

# What should you do when you see a fellow student behaving inappropriately?

After a group of students wrote to the *BMJ* about their experience during an elective, we sought the opinions of a dean, an ethicist, a GMC representative, and a lecturer from an African university



## Case history

Medical students are in a position of privilege and trust in their everyday interactions with patients. The General Medical Council (GMC) guidance states that students must protect patients from harm posed by another colleague's poor behaviour, performance, or health and raise any concerns with an appropriate person.<sup>1</sup> However, there is no obvious channel for raising concerns, particularly when problems are encountered away from your university. We describe our experiences, which highlight the issues encountered when students abuse their position.

### Unethical behaviour

We spent an elective placement in a busy hospital in a developing country. Our supervisor was a Western doctor who went on annual leave for the last three weeks of our placement. One day before the supervisor's departure a new student arrived from the United Kingdom. He was shown around and had the opportunity to observe in theatre before our supervisor left. We later discussed with him our experiences since arrival and mentioned that we had been offered opportunities to perform procedures for which we lacked competence and training, such as inserting chest drains and hernia operations, which we had firmly declined. He replied that he couldn't "wait to get into theatre and have a go," a comment we assumed to be in jest. Over the following week we became increasingly concerned by his attitude after several incidents, including altering a prescription written by a local doctor to an alternative antimicrobial drug despite being unaware of local sensitivities, photographing patients having invasive and intimate procedures without consent, and performing an unnecessary lumbar puncture because he "fancied having a go."

The local healthcare professionals sometimes perceived white skin to be synonymous with expertise, placing unprecedented levels of trust in us and allowing us to make decisions and perform procedures that would be unacceptable in the United Kingdom. Although we relished the thought of learning advanced new procedures, we thought this would be unethical. The new student considered it an opportunity to gain valuable experience where "it doesn't matter if we mess up—no-one would know." He recounted how, on placements in the UK, he introduced himself as a doctor rather than student because "patients won't let you do anything otherwise."

We unsuccessfully attempted to discuss our concerns with him before approaching a more senior doctor, who also had concerns and agreed to contact our supervisor. However, the student left for the weekend and did not return, his assessment form having been completed on his first day because of the supervisor's imminent departure. We were informed that our supervisor thought that because the student had left the hospital the issue was resolved.

### Where next?

We were uncomfortable with the lack of resolution and concerned that, were the student to be involved in further incidents, our failure to report our concerns could leave us accountable. However, we were unsure of the appropriate course of action. We were concerned that contacting his medical school without the support of our supervisor or evidence other than our observation might be considered unprofessional. In fact, and unbeknown to us at the time, our supervisor did later contact the student's medical school. However, before we knew this, we had sought advice from senior doctors, and it seemed to us that there was no consensus on the appropriate course of action for undergraduates causing concerns.

Names and addresses withheld.

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1 General Medical Council. *Medical students: professional behaviour and fitness to practise*. 2007. [www.gmc-uk.org/education/undergraduate/undergraduate\\_policy/professional\\_behaviour.asp](http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/professional_behaviour.asp).

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## Role of universities



The behaviour of the student described in this report is clearly unacceptable and worrying.

If this was one of our

students I would want to know and I would take urgent steps to understand exactly what had been happening and then either provide help through student support mechanisms or, if necessary, invoke fitness to practise procedures. Equally, had the students faced with this difficulty been from our school, I hope that we would have mechanisms in place that would allow them to report their concerns and, just as importantly, that they understood what their professional responsibilities were in situations like this.

Dealing with poor or unsafe performance in colleagues is an uncomfortable process. The situation described by these students could have equally taken place in UK medical practice, although the distant setting and the fact that there was no one immediately obvious to whom they could report their concerns no doubt highlighted the anxiety.

