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Article abstract

Background: The education of medical students necessitates teaching not only the science of medicine but also the skills needed for ethical reflection and moral reasoning as well as professionalism. At the Université de Montréal, starting in 2004, third-year medical students were initiated to ethics and professionalism during a weekly seminar on clinical skills during their surgery rotation. Students had to recognize an ethical dilemma or a professionalism issue that occurred during the rotation and write a case narrative and reflection on the moral issue. **Method:** Student narratives describing ethical or professionalism incidents were collected between 2004 and 2020. These were analyzed to identify the moral challenges that students experienced, and how they reacted to ethical dilemmas or professionalism issues. **Results:** Of the 1145 narratives collected, 396 were coded as an ethical dilemma, subdivided into end-of-life decisions, decision for treatment, dilemmas concerning justice and resource allocation, and student educational dilemmas including relationships with residents. Professional issues were more frequently reported (n=749), subdivided into communication of bad news, professional behaviour and attitude, consent, confidentiality, truthful disclosure of sensitive results, errors, professional responsibility and commitment and relationships with colleagues. In 40% of narratives there was a positive opinion about the issues reported, while in 60% students felt the ethical decision or professional attitude or conduct was less than ideal. **Conclusion:** This seminar was an effective means for medical students to identify and discuss the ethical and professional issues experienced during their clerkship – issues regarding communication were the primary concern followed by professional behaviour. These narratives provide a good picture of the hidden curriculum; and they show that students can reflect meaningfully on issues concerning ethics and professionalism.

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Students Narratives of Ethical Dilemmas and Professionalism Issues During a Rotation in Surgery

Gilles Beauchamp[a], Ramses Wassef[a], Bryn Williams-Jones[b]

Résumé

Contexte : La formation des étudiants en médecine nécessite non seulement l'enseignement des sciences médicales, mais aussi celui des compétences nécessaires à la réflexion éthique et au raisonnement moral, ainsi qu'au professionnalisme. À l'Université de Montréal, depuis 2004, les étudiants en troisième année de médecine sont initiés à l'éthique et au professionnalisme dans le cadre d'un séminaire hebdomadaire sur les compétences cliniques pendant leur stage en chirurgie. Les étudiants doivent reconnaître un dilemme éthique ou un problème de professionnalisme survenu pendant leur stage et rédiger un récit de cas et une réflexion sur la question morale. **Méthode :** Les récits des étudiants décrivant des incidents éthiques ou liés au professionnalisme ont été recueillis entre 2004 et 2020. Ces récits ont été analysés afin d'identifier les défis moraux auxquels les étudiants ont été confrontés et la manière dont ils ont réagi aux dilemmes éthiques ou aux problèmes de professionnalisme. **Résultats :** Sur les 1 145 récits recueillis, 396 ont été codés comme des dilemmes éthiques, subdivisés en décisions de fin de vie, décisions de traitement, dilemmes concernant la justice et l'allocation des ressources, et dilemmes éducatifs des étudiants, y compris les relations avec les résidents. Les problèmes professionnels ont été plus fréquemment signalés (n=749), subdivisés en communication de mauvaises nouvelles, comportement et attitude professionnelle, consentement, confidentialité, divulgation véridique de résultats sensibles, erreurs, responsabilité et engagement professionnels et relations avec les collègues. Dans 40 % des récits, l'opinion sur les problèmes signalés était positive, tandis que, dans 60 % des cas, les étudiants estimaient que la décision éthique ou l'attitude ou la conduite professionnelle n'était pas idéale. **Conclusion :** Ce séminaire a été un moyen efficace pour les étudiants en médecine d'identifier et de discuter des questions éthiques et professionnelles rencontrées au cours de leur stage – les questions relatives à la communication ont été la principale préoccupation, suivies par le comportement professionnel. Ces récits donnent une bonne image du programme caché et montrent que les étudiants sont capables de réfléchir de manière significative à des questions relatives à l'éthique et au professionnalisme.

Mots-clés

narratif, dilemme éthique, professionnalisme, chirurgie, étudiants en troisième année de médecine, stage, pédagogie, curriculum caché

Abstract

Background: The education of medical students necessitates teaching not only the science of medicine but also the skills needed for ethical reflection and moral reasoning as well as professionalism. At the Université de Montréal, starting in 2004, third-year medical students were initiated to ethics and professionalism during a weekly seminar on clinical skills during their surgery rotation. Students had to recognize an ethical dilemma or a professionalism issue that occurred during the rotation and write a case narrative and reflection on the moral issue. **Method:** Student narratives describing ethical or professionalism incidents were collected between 2004 and 2020. These were analyzed to identify the moral challenges that students experienced, and how they reacted to ethical dilemmas or professionalism issues. **Results:** Of the 1145 narratives collected, 396 were coded as an ethical dilemma, subdivided into end-of-life decisions, decision for treatment, dilemmas concerning justice and resource allocation, and student educational dilemmas including relationships with residents. Professional issues were more frequently reported (n=749), subdivided into communication of bad news, professional behaviour and attitude, consent, confidentiality, truthful disclosure of sensitive results, errors, professional responsibility and commitment and relationships with colleagues. In 40% of narratives there was a positive opinion about the issues reported, while in 60% students felt the ethical decision or professional attitude or conduct was less than ideal. **Conclusion:** This seminar was an effective means for medical students to identify and discuss the ethical and professional issues experienced during their clerkship – issues regarding communication were the primary concern followed by professional behaviour. These narratives provide a good picture of the hidden curriculum; and they show that students can reflect meaningfully on issues concerning ethics and professionalism.

