"Who Am I?"

Ward Ethics: "What Do I Do Now?" is a section created in response to our growing awareness that despite the ever-expanding bioethics literature and curricula, medical trainees are not being adequately prepared for the daily struggles they face in becoming physicians. Scenarios presented here are part of an ongoing project of interviewing medical students and doctors in training from around the world as to the specific dilemmas they face in trying to balance learning medicine, performing procedures, and interacting with patients and colleagues. In this section, trainees pose, in their own voices, the questions they find most troublesome, but which are all too often surrounded in silence. Interdisciplinary commentary follows from noted bioethicists.

Students are invited to submit their own dilemmas for possible presentation and discussion. In all cases, scenarios are presented anonymously to prevent identification of individuals and institutions involved. Send manuscripts to Thomasine Kushner, 104 Bulkley Ave., #4, Sausalito, CA 94965. Some of the real-life dilemmas appeared initially in *Ward Ethics* (Cambridge University Press, 2001).

As medical students we were not discouraged from introducing ourselves by saying, "Hello, I'm Dr. So-and-so," as opposed to identifying ourselves as students. If we happened to be doing rounds with an intern or resident, the physician would introduce himself or herself as "Dr. X and over here is Dr. Y"—indicating a student. When I introduced myself as a medical student, I got the feeling that people thought it was silly or unnecessary.

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Commentary

Griffin Trotter

The question "Who am I?" would fit rather comfortably in a primer for adolescents. We might also expect to hear it issuing from the bluish lips of an inebriated, chain-smoking existentialist. But here the question seems a little oblique to practical medical ethics. Shouldn't we stick to the basics and

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concentrate on articulating medical values that enjoy consensus support?

I believe, to the contrary, that questions of personal identity constitute a central moral problem for students of medicine. Training to be a doctor is a process of self-transformation where success is measured largely by the ability to reengineer one's personhood in a manner that integrates values and norms of a new, physician identity. By invoking the concept of an identity crisis, and exploring its moral and psychological dimensions, we can shed light on a number of ethical dilemmas that confront medical students. From the standpoint of descriptive ethics, the identity crisis may be an appropriate model for understanding the genesis of these dilemmas. From the normative standpoint, insights about the resolution of identity crises (coupled with the assumption that a functional, integrated sense of personal identity is morally desirable) can provide guidance for the cultivation of clinical virtues and for critical appraisal of the moral tradition in medicine.

The identity crisis, often misunderstood as solely a problem of adolescence or middle age, is a ubiquitous aspect of human experience, occurring at any age. Roy Baumeister and his associates have distinguished two varieties of such crises.[1] The first—identity deficit crisis—occurs when personal identity is not sufficiently developed to meet current demands. Identity conflict crisis, the second form, occurs when various components of personal identity generate conflicting demands.

The circumstances of medical training provide a perfect medium for identity deficit crisis. In the effort to become doctors, medical students strive to establish a radically new and thoroughgoing component of personal identity. In early clinical years, they are often asked and expected to do the things that doctors do, as if they were, in fact, already doctors. They approach patients in white coats, asking serious questions and examining exposed flesh. They are frequently expected—by patients, nurses, fellow students, and attending physicians alike—to generate sophisticated diagnoses and treatment plans, and to impart medical wisdom seamlessly to patients. Of course, if they were up to these tasks, there would be no need for medical training. Hence, there is fertile ground for an identity deficit crisis. Medical students never know enough, never exhibit enough skill, and never harbor enough experience in the ways of clinical medicine to meet the demands of full-service doctoring. This failure to measure up is acutely painful and, at times, debilitating. However, it is also a stimulus to moral and personal growth.

Several maladaptive ways of coping with identity deficit are illustrated in this case. It may be reassuring or even exhilarating for medical students to be introduced, or introduce themselves, as "Doctor." However, these practices strongly countervail one of medicine's core values—honesty. As such, they fail not merely because they are objectionable but also because they do not succeed in ameliorating the identity crisis. Calling oneself "Doctor" isn't a very effective way of alleviating anxiety about insufficient knowledge or skill. A more likely result is a magnification of feelings of inadequacy and guilt. Not only is the student who calls herself "Doctor" not a real doctor, but now she is also a liar. Trust is the cornerstone of patient-physician relationships, and honesty is the medium of trust. Any attempt to establish one's professional identity by sacrificing these values will be counterproductive, heaping an identity conflict on the already inevitable identity deficit.

Faculty members and residents may be culpable for creating ethical dilemmas of this nature. In our case, faculty members apparently engage in a habit of introducing students as doctors. If students later explain to patients that they are actually students, then the faculty members' deceptions are exposed and confidence undermined. Students may also be vulnerable to the wrath of attending physicians. On the other hand, if students acquiesce to the charade, they are cooperating with dishonesty and undermining one of medicine's pivotal values.