Although overseas electives are a popular part of the curriculum and a great opportunity to see a completely different healthcare environment, they pose headaches for medical schools. These include concerns for the health and welfare of the students, but schools also want to ensure

that there is proper educational supervision, something that clearly was not quite right here. Key to this is detailed preparation by both the school and the student. At Brighton—and I'm sure it's the same elsewhere—a senior member of the faculty is responsible for the electives programme and can be contacted by email or telephone by any student while they are away for any problems that cannot be sorted out locally. Ideally this would have been the route that the students in this case could have followed.

### Professional behaviour

The students were concerned that it might be unprofessional to contact the other medical school directly. They thought that they should have gone through a senior colleague or have had “objective evidence” of their concerns. As a dean I would hope that students would feel able to report these concerns and that I had in place the mechanisms that would allow them to feel safe to do so. There is no single right answer to this, and indeed, I think it is important that a range of options are provided. Like most schools, we have academic and clinical tutors, student support advisers, and senior colleagues with overall responsibility for student welfare. Students differ in whom they feel most comfortable speaking to, and we need to be sure that they know that they will be listened to carefully and respectfully.

The issue of what it means to be a professional and how that applies to medicine is topical. The Tooke report<sup>1</sup>

acting improperly. The authors cite guidance from the General Medical Council which describes behaviour expected from medical students.<sup>1</sup> They might also have noted that, under domestic law, the student committed assault(s). But what of the location—should we acknowledge that norms differ in societies? Ethicists do indeed argue about cultural relativism, but here it is a red herring. To claim that ethical practice in Africa differs is to overlook fundamental moral precepts. The behaviour showed apparent disregard for human dignity, trust, and vulnerability. The student prioritised his interests over those of the patients. He was not learning with, or from, patients but on them and by misrepresentation. The authors suggest that patients may defer to a white person,

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drew attention to this, and the Royal College of Physicians together with the King's Fund have recently published their report “*Understanding Doctors: Harnessing Professionalism*.”<sup>2</sup>

Medical students are not qualified doctors, but one of the most important things medical schools can do is to begin to instil the principles of what being a professional means. Perhaps unintentionally, this has slipped off the educational radar in recent years, and it is reassuring to know that it is re-emerging as an important theme in the forthcoming revision of *Tomorrow's Doctors*.<sup>3</sup> Ethical problems such as the one faced by these students provide a clear illustration of why we need to think about this more actively.

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- 3 General Medical Council. *Review of tomorrow's doctors*. [www.gmc-uk.org/news/articles/Review%20of%20Tomorrow.pdf](http://www.gmc-uk.org/news/articles/Review%20of%20Tomorrow.pdf).

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potentially rendering the therapeutic relationship even more unbalanced. Default trust and socially determined deference demand that the ethical student responds with humility and honesty. Taking advantage of the vulnerable and dependent is wrong, and remains so even if this student were technically brilliant at chest drains, lumbar punctures, and hernia operations.

### Moral challenges

The authors' predicament elucidates the unique moral challenges for medical students. Medicine has always differed from other degrees. Clinical experience, with variable supervision, is a privilege and with privilege comes responsibility. Recently, the focus on student conduct has been considerable. Janet Smith identified the undergraduate years as a formative period where professional norms are learnt, role models (positive and negative) observed, and choices made.<sup>2</sup> The GMC has defined how

## Ethical perspective



This account captures well the contrast between defining standards of behaviour and navigating effective implementation

of those standards. Four issues arise. Firstly, even when standards are defined, application of those standards is a moral enterprise that can be confusing and frustrating. Secondly, cultural relativism may be seductive when working overseas. Thirdly, students have to discharge significant responsibilities in a system where power imbalance and complex role delineation prevail. Finally, the question of who owns a problem is a bar to effective resolution.

Were the authors correct to identify this student's behaviour as unacceptable? Yes. Although matters of ethical behaviour are redolent with uncertainty, the student was

students should behave and the implications for fitness to practise. Undoubtedly, the authors were correct to conclude that they had to prioritise the interests of patients. Yet, the account also reflects the challenges for students who are aware of their responsibility to “do something” but ultimately can depend only on their seniors.