Keywords

narrative, ethical dilemma, professionalism, surgery, third-year medical students, clerkship, pedagogy, hidden curriculum

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INTRODUCTION

At the Université de Montréal, like most North American medical schools, the four-year curriculum has been developed to include the teaching of ethics and professionalism. Over the first two years, under the supervision of a clinician, small groups of 10 to 12 students examined and discussed classic cases of ethics, bioethics and professionalism. This is the introduction to ethics and moral reasoning and the beginning of the transmission of a professional idealism. With this background, students reach the clerkships and begin their clinical training. They now must work in the hospital setting, with daily interaction with patients, residents and staff, and this transition is not always easy (1). Some students are anxious about their new role as an

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apprentice doctor, as this brings with it the stress of learning the fundamentals of clinical science while performing procedures on patients. In this context, students are not yet knowledgeable about the moral dilemmas that they will encounter as a medical student and later as a practicing physician.

As medical educators, it is our responsibility to sensitize our students to the challenges of ethics and professionalism issues they will meet during the clerkships. Many medical educators have mentioned the need to listen to medical students to understand the ethical questions or dilemmas that they encounter in the hospital and clinic (2-6). These ethical issues are not theorical abstractions or a simple choice between true or false, right or wrong — they are much more complex (3). Knowing about the difficulties of teaching ethics and professional behaviour in the context of a very busy surgery department, the authors (GB and RW) decided to implement, during the surgery rotation, a seminar on ethics and professionalism with a view to helping students recognize and better reflect on these issues. This paper analyzes the results of 16 years of written narratives provided by third-year medical students during their clerkship in surgery.

METHOD

Teaching ethics and professionalism

During the clerkship in surgery at the Université de Montréal, medical students do two three-week rotations, one in general surgery and a second in a subspecialty such as vascular, urology and thoracic surgery. Students spend their time caring for surgical patients on the ward, in the clinic, and in the operating room. They are exposed to complex cases, participate in the investigation of patients; and they are introduced to the operating room environment and participate in some surgeries. This is their first exposure to the speciality of surgery. While they will have learned about ethical principles and their medical code of ethics during the pre-clerkship, these students also need to learn to identify and analyze the ethical issues that occur every day in surgical practice (2,3).

At the very beginning of their surgery rotation, a group of 8 to 12 students would meet with the facilitator (a clinician-educator) responsible for leading the ethics and professionalism seminar. After a brief review of the fundamentals of ethics, the students were provided with a definition and explanation of what constitutes an ethical dilemma, what is a professionalism issue, and with specific examples related to surgery. Ethical dilemmas were defined as situations in which there is a conflict between two or more moral principles, making it challenging to decide on the right course of action. These situations arise in various aspects of life, including personal decisions, professional conduct, and societal issues (7). Professionalism is at the core of medical practice and forms the basis of medicine’s contract with patients and society. The values of the profession include competence but also compassion, altruism, trustworthiness, protection of confidentiality and privacy as well as responsibility and accountability, to name a few fundamental values (8).

In this seminar, professionalism was incorporated because of its close interdependence with ethics and because professionalism often includes adherence to ethical principles and the use of moral reasoning (9-13). Even if some people find it difficult to articulate or distinguish ethics and professionalism, in our experience students had no difficulty understanding that professionalism included adherence to ethical principles, ethical virtues, and moral reasoning. Health care ethics often invokes values and principles, whereas professionalism tends to encompass but also move beyond principles by invoking moral resources such as attitudes, commitments and motivations traditionally associated with virtue ethics. While the contrasting emphases of principles and virtues are real, they can be understood as complementary aspects of the same ethics.

An ethics or professionalism critical incident was recognized by students as a clinical experience that involved patients or families, hospital personnel, residents, medical students or any educator, and which raised an ethical or professionalism issue with which they personally had difficulty. A critical incident could also be a situation or a difficult issue that they had observed a clinician dealing with in an exemplary fashion. Critical incidents reports are widely used in medical education to promote reflective learning and are based on an event chosen by the student that influences their professional development (14-17). Professional and ethical issues in surgical rotations are particularly relevant for students because they highlight the reality of and challenges that emerge in everyday practice (18-20).

“Narrative medicine” is the term introduced by Dr Rita Charon to describe the application of story to medical education and practice (21). The students in the ethics and professionalism seminar were asked to share a brief story describing a critical incident they experienced during their surgery clerkship. Writing this story as a narrative is significant because it encourages the writer to pursue the meaning of the experience they are describing and reflect on their thoughts or behaviours. Moreover, when others read and respond to the narrative, the discussion process promotes further reflection on the part of the writer. Writing narratives may also increase ethical sensitivity, as the process of writing can help the writer to recognize ethically important moments and so increase their ethical mindfulness. Further, the act of writing a medical narrative can appeal to both rational and emotional faculties, forcing the writer to question why they felt as they did and what the patient might have felt (22).

