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At the Bedside

What Do We Owe Medical Students and Medical Colleagues Who Are Impaired?

Edmund G. Howe

ABSTRACT

Physicians who are impaired, engage in unprofessional behavior, or violate laws may be barred from further practice. Likewise, medical students may be dismissed from medical school for many infractions, large and small. The welfare of patients and the general public must be our first priority, but when we assess physicians and students who have erred, we should seek to respond as caringly and fairly as possible. This piece will explore how we may do this at all stages of the proceedings physicians and students may encounter. This may include helping them to resume their medical careers if and when this would be sufficiently safe and beneficial for patients.

In this issue of *The Journal of Clinical Ethics,* in "Medical Boards and Fitness to Practice: The Case of Teleka Patrick, MD," Katrina Bramstedt relates the story of Teleka Patrick, a physician who was caught stalking her pastor and later drowned when she drove her car into a lake.[1] Bramstedt uses this case to ask what we should do, as a profession, when clinicians engage in behavior like this. Bramstedt's concern that, above all, we protect patients is longstanding. Its rationale is indisputable: patients are vulnerable and cannot protect themselves. The belief that we should protect patients to the greatest extent possible is widespread and may be increasing.[2] Still, there is another side—less often formally discussed—that I will present: that we should show impaired students and clinicians the same compassion we insist be shown to patients. This may be warranted in part because pursuing a career in medicine may be almost as important as life itself to them. And this compassion should not be limited to those with such passion, but to all.

The outcome for Teleka Patrick was tragic. For months before her death she heard voices in her head. She believed God directed her to attend a particular medical school so she could be near the man she stalked. She said that she felt she was being tortured by a "demonic power." Perhaps most sadly, just before she died she begged a friend to come to see her as soon as possible, because she felt scared and distraught—but her friend never arrived.[3] Even with subsequent investigations, it is not clear why Patrick didn't seek help. Maybe she feared she would lose her license to practice. Other physicians may not seek help for similar reasons. If this is so, we should want to change how this system functions. Medical facilities have generally done well in caring for clinicians who are mentally ill, so that they can return to practice, if possible. One study reports that many as 70 percent of clinicians who experienced mental health problems returned to practice after five years.[4] Since stalking may be due to mental illness, we should want to help clinicians like Patrick, not deter them from seeking help.

Just prior to her death, Patrick said she knew no one who would come to help her if she asked for help. In this article I will suggest how we can try to prevent this from happening to others, and ways we can respond to students and clinicians who suffer

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impairments. I will explore what we can do differently from what Bramstedt suggests for medical students, and what we can do for physicians, like Patrick, who are already in practice. Finally, I will consider how we might continue to offer compassionate contact for students and clinicians, even under circumstances when their outcome is the worst it can be for them, namely being barred from being able to continue to study or practice.

My goal is not to outline specifically what we should do, but instead to initiate a discussion. That said, I suggest that we often abandon these colleagues knowingly or inadvertently, when we should continue to care about them and strive to help them, even though they may have done wrong. I begin by considering how we treat medical students.

HOW TO TREAT MEDICAL STUDENTS?

In this section I address three questions: What should we consider when we interview students prior to admission to medical school, to determine whether they should be admitted? When should students be expelled? What should ethics teachers or other faculty members do when their views regarding expulsion differs from school policy? It is my hope that these examples sufficiently represent other major ethical issues that may arise.

What Criteria, Good and Bad, Should Be Prioritized during Pre-Admission Interviews?

Faculty often interview students for admission to medical school. Alberto Giubilini, Sharyn Milnes, and Julian Savulescu, in "The Medical Ethics Curriculum in Medical Schools: Present and Future," in this issue of *JCE,* stress the importance of this screening.[5] It makes sense to include one-on-one interviews in the admission process. They enable schools to go beyond the stereotypical inferences schools would otherwise use—only words and numbers. What is deemed important during these interviews, as a result, becomes even more important.

An example of what faculty may deem as important during interviews is an approach used by Edmund Pellegrino, MD, an internationally recognized physician and ethical thinker, who died in 2013. Ed was, I should mention, among the first persons who agreed to be on *JCE*'s editorial board, almost three decades ago. Others were then eager to join him. When faced with an ethical problem, I would often ask myself what Ed would do. Ideally, we all know such a person. I would often ask his advice, and he didn't ever respond by saying, "I'm sorry, I can't answer, because I am not you." Since I had asked, he knew I wanted his advice. I believe we should always respond to our colleagues and patients in this way.

When lecturing medical students, Ed would sometimes say that when he interviewed students who were applying to medical school, he would ask them harder and harder questions about medicine until they didn't know the answer. (He would add with a smile that he "usually" knew more medicine than they did.) When a student acknowledged that he or she didn't know the answer, Ed considered this a plus. When a student wouldn't admit he or she knew the answer, it raised doubts, Ed said, regarding the student's integrity. (It is unclear what weight, if any, Ed would place on his doubts when submitting a recommendation for the student's admission to medical school.) He may have shared his approach to interviewing to convey to students the importance of noting and acknowledging when they lacked knowledge. This may be particularly productive now, since the internet provides immediate, up-to-date information.

