Confronting the Gap between Classroom Ideals and the Reality of Clinical Culture: A Student's Perspective

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Abstract

This pair of narratives that engages with the moral and emotional tensions experienced by a medical student and a faculty physician during a clinical encounter with an incarcerated patient. This is the student narrative which recounts the discomfort and internal conflict provoked by witnessing behavior she perceived as racially biased and dehumanizing, alongside her uncertainty about how—or whether—to speak up. The companion piece, written by her faculty mentor, reflects on this moment through the lens of the hidden curriculum, arguing that medical education too often neglects to cultivate the moral courage necessary for such moments. Together, these essays illuminate the silent lessons of professional socialization, the limits of formal ethics instruction, and the urgent need to teach advocacy and moral agency as core components of clinical training.

Keywords: Professionalism, Moral Courage, Medical Education, Moral Injury, Medical Student

Case

A surgical resident ushers me, a medical student on her first day of third-year clinical clerkships, into the trauma operating room (OR) and whispers, "Inmate from Rikers. Stabbed four times. They need a student to help them retract." The patient is JA, a 31-year-old man with no past medical history presenting to the emergency department at a public hospital in New York City, after sustaining a penetrating stab wound to the abdomen with omental evisceration. After stabilization, he is rapidly transferred to the OR for exploratory laparotomy.

Three surgeons surround the operating table where the patient is intubated and his abdomen dissected and splayed open from sternum to pelvis. Despite my earnest attempts at suctioning, blood decorates the team's blue gowns and seeps into their socks and shoes. As the surgeons systematically "run the bowel," sliding their fingers along every centimeter of JA's small intestine, the scrub technician leans towards the intern and asks, "What happened here?"

The intern chuckles, "inmate from Rikers. Another stabbing, by another inmate! It's all in his chart."

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After the bowel injuries are repaired, the attending surgeon removes his gown and gestures to the senior resident, "you got the rest, right?"

She nods. The resident offers me the opportunity to staple closed the incision. It is my first day on the surgery clerkship. The resident models the first few staples, then I take her place and close the remaining length of the wound. The scar is long and crooked, with poorly aligned skin edges in several places. "Good enough," the resident says. "He won't care if this *looks* good." I leave the OR feeling uncomfortable, but do not mention the experience to anyone.

I had many sessions on professionalism and humanism in medical school, but none prepared me for this moment. What made it so hard for me to speak up?

Commentary

My medical school curriculum dedicated one day per week, during the first and second year, to humanism in medicine. The sessions often focused on the provision of compassionate and equitable care for vulnerable patients, including but not limited to those who are temporarily unhoused, incarcerated, or undocumented. These sessions inspired us. Professors discussed the harms of using stigmatizing language in the electronic medical record and how to write about patients with sensitivity. A panel of lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) patients shared experiences of discrimination in healthcare and advised students on providing sensitive and patient-centered care. Small groups of students regularly reflected on systemic racism in the American healthcare system and discussed principles of antiracist medical practice.

As I started my third year and entered the clinical arena for the first time, I anticipated that the real patients I met would be afforded the same painstaking care and thoughtfulness as the hypothetical patients we had discussed in the classroom. Unfortunately, I quickly learned that exalted classroom principles, like confidentiality, devolved precipitously in busy hospitals. I most often witnessed this as seemingly innocuous gossip about patients, which casually floated through hallways and work rooms. Trainees on the trauma service traded shocking patient stories like pieces of bubblegum. During rounds, a resident whispered, "She woke up to her husband standing over her bed ready to stab her with a kitchen knife." While genuine empathy for patients was usually expressed, I wonder what purpose recounting these narratives served and what harms these casual disclosures produced. Did it allow for the collective reflection on tragic cases? Or did it nourish egos as if to say, *this tragedy befell this patient, but I was there to sweep in and save them*?

