The student code: ethical and professional expectations of medical students at the University of Otago

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Abstract
Medical students at the University of Otago are now required to sign a ‘student code’ on beginning medical school. This new requirement has been put in place in response to changes to the medical curriculum that have resulted in earlier and increased contact with patients, healthcare staff and the general public, and in order to recognise and formalise the students’ own learning needs. While a student code can most obviously be useful for disciplinary and assessment purposes, the authors make a claim for the code to be used as educational tool to assist students to internalise their obligations to others. The student code, while having common values espoused in other extant codes, is framed with the student experience in mind. The authors discuss the process of development, implementation and proposed review.

In this article we describe a code of ethics developed for medical students at the University of Otago and stake a claim for its importance as an educational tool.

Medical students do not have the standard university student experience. Unsurprisingly medical students see and do many things that are uncommon for other groups of students on a university campus. The most obvious activity that springs to mind is the dissection of cadavers, but that is just a small element of the differences. As medical students progress through their training, they will have increasing interaction with patients. They will talk to and have access to patients’ personal stories; they will examine the bodies of patients, and bear witness to significant events in patients’ lives including birth, death, and the consequence of illness and injury.\(^1\)

The unique level of access medical students have into the lives of others needs to be acknowledged and some consideration given to standards the medical school and the public expect of students in this role.

Because of this unusual student experience, medical students have always been asked to sign forms giving undertakings which it would be unnecessary for many other students to give. For example, historically, medical students on first arrival at medical school signed a confidentiality and consent agreement. But such undertakings were not much used educationally—they were more administrative, and were often signed along with other similar forms.

Anectodally, when asked later if they could remember having signed the confidentiality and consent agreement, few could (even when shown the form again). Students are also expected to sign yet another document rather clumsily entitled ‘Code of Practice for Fitness to Practise’ (CPFP). This document is written as part of a memorandum of understanding between the Medical Council of New Zealand (MCNZ) and each training institution.
Currently the MCNZ do not register students, but will credential the ‘fitness to practise’ policy of each training institution. The New Zealand structure is in contrast to some overseas medical boards that register students on admission to medical school, for example, the New South Wales Medical Board registers medical students on enrolment.

The CPFP document helpfully describes the policy if a student comes to the attention of the training institution as raising concerns for future practice, but it does not set out what the conduct or behaviour of a student should be. For this, students are directed to yet another document, the MCNZ’s Good Medical Practice.

*Good Medical Practice* is written for all registered medical practitioners, and as such has little relevance for a medical student traversing their studies. The most immediately relevant guides to student behaviour come in the shape of informal ‘ground rules’ for the operation of small groups. But, no document pulled together all the threads of ethical and professional obligations directly relevant to a student. Three staff members (Neil Pickering, Lynley Anderson and Hamish Wilson from Bioethics, Professional Development, and General Practice) decided to change that.

A student code was therefore developed entitled *Ethical and Professional Expectations for Medical Students at the University of Otago* (‘the student code’).

This document sought to bring together common values from existing documents as well as other student based concepts such as expectations for learning. A code format was selected as an appropriate method for putting these ideas across, partly because codes of ethics are familiar in medicine, and students will be faced with codes once they move into the workforce.

This article describes the rationale for developing the student code at this point, how it reflects the students’ experience, and the process of its development and ongoing use. We then offer a rationale for its use in medical student learning.

**Why now?**

Medical students have been trained at the University of Otago for over 130 years, so it could be reasonably asked why a student code is needed now. Recent changes to the medical curriculum at Otago have meant that students get to see patients earlier. Previous curricula were structured so that medical students covered basic sciences and theories in the first 3 years of medical school, followed by immersion into clinical work during subsequent years.

The marked distinction between preclinical and clinical students has been reduced and students now interact with members of the community, including patients, from the first year of medical studies. It was perceived by staff that students needed to be aware of the responsibilities that came with such access.

**The student code: reflecting the medical student experience**

A code of ethics serves to express the shared values of a group and the virtues demanded and desired of its members. A code can be used not only to inform and guide individual members of a group about the kind of behaviour expected but also as a yardstick against which to measure the behaviour of someone considered to be
acting outside expected norms. Later disciplinary action by regulatory boards is strongly associated with such unprofessional behaviour amongst medical students.7

A primary aim of the student code was to provide meaningful standards of practice and aspirations across the range of actual situations the students were likely to find themselves in on a day-to-day basis. Given the students’ increasing contact with patients and members of the community in the new curriculum, the student code needed to reflect the importance of keeping personal health information confidential, getting informed consent, of not exploiting patients, and respecting patients’ needs, values and culture.

