

Final Report

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Please see the colophon on the last page for information on this document and the original *Draw The Line II: Professionalism* project.

Introduction

The genesis of the Draw the Line II: Professionalism (DTL II) project was a desire to discuss professionalism in a manner that would be useful to the "recipients" of professionalism education, i.e. medical students. While much discussion and talk has centered around the topic of professionalism in the last few years, two fundamental problems have become evident: first, defining exactly what is meant by "professionalism" and second, the involvement of students themselves.

In the first issue, professionalism is a very nebulous subject; attempts to define it tend to suffer from overly general terminology and imprecise concepts which are difficult to apply empirically. While no one may disagree with the principles themselves, translating them into specific actions in situations where professionalism skills are required is difficult, particularly in instances where a clash of "rights" (and not of "wrongs") is involved.

The other issue stems from the nature of professionalism discussions; while general principles, guidelines and concepts should be promulgated by those who have studied the concepts, professionalism does not led itself to easy didactic instruction. In the same manner that it is impossible to teach someone to be a clinician simply by having them read a textbook, it is unconscionable to expect that providing a general set of principles and rules will suddenly result in the creation of a "professional" as if they were Athena springing fully-formed from the head of Zeus. The adequate and ethical teaching of the practice of professionalism requires not only the imparting of principles, but also reasonably supervised consideration, reflection, and guidance during the phase of being a nascent professional.

DTL II stems from an earlier AAMC OSR project, Draw the Line,[1] which examined issues of medical student abuse. DTL II takes this concept and expands it into the realm of professionalism issues.

[1] Presented at the 1998 AAMC Annual Meeting. [Better way to cite this?]

Group Narrative Model

DTL II consists of a set of twenty-two vignettes involving professionalism–related situations and problems. Some of the vignettes are borrowed from other professionalism projects formulated by the American Board of Internal Medicine[2] and the American Board of Pediatrics.[3] Others are original and formulated expressly for this project.

In the original conception, the vignettes are to be printed on posters. The participants are then invited to read them and then mark the point where they thought the situation moved into a serious lapse of professionalism. Comments could also be made in the margins regarding the vignette, and the use of different colour markers would indicate the participant's position, e.g. 3rd year medical student, student affairs dean, faculty, etc.

Participants are encouraged to informally talk amongst themselves about the vignettes. After an appropriate amount of time (based on the number of vignettes used and the number of participants), a group discussion and reflection is then encouraged — this can take a variety of forms and can be decided upon by the organizers.

During development of DTL II, a discussion ensued which was illuminating regarding the concept itself. Some objected that the format and setup of the project meant that the project was not appropriately blinded and the results not quantitatively reportable to the fullest extent possible.

This is far from a liability—indeed, it is an asset. It should be made very clear that DTL II is not a research project in the classical fashion. Rather, DTL II rests atop a group narrative model. In essence, the process of reading, responding, and considering the responses of other participants

[2] American Board of Internal Medicine. *Project Professionalism*. Philadelphia, 1995 http://www.abim.org/pubs/profess.pdf [need to add references as cited in final version]

[3] American Board of Pediatrics. *Vignettes on Professionalism*. July 2000.http://www.abp.org/resident/profvign.htm

allows for a form of "group story" to be informally written within the context of the meeting, conference or exercise. This can involve as few as a handful of students, or as many as the participants in a large conference.

The primary value of DTL II is not this report; as noted, the "research findings", while interesting, are not intended to be considered objective data upon which conclusions should be readily drawn. The value of DTL II *is in the process itself* — not only in viewing each other's responses and considering them, but in dialogues and discussions that ensue in and around the posters. These can be informal discussions ("Can you believe someone thought this situation was okay?") or more formalized "debriefings" ("Let's all come back together and discuss what we thought about this exercise. Did anything in particular surprise anyone?")

There are several clear advantages to this approach. One, participants are being challenged to think about and work through challenges that they may very well face (or have faced). Two, by viewing others' responses and discussing them, the group can build a sense of what the community they exist in thinks.

The developmental psychologist Kohlberg[4] felt that moral development occurs through social interaction. In their view, cognitive conflict through experience or discussion will lead to insight. Reaching conclusions by dint of guided experience is far superior to hierarchy–oriented fiat. It's far more powerful to understand the nature of professional behaviour by reviewing situations such as these vignettes and reaching conclusions with the assistance of others than to simply be told that a particular standard is the rule. Internalizing values is far more likely to happen in the former situation.

Professional standards do not exist in isolation — they are functions of context, community, society and culture. Behaviour that is acceptable and perhaps even expected at one location may be

[4] Kohlberg L. *Essays on Moral Development Volume 1: The Philosophy of Moral Development*. 1981.

viewed as reprehensible elsewhere. Through reaching an understanding of what the shared values of other participants are, individuals can hone their understanding of their own values. They may find that they are in concurrence with most of their peers. They may find themselves challenged by the minority viewpoint on a particular case. They may find themselves in the minority, and need to consider why that is and whether it affects their thinking about the situation.

Facilitators may also find this process useful in deciding where to guide participants, particularly in educational environments. If particular aspects of professionalism (for example, patient interaction) are in line with the values which the program wishes to espouse, those areas should be de-emphasized in favour of aspects where there is wide disagreement or significant variation from expected standards. Not only is this the famed "teachable moment", but educators themselves may realize that their own standards were either being misinterpreted or could stand to be revised.

Where's the Lapse?

