

Secrets and lies

Are you always truthful about your knowledge, abilities and actions, ask **Daniel Sokol** and **Deborah Bowman**

Medical students often share particular characteristics, such as perfectionism, determination, and conscientiousness. Such qualities are useful for those undergoing a demanding training, but they can also become problematic. Perfectionism may lead to “imposter syndrome,”¹ in which you constantly feel inferior and anticipate being “found out,” or even cheating. Determination may elide into competitiveness and conscientiousness tip over into obsession. There is great pressure on medical students to achieve, and there are moral implications that may come out of stress provoking behaviour. Consider the experience of Mark and Sheetal.

Mark and Sheetal have been working as a pair on a clinical attachment. Both students were asked by the consultant to take a history and to conduct a full examination of Mr Holmes, a patient in the ward. Sheetal took a history and undertook an examination. However, Mark, who was busy doing last minute revision for an impending exam, took only a cursory history and did not examine Mr Holmes. When asked for the results of the examination by the consultant, Mark makes up incorrect but realistic sounding results, which the consultant records in the patient notes. What should Sheetal say or do?

Strong bonds

Medical school encourages strong bonds between students. Friends who understand the rigours of the course and share the burden of a heavy workload and frequent examinations are valuable sources of support.² However, loyalty to one's peers can present moral difficulties. Sheetal has witnessed Mark being dishonest. Irrespective of the perceived stress or panic that may have motivated his response, Mark has been deliberately untruthful. To use the language of ethics, Mark has not acted as a “virtuous” medical student.

There may be serious consequences arising from his dishonesty. The “findings” have been recorded in the notes, which is a legal record of care. The clinical team may rely on the notes and use them to inform Mr. Holmes's management. Even where a consultant doesn't depend on a

medical student's examination, there may be delay and discomfort for the patient if the team thinks that he has already been thoroughly clerked and examined. Mark's deceit goes to the heart of medical work: it compromises trust. Clinical teams depend on trust if work is to be safely shared. Patients assume that they can trust those whom they meet, including medical students, to provide care of an acceptable professional standard. Mark has shown himself neither to be a reliable team member nor to give the basic care owed to patients. He quite simply put his own interests before those of the patient: his desire to perform well in an examina-

tion relegated the patient's wellbeing to a poor second on his priority list.

There may also be implications for Mark himself. Dishonesty is a red flag in medicine and “covering up” can quickly become a default defence. Mark will encounter more exams and far more stress in his career, and he needs to learn how to function without compromising patient care when under academic pressure.

Disapproving culture

Sheetal knows that Mark has been dishonest and has her own choice to make. Sheetal is in an important position: that of influencing Mark's future conduct when

