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Editorial Article **Open Access**

Bioethics of patient involvement in clinical education, a call for guidelines

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On October 16, 2025, I attended a workshop at the annual conference of the Association of Medical Schools in Europe (AMSE) in Olomouc, Czech Republic, on the topic of learning and teaching of bioethics, conducted by educators from Australia, India and Germany. UNESCO's bioethics framework was used to discuss this. This universal framework of principles and procedures of bioethics ("ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions"), unanimously adopted by UNESCO's 191 members states in 2005.[1] Several workshop participants appeared to use the 15 principles to shape their education (Table 1).

Table 1. Titles of UNESCO's 15 bioethics principles and procedures

1. Human dignity and human rights	9. Non-discrimination and non-stigmatization
2. Benefit and harm	10. Respect for cultural diversity and pluralism
3. Autonomy and individual responsibility	11. Solidarity and cooperation
4. Consent	12. Social responsibility and health
5. Persons without the capacity to consent	13. Sharing of benefits
6. Respect for human vulnerability and personal integrity	14. Protecting future generations
7. Privacy and confidentiality	15. Protection of the environment, the biosphere and biodiversity
8. Equality, justice and equity	

While I listened in, it occurred to me that one topic that was not brought up, but would be worth considering here – as a suitable topic for an editorial. While bioethics education pertains to moral behavior in patient care, the principles might also be used to evaluate education with patients.

Much of health professions education involves student and trainee interaction with patients; it dominates during all of postgraduate training, but also significantly in undergraduate education. Without patients, there is no health professions education, despite all the advances in simulated health care environments.

In competency-based education the notion of entrustment of students and trainees with clinical tasks is gradually being embraced, worldwide.[2] Much of the guidelines and research studies in this domain regard the position of the trainee, and the possibility of increased autonomy for contributions to patient care (commonly known as entrustable professional activities or EPAs).[3] The patient's willingness to be attended by a trainee (for history taking, diagnostic procedures, or treatment, in part or in whole), has received much less attention. Patients may be aware of their role in education, for instance when their doctor visits them on bedside rounds with a flock of students, or at teaching sessions in a lecture theater. A patient may not be aware when, for example, their surgeon during an operation under general anesthesia, asks a resident to perform much of the operation. Should the patient know? Asking patient consent for intimate examination under anesthesia for training purposes is a continuous issue of debate.[4, 5]

Many schools may have rules regarding the consent of patients for education, but there is no universal code of conduct. Having this may be a useful idea, particularly now that many schools and programs start using EPAs, and incorporate summative entrustment decisions to qualify trainees to contribute to health care. EPAs specify what these contributions are, and entrustment-supervision scales specify the level of supervision and

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autonomy that should be appropriate for the trainee. The object of entrustment is usually a patient. What do patients think? Would they consent to be examined and even treated by a trainee, knowing that there is no close supervision at the time but only debriefing directly afterwards, indirectly, later, or just via a check of the students' input in the patient's electronic health record.

The attention to patient involvement in education and its ethics has focused much on their active roles, such as in bedside teaching, in acting as standardized patients, in providing patient narratives, useful for learning, or as teachers or assessors of students [6–9]. The ethical question has not often focused on the benefits or disadvantages for patients of being attended by a trainee.

Long before Osler (1849-1919) elaborated bedside teaching, using patients for education was introduced in Italy (Padua ~1550) and in the Netherlands (Leyden ~1700) and subsequently in Vienna and Edinburgh and the USA; before that time, university medical education was predominantly theoretical.[10] Now, health professions education and postgraduate training cannot do without patients. If, under full disclosure, a patient would be given autonomy to choose whether to be attended and treated by a licensed physician or board-certified specialist versus by a trainee who does not yet have such qualification, it is hard to imagine they would choose for the trainee. Yet, if all patients would be given this option, there would not be a possibility to educate a next generation of health professionals. Luckily, in general, patients seem certainly willing to participate in education [11, 12] and trust in doctors is generally high [13]. However, there are signs of a decline in population trust in doctors and in science in some countries [14], which may also affect the willingness of patients to be attended by trainees.

The license to practice seems a clear divide, that might allow to say to a patient, "this *physician* will take care of you", obscuring however that 'taking care' could be a specialty task and the physician could be a PGY1 in training, with many years to go. The issue is not that we should avoid such terminology, but it may implicitly obscure the trainee's limited experience. So, what should we do? Should every 'first time' for a trainee be openly revealed to the patient? Probably not, to avoid anxiety and avoid patients blocking valuable trainee experience.

For moral and ethical reasons, guidelines are needed to help navigate the patient's fundamental rights (see Table 1), which include Human dignity and human rights, Potential harm balanced with benefits, Patient autonomy and individual responsibility where a choice is possible, the possibility to Consent or dissent, and other principles from UNESCO's list.

My point is that preserving high quality clinical training requires cooperation of patients, explicitly or implicitly; walking the tightrope of serving education and patients' right can be difficult. Besides a model for education in bioethics, we need a model for bioethics of education with patients.

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