Ed's practice, in any case, provides an excellent to way to ask what an interviewer can validly infer when interviewing students prior to their admission to medical school. How valid is it, for example, to infer from a student's not saying "I don't know" that the student might offer less as a physician? Is this inference, and others like it, sound enough to suggest that such students are more likely to have significant flaws? Using this specific example, we might ask why a student might not want to say "I don't know." One reason may be that they want so strongly to become doctors, and want to help others to an exceptional degree. Such an exceptional desire may be a positive trait, but it may lead students to not even consider "I don't know" to be an option.[6] This shortsightedness could be a plus or minus. If it is an indication of students' commitment to helping others, interviewers could see it as a plus. If it reflects an underlying, emotionally driven, and habitual disregard for empirical facts and the "truth," an interviewer should see this lapse more negatively, and have greater concern. An interviewer's task is to imagine that a student's behavior may be either, and to seek to place it in context.

Students' hopes to practice medicine may so drive them that, rather than considering saying "I don't know," they will search for any related knowledge they have, even if it is, as it were, only crumbs. Such blindness might reflect the exceptionally good physicians the students might become, as it may be an expression of their exceptional commitment to patients. Of course, this kind of blindness is not limited to clinicians. The clichés that every strength may be a weakness—and *vice versa*—and that every

good character trait may be taken too far, are millennia old, and true of everyone of us.

Even so, it is ironic that a screening question intended to help rule out students who may be the least fit to serve as physicians may actually indicate the students who may be among the best physicians. Of course there are multiple other possibilities. For instance, students know that in this highly competitive academic culture, the greatest rewards and highest recognition often go to those who "know the right answers," whether or not they see their answers in a wider perspective. Deciding who enters and graduates from medical school is fraught with many similar risks, and illustrates how challenging it is to accurately perceive another person's character.

I have met many exceptionally committed students. They often come from a family that includes a child who has special medical needs, such as a younger sibling. Experience with a family member can set students off on this path at an early age.[7] In high school, in their spare time, students may seek out volunteer work with children like their sibling rather than participate in activities more common among their peers, such as social outings or sports. Here's one example. A medical student was a gifted artist, and before entering medical school she spent hours in a children's hospital drawing sick children. They loved it. She noticed how much the children and their families came to trust her, and that they would often share their innermost feelings and fears. When she became a med student, though, she noticed this changed when she wore a "white coat." Children and their families seemed more distant and guarded. She vowed that she would strive, with every patient, to acquire the same trust in a white coat as she had when dressed as an artist. This endeavor has been painful for her because she so often sees herself as failing. Nonetheless, striving to achieve this with each patient and family continues to be warranted, she says.

In their article in this issue of *JCE,* Giubilini and colleagues describe the qualities they believe are the most important for medical students to "demonstrate professionalism: compassion, integrity, respect, responsiveness to patients' needs superseding self-interest, respect for patients' privacy, accountability, and sensitivity to a diverse patient population." If the authors are right, students like the artist may be the ones we most want to become doctors—and, in some cases, they may be the same students who fail "the Pellegrino test." They may be driven by an exceptional capacity to empathize, and so may be the people we would most want to become physicians. Truthfully, the med student/artist would be the physician I would most want for my family, whether she had more medical knowledge than other students or not. Why? First, because of her self-reflective awareness and compassion; even encyclopedic knowledge does not the best clinician make. Second, with sufficient commitment, any student can access up-to-date information on the internet. This may result in better treatment.

Here is an example from my own experience. A physician recommended surgery to his patient because the surgery was the best-known, standard treatment for the patient's condition. Surgery was also the treatment indicated in the most current texts. But the patient was himself a doctor. He looked up his condition on PubMed and read about a cure for his problem using only meds. The patient-doctor emailed the author of the PubMed study, and learned there were doctors in the United States who were familiar with the treatment, and that he had worked with some of them. One of them worked at a medical center near where he lived. He went to this doctor and was cured without surgery. What may have made the difference between the approaches of these two doctors is how they were trained.

Checking for the newest treatment is the kind of practice that Ed Pellegrino would have found so important. Doctors must have sufficient humility to welcome being challenged and to go beyond their training. A clinician who is as committed to patients as the artist/medical student was might be especially inclined to check the internet, as consistent with a high degree of commitment. The identification of this proclivity should be a second priority for faculty who interview students for medical school.

In the next section I will consider the opposite and more vexing side of student evaluation: when faculty must make decisions about dismissing a student from medical school.

When Should We Dismiss Students from Medical School and When Should We Not?

In these instances, we should be careful to not make unwarranted assumptions based on inference. Authors who have studied how physicians assess "professionalism" note several common errors. For example, attendings often wrongly judge medical students' professionalism by overemphasizing factors that are related to the specific person, rather than by external factors. This is how people, in general, err when judging another's behavior. The authors call this "the fundamental attribution error."[8]

Hindsight may also compromise our objectivity. There is empirical evidence that when doctors learn of a patient's adverse outcome, they often reason backward—erroneously—that a doctor must have made a mistake.[9] Our negative feelings, and

especially negative countertransference, "distorts clinical moral perception."[10] (*Countertransference* is a therapist's transfer of emotions to a patient, often in reaction to *transference,* which is when a patient redirects feelings for others onto the therapist.) Faculty who are confronted with acts that they consider to be unprofessional may have negative feelings in response. Their feelings, in turn, may darken and impair their ability to see and infer accurately.

A second consideration is consistent with the views of Giubilini and colleagues. The authors recommend that faculty and those who interview students for admission to medical school place relatively greater emphasis on students' having exceptional compassion, rather than on knowledge, as happens now. The gains of having a clinician with exceptional compassion are well-acknowledged.