The authors seem to have done everything right. They did not jump to conclusions but identified specific behaviours. They tried to discuss their concerns with the individual himself. They sought advice and involved seniors. It seems that the authors were let down by the systemic response to their demonstration of integrity. Once concerns had been expressed the authors were entitled to rely on a thorough and accountable investigation. Although the supervisor did later report the medical student to his

medical school, the authors did not know that until much later. Opportunities were lost. This situation offered an opportunity for senior staff and medical schools to model a thorough, fair, and accountable response to questionable behaviour. I hope that the student who was apparently breaching professional guidance and the law was given the opportunity to learn, change, and to develop into a doctor who will thrive rather than become another “problem doctor” statistic a few years hence.

Most medical schools have included ethics in their core curriculum for over a decade,<sup>3,4</sup> but this rarely engages with student experience. The apparently simple issues of introductions, conflicts that arise from an eagerness to learn and impress while having regard for patients, and the difficulties of responsibility but limited

power in a hierarchical environment are matters that challenge students daily yet are at best implicit, and at worst absent, from many curriculums. This account shows how medical students grapple with moral choices and dilemmas throughout their training. Students must be able to rely on staff to support them.

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## The GMC's view



These authors have shown a good understanding of the ethical professional behaviour expected of both medical students and doctors. It takes great personal resolve to confront a colleague whose behaviour is cavalier and who deliberately puts patients at risk. These students tackled the situation maturely and are right to seek ways to communicate their concerns.

### Concerned students

Students and doctors have a professional duty to work within the limits of their professional competence, to know when the best interests of the patient require them to step back, and to ask for help. Many fitness to practise cases heard by the GMC result from doctors who fail to show such insight.

The students rightly identified it as their duty to raise concerns about a colleague when patients are at risk. The GMC expects students and doctors to inform the appropriate person locally of any concerns they have about a colleague's conduct, performance, or health when this is putting patients at risk of harm.<sup>1</sup> These students properly escalated their concerns to the senior doctor who was supervising them. Still concerned, they sought further advice. If they think that their concerns for patient safety are being ignored, they should discuss the situation with their medical school dean, who should contact the other medical school. If they are still uncomfortable, the students

may consider it necessary to contact the other medical school directly.

To provide documentary evidence, the students should have recorded their concerns, the student's attitude, inappropriate actions, and procedures that they witnessed. I appreciate that they were abroad and it is easy to be wise after the event, but this is a learning point. A written record of all conversations with the student, the local doctor who was their supervisor, and the medical school dean and any written complaints are valuable in establishing what occurred. Ultimately, it is the responsibility of the unprofessional student's medical school to investigate the accusations about its student and determine if there is a case to answer.

### Unprofessional student

The GMC emphasises that medical students “have certain privileges and responsibilities different from those of other students. Because of this, different standards of behaviour are expected of them.”<sup>2</sup> Clearly, the student described has little respect for patients, colleagues, and the locality where he was working. His desire to further his skills at patients' expense contravenes the first duty of a doctor in *Good Medical Practice* to make the care of your patients your first concern.<sup>1</sup>

The GMC does not register students and has no jurisdiction over them, but it does have a duty to consider the fitness to practise of all applicants at the point of registration. Even if a medical school decides to graduate a student,

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it does not guarantee provisional registration. Students must complete a declaration to confirm that they are fit to practise.

### Local supervisor and medical schools

The authors' position was made harder by inadequate supervision during this student's placement. Medical schools are responsible for ensuring that their students are supervised appropriately, whether in the UK or abroad. The errant student's supervisor also acted inappropriately in completing his assessment before the end of the placement. Reports from clinical supervisors inform the medical school's decisions, allowing the dean to confirm at graduation that a student is fit to practise as a doctor.<sup>3</sup> Finally, medical schools have a responsibility to ensure there are systems in place to support students. During the GMC's current consultation on fitness to practise of medical students and its review of *Tomorrow's Doctors* 2008 we have received feedback that medical students are concerned there are few channels for raising concerns about students, supervisors, or lecturers and worry that taking action may open them up to victimisation. The GMC aims to work with medical schools to strengthen these mechanisms.