Similar expectations apply to students’ interactions with their peers, for example students increasingly practice core clinical skills on each other. The new curriculum also facilitates greater engagement with health professionals. Thus we wanted the code to encourage effective and respectful relationships with medical, nursing and allied health professionals, as well as hospital and university administrative staff. Students interact daily with teaching staff, so we also wanted to include material that was relevant to the students’ interactions with their teachers, including a responsibility to provide feedback.

The new curriculum also encourages a variety of learning methods, for example, collaboration among students to produce short presentations, and a good deal of self-directed learning, where the onus falls on the student to follow up ideas presented in lectures and labs. Thus we also sought to spell out the kind of expectations students should have about their learning, including supporting their peers, being aware of their own health and wellbeing and when and how that might impact upon patient care.

Development and ongoing use of the code

A search for similar codes for students led the authors to the Australian Medical Students’ Association who had already developed a code of ethics.8 That document formed the basis of our code, which has been significantly altered to add items particularly relevant for students in New Zealand, and further elements we considered to be important.

The first draft of the student code was sent to senior medical school staff in the three teaching centres (Wellington, Christchurch and Dunedin) the New Zealand Medical Students’ Association and others for comment, correction and additions.

In developing the student code, we considered some important elements that should be present in any well functioning code of ethics.

**Compatibility with other codes and legislation**—Codes should generally seek to be compatible with relevant legislation in the country of practice.9 As stated earlier, some New Zealand legislation applies to students working with patients and this needed to be acknowledged.10

A student code, while laying out expectations directly relevant to the student experience, should generally also be compatible with other codes that the student will be subject to on graduation, thereby making the transition as streamlined as possible.4
Correct balance between minimal standards and aspirations—We selected a must/should structure found in other codes,\textsuperscript{1,12} because it allowed for the expression of minimum standards expressed through the term ‘must’, while the term ‘should’ was used to express aspirational aims.

The use of ‘should’ statements allows for guidance in situations where it would not be possible or appropriate to set a rule. Deciding what expectation is to be a ‘must’ and which is to be a ‘should’ is a particularly difficult task which requires a great deal of consideration. If behavioural expectations are too high then they may be unachievable. Similarly placing ‘should’ in the wrong place may undermine minimum standards.\textsuperscript{9}

Appropriate level of detail—A code that contains too much detail will be long and unwieldy, potentially challenging its usefulness, both as a guide for behaviour and as a tool for learning. Attempting to cover every possible scenario that a medical student might encounter will inevitably lead to problems when some unconsidered possibility has been overlooked. This leaves the student unsure how the code applies, and may paralyse the development of the ability to explore the meaning of a general idea in a specific situation.

On the other hand, a code that is too general can also cause problems.\textsuperscript{13} Statements such as ‘always act for the good of the patient’ without further explanation will be of limited practical use. Such general statements leave people unsure about how they should behave in specific situations, and makes it difficult to measure a student’s actions against.\textsuperscript{9}

Reflecting the needs of key stakeholders—Students are the greatest stakeholders in the code as they will bear the greatest burden from the obligations or expectations placed on them. Patients are also stakeholders as they also have an interest in the behaviour of students. Although no empirical research was done into the ethical concerns of medical students, we did seek input directly from senior representatives of the New Zealand Medical Students’ Association.

Criticism could be levelled at this code because instead of expressing the shared values of a group (as stated earlier) the values espoused in the code are imposed on students on entry to medical school. In defence, the code was based on one drafted by students (admittedly Australian medical students), consultation on an earlier draft was carried out with the New Zealand Medical Students’ Association, and students will be involved in future reviews of the code. A variation on this criticism is that students do not get the opportunity to consent to the code, at a stage when they could not reasonably be expected to understand its full meaning. In short, the imposition of the code does not appear to model its own concern with one of its central values of fully informed consent. There is some force in this criticism, but it is not uncommon, and nor is it regarded as inappropriate for people entering a group to be presented with an existing code.

Criticism could also be levelled because patients were not directly involved in the development of the code. However it was considered that the presence of a student-specific code could only be an advance for patients. Future reviews of the code could canvas patients for their input.
**Introduction and implementation**—The authors decided, with the support of senior academics in the medical school, that student signing of the document needed to be a significant occasion for students. During the very first morning of their very first official day of medical school new medical students are given two copies of the code, one to keep and one to sign and hand back to us.

After a break and an opportunity to read the document, students are asked to stand and make a declaration to their peers and staff that they agree to comply with the expectations listed within the document. This ceremony is attended by senior staff members.

**Review**—The authors plan a full review of the document during 2010 and to review the document on a regular basis thereafter. Already we have discovered areas in the student code that could be improved, but this is part of the ongoing evolution of the document in the light of experience with its use. The make up of the review committee is yet to be determined. We are also considering ways in which the document can be used as a means of assessing professionalism among students.  