In her article in this issue of *JCE,* Bramstedt notes that while stalking is not generally considered a crime, it "is clearly unprofessional and a marker of problematic character and fitness, which are under the jurisdiction of medical boards and educational institutions." She raises the question of how far medical schools should go to dismiss students who commit acts that are unprofessional but are not illegal. She states that medical bodies see themselves as having a moral obligation to protect the public, regardless of the law: "There is ample evidence of that the courts use medical codes of ethics to inform legal decisions. Thus, not recognizing professionalism in this same manner is inconsistent and potentially puts the public at risk." As Norman Quist noted, socially constructed behavioral guidelines and expectations may cross over and occupy a place under the rubric of "professional," and even determine how we understand professional behavior.[11]

An alternative view that has been set forth by S.C. Rennie and J.R. Crosby is that some student behaviors are worse than others in ways that warrant qualitatively different consequences.[12] Differences in unprofessional behavior may warrant disparate responses, much as the law does in drawing a distinction between felonies and misdemeanors. Some medical students believe, for example, that the critical distinction in unprofessional behavior is whether a behavior harms another.

Emilie H. Osborn provides an illustrative case.[13] Two first-year medical students had the same take-home paper to write for a final exam. George, who said the paper was "stupid," put off writing to the night before it was due. His friend Ellen had already written her paper and offered to write one for him, and he accepted. The papers were handwritten in the same script, shared identical language and syntax, and George wrote, on the back of the paper he turned in, "Thanks for helping me out, Ellen, have a great summer! George."

The instructor saw this as plagiarism and confronted George and Ellen when they returned from break to begin their second year. "Both [students] flushed, and immediately admitted they had cheated. George . . . blamed only himself. . . . Ellen was very apologetic. . . . Neither of them blamed the course director, the school, or the assignment. They said merely that they had been foolish." The faculty members on a student-faculty committee that reviewed cases of misconduct recommended George and Ellen be dismissed for at least one year. The student members of the committee recommended George and Ellen each have a letter placed in their file and perform some community service, which was accepted as the penalty. Ellen chose to work in a homeless clinic. George chose to conduct research on ethics and on medical students' views regarding his own cheating. When he did, Osborn reports, "The students [in the four class years] were outraged. . . . [S]everal . . . said this was not a crime. . . . Many said they would have done the same thing. . . . A few students said that they felt that this was cheating and supported the faculty's decision."

Osborn reports that the faculty were surprised by the opinions expressed by some students, that the assignment Ellen and George cheated on "wasn't 'real' medicine" like anatomy and physiology (it was a course on health policy), and that "helping each other was more important than being honest with the faculty." This led to a long discussion about whether the school should have an honor code (at that time it did not), and, in his third year, George, with several other students, formed an ethics committee that looked into codes of ethics at various medical schools and developed a statement of principles that is now handed out to the entering class at the school, during its White Coat ceremony. The five principles listed in the code are honesty, confidentiality, respect for others, responsibility, and the expectations of students and faculty.

Even after Ellen and George performed public service and proved to be good students, the letters remained in their files and prevented the receipt of some honors. Osborn writes that the school's response modeled a failure to forgive, and "this lack of forgiveness is puzzling because it seems antithetical to the role of the physician-healer. We forgive our patients their transgressions and agree to help them no matter how much harm they have done to their bodies." Osborn's observation is compelling. It challenges us to think again about our response: that and how we punish, that and how we forgive, the example we set for our students and colleagues.

We may punish students and colleagues who violate professional standards for many reasons. Perhaps the most ominous of these reasons is defensive: that by placing excessive blame on others, we protects ourselves. We may deny the risks and vulnerabilities we face by psychologically projecting wrongdoing onto others.

Osborn's point may be broadened: we should treat students and colleagues as we treat patients. For example, our professional obligation is to treat the patient before us, even if the patient is a serial killer or terrorist. We continue to treat patients who are noncompliant. We treat patients in the order in which they appear before us, not according to their status. Given how we treat patients, which view should medical bodies adopt toward students and colleagues: an automatic response and consequence based on whatever a medical student has done, or a response that takes into account individual factors, such as the context and the student's intentions? In some cases perhaps the best response incorporates both features, just as there are strong societal efforts to not just incarcerate criminal wrongdoers, but to simultaneously help them.

The same sort of question may arise in regard to clinicians who are already in practice, for example, a doctor who is disciplined for a financial crime and serves a jail sentence. When the doctor completes the jail sentence and prepares to resume "normal life," other clinicians may be asked by a medical body or prospective employer whether they would recommend that this doctor resume practice. Clinicians who are asked this question have to decide whether they will vouch for the doctor. Whether the crime committed was financial or was one that harmed another person may make a difference in the recommendation that is requested and given. The principal ethical concern behind our response to students and clinicians who have made these kinds of mistakes is when and how to protect patients from possible harm, to a greater or lesser degree.

Because patients can be especially vulnerable to harm, Bramstedt asserts that, in many cases, we should permanently end students' and clinicians' careers. Key considerations are (1) which behaviors are unlikely to change and, (2) if the behaviors don't change, are they too harmful to patients to be risked? Both of these criteria are met by physicians who knowingly exploit patients' vulnerabilities to further their own ends. Bramstedt writes that, in medical school, infractions that merit dismissal might include engaging in plagiarism, falsification, human or animal abuse, boundary violations, poor reliability and responsibility, lack of self-improvement and adaptability, poor initiative and motivation, negligence, inappropriate use of drugs or alcohol, criminal behavior, and serious matters of moral character.[14] This risk of using this list (or any list, for that matter) is that it may be implemented without nuance or at least without a consideration of any possibly desirable, mitigating factors. An important question is whether, in net effect, the use of a list will lead to a better or worse outcome.