Another issue which has been occasionally raised is that some of the vignettes are very unclear as to who is potentially being "unprofessional". This is intentional — many situations have nebulous moral positions taken, and one of the core tasks of considering these issues is to discern where the problem lies. This may involve more than one individual, and in certain cases the entire system can be held accountable. This should not simply be a discussion about student lapses, but about everyone and everything involved.

Sometimes, an unconventional reading of a situation can easily change a group's thinking, and can make important points about considering all aspects. Examine Vignette No. 17:

> You are a student on an outpatient rotation in a private attending's office. The physician prescribes valproic acid (Depakote) for migraine headaches to one of the patients, but he doesn't advise the family of the risks and benefits. You ask: "Shouldn't you mention the possibility of liver disease or other complications?" The

> physician replies: "That's just PDR stuff." You feel this is a disservice to the patient, so you catch the patient as she is leaving and say the physician sent you to make sure she understood. You then discuss the risks and benefits with the patient.

When this author reviewed this vignette with approximately 15 third- and fourth-year medical students as part of a DTL II activity, the consensus was 100% against the physician, which included comments about properly disclosing medication side effects, honesty, etc. However, I then added an impromptu "postscript" to the vignette, where the patient decided not to take the medication and the physician told the student that their action was inappropriate since the physician had known this patient and their family for many, many years and knew that this patient had an almost pathological fear of medication side-effects, irrespective of how unlikely they were.

While there's still room to debate about whether the physician's actions were appropriate, it suddenly becomes not as clear-cut. This also affords an excellent opportunity to discuss the value of long-term provider-patient relationships, the "moral relativism" necessary at times in human interactions, and the delicate balance schools must maintain when relying on private practices for ambulatory teaching experiences. (After all, if the physician decided to no longer accept medical students because of this experience, there could be a negative impact on the school.)

Theme & Variation

As noted above, multiple variations are possible with this project. Indeed, the first use at the Association of American Medical Colleges' 2003 Annual Meeting in Washington was different from the original concept in order to fit the location of the project within the time and space of the conference as well as staff resources. DTL II should fit the needs of the participants, not the other way around.

In the form used at the aforementioned AAMC meeting, participants were invited to read the vignettes and then respond on index cards pre-printed with the vignettes and several questions.

On the cards, they were to mark points in the vignette where they felt that a lapse in professionalism began. Comments were also encouraged, and specific questions were also asked, as follows:

- I experienced a similar situation in my medical education (yes/no)
- What is the issue?
- How would you resolve/address this issue?
- How would you advise the institution regarding this incident?

The cards were then deposited in a box and collated for later analysis. While this effectively prevented participants from viewing each others' responses (see below), the temporally spread-out format and staffing limitations made this modification necessary.

Several other variations utilized (of which this author is aware of) include:

Likert Scale: After each vignette, a Likert Scale numbered from 1–10 was printed underneath, with 1 labeled as "Very Unprofessional" and 10 as "Very Professional". Participants were invited to make a mark on this scale as to where they thought the problem fell on this continuum.

Sticky Notes: Sticky pads were made available for participants, who were invited to write comments on them and place them on the vignette posters themselves. While this is awkward in terms of indicating specific points in the vignettes themselves, it is excellent as a format for comments.

Writing on the posters directly: Posters can be printed onto paper and participants can be invited to write directly on them. This can be useful if there is a desire to save the posters or display them as an example or record of this type of activity. In a variation on this, another group had the vignettes printed out and laminated so dry-erase markers could be used and the vignettes reused in the future.

Overhead projector: Where there is a large group and limited time, a modified version of DTL II can be created. Displaying two to three vignettes on an overhead projector and asking participants to write down relevant impressions (a one-to-ten rating of the professionalism in the situation, comments, possible ways to prevent the situation, etc) onto index cards can work reasonably well in these situations. To productively allow for some dynamic feedback to the group, use an semi-anonymous card-sorting method, for example asking the group to exchange cards with others they don't know at least three times; the cards should not have any identifying information, so whoever volunteers to read out a card (or, in the case of recalcitrant groups, is chosen by the facilitator) will not know which individual in the room wrote the responses. While this won't permit for extensive feedback and discussion, it is a way of incorporating the essential elements in a constrained format.

Results

Vignette	Total Responses	MS 1/2	MS 3/4	Residents	Faculty	SA	Others	Self Exp?
1	57	11	16	1	19	6	4	4
2	47	8	15	1	13	6	4	7
3	44	8	15	1	11	6	3	4
4	39	8	15	1	7	5	3	1
5	40	9	13	7	0	5	6	4
6	35	3	11	1	9	7	4	12
7	26	2	9	1	4	6	4	3
8	24	2	8	1	4	6	3	1
9	23	2	8	1	3	4	5	5
10	21	2	7	1	2	5	4	1
11	17	1	5	1	0	5	5	0
12	21	1	6	1	2	7	4	2
13	15	1	5	1	3	4	1	1
14	15	1	5	3	0	3	3	5
15	15	1	5	2	5	1	1	0
16	15	1	5	2	0	5	2	1
17	14	1	5	2	0	4	2	2
18	14	1	4	2	0	5	2	1
19	13	1	4	2	0	5	1	0
20	13	1	4	2	0	5	1	1
21	15	1	5	2	0	5	2	4
22	14	1	5	2	0	5	2	4

Total Responses = Total Respondents for each vignette.
MS 1/2 = First and second-year medical students.
MS 3/4 = Third and fourth-year medical students.
SA = Student Affairs Deans.
Self Exp? = Respondent experienced this or similar situation in their own lives.

Three sample vignettes, complete with results as to how the "marking" was done and verbatim comments, are included in Appendix A.