The students had to identify a critical incident, describe it in a one-page written narrative and make a judgement on whether the situation they were reporting was morally acceptable (positive) or questionable (negative). They then had to give their opinion on how the dilemma should be resolved. Students were asked to keep the narrative anonymous, and they were aware that their narratives would be discussed at the end of the rotation, during the seminar. At the seminar, the facilitator’s role was essentially to stimulate the discussion and complete the information (e.g., raise questions or concerns) about ethics and professionalism. At the end of the seminar, students were asked to complete a written evaluation and grade the quality of the class and their level of learning.

The results collected show that the seminar enabled third-year medical students to better identify an ethical dilemma or a professionalism issue. Further, their comments showed that most were happy to participate in the seminar and grateful for the opportunity to talk freely about some problematic issues that they encountered during their rotation. Many stated that in other rotations they had never had such a frank discussion about ethics in medicine and professional behaviour. They were also asked to identify if a surgeon, a resident, or another person had been a role model: of 125 evaluations, more surgeons (n=53) than residents (n=49) were seen as being good role models, although 21 students felt that residents and staff were equally good role models. Only 2 students reported that they found no good role model at all in their clinical rotation.

Analysis of the student narratives

Between January 2004 and 2020, 1145 narratives written by third-year medical students at the Université de Montréal (Montreal, Canada) were collected following each ethics and professionalism seminar. These narratives were read and analyzed by one of the authors (GB), to identify and better understand the ethical or professional issues encountered by students during their clerkships. These issues were then organized into a taxonomy with 5 sub-groups of ethical dilemmas and 9 sub-groups of professionalism issues (see Table 1, below).

The students' narratives were also analyzed with regards to their judgment of the critical incident and its management by the surgeon and their team, i.e., a positive or a negative opinion. A positive narrative reported a critical situation judged to be in conformity with key ethical principles or the professional code of ethics. For example, a critical incident was perceived positively by students because it demonstrated respect, good communication and compassion for the patients. It was found excellent if the behaviour of the health care provider was in alignment with evidence-based science and carried out with humanism. By contrast, a critical incident was judged as negative when ethics principles were forgotten or simply not used in the resolution of an ethical dilemma. In the case of unprofessionalism, a major lapse was identified in the attitude or the behaviour of a member of the health care team (see Table 1, below, for the number of positive and negative narratives for each subgroup).

The students were not consulted to confirm the relevance of the different categories of the taxonomy, nor were other steps taken to ensure trustworthiness of the coding themes. Nonetheless, this work was presented on two occasions to students and staff of the Department of Surgery at Université de Montréal, and on one occasion at the Department of Surgery at the Université Laval. There were no negative comments on the taxonomy.

Ethical considerations

After the completion of the seminar, students were given the choice to leave a copy of their narrative with the facilitator or have it destroyed. It was clearly explained to the students that their narrative would be kept anonymous and remain confidential; only the facilitator would have access to the narratives, which could be used for research purposes in the future. The data presented here are fully anonymized and only include those narratives which students had initially accepted to be potentially included in research. Retrospective ethics approval for the use of these student narratives for research purposes was obtained from the Université de Montréal Health Sciences Research Ethics Board (CERSES).

RESULTS

The findings reported here are descriptive and retrospective, with a view to capturing the ethical issues that students encountered during a rotation in surgery. We tried to identify, when possible, the moral reasoning of the students to justify their opinion. Most of the time students referred to bioethics principles in their narratives, but rarely to ethical theory; in the case of professionalism issues, they referred to the code of ethics. Further, in some narratives or in their discussion the student's emotional reaction to a critical incident was evident, so we have identified these where pertinent.

A total of 1145 written narratives, written during the period of 2004-2020 by third-year medical students participating in an obligatory ethics and professionalism seminar, were retained for this study. Each narrative was classified as a critical incident related to a clinical ethical dilemma (n=396) or a professionalism issue (n=749), and then sub-categorized (Table 1). The narratives included a discussion or opinion on the critical incident reported, where they explained why they agreed or not with what they had observed, with a reference to ethical principles or the code of ethics. (See Annex 1 for a lengthier analysis of the ethical dilemmas and professionalism issues, with examples from students' narratives)

Table 1. Category and sub-category of reported narratives

Ethical dilemma issues (n=396)		**+ve**	**-ve**	**Professional behaviour issues (n=749)**		**+ve**	**-ve**
End-of-life decisions	n=172	123	49	Communication with patients and family	n=142	66	76
Treatment decisions	n=111	66	45	Communication of bad news	n=168	89	79
Justice and health care resource dilemmas	n=48	1	47	Obtaining consent	n=110	43	34+33
Student-specific educational issues	n=41	1	40	Confidentiality	n=56	19	37
Student relations with residents	n=24	10	32	Truthful disclosure	n=38	10	28
				Dealing with medical errors	n=33	4	29
				Professional duties, conduct and attitude with patients and staff	n=143	44	99
				Professional responsibility and commitment	n=34	11	23
				Relationships with medical colleagues	n=25	3	22

The most prevalent issues experienced by students were related to communication (n=458), such as communication with patients (n=142), communication of bad news (n=168), consent (n=110) and disclosure (n=38). The second category of importance had to do with issues of professional behaviour (n=291), such as duties and conduct (n=143), confidentiality (n=56), dealing with medical errors (n=33), responsibility (n=34), relationships with colleagues (n=25). The third category of issues had to do with decision making (n=283), end-of-life decision-making (n=172) and decisions about surgical interventions (n=111). The fourth category of importance was education (n=65), while the last concerned the health care system (n=48).