We might pause and focus for a moment on a distinction mentioned previously: some behaviors harm persons and others do not. How should that matter? This might be the first question asked by medical schools and boards of medicine, as well as clinicians, when they assess a colleague's unprofessional conduct. The work left to be done is considerable: to devise caring and compassionate processes for assessment and teaching and at the same time to adequately protect patients.

Using the example Osborn wrote about, Ellen wrote a final paper for George because she was trying to help him. Some medical students thought that although this was cheating, it was done for the right reason, namely, to help another student, and that this was the faculty's ethical code, not theirs. A few students wholly disagreed and thought that cheating, by itself, was grounds for dismissal. How much should students' views matter? On the one hand, they may have a greater understanding than faculty about the "here and now," but, on the other hand, they may not see the real or likely consequences of cheating over the longer run. Ellen may have been responding on the basis of her moral conscience. She may have been putting her concern for George's well-being above her own moral principles. Of course, people who act on this basis may cause great harm. How then should this possibility be taken into account? And, if such a possibly altruistic motivation is taken into account, how should its presence (or absence) be determined? I shall address the procedural concerns this last question raises shortly.

It may be profoundly traumatic for Ellen and George to be interviewed in such determinations. The stakes may be incredibly high, as becoming a doctor may be the dream of a student's life. Osborn writes that the medical students believed, more than the faculty, that helping a fellow student was a higher moral road than adhering to other moral principles. What, if anything, might that imply? For example, are students in general more morally naïve? Or have others lost their capacity for compassion?

Ellen's behavior might indicate that she would become a compassionate and altruistic doctor. This potential could be sharply contrasted with what we might expect of a physician who stalked another person. But both examples raise the question of an

appropriate institutional response: What behaviors, if any, should be forgiven? How might we further support and model compassionate behavior?

In this instance I think of major and minor efforts to improve the care of patients. In psychiatry, a major example would be to seek out a magistrate in the middle of the night for permission to involuntarily hospitalize a patient whom one fears is suicidal—too suicidal to risk leaving alone for the remainder of the night. And going with police and hospital personnel in white coats to bring the patient from home to the hospital. An example of a minor effort is a doctor's effort late at night to find a pharmacy open so she can prescribe sleep meds for a patient who cannot sleep. Another example of a major effort is a dentist who is willing to provide sedation for a child with autism in a parent's car, to provide the dental care the child needs. The dentist may not have the ideal legal protection to do this, but there may be simply no other choice.

Another minor example is a dentist's coming into the office at midnight because a teenager with braces, with two tiny, round, rubber bands in his mouth to help move his teeth swallowed one rubber band and feels it has become stuck in his lower throat. It was not an emergency to remove the rubber band immediately under general anesthesia. It probably would have been resolved when the band was completely swallowed. It was altruistic of the dentist to provide reassurance to this adolescent.

In each of these examples, the doctors did not respond on the basis of deontological policies. Do such examples strengthen the case for medical schools and institutional bodies not to respond automatically to students and doctors on the basis of deontological policies? Should violating principles for altruistic reasons warrant lesser penalties and forgiveness when students or doctors act unequivocally not to harm, but to care? If a caring intention is present and can be reliably confirmed, this kind of response, in principle, could be far-reaching. Perhaps too far, as it might be applied in situations ranging, for example, from patient-favorable coding for insurance to euthanasia.

How should Ellen's altruistic intentions to write a paper for George have been weighed against her having cheated? Should other factors be taken into account? Should it matter what the paper was about? Should it matter whether it was about detailed physiological principles essential for all doctors to know, or about, say, ethics? Would taking an exam for a fellow student warrant a different outcome? What if the other student was exhausted after providing exemplary care to a patient who was suffering all alone through the night? The question is where and how to draw boundaries for behavior that we should excuse, forgive, or punish.

When confronted, Ellen and George immediately admitted they had cheated. But what if, when asked, they had lied, to try to protect each other? It is hard to imagine that any medical school would not take additional severe sanctions, such as dismissal, in that circumstance. Otherwise, the school's credibility would be lost. Yet is there another reason students might not want to admit guilt? Perhaps, like students who don't want to admit "I don't know" to Ed Pellegrino, students might fear that if they admit guilt, it will end their medical careers.

As for how we should respond to lying in this instance, we might look to how lying applies in clinical contexts, when doctors lie to benefit patients. Examples abound. For example, psychiatrists "shade" diagnoses so patients with different insurance policies can afford better treatment. The diagnosis "autistic spectrum disorder" has been structured even more generally in the present diagnostic scheme to enable patients with less-severe disorders to better pay for treatment. All of the above acts may be altruistically motivated. Should this matter?

Practically, there may be no way to recognize when students lie about cheating. Beyond this, though, students who are caught cheating may not know whether to deny or to admit wrongdoing. If they admit it, they incriminate themselves. If they lie and are discovered, it may end their medical careers. Students may be placed in situations of irresolvable uncertainty when the stakes are so high, especially if they entered medical school because they are exceptionally altruistic. Students may see the loss of their chosen career as a sort of death. Such stakes are not unique. Another example would be an Olympic athlete who is disqualified from competition in response to some wrongdoing. In the case of Ellen and George, Osborn writes that many students believed "there was a spectrum of cheating that becomes more serious as the stakes get higher. A patient's lab values could be a significant detail in deciding therapy. Writing a paper for a health policy course did not have the same value."