Vignette No. 6 was one which stood out as having been experienced by almost a third of respondents in their own lives. This vignette concerned the always-contentious issue of classroom

lecture attendance by medical students. Interestingly enough, while the comments and markup covered the expected range of concerns, the majority of the comments focused on the poor quality of lectures and faculty responsibility in ensuring quality teaching — this included not only students, but faculty themselves.

Twelve of the twenty-two vignettes had generally high levels of agreement as to where in the vignette a lapse of professionalism began. They centered around the expression of a thought, an action, or a decision which was judged to be critical in making the situation "unprofessional". For the most part, these vignettes had a fairly clear expression of who the unprofessional individual was, whether it be a student, a resident, or an attending.

At the same time, ten vignettes displayed a wide variety of responses. These often concerned situations in which a "second chance" to address the situation was available (but not taken), in which it was unclear as to whether the issue lay with the individual or with the system or context they were placed in, or in which the transgression lay in not speaking up when unprofessional behaviours were occurring around them. This may point to a need to clarify these types of issues, for wildly differing interpretations could lead to markedly different institutional actions depending on which set of competing values acts as the foundation for policy.

Eight of the twenty-two vignettes (36%) are either known by the author to be true or very similar to true situations. However, only three of the vignettes received no marks in the "experienced similar situation in my medical education" column at all.

Motifs

"Placing the Blame"

An interesting aspect of this form of activity involves "placing the blame". The initial judgment that most participants make is to decide who is at fault. In many cases, the answer is fairly clear, but in others, it may be less clear.

Participants did seem to be able to draw distinctions, however, between the points where a specific individual was to blame and where a systems problem was apparent. One of the key points in discussing professionalism is the importance of analyzing context and local culture (whether it be a small as a particular hospital unit or clinic or as large as national values) rather than simply placing blame on the individual at the center of the controversy.

Also important is to consider the others involved in the situation. Was it correct to put someone into the situation described? Should that have ever been allowed to happen?

"This Isn't a Professionalism Issue"

A comment made on one card was that "this isn't a professionalism issue". The writer may not have seen a problem in the scenario described, but this is where the impact of group narrative and discussion can come into play. While it may indeed be valid for that individual to have that interpretation, it is just as important for them to realize that others may not see it that way.

Taking the perspectives of others and being aware of the existence of those views is a key part of self-reflective behaviour, and this structure of DTL II can help move towards that awareness.

Reporting the Actions of Others

Another point which came out of the responses was of the responsibility to report or act upon situations. Even if the "student" had done nothing wrong, a failure to report another's lapse

or intervene directly was viewed as less than desirable. This speaks to a general notion that one has a duty to act when aware of issues, and has ramifications for putting professionalism into practice — arguably most individuals will witness more lapses in professional behaviour around them than commit those lapses themselves. At the same time, we have strong societal disapproval of "tattle-tales"; the question of how to balance the two extremes requires serious contemplation.

Making Assumptions

The situation mentioned above involving the vignette about the side effects of valproic acid was an example of how assumptions can be made regarding a situation. In another vignette which discussed a classmate who was likely suffering from depression and as a result neglecting his clerkship duties, while some comments discussed the moral responsibility to try to help, a few interpreted the lack of attention to clinical obligations as apparent laziness and favoured reporting the student for shirking responsibility.

One comment also pointed out the importance of not making assumptions based solely on demographics. In a situation involving a female medical student choosing to attend to her responsibilities as a mother rather than a last-minute call-in to cover for a sick classmate, a comment was: "The student is correct. This is 2003, not 1853. Women in medicine and medical school can have a life! P.S. I am a 60 year-old male raised in a medical family. I know how it was in the 'good old days'."

What are Students Responsible For?

Several comments related to the status of medical students with respect to patient care responsibilities. It was pointed out multiple times that students "are not responsible for patient care." Legally speaking, and, in many cases, educationally speaking, this is entirely true — a presence

of a medical student should not be necessary for health care to function effectively. Additionally, the combination of relative inexperience and didactic responsibilities (lectures, exams) tend to make the student role less intense than that of others.

At the same time, many in medical education believe that students should be treated as if they are responsible for care of the patients they have been assigned. While others will clearly follow-up on and check student work carefully, the argument is that the only way to learn this sort of responsibility is to be given it. Additionally, what of the student who wants this sort of responsibility and seeks it out?

Understanding that while students are generally not responsible for patient care, others may have different opinions and expectations is important. What one individual views as appropriate behaviour for someone who does not have significant duties to a patient may be classified as abandonment by another. Significant dissent on this point within a group may point to a need for clarification.

Is a Poor Grade Worse Than a Poor Example?

In one vignette, it was apparent from the responses that it was relatively "okay" for the student to be exposed to a bad example of behaviour but not for them to be graded lower as a result. This is interesting because it seems to imply a notion of what "harm" to the educational experience really means. A lowering of a grade is not acceptable, but the clear and emphatic modeling and instruction of a poor way to interact with patients is? While a self-reflective and self-aware student may possess the resources to realize that the advice and behaviour was not optimal, a more impressionable student exposed to this at a particularly vulnerable time in their learning about patient interaction may end up significantly deviating from a norm that most others would espouse.

Another aspect of this project is the importance of realizing that the mythical "you" of the vignettes is not always "you", the self-reflective, aware individual reading about professionalism. It may be a nervous, eager-to-please individual on their first day in clerkships and adrift without any moral or professional compass to guide themselves with. Others have spoken about attempts to "inoculate" students against the difficult realities of "life on the wards" and DTL II may help serve that function. At the same time, it would do participants good to realize that others may not have had access to the same benefit they've had.

