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FACULTY VIEWPOINT

A Medical Student Is Psychiatrically Hospitalized

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The following case depicts one of multiple similar instances over the last several academic years. We have arbitrarily designated the gender of the student-patient as female; we are unaware of the actual gender of the patient. For clarity, we have designated the clerkship student as male.

Case A clerkship-year medical student is admitted as a patient to a psychiatric unit at the academic medical center affiliated with her school. The unit serves as a core teaching site for the medical student clerkship and residency training program. A classmate of the student-patient had been assigned to begin his 3-week inpatient psychiatry rotation on the same unit the following week. The unit has two treatment teams, so the rotating medical student could have been assigned to the other team, but he and his classmate would have been likely to see each other on the milieu. The medical school has a limited number of inpatient slots for rotating medical students, so reassignment to another unit is challenging and not always feasible. To best manage this situation, psychiatric clerkship directors must weigh various ethical considerations including patient privacy and student educational experience.

Deliberation What follows is a reconstructed transcript of a conversation about the situation in which the clerkship director (CD) and associate clerkship director (ACD) discuss various considerations and scenarios.

CD: It seems like we should figure out alternative arrangements for the clerkship student. Preserving the student-patient's privacy must be our top priority, and I do not think that can be done if a clerkship student is rotating on the unit.

ACD: What if the student is assigned to the other team on the unit? That way he would not learn any clinical data about the student-patient other than the fact that she's been admitted.

CD: Even that piece of information might seem to the patient like a breach of privacy. Also, the clerkship student may learn other information simply from being in the milieu with the student-patient. He may witness her symptoms or learn about her observation status.

ACD: That's true. I am concerned, though, that we are treating psychiatric hospitalization differently than a medical or surgical hospitalization. I worry that we are perpetuating the stigma of mental illness by restricting students from a unit when another student is a patient there. Are we endorsing the idea that psychiatric hospitalization is shameful? Are we missing an opportunity to demonstrate that psychiatric illness can affect us all? Let us say the student had been admitted to surgery with appendicitis. The students on that service probably would not care for their classmate directly but would not have to be reassigned to another service or ward.

CD: Two issues. First, the care setting in psychiatry offers less privacy than medical/surgical floors. Second, stigma about psychiatric illness *does* exist, even if we wish it did not. I do not think we should compromise this student's privacy in hopes that we are serving a larger anti-stigma goal. And certainly not without her consent.

ACD: That's an interesting idea. I wonder whether we should ask the patient, although that's probably not wise and we do not know, nor should we know, the patient's identity. Furthermore, we do not know whether she is in a condition to offer informed consent/refusal. And even such a question, from school faculty or her treatment team, may seem inherently coercive.

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CD: I think that's right. And there's another important reason why we would not want to place a clerkship student on that unit with a student-patient. We would not want to do anything to discourage the patient or other students with mental health problems from seeking help in the future. If word got out that the school and hospital were not ensuring privacy of student-patients, that could have a chilling effect on the help-seeking of other students.

ACD: That makes a lot of sense. I was also thinking about whether it would matter if the student was in a different year than the clerkship student and therefore less likely to know her. But it's reasonable to assume that students may know each other across class years, and as you indicated, whether they know each other is not the only consideration.

CD: The other consideration, of course, is the educational experience of the clerkship student. Can we find another placement that will offer similarly excellent training? Our inpatient clerkship placements are limited.

ACD: We may have to assign him to a unit that already has another student, so both students may get less individualized attention from an attending and resident. The good news is that the move will not feel too disruptive to continuity because the clerkship student has not started yet.

CD: Right. I do wonder whether our decision would be different if the clerkship student had already started his rotation on the unit when the student-patient was admitted. Would we remove the student? Also, would it matter if the student was a sub-intern on the team?

Resolution

Clerkship directors had to weigh various ethical considerations in managing this case: (1) responsibility to the student-patient, specifically her privacy and autonomy; (2) responsibility to the learner, namely, valuing the fairness of his educational experience; (3) responsibility to the medical school community, including potential student-patients; (4) responsibility to other patients being cared for by the learner (ensuring no harm/non-maleficence in continuity of care); and (5) responsibility to the broader society in addressing/perpetuating the stigma of psychiatric treatment.

Like all medical schools, the school has an established policy forbidding students to access the electronic health records of fellow students, family members, or friends. It had no specific guidance, however, on what, if any, measures needed to be taken in this situation, namely, that a student would be aware of but not directly participating in the psychiatric care of a classmate. Citing the primacy of patient privacy, and because a decision had to be made immediately, the clerkship directors reassigned the clerkship student to another site, where he was the second medical student on a treatment team, at least until the student-patient was discharged.

Given the prevalence of mental distress among medical students, it is reasonably likely that such a scenario will arise again. More than a quarter of US medical students experience depression, and greater than 1 in 10 experience suicidal ideation [1]. Liaison Committee on Medical Education (LCME) Standard 12.4 requires that medical schools provide "timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required educational experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care" [2].

The clerkship directors discussed the case with the department's educational leadership to establish guiding principles. The leadership group agreed that patient privacy trumped student placement in this acute situation but that the department also had a responsibility to ensure optimal standards of clinical exposure and supervision for clerkship students. The group acknowledged the need to identify at least one extra clinical slot each rotation in case a last-minute reassignment becomes necessary for any reason.

Regarding students already working on the unit, departmental leadership agreed that a clerkship student should be reassigned for the duration of the student-patient's admission. However, a sub-intern is often assigned to a unit in place of a junior resident and therefore has significant patient care responsibility. To reassign a sub-intern could have negative consequences for the care of other patients on the unit. In this case, the group felt it would be reasonable to ensure the student-patient is not assigned to the same team as the sub-intern.

The primary administrative responsibility of clerkship directors is the educational experience of clerkship students including the compilation of student evaluations and assigning of grades. Per LCME Accreditation Standard 12.5, "health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion of the medical student receiving those services" [2]. The clerkship directors managed the placement of the clerkship student, but only the clinical staff of the unit were involved in treating the student-patient, whose identity was never revealed to the educational team. Student affairs personnel at the medical school, her treating physician, and the student herself were involved in decisions about her educational status including her return to school.

Dent [3] previously described the possible sequelae for a medical student who is psychiatrically treated during training. One such consideration germane to clerkship directors is what to do when student-patients later become clerkship students themselves. If the psychiatry clerkship follows a psychiatric admission, clerkship directors are charged with adhering to the aforementioned LCME standard that mandates that medical students must not be evaluated by anyone who has participated in their health care. In such a case, a student, in conjunction with the Office of Student Affairs, could request a specific clerkship placement. At many institutions, these placement requests are not uncommon and are made for a variety of health-related and personal reasons. Clerkship directors need not be privy to the specific reasons for such a request.

A future option may be to offer to refer student-patients to outside hospitals where fellow students do not rotate, obviating the privacy issues discussed above. However, student-patients may prefer to be admitted locally, for reasons of logistics and familiarity and to benefit from the clinical expertise of the academic medical center.

The destigmatization of psychiatric illness and treatment is a worthy goal. Some medical schools' curricula now include sessions on psychological distress and mental illness in health care providers that include first-person accounts by attending, resident, and student colleagues and encourage appropriate help-seeking behavior [4]. In all cases, educational leaders should support students who wish to share their stories of mental illness and recovery. But ultimately the choice must be the student's, not the educators'.

Compliance with Ethical Standards No IRB approval required for this work.

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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