Given this, perhaps it would be appropriate for medical schools to create a "two tier" system that sorts infractions into lesser and greater. If a student's infraction was not in the greater tier of infractions, for which the student could be expelled, a faculty member could say to the student, "It looks to us like you wrote a paper for another student. It's conceivable you didn't, but we must go by what we see. Fortunately, this is not an infraction for which you will be expelled. I'm glad. I want, as you do, for you to be able to go on to become a doctor." The faculty

member could add, "Perhaps you moved to help a fellow student by a concern for others, that could move you to be a compassionate physician. You could prefer to acknowledge that you cheated, if you did, or not. Generally, it's considered to be a higher road ethically to acknowledge being at fault, if that's the case. For this reason, if you are at fault, I hope you acknowledge it. But it's your choice, and there won't be added consequences one way or the other." The faculty member could also say, "We all err. You may have had a good reason to do what you did. You may have wanted your friend to do well enough to graduate. I'm sure you know now you should not do something like this again. It's important to me that we feel at ease with each other, should we meet in the future. Please know that I value you for who you are. What did or did not happen will not diminish this." This approach can be altered when a student's mistake was not intended to help another, but may still convey that an unconditional regard for the student will continue.

These approaches are radical departures from what most of us might do now. They are problematic at the level of policy and the level of practice. Policy-wise, making any such distinction may unavoidably open the door to further exceptions, and, legally, open the door to new litigation. Ethically, a rule-bound solution might be pragmatic and considered morally best, in and of itself, and, all-in-all, might be the most fair and consistent. Still, what might rightly offset this is our need to respond, in the most just way possible, to situations of human weakness and to be able to take into account "good reasons" to a greater extent. Doing so requires a great deal more effort. To respond with continuing, uninterrupted, unconditional regard to those who err may be still more demanding.

Experiencing this kind of unconditional warmth, even after another makes a mistake, may exert an indelible positive impression on students. Giubilini and colleagues note that attending medical school has been documented to have a negative effect on some students, and their moral values may deteriorate during their medical studies.[15] Even for a few students, a profound memory of positive regard after erring might offset other factors, and so prevent this kind of negative effect. That is, compassion modeled by faculty members may go a long way to offset this effect.

Faculty Who Teach Ethics

Faculty who teach ethics may be expected to help identify students who shouldn't become doctors. This is reasonable, but not without peril. I provide an example of why this is so below. Ethics faculty will want to encourage students to write about topics on which they feel emotionally engaged; otherwise, writing and analyzing a case or topic may merely fulfil a requirement and be, for the most part, unproductive. For students to write about what they really care about, ethics faculty must assure them that what they write is for their instructor's eyes only. Guaranteeing absolute confidentiality may elicit students' heartfelt—or hateful—emotions. When students are assured confidentiality, they may write about what they most care about, often about what has affected them profoundly. For example, some female students express feelings about having an abortion. Some men express shame about being bullied. One essay that stays in my mind was written by a student who expressed shame because, before she began medical school, she provided care for a child with special needs, until the girl was in her late teens. Then the student began to feel "burned out" and ended the relationship. She wrote about how she and the girl would romp through shopping malls, the child in a wheelchair with the student by her side, both waving to passersby, who waved back. The student heard the girl had died, and attended her funeral with great trepidation. But it was fortunate she went, because she learned that the girl and her family did not hate her, as she supposed. Rather, she learned that the family, and the girl, saw her as the brightest light the girl had had in her life.

On the other hand, ethics faculty may feel that they are obligated to report students who express views that are morally problematic. I provide a personal example of this below. If this is the case—that we will report students—we should warn students about this ahead of time. These warnings can be expected to squelch the integrity of students' essays, and violate a core value of teaching as well. Students will most likely write in ways that will keep them wholly safe. In my classes, when a student expresses a view that is problematic, I meet with the student and discuss what was said or written. I take care to indicate, prior to discussing the view, the sound values that may underlie it. I do this in part because I believe it is always possible to find a sound belief behind a troublesome statement. Here's an example of what I am suggesting. A student may feel strongly that it is wrong to make adolescents wait until a certain age to access genetic knowledge that will not benefit. I would tell the student I value his or her concern for adolescents' desires for this knowledge about themselves, and their autonomy.

Validating the other person first is an approach used by most mediators. Having been validated, students, like patients and family members, typically feel more trusting and are more open to adopting a

different moral view—perhaps even a moral view that contradicts their own. But we shouldn't validate others because it may increase the likelihood they will become more open to new ideas. We should do it because, when we look at the ethical bedrock supporting others' moral views, it is likely that some aspect of their view is sound and true, and we can pursue the discussion, as appropriate, from there. After their views are validated, some students, patients, and family members may be able see and accept another's point of view. Some will not. But later, they may become able to accept another's point of view, or at least to soften their own view. There is no way to know. Is there a possible price to pay for taking this approach with students? Yes: we might miss the rare student who should be dismissed. But for that to happen, other faculty also have to miss an indication that the student should be dismissed.

Here is an example. After having read thousands of student essays over the years, only once has a student expressed views that triggered my fear. Late one Friday afternoon, a fellow faculty member approached me and said, "This student should be disenrolled." He had checked with other faculty members, and all agreed. I felt vicarious angst for the student, and dread at the thought of going to the appropriate medical school authorities Monday morning. I said I would read the student's ethics essay.

The student had written that parents should be allowed to kill their children up to the age of 18: "We all know that there are bad kids. Parents already can abort their fetus up to six months. Why not extend this to 18 years? Since we know how some children can turn out, shouldn't we just extend this option of parents being permitted to end the lives of their offspring up until this later age?" (At this point, reader, please ask yourself: How would I respond if I were reading this paper?)

Fortunately, as I read the essay, something seemed familiar about the title: "A Modest Proposal." This was the title of an essay written by Jonathan Swift in 1729, arguing that the poor children could be sold as food to the wealthy, so the children would not be an economic burden.