Conclusion

DTL II serves a variety of functions — as a snapshot of perceptions, a communications vehicle, and an opportunity to engender self-reflection and self-correction for all involved, including facilitators. While it is far from perfect, the basic concepts and principles embodied in the project are central to the education of professionals.

While many may assume that student priorities and actions diverge widely from those of faculty, the responses above would seem to suggest otherwise. It would appear that nascent professionals and experienced professionals have the same basic interests at heart, and it would not do to forget this fact.

This pattern (of faculty siding with student perceptions) was noted in several vignettes, and may not be what many would have otherwise expected. At the same time, the faculty that were likely to attend the AAMC Annual Meeting, read through and respond to DTL II may indeed be those who would examine educational quality issues first and foremost in their own institutions. The faculty that may initially blame students for issues which arise (and term that "a lapse of professionalism") may benefit from the exposure to multiple viewpoints through an exercise such as DTL II.

While not originally intended as such, the experience with utilizing variations on the "standard" DTL II format makes this tool adaptable for a variety of situations and circumstances. Future directions could include a variety of options. The refinement of the vignettes to remove points of confusion would be one place to start. New methods and procedures of incorporating responses in an efficient manner could be added to the several possibilities already delineated above. Electronic response systems could allow effective "scaling" to larger audiences with limited time, something that isn't possible with the current format.

Finally, the vignettes available here are by no means intended to reflect all possible themes or situations likely to be encountered. The number of vignettes was reduced to twenty-two, and arguably could be reduced further, given the drop-off in the number of responses. As several of these were drawn from other projects which kindly gave their permission for their use, it would seem possible to create a professionalism vignette repository by which vignettes could be submitted and refined. The use of appropriate metadata schema would permit users to search for vignettes reflecting particular themes or concepts based around the training level and current issues facing a group. In effect, it would be a "roll-your-own" DTL II project, enabling more specific applicability than would be possible by any pre-determined set of vignettes. It would also gain power from the contributions made by various groups and individuals, thereby enhancing value.

Professionalism is a complex subject, but a very necessary one for contemporary practitioners, educators, and students. By encouraging discussion and debate in our educational programs, we can only enhance their value in fostering learning which will directly impact patients. Treating others as our partners in this endeavour, irrespective of training level and status, will optimize the experience for all.

The author would like to thank Robert Sabalis and the 2002/3 and 2004/5 Administrative Boards of the Organization of Student Representatives of the Association of American Medical Colleges for their input. A special thanks to Ally Anderson and Denine Hales for their hard work and feedback in making the logistics and analysis of *Draw the Line II: Professionalism* possible.

While professionalism may be difficult to define, I can definitely state that these individuals are all stellar embodiments of it.

There is nothing either good or bad, but thinking makes it so.

— Hamlet, Act II, Scene 2

Appendix A — Sample Results from Selected Vignettes

Vignettes are marked up using the following code:

- A 1st/2nd year medical student
- B 3rd/4th year medical student
- R Resident
- S Student Affairs Dean
- D Medical School Dean
- F Medical School Faculty
- O Other

The superscript indicates the number of responses at that point in the vignette. For example, [A^1 F^2] means one 1st/2nd year medical student and two medical school faculty members marked this as the point in the vignette where the situation crossed the line into unprofessional. In some cases, the number of responses to the vignette does not correspond to the numbers indicated below due to some individuals not completing all parts of each card.

This markup method was the format used to compile and report the results from the AAMC Annual Meeting; for group review immediately after DTL II sessions, the use of markers with different colours would provide a more visually striking and easy-to-read format.

Vignette 1

As a medical student in an outpatient clinic, you help care for a 15-year-old boy with a malignancy. You developed a close relationship with him during your time there. After some time, his illness is diagnosed as terminal and he has begun to talk openly with you about dying. You have assured [A^1 B^2 F^3 S^5 O^1] him that you will[A^1] be there as a support for him whenever [A^2 B^2 F^4 S^3] needed. He is admitted to the hospital conscious but close to death and asks the staff to call you at home and ask you to come in [A^1]. You are not on call and are just on your way out the door, as your spouse is scheduled to graduate from her doctoral program this afternoon. After a moment of thought [B^4 F^1], you tell [B^2 F^2] the staff you are unavailable [A^1 F^2] and proceed to the graduation ceremony.[5]

1st/2nd year medical student	**11**
Experienced similar situation in my medical education	**0**

What is the issue?

- A commitment to your family comes first
- Personal choice
- Making a promise you can't keep; breaking a promise.
- Maintaining professional, yet personalized patient care.
- Being called at home.
- He is a liar.

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[5] American Board of Pediatrics. *Vignettes on Professionalism.* July 2000. http://www.abp.org/resident/profvign.htm

- Wouldn't assure the patient you would be there no matter what.
- Can't promise to always be on call.
- Broken promises; careful of your words.
- I don't see this as an issue of professional. The student's decision not to be with the boy may be a breakdown in their personal relationship, but not their professional one.

How would you resolve/address this issue?
- Call spouse & discuss the situation – call another physician who you have confidence & trust in to go in and talk to the patient if you cannot reach your spouse or she wants you at her graduation.
- Ask to talk to him briefly over the phone
- The physician must understand the weight that his promises carry with a patient
- Do not promise to be there whenever.
- Inform the patient that you will be in to see him first thing on your return to work.
- I might have spoken with the patient on the phone, and then gone to the graduation.
- No discipline needed; kid will get over it.
- Speak to patient yourself.
- Visit patient ASAP, after family obligation.
- Not say "whenever needed"

How would you advise the institution regarding this incident?
- Other physicians are capable of handling the situation at the hospital
- Come up with a policy regarding after hours call/emergency calls
- Training should cover this scenario.
- Refer patient to Chaplain/social work services
- I do not think it was unreasonable for the hospital to call the physician at home.
- Tell institution to advise student not to do that (making promises).
- Awareness about promises to patients vs. personal time

Comments:
- I do not find any place where the situation was unprofessional.

