A First-Year Medical Student's Dilemma

For even the most relaxed and confident medical students, clinical rounds can be intensely stressful. This was certainly true for Eric Taylor, a third-year medical student. Although studious and conscientious, Eric often felt somewhat disconnected from his peers—and even more so from those senior to him who guided rounds.

Eric grew up in a small town and was the first in his family to attend college. Access to healthcare in his community was limited to an urgent care center. The closest hospital was nearly an away, but the care was not specialized and clinicians rarely stayed for more than a couple of years. Most community members preferred to drive to a regional tertiary care center about two hours away. Witnessing both the logistical barriers to care and the strain on overextended clinicians motivated Eric to pursue medicine. He aspired to be an advocate for improved access to care that maintained the dignity and respect of patients in underserved, rural communities.

Rounds that day began poorly for Eric when he struggled to answer a question from the chief resident in front of the patient and his peers. The resident, known for a particularly exacting style, did not hesitate to publicly correct students, and emphasized the real-world consequences of clinical errors. While this could feel intimidating, it also underscored the importance of vigilance and professional responsibility. For the remainder of rounds, Eric resolved to stay near the back and minimize attention—just trying to get through the session.

When they reached the final patient, Eric was reviewing medication administration record (MAR) and noticed something unusual. The patient had been prescribed an antibiotic that he would not have anticipated for this clinical scenario, and that was known to interact poorly with other medications prescribed to the patient. And indeed, he saw a potential interaction flagged in the MAR that had been ignored or gone unnoticed by the busy team.

Part of Eric wanted to immediately alert someone about the interaction, but he wasn't sure of the best approach, or even whom he should speak with. He remained embarrassed from earlier, and especially uncomfortable with the prospect of pointing out a potential mistake to someone senior to him. Additionally, he recognized that he was still a learner, and his knowledge was limited. Perhaps this was already noticed and left unchanged for reasons that he was unaware of. The tension between speaking up and acknowledging his own inexperience left him uncertain. He considered consulting a fellow student, but that option felt equally uncomfortable. Not wanting to disrupt the flow of rounds, he resolved to review the interaction in more detail on his own later in the day.

Discussion Questions

1. How does Eric's hesitation reflect both humility and a lack of confidence? Are these two qualities always aligned in clinical settings?
2. In what ways can humility protect patients in medicine? How does it differ from passivity or self-doubt?

3. What factors contribute to a student or clinician deciding whether to voice a concern during rounds? How do hierarchy and team dynamics influence this?
4. How can clinicians maintain humility while also developing confidence in their medical knowledge and decision-making?