MEDICAL ETHICS

"Trust me, I'm almost a doctor": The Ethics of Calling Oneself an (Almost) Physician

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Introductions mark the beginning of most verbal interactions. By convention, an individual initiates a professional exchange by declaring her name, title and affiliation. In medicine, this truism is no different. Physician-patient exchanges often begin with a greeting; the physician identifies her name and her title or role within the given clinical situation. It is a simple collection of words; however, when done well, the introduction sets the climate for subsequent, appropriate interaction. Given the complex nature of many of the issues physicians must explain to their patients, this ability to communicate effectively, from the onset of physician-patient interaction, is paramount. However, there are instances in which an introduction can, unintentionally, cause confusion or outright anxiety.

Within the context of a clinical scenario presented below, this article will examine the ethics involved in the introduction of a medical student to a patient in the clinical setting. In particular, this article will scrutinize the appropriateness of identifying a medical student to a patient as a "doctor".

THE SCENARIO

Imagine the following scenario: You, a clinical clerk*, have been assigned to the clinical team of a resident doctor** for the duration of your internal medicine rotation.[1,2] It is your first evening on-call. Upon entering the room of a newly-admitted patient to whom you have been assigned, the resident introduces herself first, including the title of "Dr." before her surname. She then turns, gestures towards you, and introduces you as "Dr." as well. Immediately, you feel alarmed by this and attempt to amend her statement, sheepishly adding, "Actually, I'm a student-doctor". The patient looks at you blankly. Clearly, your attempt at clarification has produced confusion.

For those who have been students or apprentices in various disciplines, this scenario may be a very familiar and, perhaps, uncomfortable one. It raises the following questions: 1) Is it ever acceptable to ignore the fact that a medical student (who will soon be a doctor and who bears some of the responsibilities of an actual doctor) is not in fact an actual doctor? and 2) Does the term 'student-doctor' mislead the patient public by suggesting that the student is a licensed physician? After considering various arguments from different perspectives, what is "acceptable" may not be as obvious as it first seems.

GUIDING ETHICAL PRINCIPLES

There are certain core ethical principles by which physicians and other healthcare professionals abide. For many, these principles were first introduced as a component of formal medical education. These include the principles of autonomy, beneficence or non-malfeasance, and justice.[3] Before tackling the questions raised above, it is useful to understand these core ethical principles.

Autonomy refers to a patient's ability to guide his own treatment, to adjust the treatment course according to his desires. In order to promote a favourable outcome, the physician weighs the pros and cons of a given decision, and presents these to the patient who ideally, as the autonomous individual, directs the eventual course of action. By attending to a patient's well-being, a physician is performing beneficence. Non-malfeasance refers to adopting the action that is least likely to harm the patient, once potential benefits have been assessed. Finally, the principle of justice simply asks whether or not the choice of intervention is fair for the patient involved. In some instances, the wishes of the patient's close contacts may also be considered in determining the fairness of a particular course of action.

APPLYING ETHICAL CONCEPTS TO SCENARIO

In the scenario above, the patient was initially told that the clerk and the resident were both "Dr.'s". This inevitably leaves the patient with the impression that both healthcare providers share equal status with respect to hospital responsibility, privilege and clinical knowledge. Did this threaten the patient's autonomy?

Part of patient autonomy includes the patient having knowledge of who is assessing her. The use of the title "Dr." during an assessment is a direct indication of the healthcare

* Clinical Clerks are considered senior medical students. They are in the latter half of undergraduate medical education which consists of rotations in disciplines within the hospital (clinical) setting, supervised primarily by Resident physicians and Staff physicians.

** Resident Doctors, or post-graduate clinical trainees, are those who have graduated medical school and earned a degree in medicine, and are continuing in specialist education, including family medicine.

practitioner's level of expertise and training. Perhaps this patient would decline a physical examination performed by an "amateur" student, or perhaps she would have been delighted to aid in the student's learning. Regardless, the ability to choose based on fulsome information has been stripped from the patient when both individuals were presented as equally adept colleagues according to the shared title of "Dr."[4] In subsequent interactions, the confidence and trust placed in the clerk by the patient may be attributed directly to the belief that the clerk is a full-fledged physician. In turn, any consent granted by the patient based on these beliefs is misguided.

Theoretically, however, it may be argued that this tactic may not violate a patient's autonomy. If the clerk physically examines the patient without providing medical advice or information, she is still acting within her duties as a student. Once the resident physician has provided authority to the clerk to relay advice and information, the clerk's actions are arguably guided by an actual physician. Because the clerk is acting as the doctor's spokesperson, the same medical information is relayed to the patient, allowing the patient to make the same informed decision regarding his management. The clerk then becomes an essential communication link between the patient and the attending physician, without jeopardizing the patient's autonomy.

There are also certain instances in which a lack of explicit communication does not impair patient-professional interaction. The lack of introductory detail in the scenario may, initially, place the patient at ease because she is able to assign a familiar title to both new visitors. While this perception may be presumptuous, there are individuals who would prefer not to be overloaded with information. For this subset of patients, the utmost concern is their current health status, not the protocol for who will take care of them. Upon observing the patient's preference, the physician would actually practice beneficence and avoid the induction of harm. For the resident and clerk, the tedious nature of explaining the various ranks and roles within the medical system, which may be irrelevant to this particular patient, has been circumvented. There is the sentiment that "all sides win" with this approach.

It may be argued that justice was circumvented by the resident in the above scenario. The resident did not disclose the exact nature of the accompanying student as that of a clinical clerk, or non-physician. In the setting of a simple introductory meeting where there was no clinical decision at hand, or risk of imminent injury to the patient, it is possible that her action would be of no grave consequence. However, in the event that decisions about procedures and treatments must be made in subsequent encounters, this patient may appreciate having full disclosure of the student's level of expertise.