3rd/4th year medical student	**16**
Experienced similar situation in my medical education	**1**

What is the issue?
- Keeping your promise, letting down someone who is depending on you.
- Personal promise to child vs. personal obligation to family member.
- The student/doctor made a promise that was unreasonable.
- How dedicated are you to the patient; what are your priorities; (patient vs. personal life)
- Whether or not you follow through on promises to others.
- Balancing personal and professional roles.
- Assurance of something you may not be able to do.
- Responsibility to patients vs. personal life.
- Making promises you don't keep.
- Patient responsibility vs. personal.
- Breach of patient trust.
- Should the student make a commitment that may lead to patient distress when broken.
- Offering services to patient(s) you may not be able to follow through with.
- Commitment to self and personal life vs. commitment to patient.
- Promising to be available whenever needed.

How would you resolve/address this issue?
- Call this young boy and tell him the truth – you are going to your spouse graduation and will come sit with him as soon as you are done.
- Speak to spouse about the situation. Go see patient.
- Because the student/physician made this promise he/she should go to the hospital.
- I would stop by the hospital on my way to the graduate ceremony and stay 5-10 minutes (if time allowed). If no time allowed I would go to the graduation ceremony and call the family on my cell phone and explain my situation and express my empathy/sympathy.
- Think before you make promises.
- If possible, stop at hospital and connect the boy with the other doctors and support staff. if impossible, talk via telephone.
- Don't make assurances.
- Spend some time with the patient then go late to the graduation.
- Discuss with student.
- See the patient as he has requested.
- Tell staff nurse the truth and that you will come by afterwards. Should always be careful making promises to patients that you may be unable to keep.
- Make a less sweeping promise. If it's already happened, the student should return to the patient asap and explain that he/she did his best to respond quickly.
- Personal comes first. You will not always be available all the time for your patients and if you are you risk the possibility of not having anything personal for yourself.

How would you advise the institution regarding this incident?
- I wouldn't advise them of anything.
- No. Upon reflection, I believe this scenario reflects a personal choice that every physician will encounter. I don't believe it is a situation of professionalism however. It is just as important for family commitments to be met so it is up to each individual physician to draw the line for him/herself.
- This student/physician really meant very well. He/she should be educated in issues surrounding developing close personal relationships with patients.
- Institution should remind students to never make promises or commitments that they cannot keep with absolute certainty.
- I don't know this is an institution issue.
- Make sure they do not make promises.
- Remind students when you make a commitment to your patients to follow through, and it's unethical to lie to patients period.
- Patient responsibilities should come first.
- Try to educate students about appropriate boundaries.
- Balance is difficult and I think it is a personal decision as to how much you takeaway from yourself and family to give to your patients.

Comments:
- Patients come first while you are at work, but you must draw the line for family because they are really the people who need and love you and vice versa.
- "Support whenever needed" could be interpreted to be physical, emotional or spiritual. The student did not act unprofessionally when choosing to attend an important family function when he was not on duty. Physicians have a right to personal time.
- An understanding spouse is very critical to success as a physician.
- Role-playing death and dying issues was very helpful in preparing me for this kind of situation.
- Discuss with medical student he/she cannot offer to be with patients "whenever" needed because they do not have that much control over their time.

Resident **1**
Experienced similar situation in my medical education **0**

What is the issue?
- Promising to be available whenever needed.

How would you resolve/address this issue?
- Talk to patient on phone, tell them you will be there as soon as possible, but might not be until later and that you're thinking of / praying for them.

Medical School Faculty **19**
Experienced similar situation in my medical education **3**

What is the issue?
- Committing to a situation (1) not for a medical student (2) not possible to fulfill.
- The student made an honest, understandable and altruistic misstep – assuring he would be there – if you insist on scrupulous honesty – impossible to assure this. There are limits.
- Commitment to provide support for a patient when you do not know if you will be able to fulfill.
- Conflict of personal and professional commitments.
- Trust.
- Made a promise to a dying patient – needed to also be there for family. Should explain to patient that you will come back as quickly as you can but don't use staff to "dodge" him.
- We should be clear with patients that there are limits to our availability and be a support whenever possible.
- Promise keeping, professional responsibility vs. family personal responsibility.
- Truthfulness – you said you would be support, but you didn't mean it.
- Promises to spouse / patient… conflict.
- Honesty.
- "Altruism".
- False hope – promise you can't keep.
- 1) Duty to family and profession (2) Altruism.
- Personal/professional boundaries and balance.
- Should not make promises you cannot or may not be able to keep.

How would you resolve/address this issue?
- Would stop by the hospital to see the patient and promise to return after the graduation and would keep the promise.
- You now owe his family an apology.
- I would go to my spouse's graduation. If possible commit to attend to the patient afterwards.
- Explore possibilities for a brief stop at the hospital on the way to the graduation.
- Coverage helps.
- Do not make promises you cannot keep. Educate student on this issue.
- Teach refusal skills – drawing appropriate lines.
- Critical incident – review with mentor.
- Figure out how to do both.
- Avoid promising what I cannot provide.
- Learn from it. Tell patients you will be there if it is possible then explain the backup plan.