The student's essay was, as readers may have surmised by now, satire. In writing these essays, students are permitted to address ethical issues in the way they would like, including short stories, drama, and satire, taking into account what these forms, and the humanities more generally, can add to the study of ethics. This student wrote a satire to express his opposition to abortion. I called the faculty member to inform him of this. He thought about it and suggested that I chastise the student in any case, because he had plagiarized the title of Swift's essay.

All inclinations to punish—responses from faculty or colleagues—are worth considering further. The responses may sometimes point to a tendency we all have, but one we must work to see in ourselves: to see in others who have erred, whether faculty, students, or colleagues, what is not there, sometimes a quality or tendency that we may have, but not like, or one we fear.

If a faculty member sees or suspects plagiarism, his or her views on the appropriate response may differ from school policy. If the school favors expulsion and the faculty member favors a lighter penalty, the faculty member may know that if he or she triggers the school policy, the student will probably be dismissed. On one hand, there is a prior, implicit promise to the faculty, school, and students to report a suspicion of cheating. Going against this is the duty to follow one's own values and strong moral views; for example, views based on compassion as embodied and prioritized by the care perspective. There can be profoundly good and bad consequences for following what we, "in our hearts," most believe.

To help focus the discussion, I will return to Ed Pellegrino, and my own guide to moral deliberation: What would Ed do? He often said he was true to his own values—specifically, his spiritual values—first. Another approach might be that of Hannah Arendt, who contributed significantly to philosophy and to how we should regard wrongdoing, or, to use her term, "the banality of evil." She knew the philosopher Martin Heidegger, who, for some time, it is argued, may have supported the Nazis. What enabled some people to resist cooperating with the Nazis, Arendt wrote, was that they asked themselves what would enable them to live most at peace within themselves, and whether they were unwilling " 'to live together with a murderer—themselves.' " She concluded that "living together explicitly with oneself" was "not only the basis for any trustworthy morality," but "at the root of all philosophical thinking."[16] Going one's own way may be the best approach to a problem, but can be risky. Faculty who do not report a student to avoid triggering a dismissal is an example. But it may be, for the reasons aforementioned, a morally acceptable option.

HOW SHOULD WE ERR WHEN A PRACTICING DOCTOR ENGAGES IN WRONGDOING?

What should we do when a practicing doctor engages in wrongdoing, as Teleka Patrick did? What should we do if it comes to our attention that a doctor has erred? What should we do if we are asked to recommend that a physician be allowed to return to practice after fulfilling whatever penalty was as-

signed? These questions are complex, and involve various subtleties and contradictions that should be taken into account, but we might begin by considering, imagining along a sliding scale, the risks that these doctors might pose to patients.

The Psychopathic Physician

Certainly a clinician could be a psychopath. This would mean essentially that he or she lacks the capacity to feel empathy for anyone, including patients. This disorder is addressed by Fawcett, a psychiatrist who is a leader in this area. He asks, "Are there successful psychopaths . . . that we are unable to study because we can only observe for the most part those who have been incarcerated?" He gives, as an example of "successful psychopaths," corrupt leaders who sell out their constituencies, and answers, "Perhaps there are. . . ."[17] Among this group are those who can behave horrifically to some and kind and loving to others. Underworld figures who care for their own family members are examples.

Heidegger is an example of a professional person who furthered the field of philosophy who had ties with the Nazis.[18] What this may mean is hotly and fiercely contested, but his example may serve to introduce the notion that it may be possible for a physician to serve patients effectively as a doctor, but at the same time be immoral in other spheres. One such physician went "all out" for his patients; for example, he allowed a teenager who tried to end his life to stay in his waiting room during the day, so he would not be alone until he was willing to go home and be on his own. The same doctor was convicted for tax evasion. If we were asked to recommend that he return to practice after he "served time," should we take the nature of the crime into account? The crime was "mild" and didn't harm anyone directly. He did later return to practice and continued to help patients greatly.

Such physicians (as any other person) may be able to change. A surgeon who threw knives in the operating room, for example, got help, and went from being the most reviled physician in the hospital (by a census!) to a doctor who was most beloved. One possible point from all this may be that, rather than allowing our responses to be automatic in these cases, we might better respond based on considerations that are more complex. Our guide might be the psychiatrist Viktor Frankl, who had been interred in a concentration camp during World War Two. He found human kindness in all groups. He advised that we must "not try to simplify matters by saying that these men were angels and these men were devils."[19] This instruction may make choosing what to do more difficult. But it may save us, when making a determination, from arriving at an answer that is too easy, and wrong.

Physicians Who Have Difficulty Understanding Others

Many doctors seem distant. Most medical students can, when asked, rank all those in their class from those who are the warmest to the least warm. Physicians who are the most distant and cold may be brilliant and the sharpest of clinicians. They may have traits like people with autistic spectrum disorder, and, as a result, have more difficulty understanding patients who don't "work" they way they do. They may cause harm. They may also be wizards with a scalpel and have the best surgical outcomes. For instance, one patient told her doctor that she had had a one-night stand. He shouted, "You what?!" She never went back to see him again. Another patient who had a terminal illness told her physician that she feared dying. His reply: "We all die." Same result. A doctor who sought to be empathic to a mother who had just given birth to a baby with Down's syndrome said, "I'm so sorry." The mother still hates him, decades later.