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## What should students' hosts do?

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It is increasingly important for future healthcare professionals to understand and experience health in a global context.<sup>1,2</sup> Many

medical schools and colleges in the developed nations have an international elective as part of their training. Increasing numbers of students opt to spend this time in resource limited countries in sub-Saharan Africa, Asia, and South America.

Students' experiences from such electives are mostly positive<sup>3,4</sup>: hands on experience is usually unprecedented; the range of illness is different; more advanced disease states are encountered. The resources available are mostly basic or absent, making it more interesting and challenging for students.

The doctors or supervisors under whom the students work are often overwhelmed by clinical and administration work and are not available to monitor every move of the students. Indeed, the presence of students is often a welcome relief for supervisors, though this is countered by the need to demonstrate, explain, and supervise. This also depends on the competencies of the students. Sustainable, round the clock supervision is a challenge. So how can a site that receives students on electives prevent the sort of behaviour described—and what should they do if it happens?

### Groundwork

For high quality international experience, systematic preparation, including

identification of suitable sites and clear objectives is essential.<sup>5</sup> Some sites have developed guidelines on how to handle international elective students. Sites that receive students infrequently may not have such guidelines. Sending institutions should therefore consider selecting sites with experience in handling international electives.

Most students arrive with introductory letters that state the purpose and objectives of the placements. Some of these are explicit, but others are not and may not state the competencies of the students. It is important to have briefing sessions when students arrive to discuss expectations and debriefing sessions at the end. The level of responsibility of clinical decision making and care should be defined at the outset. Students should get permission from the site supervisor to diagnose, prescribe, and perform procedures—and if necessary these should be supervised. If the level of responsibility is exceeded, fellow students should have the mandate to communicate this to the supervisor. Some sites hold regular feedback sessions with students, and this helps provide the confidence, support, and guidance students may need.

Most patients cannot tell the difference between qualified doctors and students. Nametags may help, but only if the patient can read. A verbal introduction through an interpreter is most practical. The ethical standards of seeking consent in its most practical form should be upheld by all elective students wherever they may be. Whenever possible, students should be in pairs (as the least number at a site). Warnings about violation of ethical norms should be defined in the briefing session. Any violations should be handled as soon as they happen.

**Students are helpful when they go to work in poor areas, but both the sending institutions and the host sites need to make clear the ethical rules under which they should behave**

### Ethical oversight

In the case described the authors owed it to the patients to ensure that the unethical behaviour is satisfactorily handled—and they tried to make this happen. The issue should ideally have been handled by an ethics committee at the host site—even an ad hoc one if one did not already exist. As well as taking any immediate action to protect patients and educate the student, the host site should also report back to the sending institution.

Students are helpful when they go to work in poor areas, but both the sending institutions and the host sites need to make clear the ethical rules under which they should behave. And hosting sites should have procedures for handling unethical behaviour.

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## BMJ/MSF Christmas appeal

Last year the *BMJ* launched its first Christmas appeal and is calling on readers to support our chosen charity, Médecins Sans Frontières. MSF seemed the obvious choice for our first Christmas appeal. We hear—and indeed report—ever more tragic stories of people around the world caught up in conflict and political unrest, including Zimbabwe and the Democratic Republic of the Congo (right). It's important to know that MSF is there, delivering medical care and expertise to people in direst need in some of the toughest places on earth. MSF's staff and volunteers deal daily with extraordinary personal risks and practical clinical challenges. I hope readers will feel inspired to support this unique charity in whatever way they can.

**Fiona Godlee, editor, *BMJ***

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