FOR THE SAKE OF STUDENT LEARNING?

It is obvious that opportunities to practice clinical manoeuvres on patients aid a medical student's development of practical skills. Unfortunately, many patients do not like to be scrutinized in the "hands-on" environment of the physical examination. In such instances, it is understandable, in terms of convenience, to present a student as a physician in order to facilitate clinical practice. However, a patient's safety should never be compromised for the sake of a learning experience. By the same token, however, when a patient is examined by various members of the medical team, there may be a greater yield of findings which can potentially enhance patient care.

Even with the utilitarian, practical advantage of furthering student education, a moral dilemma exists once the student is labelled "physician". In reality, the clerk in question lacks both a recognized medical degree, as well as a practicing license granted by a governing body.[1] Thus, the clerk is officially not a doctor. The utilitarian argument, in effect, legitimizes taking shortcuts in the interests of expediency, rather than being completely forthcoming. For the student who glosses over details today, what might he gloss over, or completely misrepresent tomorrow? The concern that one falsehood will lead to others could eventually compromise a patient's health and erode the ethics of a future physician.

While it may be difficult for individuals outside of the healthcare community to fathom why one would accept or apply a label which may misrepresent their professional rank, for a student to be bestowed with the title of "doctor", even momentarily, it can provide a great sense of importance and esteem. Acceptance of this label can even encourage the student to strive for the intellectual capacity and professional standard of the physician during their apprenticeship. It is also an indication that one has been deemed professionally competent by his superior. This judgment is particularly significant to the apprenticing student, who may lack direct, consistent evaluation of their abilities. It is also a sign of collegiality between the ranks of medicine, which can be rare in a profession traditionally obsessed with hierarchy.[5]

In the scenario above, upon being introduced as "Dr.", the clerk attempts to clarify the introduction by describing herself as a "student-doctor". Doing so elicits a blank stare of confusion from the patient. In the scenario, it was not the initial introduction which caused the patient to become perplexed, but the commission of introducing oneself with two seemingly conflicting terms, "student" and "doctor". Although combining these titles may seem like a concise way of explaining one's role, it is actually a form of short-hand that is too often used (in this author's experience) and unnecessary, and may actually lead to confusion. Instead of describing oneself as a "student-doctor", the clerk should introduce herself as a "student-who-is-currently-training-to-be-a-doctor". If one mumbles one half of the term, be it "student" or "doctor", or only selective listening occurs, the patient may be left with a false sense of apprehension or, alternatively, of security. Instead, uttering the full explanation helps to avoid the generation of inappropriate expectations by the patient.

Some would argue that this debate is actually frivolous. In getting muddled up in semantics, the true focus, being the optimization of the patient's health, is lost amidst unnecessary technicalities. It is rather easy to argue that when patients visit a designated teaching hospital within a publicly funded healthcare system they should be aware of and prepared for

various student-learners to be participating in their care, and to not object to this extra attention. Given that these learners are training to become doctors, they should be treated as such, including using appropriate titles. Furthermore, even without titles, there are other observable signs of rank within the clinical setting. Clues consist of the length of the coat worn by the healthcare professional, a tradition currently observed by many schools to delineate clinical clerk from physician (short/hip length versus long/knee length, respectively), or the individual's badge, which often has a title and specific colour code corresponding to level of training.

The reality, though, is that patients, even within large teaching hospitals, do not always understand who is taking care of them. Even if signs like length of coat and colour-coded badges are readily visible and may have certain significance within the hospital community, the truth is that many of these signs will have almost no meaning to the average visitor to a hospital, and even less to a patient who is ill, anxious, or semi-conscious.

THE BOTTOM LINE

A cavalier approach to the proper identification of apprentice students – whether by residents, staff physicians, or students themselves - has major implications on clinical, legal, and professional grounds. Clinically, there are certain skills and expertise that a clinical clerk lacks. To place the clerk, and his patient, in a situation that demands the clerk perform unsupervised manoeuvres under the auspices of a physician is dangerous and unfair to both parties. The clerk does not have the same legal responsibility or powers as a licensed physician. She cannot order medications, or diagnostic tests, or admit and discharge patients without the consent and co-signature of the doctor. In this sense, it is inaccurate to identify the medical student as a "doctor", as the two cannot operate to the same capacity. It is also evident that the physician is highly esteemed within greater society. This respect is based partially on the fact that physicians and patients share a common goal: health and well-being of the patient. Accordingly, it is fitting that physicians operate in a professional manner that upholds this goal and the patient-physician therapeutic alliance.

It is not common practice to introduce one's fiancé as one's "wife" or "husband". Although the marriage is pending, it has not actually occurred, and no marriage license has been issued. In parallel, it is misleading to refer to a clinical clerk as a doctor, given that completion of undergraduate medical studies and receipt of a medical degree are also pending. Just as an airline passenger would feel deceived upon reaching an overseas destination, only to discover that the aircraft has been operated by a student-pilot, a patient would most likely prefer full disclosure as to the rank of his caretaker up-front. In either case, the client will naturally wonder whether he was put through unnecessary danger, or question the justice of having not had the right of revelation in the first place. The most honourable approach is for healthcare team members to clearly stipulate their duties and capacities, even if it takes extra time, or elicits questions and even concerns. Ideally, these disclaimers should occur within the introductory conversation. In this regard, the objective remains not only to provide quality care for the patient, but also to educate the clinical clerk to be a competent clinician, and an ethically sound professional.

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