How would you advise the institution regarding this incident?
- Conduct introductory seminar with students on such issues.
- Education about Dr./patient relationship, pre-clerkship and by attending caring for patient.

- I fear that to say patient care always trumps family is unhealthy and placing undue expectations on this generation.
- Not issue for institution student could talk to advisor for how to handle in future.
- Why did we assume the spouse was a woman.
- Must have coverage.
- Need to articulate expectations.
- Case study.
- Not needed.

Comments:
- I don't believe his action was unprofessional. All things considered – the humane response – not perfect.
- I really don't think this is unprofessional. We are not always available to patients and being available does not mean coming to see the patient. The student could have spoken to the pt. via telephone (cell phone) or stated when he would be able to come to the hospital that night, next day, morning, etc.
- Conflicting demands are going to happen.
- It is only true honesty that builds trust with patients and the public.

Student Affairs Dean **6**
Experienced similar situation in my medical education **0**

What is the issue?
- Student's well intentioned, but unrealistic, excessive commitment to patient – makes a promise he can't keep.
- Altruism.
- A promise you might not be able to keep.
- Personal vs. professional time.
- Making unrealistic promises to a patient then showing disregard to the patient.

How would you resolve/address this issue?
- Teach student appropriate limits.
- Might go see child for a few moments on way to graduation.
- "I'll support you as best I can".
- Go "see" patient or talk to on phone or something – explain. Take the 5-10 minutes to "be there" then go to my graduation ceremony – get coverage in.

How would you advise the institution regarding this incident?
- No action.
- Don't promise "yourself" completely – draw a line – be part of a team.

Comments:
- Not sure this is lack of professionalism – Is unlikely physician may behave differently.

Other: **4**
Experienced similar situation in my medical education **0**

What is the issue?
- Student has over committed themselves to the patient.
- Honesty and professionalism, keeping promises of support made directly to patient.
- Integrity and honesty.
- Making promises that one may not keep – violation of trust.

How would you resolve/address this issue?
- Go to spouses graduation and then go into the hospital. The spouse is as important or more so that the commitment to the patient.
- Issue sounds resolved for this individual, but hopefully s/he has learned from it; reality s/he has not been honest and avoids making similar promises in future.
- Explain the context to a hopefully understanding spouse.
- "If at all possible I will be there for you. If I can't I'll find someone who will have your interest."

How would you advise the institution regarding this incident?
- Remind students that they should not to over zealous in committing themselves to patients to the detriment of their personal lives.
- In future, students should be advised not to assure "support whenever needed" if don't intend to follow through could say "I will come if I can…" or set regular hours of availability.
- That the promise to be there at the end should have not been made – however, once made it must be kept if physically possible. The "moment" it took for the student to make the choice shows a lack of integrity and honesty with himself and a patient.

Comments:
- Student should not be discouraged from emotional involvement with patients, but must not make empty promises.

Vignette 2

On your obstetrics/gynecology rotation, you accompany an attending to a patient with a routine vaginal delivery. You are introduced to the patient, who tells the attending that she "doesn't want her child being brought into the world by a student." The attending reassures her [S^2] that he'll be the one doing [S^2] the delivery. However [A^1], when the time comes[F^1], the attending [B^2 F^3 O^1] has you stand next to him and motions [A^1 B^4 R^1 F^3 S^2 O^1] that you should be doing the "catching" [B^3 F^5]; you don't [A^1 B^1 S^1] have time to think and so you comply, delivering [A^1] the child without a problem. The patient has her eyes closed and doesn't notice what happened. You feel uncomfortable but do not say [A^1 F^1] anything.

1st/2nd year medical student	**8**
Experienced similar situation in my medical education	**0**

What is the issue?
- Patient requests vs. responsibilities and rights as a medical student.
- What the attending told the patient.
- Dishonesty.
- The attending going against the woman's request.
- Patient is stupid.
- Made to do something patient wasn't comfortable with.
- Not fully honest with patient.
- Lying.

How would you resolve/address this issue?
- Talk to the attending about the issues and how to deal with it in the future.
- Leave as is unless the patient asks you the truth.
- Emphasize honesty with patients in order to generate patient confidence.

- I would want the woman to know that a medical student delivered her baby to give her more confidence in students. I would also speak with the attending – he should be honest.
- The same way as Dr. did.
- Speak to attending afterward.
- Communicate more/better with patient.
- Discuss the situation more with patient beforehand – this is a teaching hospital, etc. MD will be present whole time.

How would you advise the institution regarding this incident?
- Spell out medical student rights on the wards.
- Discuss with the attending what s/he thinks should be done.
- The institution should make sure that patients are aware that they are in a teaching hospital and students will be learning procedures.
- None needed.
- Don't wait until to late to talk with patients.

Comments:
- I do not find any place where the situation was unprofessional.

3rd/4th year medical student **15**
Experienced similar situation in my medical education **6**

What is the issue?
- Attending knowingly lied to the patient and put the student in a very uncomfortable position.
- The attending made a dishonest statement in promising the patient he would be doing the delivery.
- Going against explicit wishes of the patient.
- Respecting patients rights/wants.
- Ignoring a direct request of a patient! (The physician does not have the right to decide who delivers the baby)
- Physician not complying with patient wishes.
- Inconsistency/dishonesty by attending.
- The attending not respecting a patients wish and putting the student in a potential lose.
The attending is not complying with the patients wishes and puts the student in a bad position.
- Patient wishes vs. education.
- Breach of patient trust.
- Should the attending lie to a patient (secondarily, should a student tell the pt what happened)?
- Lying.
- Patient care.
- Not complying with patient wishes/rights.