These doctors can learn to do better. There may, though, be limits to how far they can go. This possible limitation was best expressed by Jay Carter, a person with full-blown autism spectrum disorder, also known as Asperger's syndrome, in an article he wrote for *JCE* a decade ago.[20] Carter's psychiatrist asked for Carter's consent to write up his "case," although it was later apparent that he did not realistically anticipate what this would involve. When Carter read the published case, he was at a loss: "As I began to read the article, I responded with horror and dismay . . . my situation was far worse than I could have imagined . . . there was . . . a terrible Catch-22 in all of this. Since I had Asperger's syndrome, which limits my ability to perceive social cues, perhaps what [the psychiatrist] had written was true and, worse yet, I was incapable of realizing it. I was blind to my own blindness!"

This depicts the type of limitations some physicians have: they are blind to their own blindness. Realizing this may help us to not set too high a threshold for those we should accept and value as doctors. This may be useful when a physician behaves in a way that appears most insensitive. A harsh response may fail to take into account the doctor's mix of strengths and limitations. Counseling, not punishment, may be the optimal response.

Doctors Who Are Altruists

I remember during psychiatric training that a patient began crying in a group session. A psychiat-

ric resident got up, walked over to the patient, and gave her a hug. Nonsexual. He was severely reprimanded. Bramstedt speaks of clinicians who have trouble with boundaries. Altruists may have more trouble with boundaries than others. A social worker I know offered, for example, to take a patient home with her. I believe the patient would have responded very well to this. The social worker was strongly reprimanded for offering. One doctor didn't bring his child in for care because he wished to respect the values of his wife, who was opposed to most Western medicine. He almost lost his license. Still another doctor prescribed valium for his son when he was in college, because he was very anxious about exams. The doctor could have lost his license. He was called before his medical board—and I don't know the result. These clinicians cared, perhaps too much. These examples remind us how we should be wary of seeing such wrongdoings as more simple than they are. They raise the question of when such behaviors should be actionable and when they are excusable. The answers should never be easy. These examples remind us that even doctors who are caring may err, and they may or may not repeat their errors. To echo Frankl, we should not respond automatically and unthinkingly, as a reflex.[21]

HOW SHOULD WE TREAT STUDENTS AND CLINICIANS WHEN WE ASSESS THEM?

When discussing students and doctors whom we might want to bar from practicing medicine, I note a very important aspiration: to be able, during and after assessment, to have the best possible continuing relationship.[22] How might this be possible? I will address this topic in three sections.

1. When Possible, Resolve Issues to Limit Harm

As discussed above, when a medical body determines a student's or clinician's outcome, it may choose to go either of two ways: (1) treat all infractions in essentially the same way, or (2) consider an infraction as falling into one of two groups: (a) more serious, similar to a legal felony, or (b) less serious and not requiring disbarment, similar to a legal misdemeanor. If the medical body adopts the second way, and the infraction is less serious, an assessor may want to consider other values in deciding what to do. The interests of third parties may, for example, be so profound that they should warrant priority. Here is an example. A clinician committed a minor infraction that did not affect a patient or other person. (The nature of the infraction isn't important to the discussion.) A nurse working with him noted the error and shared it with a colleague. Her colleague felt he should report the error, but the nurse greatly opposed it. She had meant only to share that the error had occurred, she said, not to have her colleague act on it. She planned to work with the man who had erred over the next several years, and she feared that if he was reported, he would know that she had reported the error, and that would destroy their working relationship, which was very important to her. Further and perhaps most importantly, this was an error that wouldn't recur. Her colleague decided to accept her request. They both thought, in fact, after discussing it, that this was by far the best way to proceed.

This case illustrates that if the unprofessional conduct is minor, and another person's best interests might be profoundly at stake, especially if the wrong won't be repeated, or is extremely unlikely to be repeated, it may be ethically preferable, or at least acceptable, to not report. Such conduct may not always require remediation. Assessors who believe that every such instance must be remediated and engage in all-or-none solutions should at least consider that this approach may create some exceptionally painful problems.

2. What Should an Assessor Say, Prior to Determining an Outcome?

Assessment sessions may be painful for all parties involved. Richard Holloway, a dean of students at a large private medical college, writes that "the specter of the dismissal hearing is among the most dreaded of our responsibilities." Part of the problem, he says, is that an "advocate is supposed to be the students' advocate on the one hand, the institution's on the other hand, and perhaps crusader for the good of society on the third. . . ." He continues, "It is hard to maintain a demeanor of dispassion when so much is on the line for the student. . . ."[23] Under these circumstances, assessors should be compassionate, to the greatest extent possible, to the person being assessed. It may not matter to the person who is being assessed, relative to the other stakes they face. Assessors should indicate that they care about the person being assessed because he or she is a fellow person, and deserves nothing less.

When forensic psychiatrists evaluate an alleged criminal for competency to stand trial or for insanity, they tell the alleged criminal that they are working for the state. They may go the extra mile, being morally conscientious, and repeat this warning when they sense that the person being assessed may be about to incriminate him- or herself, in spite of the warning. The person being examined may develop too much non-self-serving trust. Or they may have been acclimated to trust clinicians. Consequently,

psychiatrists may purposefully choose to be distant to reduce the risk of eliciting too much trust. They may not do this to be two-faced; they may do it kindly, to not engage the person they are assessing while simultaneously acquiring information about the person that may work greatly against her or him.

Warning the person being assessed may, paradoxically, have the opposite effect. Telling a person who is being assessed not to trust the interviewer may mean to the person being interviewed that he or she *can* trust the interviewer. When interviewing or assessing a student or colleague, a better way to warn may be to directly express discomfort, by saying: "I want you to know how badly I feel having to do what I am doing now. I don't know anything like your pain. But please know, regardless of the outcome, my caring for you as a colleague will continue." To do this is uncommon. It may, to those interviewed, seem wholly too much. Still, it is a start.