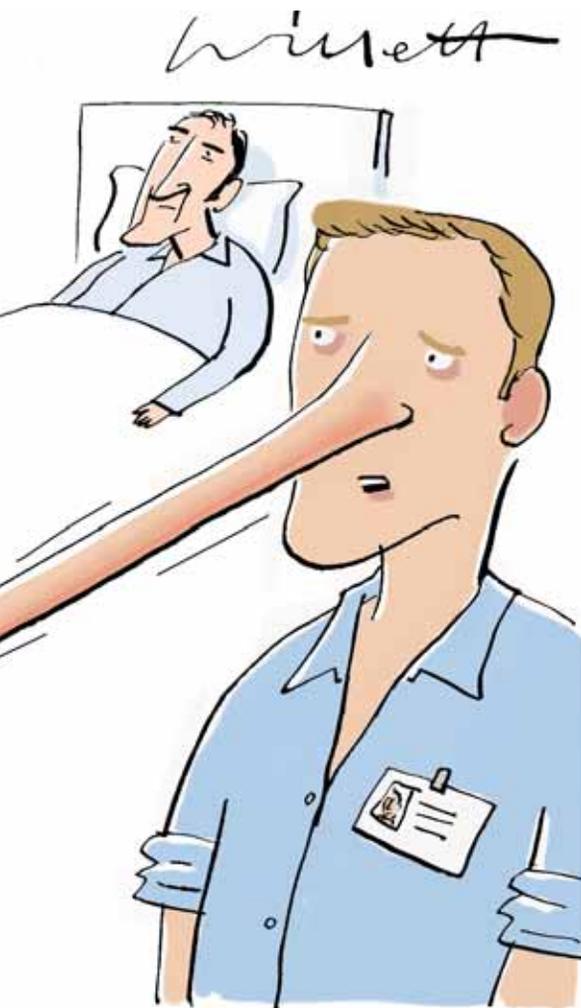


he is under pressure.³ If Mark is unchallenged, dysfunctional responses to stressful situations in medical training are likely to continue, and lying may become a habit. The influences on Sheetal are likely to be considerable: medical school culture is disapproving of students who tell on their colleagues,⁴ which, taken with her likely feelings of loyalty to, and empathy for, Mark, will make it difficult to address the situation. Yet tackle it Sheetal must. If she were to say nothing, her omission would itself be unethical. There are situations when we are under a moral obligation to speak out. To say nothing is to collude with deception and its concomitant effects on patient care, professional integrity, and therapeutic trust.

Sheetal must talk to Mark quickly and in private. She can and should acknowledge that the anxiety and stress of medical training can lead anyone to make choices that are out of character. She should tell Mark that although she understands his worries about the impending examination, she is unhappy about his behaviour, explaining the possible consequences of the lie for the patient, the rest of the team, and his own future career. The pair may discuss ways in which Mark can correct his error with the minimal fuss and strategies for managing times when they are balancing clinical learning with examinations.

Difficult exchange

Even if Sheetal is empathic and kind when talking to Mark, the exchange may be



difficult and will probably feel uncomfortable. Unfortunately, doing the right thing will often be harder than saying nothing. Sheetal should remain clear that she expects Mark to correct the misleading information that he proffered earlier by ensuring a note is added to the medical record. If Mark does not act to rectify the situation after the conversation, Sheetal should tell Mark that she intends to confide her concerns to a trusted member of the clinical team and give Mark an explicit timescale in which to correct his misleading results and the subsequent entry in the notes. Finally, if Mark still does not amend the record, Sheetal must talk to a member of the team, being careful to share only what she knows to be factually accurate.

Finally, there is an ethical obligation on medical schools to consider the ways in which systems can contribute to and exacerbate student stress and distress.⁵ Some commentators have argued that the admissions process should assess the ability of prospective medical students to cope with stress through formal personality screening.⁶ One method uses the Hogan development survey, a validated instrument that is often described as assessing 'the dark side' of human behaviour in 11 predetermined domains. One high profile medical school in the United States reported that moving to pass-fail grading as opposed to grading that distinguished between competence and excellence (using merits, distinctions, and prizes) reduces anxiety and fosters cooperation.⁷ In examinations the move from norm referencing (which limits the proportion of candidates who can achieve a particular grade) to criterion referencing (in which students achieve a grade based entirely on their performance against the assessment criteria) is to be welcomed.

The hidden curriculum

There is also a hidden curriculum that may contradict and undermine the formal curriculum and send mixed messages to students.⁸ The hidden curriculum involves messages that the medical school sends to students. This can be done in various ways, such as through the use of role models, rewarding certain behaviour, and language. These messages have long been suggested as being more influential than formal teaching. Students may be simultaneously encouraged to admit uncertainty while being humiliated when they do not know something or are perceived to "fail" in the wards.⁹ There may be flashpoints when students' attitudes towards conduct they would previously have judged to be dishonest become less clear cut.¹⁰⁻¹² Sheetal and Mark are part of a system that is sometimes contradictory in its expectations. In this case the contradiction is that the students are expected to pass written exams but attend all clinical opportunities. Students may also be expected to answer exam questions without resources to hand while being taught not to make a decision if uncertain without looking things up or to have a go at a difficult question but to admit uncertainty. These situations are often confusing and always demanding. Those who deliver and influence medical



education also have a responsibility to facilitate ethical conduct.

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