How would you resolve/address this issue?
- Talk to the attending – tell him you were uncomfortable with what happened and suggest that you not gown up next time that situation occurs.
- The attending was present and involved in the delivery, the mother can truthfully be told that both people were involved.
- Do not catch the baby (of course make sure baby is being caught by attending).
- Sit down with the patient, attending and student in a private setting and be truthful about what happened.
- Ask the physician to tell the patient what happened.
- Hard to.
- Talk to attending.

- Tell the attending I don't feel comfortable doing the delivery when I know the patients wishes.
- Discuss the issue with attending.
- Do as the attending physician orders – insubordination in this case would have adverse effects on my evaluation.
- Tell the patient of your participation.
- Not tell the patient, discuss with attending and request that he tell her and not put me in that position again.
- Tell patient when she recovers.
- Instead of the attending saying that he/she will be the deliver, he could reassure the patient that this is a teaching hospital and comfort her with the knowledge that he/she will be there the entire time. Perhaps also allow the student to interact with such a patient and develop a relationship prior to delivery.

How would you advise the institution regarding this incident?
- Probably would write about it in my evaluation of that attending.
- I would counsel the institution that no physician at a teaching hospital should promise their patients that students will not be involved in their care.
- Enforcement, by seminars /lectures, of respect for patient's choice among house staff.
- Institution should remind attending that patients rights are to be respected, and if attending disregard their rights then they should not involve the student.
- Faculty development session on "patient's rights" and patient autonomy.
- Stress attending honesty.
- Attending must respect what patients request as far as teaching.
- Educate attending on respecting patient consent.
- Attending should be clearly instructed on what constitutes inappropriate behavior.
- Remind patient's in advance at teaching hospitals that students are really a benefit to their care as well as the experimental research and technology offered.

Comments:
- It is important that those who practice medicine remember that patients have the right to make choices about their care and that those choices are respected.
- Attending should not make student go against just requests made by patients.
- Attending have frequently misled patient into thinking I'm an MD; I usually have corrected the misimpression out of the attending's presence in a way that doesn't imply a lie was told, but sometimes there's no opportunity.
- This is difficult because in teaching institution if all patients desired no students, they would never learn. How do we allow students to learn if stepping on patients wishes?

Resident **1**
Experienced similar situation in my medical education **0**

What is the issue?
- Lying to patient.

How would you resolve/address this issue?
- Tell attending you didn't feel comfortable.

Medical School Faculty **13**
Experienced similar situation in my medical education **0**

What is the issue?
- Honesty – keeping a pact.

- Dishonesty – on lack of full disclosure to patient. And making the student a part of this deception.
- Violation of patient wishes/trust.
- Honesty.
- Failure to follow patient request.
- Honesty and respect for patient.
- Consent breach.
- Unprofessional behavior of attending – lack of consent patient – conflict student.
- Honesty.
- Respecting patient issues, informed consent for student involvement.
- Lying to patient.
- Attending was dishonest and placed student in untenable situation.

How would you resolve/address this issue?
- Never lie.
- Problem – the faculty has placed educational activity high and truly was the one managing the labor. "Catching" the kid is a minor part (speaking as an OB) from a care perspective but not from the patient's.
- Add, "the student will assist" to OB's statement.
- Discuss with attending after the fact. Disclose discomfort.
- Feedback to attending – inappropriate. Feedback to student – assertiveness.
- Faculty development issue.
- Speak to the attending about your discomfort.
- Attending should have reassured patient he would be there the whole time supervising or hand over hand etc. If patient declined, attending may be able to transfer care or yet consent from patient to have house staff/student involvement before accepting patient or service.
- Attending delivers the child.
- Student should resolve never to be like the attending.

How would you advise the institution regarding this incident?
- The institution needs to come up with a policy for student involvement that is shared with patients on admit/enrollment. It needs to be gender blind.
- Punish physician – consider suspension of privileges.
- What is consent.
- Faculty development.
- Need proper informed consent prior to admission.
- Attending needs course in professionalism.

Comments:
- P.S. where was the father of the baby in all of this?

Student Affairs Dean **6**
Experienced similar situation in my medical education **0**

What is the issue?
- Faculty lying to patient between he knew he intended to have student do it.
- Honesty.
- Lying to patient.
- Dishonesty of attending.
- Acting against the expressed desires of the patient in secret.

How would you resolve/address this issue?
- Teach faculty about respect for patient direction.

- If student did talk to attending about concern – that would be ideal – a decision could ensue about the issue.
- Allow the student to observe only.
- Clearly define "catching" – MD may believe supervising is enough but MUST clarify patients choice.

How would you advise the institution regarding this incident?
- Unlikely would ever be repeated but if it does education of faculty member would be key.
- Clear explanation before "crowning" of teaching hospital – role of MD attending and student emphasize close supervision, process etc but in the end it's patient's choice.

Other **4**
Experienced similar situation in my medical education **1**

What is the issue?
- Telling the patient a lie – misleading, untruthful.
- Lying.
- Honesty and professionalism. The attending feels he's being professional and autonomous (the patient is not going to tell me what to do.)
- Going against patient wishes – direct violation of patient's wishes.

How would you resolve/address this issue?
- The student should raise the issue with the attending and make get them to respond.
- Faculty more than student issue. Faculty holds the power.
- Not sure. Student unlikely to address the attending, but an ethics/professional committee might.
- Report the physicians transgression to department chair.