The critical incidents described by students were considered as positive in 435 (38.8%) and negative in 685 (61.2%) of the narratives. Communication was considered far from ideal in 217 of 458 narratives (47.7%). The comments on professional behaviour (n=99), confidentiality (n=37), errors (n=29), responsibility (n=23), and relation with colleagues (n=22) were negative in 210 of 291 narratives (72%). With respect to decision making, in 283 narratives, 189 were believed to be adequate (66.7%). For education, 54 out of 65 narratives were negative (83%). For 48 narratives on health care and resource dilemmas, almost all comments were negative (95%).

In their narratives, students referred to the four well known bioethics principles, namely autonomy, beneficence, non-maleficence, and justice, and used these for the discussion and explanation of ethical dilemmas. For professional behaviour, most students referred to the code of ethics or the law, although a small number of students also referred to the principles of autonomy and beneficence for professionalism.

DISCUSSION

To lay the conceptual and empirical groundwork for this study, a review of the literature on ethical issues and professionalism encountered by medical students was conducted (20-31). Numerous studies have explored pre-clinical and clinical medical students' experiences of ethical and professionalism dilemmas using different method such as surveys, focus group or written essays; and over the years, the use of narrative has become a very popular method to explore student experiences.

The information generated by the study of students' narratives, combined with those reported in the surgical literature, have enabled scholars to develop various lists of ethical issues experienced by medical students. Fard et al., for example, provides an extensive list of ethical issues, including professionalism, conflicts of interest, resource allocation and justice, patient-relationships, autonomy, informed consent, determining capacity and substitute decision-making, confidentiality, truth telling, doctor and medical team relationships, medical error, ethics in medical education and terminal illness issues (23). Kadijan et al. present a more limited list of issues, such as decisions regarding treatment, communication, professional duties, justice, student specific decision, and quality of care (24). For our analysis, we combined these two taxonomies to include as wide a range possible of ethical and professional challenges that students encounter in their medical training.

Our analysis of 1145 student narratives collected over a 16-year period showed that third-year medical students can identify and capture the nature of ethical dilemmas arising in the care of patients. They observed very well the quality of interactions and relationships in the clinical and educational settings, and they develop advanced reflexive skills, while maintaining their idealism. The students were very critical about the interactions between the surgical team and the patients and family. They referred to patient best interest and they observed how well (or not) patient needs were met in the hospital environment, the quality of the communication between patients and staff, and the positive or negative attitude of the different actors of the health care team. When it came to patient care, students expected to see ideal ethical and professional conduct from every member of the health care team; and they expected medical educators, residents, and health care professionals to be role models.

Students were very critical of the way that their education was conducted. Across studies, the most common dilemma is about students' difficult experiences with learning and patient care, but also frequently reported are issues about respect and communication. Student reactions and responses are often influenced by fear of jeopardising their evaluation or their career plan; and a result is moral distress and negative feelings (30). In our study, students were extremely sensitive to the atmosphere in which they did their clerkships, appreciating a milieux that was open, friendly, empathetic, cooperative, respectful, and humanist. And communication was of utmost importance for them. Students were most troubled when there was a problem of poor relationships between colleagues. They were also very upset when there was public discord within the team. It is in the narratives dealing with education-related issues that students appeared to be most uncomfortable or upset. Some narratives expressed deception or anxiety due to feeling inadequate to accomplish an assigned task. The student narratives provided an authentic description of a medical learning environment, and we should listen to their messages.

It has been observed that third-year medical students are prone to forget about the importance of empathy and compassion learned theoretically during preclinical training. The necessity to stay current with the latest developments in medical knowledge, combined with the burden of clinical workloads and institutional requirements for efficiency can threaten essential ethical and professional values that were considered fundamental in the preclinical years. This was not the case with our student narratives. Over the years, they showed a very good sense of observation and sensitivity for ethically problematic situations. On no occasion did we witness cynicism from the students, nor was their judgment ever ineffectual; in fact, their judgment was generally very good even when discussing difficult situations.

Contrary to some reports in the literature, our students did not remain silent about the hidden curriculum (32,33). They used the seminar to talk freely about the good and less good ethical issues that they have encountered, probably because the seminar was a safe space to express their feeling and opinions. In the process of socialization in medical school, students learn rapidly to hide their emotions, and all their attention is given to the facts of a case, to objective data; there is less interest for the subjective acknowledgement of emotions. When students reported a critical incident for which they agreed, they had positive emotions or did not manifest any emotion in their report. We did not find many negative emotions but noted the sensitivity of students when the critical incidents they had observed were in contradiction with their values, ethical principles, or the code of ethics (11).

Medical students on clinical rotations are incredible observers of their educators' behaviours; and they have the potential and capacity to register our actions, smiles, and insinuations. As clinicians, we must realize that our practice is public, and it is closely observed by many persons around us, but most of all by our students. In their narratives, students were very critical when professional behaviour in the operating room was inadequate or when a medical decision was influenced by a prejudice. This analysis of the students' narratives shows that medical students have a good sense of observation of both the training environment and the professionalism (or lack) of their clinical educators.

Throughout the years we conducted the seminar on ethics and professionalism, the students demonstrated energy and enthusiasm and a very good cooperation, even if there was no direct evaluation of their performance at the seminar (it was not a graded activity). Our analysis points to the important role of the hidden curriculum in shaping professional identity. It also showed that third-year medical students may be more aware of ethics and professionalism issues than one might first assume (32-35).