Regrettably, the practice of introducing medical students as doctors or pretending that they are doctors is common. This practice is based ostensibly on concern for the well-being and comfort of patients. The reasoning seems to be that if patients believe real doctors rather than students are attending them, they will remain sanguine. The patient, thus deceived, will be more likely to trust the student and will not suffer uncomfortable doubts about the quality of medical care. Hence, the strategy is based on the paradoxical notion that we should cultivate trust through deception. As such, it is a classic instance of beneficence twisted into paternalism.

The assumption that patients will be unable to handle the generally benign presence of medical students is ungrounded. Certainly, some patients will have misgivings about students in certain situations. Often, these misgivings can be corrected with frank discussion. I frequently tell patients that having a medical student involved in their care is a distinct advantage. Since the caseload for medical students is much smaller than for residents and attending physicians, the patient gets more attention from the student than would normally be available from attending physicians. Often a diligent student will uncover crucial historical information or pursue fruitful lines of inquiry just because he or she has the additional time that is required for these efforts. Meanwhile, double doses of attention are garnered from the attending physician, who must assess the patient herself while also addressing the medical student's assessment. The vast majority of patients will acknowledge this benefit.

And what if patients staunchly refuse to be examined by students? No doubt, this situation will arise. But it is uncommon. After explaining the possible disadvantages that patients will suffer under such an arrangement, it is probably best in these cases to excuse the medical students. Of course, there is an ethical issue about whether patients have a right to expect competent medical care when they will not cooperate in establishing the necessary conditions for such a right (namely, the education of physicians). However, this issue is not a central concern, given that most patients are very willing to be seen by medical students.

Perhaps the practice of deceiving patients about the status of medical students is ultimately motivated by a desire to avoid discomfort to physicians and students than it is for the benefit of patients. If so, the practice is clearly unjustified. As the testimony of the medical student in our case illustrates, this deception is (and should be) a source of moral anxiety for students. Further, even if students and faculty feel better in the long run when they execute such deceptions, the moral imperative in medicine is primarily to benefit patients. The duty of beneficence, in turn, requires honesty and the cultivation of trust. If a certain amount of embarrassment or other personal discomfort is required to preserve integrity, then so be it.

Cases where students are asked to misrepresent themselves as physicians are straightforward. Lying and dishon-

esty are rarely if ever justified. Not only do such practices undermine legitimate trust, but they are considered by some moral philosophers to be inherently immoral even apart from the bad consequences. They fall awry of moral standards by failing to respect the dignity of patients as relatively autonomous moral agents who deserve and need to know the truth about their medical care. Students should refrain from calling themselves "Doctor," and they should refuse to participate in such deceptions. If a student is introduced as "Dr. Y," he should generally respond at the earliest practical moment with something like, "Actually, I am a medical student here at Hometown University."

Once again, however, there is an element of moral nuance. It is possible in unusual circumstances that a student would produce severely negative repercussions for herself or for the care of her patient by exposing such a deception. More often, however, acquiescence betrays lack of courage or resolve. No doubt, medical educators and supervisors are more culpable for such evils than medical students, but students also bear responsibility when they cooperate. One of the oldest and most important moral insights is the notion that every decision, no matter how small, is an act of self-construction. If we repeatedly cooperate with seemingly trivial deceptions, we eventually become habituated to deception. We become dishonest people and, in this case, untrustworthy physicians.

Medical students are faced with the daunting task of establishing a strong sense of personal identity and professional integrity in an environment that challenges them from every angle. This challenge may become almost unbearable when role models on whom students depend ask them to participate in practices that undermine core professional values. In the long run, students will be able to overcome such obstacles only if they develop a vivid image of the ideal physician they hope to become. Three strategies may help.

First, establish one or more attending physicians as special mentors or exemplars of professional virtue. When other supervisors exhibit morally culpable behavior, these bad examples can be countered with mental images of how the chosen mentor would behave differently under similar circumstances. Students may then attempt to be true to this higher standard. Second, identify medicine's core values—the values that every great physician supports. Think seriously about these values and periodically reflect on how they are (or aren't) manifested in clinical practices. Interestingly, even medical rebels like Hawkeye Pierce (from the film *MASH*) and George Clooney's character in "ER" exhibit fidelity to core values, such as compassion and honesty, and they are honored just insofar as they are loyal to these values. Third, create a personal strategy for cultivating core values. Each medical student should be honest about his or her strengths and weaknesses. The chosen specialty should be a means of accentuating strengths and of developing a personally inspired and unique way of serving. But there should also be an effort to target important personal weaknesses for improvement. For instance, students who lack empathy should go to special lengths to cultivate this capacity, attempting to be even more empathetic than ordinary virtue would require.