For example, when faculty met with Ellen, the medical student who wrote a final paper for her friend George, they could have explicitly expressed their respect and unconditional regard for her during their meeting. Perhaps they did.

3. Being There, Even if One Can Offer Nothing More

In many cases, students and doctors who have engaged in wrongdoing will be excluded from practicing medicine. Even in these situations, however, those who know the students and clinicians can arrange to be with them, as by sitting with them during the hearing and meeting with them afterwards. We can emotionally at least be there.

An incident that Frankl reported is helpful in this regard. He relates that a patient who was bent on committing suicide called him at 3 a.m. He talked with her for 30 minutes, until she said she would not take her life. But when the patient saw him later, she told him that it was not his arguments against taking her life that had convinced her. The only reason she decided not to commit suicide was that, rather than getting angry at her for calling and disturbing him in the middle of the night, Frankl patiently listened to her for half an hour. A world in which this can happen, she concluded, must be a world worth living in.[24]

Assessors may ask and invite the student or clinician to meet with them after the assessment, regardless of the outcome, to convey their sincerity by stating that they want to continue to be colleagues, if that is what the student or clinician would want.[25] Holloway, the dean of students who spoke about feeling dread, describes a meeting with Lana Tremont, a medical student whom he and others on the faculty were assessing regarding dismissal. During the meeting, he says, "Neither of us could talk freely as we had often done when [Tremont] visited my office in the past."[26] The student had not been prepared for the science required in medical school, and had repeated her first year, yet continued to struggle. During the assessment interview, Tremont's attorney revealed that she had a learning disability that she had never disclosed. Holloway writes, "I kept my head down in shame, avoiding eye contact." Tremont was not dismissed. Holloway writes that after the assessment, "I called her home at night so that she could avoid a sleepless night."

The importance of supporting a student or clinician who is at risk of losing a career, or who has lost a career, cannot be overstated. When possible, faculty members who are not assessors should go as far as they can to offer support. They can offer to sit with the person who is waiting to be assessed, join the person afterwards, and keep in contact after that, if the person wants. Doing this may be like keeping in contact with a patient's family after a patient has died. After all, the assessment may result in a kind of death. We could say, "I would like to remain with you during the interview and after it. If you wish, please take me up on it, and we can leave the interview area and maybe sit and talk together over coffee or tea. We can continue to talk even after that, if you'd like." Showing this kind of concern and care is a priority with our patients. With our colleagues, perhaps we can do even better?

CONCLUSION

I propose a different approach than Bramstedt suggests, not because it is right or better, but because it should also be on the table. When interviewing students who have erred, faculty might not make speculative assumptions, but rather look for signs that suggest exceptional compassion. Wrongs might be seen as existing in two categories, better and worse, and faculty can avoid placing students in a bind in which they may incriminate themselves in wrongdoing when they don't know which answer may deprive them of a future they deeply want. Faculty may want to follow their own conscience in these situations. When a wrongdoer is a clinician already in practice, the assessment of the physician should be complex.

Finally, assessments should be conducted compassionately, regardless of what a person has done. This can include finding ways to avoid harm, when reasonable; telling the person prior to an interview that we care and offering to be with the student or colleauge during the interview and afterwards, if the person wants this.

Holloway, the dean who assessed the student who had a learning disability, provides a follow up. The student later said, " 'I've changed and there's a lot I understand now that I didn't. . . .' " Holloway writes, "Tears filled my eyes. . . . There is nothing that could replicate the feeling of a Lana Tremont or of me as I continued to stand, reflecting on her extraordinary grace and dignity. . . . I hope she knows I will be forever grateful."[27]

ACKNOWLEDGMENT

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NOTES

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3. Patrick graduated from medical school with a medical degree and a doctorate in chemistry and "had her pick of medical residencies." J. Mack, "Teleka Patrick Case; 6 Things We Know and Questions Still Unanswered," 10 April 2014, *http:/www.mlive.com/news/kalamazoo/index.ssf/2014/04/teleka patrick_case_4_things_w.html.* See also J. Mack, "Teleka Patrick Tweeted about 'Demon,' Frustrations with Unrequited Love Just before Disappearance," 7 January 2014, *http:/www.mlive.com/news/kalamazoo/index.ssf/2014/01/teleka Patrick tweeted about_d.html.*

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16. D. May, *Hannah Arendt* (Harmondsworth, Middlesex, U.K: Penguin Books, 1986), 112-3. See also, H. Arendt, *Eichmann in Jerusalem* (New York: Viking, 1963).

17. J. Fawcett, "Expanding our Understanding of Antisocial Personality Disorder and Psychopathy," *Psychiatric Annals* 45, no. 4 (April 2015): 160.

18. Heidegger had "one big idea that should have been of use in resisting totalitarianism," which was "to take up a self that you didn't know you had." S. Bakewell, *At the Existentialist Café* (New York: Other Press, 2016), 78-9. When Heidegger's notebooks were published in 2014, "they provided yet more confirmation of something already known: Heidegger was a Nazi, at least for a while, and not out of convenience but by conviction," 80.

19. V.E. Frankl, *Man's Search for Meaning* (New York: Washington Square Press, 1970), 136.

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22. R.L. Holloway, "Reflections: Lana," *Families, Systems, & Health* 24, no. 2 (2006): 213-7.

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26. Holloway, "Reflections: Lana," see note 22 above,

27. Ibid., 216-7.