In the classroom, I had learned to avoid talking about patients in hallways and elevators, and to exclude stigmatizing, medically irrelevant descriptors (such as "inmate") from the electronic medical record and even from discussions with team members. Why were these teachings so readily ignored on the trauma surgery service? Perhaps the team assumed the patient had forfeited confidentiality when JA was admitted to the hospital in an orange jumpsuit, accompanied by a prison guard. Or maybe the team felt a general sense of helplessness against deeply entrenched societal inequities, such as mass incarceration and systemic racism, that had already set JA at such a disadvantage. *What additional harm could be borne by gossiping about the only black body in the room, that also happened to be the only one naked and anesthetized? Or by allowing an inexperienced student to fumble with a stapler on a gaping abdominal wound?*

Another justification for shirking ethical principles on the floors was that residents, attendings, and other care team members often felt exhausted and overburdened by a broken system. Studies show that high levels of stress and

burnout are associated with decreased empathy.[1] Residents worked 24-hour shifts every three days. Given the low volume of nursing staff, surgical residents were expected to wheel patients to the operating room, place IV's and draw labs. Their exhaustion was compounded by the fact that most of their patients were among the city's most vulnerable, including incarcerated persons like JA. Pathologies were more often more severe, and patients needed considerable support to ensure they could be safely discharged.

My understanding of this context contributed to my silence in this unsettling situation. If I had spoken up, would the team assume I was questioning their moral judgment or accusing them of providing substandard care and respond defensively? Would I appear idealistic and naive, implying that the team had the time to debrief every case or the capacity to provide culturally sensitive care to every patient on their busy service?

I am not proud to admit it, but I also worried about my rotation grade. I had learned that a key ingredient to a good grade on a clerkship is getting residents to like you, which requires being perceived as helpful but also having situational awareness (i.e., knowing when to be quiet and get out of the way). My experience of feeling silenced was not unique; a 2005 study found that third-year medical students frequently avoided speaking up about ethical conflicts for fear of reprisal.[2] A more recent paper noted that trainees and clinicians most commonly perform professional misdeeds when they are forced to make quick decisions in heightened emotional states, or when they face toxic work environments or hierarchical pressures.[3] This is the clinical reality I had to navigate, yet I was not prepared.

Moral courage is defined as doing the right thing, or not doing the wrong thing, despite the risk of consequences to oneself or other barriers including hierarchy.[4] Speaking up, when discussions about social justice and ethics are discouraged or even dangerous, requires tremendous moral courage. A study about moral courage among residents at Northeastern academic medical centers found that women are less likely than men to act on their moral beliefs, likely due to gender-based differences of empowerment among trainees. Other findings were that interns were less likely to exhibit moral courage versus residents.[5] Subconsciously, I think that being both a woman in a male dominated surgical service and a student at the bottom of the hierarchy, contributed to my silence. Ethicists have suggested that the development of moral courage should be a formal objective in medical education.[6] Teachings should not only focus on the development of moral reasoning and moral courage but should also attempt to explain why many "good" people sometimes don't do the right thing.[7]

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[1] Galit Neufeld-Kroszynski, Keren Michael, and Orit Karnieli-Miller, "Associations between Medical Students' Stress, Academic Burnout and Moral Courage Efficacy," *BMC Psychology* 12 (May 27, 2024): 296, https://doi.org/10.1186/s40359-024-01787-6.

[2] Catherine V. Caldicott and Kathy Faber-Langendoen, "Deception, Discrimination, and Fear of Reprisal: Lessons in Ethics from Third-Year Medical Students," *Academic Medicine: Journal of the Association of American Medical Colleges* 80, no. 9 (September 2005): 866–73, https://doi.org/10.1097/00001888-200509000-00018.

[3] Catherine V. Caldicott, "Revisiting Moral Courage as an Educational Objective," *Academic Medicine: Journal of the Association of American Medical Colleges* 98, no. 8 (August 1, 2023): 873–75, https://doi.org/10.1097/ACM.0000000000005239.

[4] Caldicott and Faber-Langendoen, "Deception, Discrimination, and Fear of Reprisal"; "Measuring Moral Choices by Physicians: Standing up for Patients," American Medical Association, August 3, 2016, https://www.ama-assn.org/delivering-care/ethics/measuring-moral-choices-physicians-standing-patients.

[5] "Measuring Moral Choices by Physicians."

[6] Caldicott and Faber-Langendoen, "Deception, Discrimination, and Fear of Reprisal."

[7] Caldicott, "Revisiting Moral Courage as an Educational Objective."

I wished that my pre-clinical years had better prepared me for what was a jarring transition from the controlled preclinical environment to the unpredictable clinical setting. Rather than questioning the team in real time or asking to debrief JA's case, I chose to discuss the case months later with a thoughtful and trusted mentor, who highly values humanism in medicine, antiracism, and ethical practice. Those conversations inspired this reflection, which I hope will resonate with other trainees who have similarly been disappointed with their transition to clerkships and have struggled to find their voice in situations that felt wrong.