In 2005, Branch described the effectiveness and impact of reflection when using critical incident reports, pointing to the importance of a reaction to and validating discussion environment, and the benefit of transformative learning (15). Reflective writing of short narratives has been shown to be an effective means of teaching professionalism when combined with feedback. Written reflection is associated with a more positive learning experience because students revisit and assess their experience, and this can help them progress in their self-reflection and eventually develop and implement high-quality practice (17). Reflection is a technique that enables learners to analyze their experience and capture the wisdom that lies within, and to then develop new knowledge and attitudes. Reflection is also associated with positive learning experiences and may help students to develop as learners and better recognize their own learning needs (16). Reflection and feedback for the teaching of ethics and professionalism involves the intentional examination of a learning experience, including feeling, meaning, and ethical implications. Discussing critical incidents related to ethics or professionalism experienced by students may stimulate self-reflection and lead to mindfulness and help in building students' professional identity (32-37).

Combining reflective narratives with the good role models they find during their rotation in surgery can help medical students to answer questions like: What kind of doctor will I be? What are my values? What are my convictions to become a good doctor? According to White, one of the most formative influences in medical education is the recognition and reflection of students on critical incidents encountered during a rotation (17).

By using the narrative approach, we wished to stimulate students' ethical sensitivity and help them develop their reflection and judgment. Essentially, the idea was to prepare them for the subjective aspects of the practice of medicine. We wanted them to learn to identify or recognise ethical dilemmas in surgery, to analyse them and resolve them were possible, and to discover their own personal ethic, along with its rationales and motives (7). Can one be a scientific and competent professional while only giving minimal consideration for the art of medicine? Is it important to become a humanistic doctor with high standard of ethics? In answering these and other questions, medical students construct their professional identity.

Learning reasoning about ethics and professionalism and observing role models while training enables medical students to progress gradually to find their own professional identity. We hope they will maintain their well-developed identity acquired during their clinical rotations and medical training, and throughout their professional career. In our case, we thought a seminar that favoured observation of practical issues in ethics or professionalism and stimulated reflection on a critical incident followed by a small group discussion would be an appropriate educational modality with which to teach ethics. Specifically, it would help students to reflect upon and learn about their clinical experience, which they lived during a 6-week rotation in surgery. This formal activity can be in addition to the habitual teaching of ethics during their exposure to surgery.

LIMITATIONS

One of this study's limitations is that the data were collected in a single institution, in Quebec (Canada), and so may not be generalizable to other institutions. The seminar experience reported here was also conducted in another hospital, but the narratives were never collected and analyzed. The study also concerns a limited number of students from a group of approximately 200 students assigned every year in a clinical rotation of approximately 3000 students. The study involved 25 surgeons, the majority from General Surgery, and the others from vascular, thoracic and urology. The evaluation and interpretation of all the narratives was done by a single person (GB). Nonetheless, the lessons learned from the students' narratives provide insight into how medical students are trained and this is pertinent for all medical schools to consider. Specifically, surgeons and medical educators should be aware that they are constantly observed by their students, who will

judge their behaviours — clinical educators can be positive or negative role models, because what is learned by students is both content and behaviour.

CONCLUSION

Medical education is not simply the acquisition of knowledge and skills — above all, it is the acquisition of a professional identity and the identification of values that will guide professional conduct. Medical students desire to become proficient and caring physicians. The students who participated in our seminar shared their belief in the professional virtues of altruism, honesty, integrity, excellence, respect, and responsibility and wished to learn from good role models encountered during clinical rotations. Negative behaviours observed by students are teachable events because they show students what is not appropriate and sometimes this is more instructive. It is an occasion for students to develop mindfulness and reflect on what went wrong and the negative effect on the persons involved. The findings of our study suggest that students' reflective narratives are a rich source of information about the informal of hidden curriculum. Experience with both positive and negative behaviours were distributed evenly and shaped the students' experience of the professional values in the daily practice of surgery. Good communication and professionalism of surgeons appeared for the students as fundamental values.

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ANNEX 1

Ethical dilemmas (n=396)

End-of-life decisions (n=172)

Clinicians who treat terminally ill or almost terminally ill patients are generally reluctant to abandon their traditional role of curing the patient, so there is often the idea that they should always fight for life (39-41). Further, they are often ill-equipped to deal with the complex confrontation of trying to promote both principles of autonomy and beneficence in patients with advanced neoplastic disease. This was true in the first years of the study, and the decisions taken by the surgical team were not always perceived as adequate by students. They based their judgment on their own values and conviction and the principles learned from their preclinical training. But in recent years, the philosophy of treatment of terminally ill patients has changed with the development and implementation of palliative-care services. Of the 172 student narratives that dealt with end-of-life decisions, 123 reported a good decision being made by the surgeon, e.g., evidence-based decision (n=28), respecting patient dignity (n=7), respect of autonomy (n=73), or demonstrating excellent communication (n=8), and other issues (n=7). By contrast, 49 student narratives recounted a negative experience. The decisions were criticized because of poor communication (n=8), overtreatment (n=18), that patient autonomy was not respected(n=8), that communication was too paternalistic (n=8), and other issues (7). Interestingly, there were more negative experiences recounted in student narratives in the period of 2004-2014 (n=36) than in the last five years (2015-2020) (n=13). This difference can probably be attributed to a change in mentality regarding end-of life decisions and better access to palliative care.