**The student code as a tool of medical education**

The most obvious use for a code for students is as a disciplinary tool. Educationally speaking, a clear related use follows, that is the use of the student code for the assessment of student progress and professionalism. Students at Otago are assessed in multiple ways. One significant mode of assessment is the Professional Attitudes and Summary of Achievement Form (PASAF) which is administered by tutors who have a good on-going knowledge of the individual student, through having personal contact with them, e.g. in a small group learning setting.

The student code’s standards and aspirations are highly relevant to the PASAF’s concern with behaviours in contexts such as community, and small-group learning settings.

But a code of ethics can be a learning instrument for other more subtle and intrinsic reasons.

We suggest that the code can have an educational role because its guidance and aspirations can become an embedded part of the students’ own personal understandings of what it is to be a student doctor. By using a code early on that has similarities and resonances with codes used on graduation, it is hoped that the student can learn to identify with and internalise these expectations. In this way the student code aims to become embedded in the students’ gradual growth toward maturity of practice.

In this regard, consider the following scenario:

A student attends a lecture at which an identified patient is interviewed by a senior clinician. The patient speaks of many events in his life and in the lives of his family, and the student takes extensive notes.

At the end of the lecture the clinician reminds the students of their confidentiality obligations. But what does this mean for a student? How is this expectation to be translated into reality? The student then meets with other medical students in a café. It is a public space – she is still interested in discussing aspects of the patient’s story, but she is concerned about whether it is appropriate to do so in this venue.
That evening, the student returns to her flat, everyone is talking about their day, and she is tempted to tell her flatmates (who are not medical students) about the patient interview—will it be OK, she wonders, if she doesn’t name him, and changes some of the details?

Her partner visits, and sees her studying notes from the interview. She puts the notes away in her bag, but reflects that perhaps next time she should leave the patient’s name off the notes, and wonders where best to store them. She recalls the confidentiality section in the student code and reviews the content. She discovers that some guidance is offered for the situations she has encountered and this resonates with and validates her concerns.

What makes the code an element of this student’s learning is precisely that it raises the student’s consciousness of these questions, and demands of the student that she think through the implications of her acts. By this means, the code ceases to be external and abstract and starts to be internal and living.

But there may be a degree of scepticism voiced about this hope. In a challenging article published in the *Journal of Medical Ethics*, Christopher Cowley argues that students in medical schools should be encouraged to use their own moral vocabulary rather than be supplied with quasi-technical terms. He has terms such as beneficence and non-maleficence particularly in mind. The fear he expresses might be extended to the student code, as it employs words—autonomy, disclosure, confidentiality and informed consent—which are not common outside medical ethics.

Cowley argues that these words may replace (‘hijack’ is his term) the ordinary everyday moral terms students arrive at medical school already equipped with. Cowley’s concern is more than a worry about language: it is a worry about practice—including the practice of ethical reflection and action informed by well-understood concepts which the student has grown up with. These common-or-garden terms, he implies, are internalised (and personalised) and are part of the students’ moral lives; the ‘quasi technical’ terms of academic bioethics aren’t—and he might object that the statements of the student code are in the same boat.

We have some sympathy with Cowley’s point, and we have endeavoured to use commonly used terms where possible. However, we have retained some quasi-technical terms, such as ‘autonomy’, ‘disclosure’ and ‘informed consent’ which Cowley might object to. Moreover, Cowley might object to use of a student code since codes are not standardly part of ordinary moral life and are external and depersonalised.

However, ethically speaking, being a student doctor is not a simple extension of being a student. For example, student doctors have to start to learn to exercise ethical and professional judgement in contexts which may be quite different from anything they have experienced before. The student code reflects the multiple expectations and challenges inherent in the students’ educational context. As they become more familiar with these contexts—speaking to people about their health, visiting rest homes, working collaboratively, discussing differences, and so on—the guidance and aspirations in the code will become a meaningful part of practice.

Terms such as autonomy, disclosure and informed consent, used in the code, may never have the ring of ordinary language, but a student can become sensitised to these concepts and become aware of the sometimes bitter experiences of patients that their use reflects. Further, personalised ordinary ethical notions are not sufficient for medical practice; for doctors have professional obligations as well as personal ones,
and these are often expressed in a language adopted by the profession, with which the students need to become familiar.

**Conclusion**

The student code developed for medical students at the University of Otago has codified the expectations and aspirations which come with the medical students' unusual situation. It places these expectations and aspirations in the context of the day-to-day experience of the medical student. This context includes contact with members of the community, including patients, for educational purposes, and an unusually high degree of access to their health and other personal information. In this context, the student code plays the role of setting standards. But it also plays an educational role, getting students used to the sorts of considerations they will need to take into account and reflect upon as they mature towards full professional practice as a doctor.

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**References and endnotes:**

1. Other health professional students may also have varying degrees of access to the lives of patients. Professional training bodies of these students might also consider instigating a similar code for their students.
11. Royal Australasian College of Physicians (RACP) http://www.racp.edu.au