Notes

1. Baumeister, RF, Shapiro JP, Tice DM. Two kinds of identity crisis. *Journal of Personality* 1985;53:407–24.

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Commentary

Kate T. Christensen

What do we call ourselves, when we are not yet doctors but are caring for patients? Will patients think less of us if we introduce ourselves as students or residents; will they feel less confident in our care and less likely to follow our recommendations? Every medical student and resident faces this issue at some point in their training. I faced it in my first month as a medical student. One of my fellow students passed out his new business cards, which said "Doctor John —," and urged us to call each other doctor, for practice. This bit of deception, even if it was only self-deception, disturbed many of us, and we persuaded him to stop.

The temptation to deceive arose again when we started our hospital duties with patients in our third year of medical school. We were still students, with no M.D. after our names, but the real physicians supervising us introduced us to patients as "doctors." Were we to object to this, risking embarrassment for our attending physicians and possible reprimand for ourselves? And anyway, after so many years of thankless toil to get where we were, wasn't it about time we were given a little respect, even if it was a bit premature? The truth was, most of us secretly liked it. It gave us a taste of the respect and power we knew would soon be rightfully ours.

Are there any legitimate reasons for this deception? Most patients do feel more comfortable and comforted in the hands of a doctor than those of a student, and they might be more apt to comply with the treatment plan. A more compelling argument is efficiency; when introducing a team of students, residents, and attending physicians on hospital rounds, it becomes quite cumbersome to describe the training status of each. Doing so can also be bewildering for the patients. And in the broader scheme of things, patients are contributing (although often unknowingly) to the greater good by serving as teaching material for future doctors.

There may be another reason for calling students "Doctor" in public hospitals, where most of the patient care is provided by physicians in training. I trained as a medical student in a county hospital and at a Veteran's Administration hospital. The unspoken concern was that if a patient was told their "doctor" wasn't a doctor, they might demand to be cared for by a real doctor, and the system was not set up to provide this. Furthermore, I doubt that most patients realized that 90% of their care was provided by trainees and that, at night, there was no Board-certified doctor in the hospital at all.

What was wrong with this? From our perspective, very little, aside from some qualms about the slight dishonesty involved. The problem becomes obvious when we change places with the patient—now how does this slight dishonesty look? I am being introduced to the physician who has my health in her hands and am informed that she is "Doctor Jones." I have no reason to think she is not. I have every reason to think she has had some experience with my illness, with the medications she is prescribing, with the tests she is ordering. If and when I find out that she is still 2 years away from even having a license to practice medicine, that she has in fact never treated my illness before, I am apt to feel angry, afraid, and betrayed. I have been deceived, and not for my own benefit but for the ego of the "doctor" or for the financial benefit of the hospital.

When looked at from the patient's perspective, we can see that the right to know the training status of those providing our care is part and parcel of the informed consent process. Informed consent is not just a form to be signed. It is the process of giving patients all of the information relevant to their care, all the information they need to say yes or no to a given course of therapy. If a patient is being cared for in a teaching setting by physicians in training, the identities and roles of the members of the care team can be very relevant. Patients should have a right to say no to this arrangement, as well as a right to agree to it.

Is there any benefit to the trainees in divulging to patients their true status as students or physicians in training? When faced with questions about whether or not to be honest with a patient about anything related to his or her care, I first assume that the patient will find out somehow. So then the question becomes: what will be the consequences when the patient finds out the truth, and do the benefits of the deception outweigh those consequences? I believe the negative effects, the sense of betrayal and distrust, that occur when a patient finds out that she has been deceived far outweigh any perceived benefits of the deception. In fact, disclosing one's training status up front can have some positive effects. Most patients appreciate the respect shown by an honest explanation of who is who on the care team. Some are too ill to care and want to believe that everyone in a white coat has expertise to bear on their illness. I believe, however, that most do not want to be treated in a patronizing manner and would like to know the qualifications of those caring for them.

Divulging one's training status can have a direct beneficial effect for the student or resident as well. It can be very uncomfortable pretending to be something one is not. Once the patient knows what our training status is, their expectations are likely to be more in line with what we are in fact able to do. We will then feel more comfortable admitting when we do not know the answer or cannot perform a procedure and need to ask for help.

In the United States, the organization that accredits hospitals has now mandated honesty. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) standard for informed consent contains the following:

> In addition to an explanation to the patient of potential drawbacks, problems, and likelihood of success, possible results of non-treatment and any significant alternatives, staff members also inform the patient of the name of the physician or other practitioner who has primary responsibility for authorizing and performing procedures or treatments; any professional relationship to another health care provider or institution that might suggest a conflict of interest; their relationship to educational institutions involved in the patient's care; any business relationships between the individuals treating the patient, or between the organization and any other health care service, or educational institution involved in the patient's care. This information should either be documented in the progress notes or on a consent form. (Standard RI.1.2.1)

Although some may find this mandate intrusive, I think it helps to overcome the resistance to change established by many decades of tradition. It will force us to be honest and to learn how to deal with any negative consequences that arise out of that honesty. An honest introduction of care providers will eventually become a seamless part of the informed consent process, as it should be.