Treatment decisions (n=111)

The initial tasks for which surgeons are trained are to identify a patient's symptoms, to make a diagnosis and to offer a treatment after the risks and benefits are explained to the patient. Communication must be respectful of patient autonomy and adapted to the patient's capacity to understand. The students reported in their narratives how they perceived the treatment decisions made by staff and whether the final decision was made in consideration of patient benefit. This process was found to be adequate in 66 narratives — i.e., good medical decision (n=26), respect of autonomy (n=36), excellent communication (n=3), other (n=1) — but considered problematic by the students in 45 narratives. One of the reasons for questioning the appropriateness of clinical decisions (n=29) was because of certain prejudices expressed by the surgeon in making their decision. The prejudice most often mentioned by the students was with respect to patient obesity, most often at the time of surgery in the operating room. Second to that was psychiatric patients and the people with drug problems. There were a few mentions about religion and sexual orientation. Some students felt that autonomy was not clearly respected (n=7) and beneficence not always evident. In a few narratives, students expressed that it was wrong that the decision was taken solely by the family instead of the patient (n=6).

Justice and health care resource dilemmas (n=48)

Justice is one of the main principles of contemporary medical ethics. In the province of Quebec (Canada), all residents have access to public health insurance, with most care provided without co-payment or recourse to private health insurance. Nonetheless, justice issues still occur, and these were raised by medical students in their narratives: they had to do with access and resources. Access was a concern for those patients without Canadian citizenship needing medical care and identified in a small number of narratives (n=5). The major concern (n=15) was that of privileged access given to patients because of their close relationship to personnel of the hospital. On one occasion, a narrative recounted a case of an offer of privileged access that was declined. The other problem noted by students (n=5) was that waiting time to access care was far too long. Fair use of resources was mentioned as less than optimal in 20 narratives and on 2 occasions necessary resources were totally absent.

> A 50-year-old patient has been diagnosed with a rapidly progressive and aggressive digestive cancer. The surgeon meets with the patient and proposes surgery followed by chemotherapy according to known medical standards. The patient has a social problem because he has already lost his job several times and his financial situation is poor. He has just found a job but does not have his permanence. The patient is unable to consider a treatment that takes him away from his current job. He fears losing his job. The surgeon therefore decides to opt for another form of treatment and to respect the patient's autonomy. The surgeon offers to call the patient's employer to explain the urgency of the medical situation. The surgeon decides on an alternative therapy while waiting to complete the treatment.

Student-specific educational issues (n=41)

Medical students faced several ethical issues related to their training during clerkships. Among the main difficulties reported in the literature were conflicts between the exigencies of medical education and patient care and wellness, being asked to assume clinical responsibilities that exceeded students' capabilities, and involvement in care that they considered to be substandard. In their narratives, students rarely reported positive events, i.e., on only 2 occasions did student narratives focus on the positive aspects of the teaching and learning environment. When faculty members and residents spent time in teaching it was recognized positively in the narratives and greatly appreciated by the students. What they most appreciated were instances when they were actively involved in the process of clinical reasoning and treatment of patients. They liked to be perceived as a partner and member of the team, but this was rarely the case and led to most negative events (n=40). To name a few such incidents, students reported occasions when the attitudes of health professionals were not compassionate: staff (n=3), residents (n=6), nurse (n=1). Probably the biggest problem, however, was the anxiety related to the tasks that medical

students were asked to perform (n=18), because they felt unprepared. Additionally, students' autonomy was not always respected (8), and there were a few cases of intimidation (n=4).

> I am doing an internship in urology and the surgeon was very concerned about my learning; he gives me the opportunity to perform the rectal exam on all patients who come to the outpatient clinic. In retrospect there is a problem with some patients being aware of my presence because the exam was done while the patient was in the prone position ready for the biopsy and each time the surgeon indicated to the patients that the DRE was being done again but did not indicate that it was a student who was doing it. In my opinion, this is an invasive medical procedure that concerns an intimate part of the anatomy. It would have been more ethical and to notify the patient and obtain his consent.

Student relations with residents (n=24)

The resident's performance with patients, as well as their relationship with other members of the health care team, including the medical students, was reported in 24 narratives. The positive incidents when observing the residents were excellent communication (n=3), respect of patients (n=2), excellent clinical decisions (n=3), and respect of staff (n=2). Negative incidents included lack of respect for the patient by the resident (n=2), bad communication with patients (n=2), lack of respect for the students (n=2), conflict with nurses (n=1), difficult relationship of the resident with staff (n=2), and in one narrative, a resident lying to one of the staff. Students also observed a lack of supervision of the residents by the staff (n=3), while another incident involved lack of responsibility by a resident (n=1).

Professional behaviour (n=749)

Communication with patients and family (n=142)

Communication must be respectful of patient autonomy and adapted to the patient's capacity to understand. Students learn early in their preclinical education that communication is essential in the process of care and in the relationship between the patient and the surgeon – it remains very important in all aspects of clinical practice. Medical students witness, every day, the conversations (or their absence) held by the medical team, and the quality of this communication, as well as the attitude of the staff during patient meetings, is scrutinized by students.