How would you advise the institution regarding this incident?
- That keeping ones word to the patient is really important or a plausible explanation as to why the word was not kept should be shared with the student and attending and a consideration of telling the patient should be discussed.
- Faculty development, discuss how teaching tasks decisions can conflict.
- If a patient asks for no student involvement, the student can be sent to do something else, either another patient or reading.

Comments:
- Faculty development.
- The attending was giving the student experience not only in delivery of baby, but also in lying. He may equate "doing the delivery" with direct supervision.

Vignette 7

You are a fourth-year medical student on an aircraft returning from a trip to Europe when you become aware of a slight commotion a few rows ahead of you. There is a gentleman who appears to be pale and in some amount of distress. A minute or two later, the flight crew asks if there are any doctors on board. Since you are not a physician, you remain seated [A^2 B^2 S^2 O^1]; two people respond, but you think you overhear that they are medical office assistants. Still unsure [B^4 R^1 F^5 S^2 O^2], you remain seated.

1st/2nd year medical student **2**
Experienced similar situation in my medical education **1**

What is the issue?
- Whether or not you have a responsibility to act.
- Responsibility as a medical student.

How would you resolve/address this issue?
- This is a personal decision, though I feel it is your ethical responsibility to help to the extent of your abilities, but not beyond your abilities.
- Go help

How would you advise the institution regarding this incident?
- Inform students of responsibility or lack there of in situations like this. It's important that students consider ethical situations like this and think about how you would react before they actually arise.
- Educate students about their responsibilities and duties after BLS training.

3rd/4th year medical student **9**
Experienced similar situation in my medical education **1**

What is the issue?
- This student is not confident enough. He should have stepped forward immediately to offer help while letting his level of education be known. If in the end his help is not needed, no harm is done. Staying seated could cause harm.
- Stranger in need of help.
- Responsibility to fellow man. With our medical training, from day one, we have additional responsibilities beyond the normal citizen.
- Failure to be a Good Samaritan.
- Cowardice
- Although you may not have all the knowledge, it is prudent to assist.
- Professional obligation
- Responding according to your experience level.
- Ability to help – do no harm

How would you resolve/address this issue?
- I would have stood up immediately.
- Do nothing – no liability, coverage; I'm not licensed
- I would check to see if there is anything I can do.
- Tell the aircraft staff you are a student and will provide the best assistance you can.
- Let them know you are a med student and may / may not be able to help. First do no harm, but don't sit by and do nothing.
- Although you aren't yet a MD, you have an ethical obligation to help.
- Hit my flight attendant button.
- Tell them you are a medical student and will do what you can to help. Students should help as much as they can but not feel pressured to try things for the first time they do not have experience without a teacher

How would you advise the institution regarding this incident?
- I would, for my own knowledge, find out if I could be held legally responsible by either helping or not helping.
- All students should be BCLS certified.
- Make sure everyone understand the Good Samaritan law.

- Coach students on what to do when the "Is there a doctor?" question arises.

COMMENTS:
- Exactly, this happened late in my second year. After the second call, I asked what the training level was of anyone else on board and it turned out I was the best trained. I made clear I wasn't an MD, showed my CPR card and student ID, assessed the patient and spoke with officials on the ground; patient was fine.

Resident **1**
Experienced similar situation in my medical education **0**

What is the issue?
- Beneficence vs. insecurity

How would you resolve/address this issue?
- Sack up. Help out.

Student Affairs Dean **4**
Experienced similar situation in my medical education **0**

What is the issue?
- Could be many – probably fears of "inadequacy"

How would you resolve/address this issue?
- It's OK to try and help out – just ID yourself as a med student

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Medical School Faculty 6
Experienced similar situation in my medical education 1

What is the issue?
- Confidence with status. Technically correct – not and MD, but in the spirit problematic. Have trouble believing that with a plane bound from Europe – no MD.
- Failure to aid person in need of medical help.
- Responding to need.
- Beneficence
- Altruism, duty

How would you resolve/address this issue?
- Offer assistance but make student status clear
- Do not remain seated. Offer help, explaining status clearly.
- Give feedback to student

How would you advise the institution regarding this incident?
- Address with discussion with students (generic – not identifying this incident).
- Discuss vignettes like this

Other **4**

Experienced similar situation in my medical education 0

What is the issue?
- Endangerment of person's life
- This is a close call. A beginning 4th year student is very different from one mid or late year – the latter are getting close to residents (MDs). An early 4th year might not have great competence. Yes, CPR skills, but 1st is there an MD on board. If not, then step in and say "I'm just a med student, but maybe I can help."
- Rendering aid when needed.

How would you resolve/address this issue?
- Let the crew know you are a student. If a nurse, EMT, or physician is available they should be first line, but you will provide assistance as able.

How would you advise the institution regarding this incident?
- Make sure all students are BCLS certified so they have confidence in rendering assistance.
- Teach the Good Samaritan law.

COMMENTS:
- Any assistance that can be rendered when a person's life is at stake should supercede the "qualifications" of the person attempting to provide assistance.
- The student waits appropriately to see if more experienced personal are available. Student needs to clarify her impression that the 2 responding are "office personal;" he may have more expertise and leadership ability than he realizes.

Colophon

This work was primarily set in 12-point Garamond for the body text, with 24–point Garamond in grey for the subject headings. Written and laid out on using an Apple Macintosh. While the original *Draw the Line II: Professionalism* project was created by the author for the Association of American Medical Colleges Organization of Student Representatives (and is available from them; contact information at http://www.aamc.org/osr), this document has not been reviewed by any officer of the AAMC and remains the sole creation and opinions of the author.