> We are in 2008, and I am doing a surgical rotation for a patient followed for a neoplastic lesion. A colonoscopy was performed, and I attended. The surgeon leaves the room immediately after the intervention; the patient was to go to get dressed to meet the doctor and obtain results. He wants to be reassured. The surgeon refused to meet with the patient saying that he did not have time and that he would see the patient again next month and he asked me as an extern to meet with the patient and answer his questions. So, I met with the patient in the waiting room, but it was an inappropriate place. I told the patients that we would go to the doctor's office, and he would answer these questions himself, especially since I did not have the knowledge to answer questions in a very specialized area of surgery. For a second time the surgeon refused to meet the patient and insisted on dismissing him. I was very disappointed with this attitude which lacked empathy.

During the daily interaction of the surgical team with patients and families, confidence should be established early on, based on an honest and compassionate attitude towards the patient and their family. Good communication is also important to relieve anxiety experienced by patients and families. Students observed that some health care professionals never demonstrated any empathy during their relationship with patients. Instead, their primary objective and interest was focused on the disease, and these clinicians paid very little attention to patients' emotions and fear. The students learned that a good surgeon should be aware of the importance of compassionate communication and respect for patient autonomy. In 142 narratives, 66 recounted instances of good communication while 76 mentioned witnessing bad communication. Good communication, as described by the students, showed empathy, involved enough explanation to the patient for an adequate understanding, and the delivery of sufficient and necessary information (i.e., informed consent). On the other hand, bad communication occurred when the explanations required by the patient were delivered very rapidly, without verifying the patient's understanding or without empathy. In a few situations (n=7), it was felt that the conversation was not friendly and was arrogant or authoritarian, or otherwise less than ideal.

> I witnessed during my surgical rotation an ethical situation where a surgeon asked a patient to communicate the list of medications that should be continued during the hospitalization. The patient was surprised that he did not know her list. The surgeon becomes more and more impatient and insists to have an answer from the patient, who remains silent and indicates that she is not able to provide a list. The surgeon became impatient and began to raise his voice. As a witness to this situation, I am confused and uncomfortable.

Communication of bad news (n=168)

Breaking bad news is one of the most difficult tasks in the practice of medicine, and medical education does not always adequately prepare students. Patients and families may not always desire a frank disclosure of terminal diagnosis or other bad news, but they nonetheless deserve empathetic communication. Student narratives were about interactions with patients, family, residents, and other health care professionals in revealing information about a terminal illness. In 89 narratives, communication with patients was considered as excellent, showing empathy, sincerity, and authenticity. Revealing bad news

by the surgical team was seen as excellent by many students but on some occasions the site for discussion was not ideal, intimacy was not always respected, or patients had to wait a long time before having access to the surgical team. On 79 occasions, the communication was below the standard expected: no communication, aggressiveness, impatience from the staff, insufficiently accessible for the patient or the family.

Obtaining Consent (n=110)

Obtaining consent is not always a simple task. A valid consent requires a variety of elements such as capacity, disclosure of information, and understanding by the patient. In their narratives, students described 110 occasions where they commented on the quality of patient consent. It was considered as high-quality on 43 occasions because it was voluntary, and patient comprehension as well as disclosure of information were adequate with alternative options offered. It was not perceived as done well on 34 occasions. For example, it was problematic because too paternalistic (n=8), insufficient disclosure of information (n=4), it was done too quickly (n=2), it was not voluntary or was missing information as well as options (n=20). Notable were 7 cases where consent was not obtained. Among the other difficulties reported by students were cases where patients were unable to decide (n=13) or the patient had psychiatric issues (n=4). On other occasions consent was referred to the court (n=1) or done by the family (n=7).

> While I was in the emergency room a 50-year-old patient with Crohn's disease presented with an anal abscess the patient was very anxious. As an extern, I notified the resident who informed me that there was availability in the operating room that evening and he planned to operate on him that evening. This situation made me think because I did not believe that the patient had given free and informed consent. The resident made no mention of the risks and benefits, no explanation Night and give to the patients taking for granted that they would accept without discussion. In my opinion, consent was not obtained in a professional and ethical manner.

> During my clerkship a surgeon had planned an amputation for a hospitalized patient without telling them. When we came to explain the details of the surgery and get her to sign the consent form, she was already at the operating room door. The patient was surprised and shocked and immediately refused the surgery. A few days later after a long discussion with the patient she finally agreed to the surgery realizing that it was really the only solution to her problem. In my opinion, the consent was not well done the first time, fortunately it was caught up and finally the patient had properly explained the nature of the surgery and the risks and benefits. A well done consent the first time would have avoided a lot of trouble for the patient as well as for the interveners and colleagues.

Confidentiality (n=56)

Incorporating privacy and confidentiality in delivering health care is regarded as essential, especially in the patient-clinician relationship. Patients have the right to expect confidentiality, however discretion in the health care system is not always respected. In 37 narratives, students thought there was a problem ensuring confidentiality by one member of the team. By contrast, it was found to be exemplary on 19 occasions. The location where confidentiality was lacking was most of the time on the ward (n=14), but breaches of confidentiality occurred in the elevator (n=2), in hallways (n=3), in emergency room (n=3) and even in the OR (n=1). Lapses in ensuring confidentiality by residents and students were frequently observed during morning round discussions carried out in public spaces, like the cafeteria (n=3). Use of photographs and digital recordings without ensuring confidentiality also occurred (n=6), as well as other issues (n=5).

Truthful disclosure (n=38)

Disclosure refers to delivering the relevant information for the patient to understand their condition, diagnosis, the different treatment options, and prognosis. Disclosure of information was reported on 38 occasions. In 28 narratives, it was believed to have failed because truth was not totally revealed by invoking therapeutic privilege (n=8) or simply hiding it from the patient without good reason (n=4). In 16 cases, patients had undue waits before receiving the information. There was also some concern raised by students because it was the family who was objecting to disclosure (n=6) or the patient themself (n=4).

Dealing with medical errors (n=33)

Medical errors occur in any surgery practice and its management is not simple. Truth telling is fundamental and involves the provision of information that is accurate, honest, and understandable by patients. The truth should always be told in respect for the patient; it is also essential to maintain confidence between the patient and the surgical team. Management of medical errors was raised as an issue in 33 narratives. Disclosure to a patient about a surgical error was done with honesty on 4 occasions but was not disclosed 3 times. Some errors were not reported as they should be because of refusal by staff to do so because patient had no sequalae (n=16). Students witnessed an error but were hesitant to denounce the situation on 10 occasions.

> A patient who had just been operated on for a colectomy was sent for an abdominal CT scan two days after his operation. The patient returns to his surgical unit and the resident finds that the exam was not ordered for this patient but for another. There was thus a medical error. Despite this, the surgical team decides not to inform the patient. I think that the note should have warned the patient and that it is a breach of the code of ethics.

Professional duties, conduct and attitude with patients and staff (n=143)

In 44 narratives, students observed compassion, empathy, and excellent communication (n=25), respect of patient autonomy (n=11) and respect of dignity (n=8) from the surgeon. In 99 reports they observed a lapse in the relationship between the patient and medical team because of lack of true compassion (n=15), lack of respect (22), or no respect of autonomy (n=10). They heard prejudicial comments from some senior surgeons when talking about patients, e.g., with regards to obesity, psychiatric problems, age, ethnicity, religion, or homosexuality (n=32). They also reported bad behaviour such as absence of adequate control, impatience, and anger (n=6) and lack of attention to patients' intimacy (n=9). Students witnessed bad jokes about some of the patients in the OR (n=4) and in other settings (n=1). Good relationships of staff with patients and family were very important for the students, who are seeking positive role models. Meeting patients with empathy and compassion was seen as key to true professionalism.

> A 60-year-old woman, she is taken to the operating room for abdominal surgery. The procedure is started by scrubbing the abdomen while the patient is completely naked. The anesthesiologist says aloud that the woman's breasts have been redone. The surgical resident and the nurses begin to discuss the old breast implants. The anesthesiologist then goes to touch the patient's right breast and says out loud that it is an old fibroid model. The resident manipulates the breasts confirming that they are heavy and indurated. The surgeon then entered the operating room and jokingly called out to the anesthesiologist, resident, and nurses to stop being jealous. As a student I was shocked because I thought this patient was being disrespected and the attitude was unprofessional.

Professional responsibility and commitment (n=34)

Professional responsibility for patients was reported 34 times: it was reported to be exemplary in 11 narratives but appeared to be problematic on 23 occasions. Lack of responsibility from the surgeon toward the patient was observed when the surgeon transferred patients to another physician (n=9), abandoned a patient (n=2) or denied availability for patients (n=12). Although most students focused on these as issues of professionalism and in relation to the code of ethics, some had been struck by the difficult resolution of ethical dilemmas happening in the practice of surgery when there was a conflict between principles of autonomy, beneficence, and justice.

> We are in a department meeting with residents and medical students. We are discussing a patient who has recently been diagnosed with cancer. The patient is very anxious and asks many questions of the surgical team. The surgeon openly complains about too many questions and the patient's anxiety with a condescending attitude. The team then looks at the patient's latest CT scan that was requested to complete the extension workup. Numerous large metastases to the liver were clearly seen. The surgeon in charge of the patient exclaims with joy because for him it is no longer a problem, it is a case that must be transferred to oncology quickly. One less case, he says, smiling... In my opinion, professional responsibility was not there, nor was empathy.

Relationships with medical colleagues (n=36)

Respect for colleagues when working closely with them appeared as very important for the students. They understand well the importance of good communication between the health care members to benefit the patient; and they manifested surprise when there was a lack of respect between colleagues. The review of the narratives indicates that the relationship between colleagues was questionable on 31 occasions; and it was reported as exemplary and excellent in only 5 narratives. Among the problems reported by students were: absence of respect for a colleague or member of the personal (n=11), no adequate communication (n=8), absence of collaboration (n=6), critiques of colleagues (n=9) and aggressivity towards colleagues (n=2).

> We are in the morning at the time of the patient visit and there is a certain animosity between the surgeons. With the residents we visit a patient who belongs to another surgeon. The surgeon who makes the visit that it is open and explicit and even rude in his total disagreement with the actions that the other surgeon chose to make. Residents and students are given feedback that encourages them to not act in the same way as the surgeon in question. The comments are made in the presence of the patient who is far from reassured. The derogatory remarks are made in an aggressive tone. The situation leaves a cold climate in the room and a patient shaken and stunned by the verbal storm. In my opinion, there is a blatant lack of respect towards another colleague.