AI Professionalism

Problem Based Learning Cases

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Session goal. Demonstrate professional AI use in academic and clinical learning contexts by maintaining independent clinical judgment, transparent communication, and responsibility for AI-assisted decisions while upholding patient-centered care.

Learning objectives (verbatim). (1) Maintain ownership of clinical decisions when AI is involved; recognize the AI as a tool, not a team member. (2) Protect adaptive expertise from cognitive offloading by maintaining independent reasoning as a professional norm. (3) Demonstrate patient-centered focus and disclosure during a real-time encounter in which AI is being used. (4) Apply academic and professional integrity to AI use in coursework and clinical learning. (5) Take responsibility for verifying AI outputs and for raising concerns about the adequacy and limitations of institutional AI workflows.

Before the Case: Two Foundations

Concept box: Professionalism vs. professional identity. Professionalism is the set of observable behaviors and standards the profession commits to (competence, honesty, confidentiality, accountability): what a professional does. Professional identity is who the physician becomes: values and ways of thinking so internalized that those behaviors are self-expected; one comes to think, act, and feel like a physician (Cruess et al., Acad Med 2014; 2015).

Because “professional identity” means different things to different people, this session is concrete about the four elements it builds on: listening to the patient's story (Charon 2001), independent clinical reasoning (Montgomery 2006; Schön 1983), honesty about the limits of one's own knowledge, and personal responsibility for clinical decisions. Each appears in the case below.

Concept box: Key terms (defined at first use).

1. **Attest / attestation.** To formally confirm that the content of a clinical note is accurate and to take professional responsibility for it. The clinician who signs a note attests to it; an unsigned draft attests nothing.
2. **Addend a note.** To add a dated, signed correction or supplement to a note after it has been signed. The original text is preserved; the addendum becomes part of the legal record.
3. **Clinical Decision Support (CDS).** Software that analyzes chart data and offers prompts or recommendations (risk flags, drug-interaction checks, guideline reminders). Background CDS runs automatically on every chart. In some systems it also inserts suggested plan items directly into an AI-drafted note; the clinician must decide whether each item was actually part of the visit.
4. **Ambient artificial intelligence (AI) scribe.** A sanctioned tool that records visit audio and drafts the clinical note for clinician review. It records only what is said while it is running, on the account of the clinician who activated it. (Mechanics and accuracy review: Session 2.)
5. **Referral expiration.** Many health systems cancel a referral order that has not been scheduled within a set period (often 90 days, sometimes longer). An expired referral must be renewed by the clinician before the patient can book the appointment.

PBL Case: “What the Note Left Out”

Objective focus. The case primarily teaches Objective 5 (verifying AI outputs and raising concerns) and Objective 3 (patient-centered focus). It secondarily exercises Objective 1 (ownership of a decision the AI proposed), Objective 2 (independent reasoning and epistemic humility in the statin moment), and Objective 4 (integrity of attestation). The discussion questions follow this mapping.

Scenario

Part 1: The visit

Sasha is an M2 on a longitudinal preclinical primary-care preceptorship with Dr. Vargas. The preceptorship runs the usual way: Sasha sees each patient alone first and takes the history; Dr. Vargas then joins, Sasha presents at the bedside, and Dr. Vargas examines the patient and settles the plan. The clinic uses a sanctioned ambient AI scribe on Dr. Vargas's account. Patients consent at check-in, and Dr. Vargas mentions it when she enters the room. Under clinic policy the scribe is licensed to Dr. Vargas and is not run during the student-only portion of the visit, so it records only the part she is in. Background CDS runs on every chart and adds suggested plan items to the draft note.

Mr. Park is 56, a line cook who came to the United States in his twenties, and here for his first follow-up since being diagnosed with type 2 diabetes three months ago. His English is fluent but he says he sometimes finds clinic paperwork hard to follow. In the fifteen minutes Sasha spends with him alone he is anxious and full of questions. Partway through he says quietly, “My uncle went blind from sugar. That's what scares me.” As they talk, more comes out. At diagnosis he was referred for a dilated eye exam. He never scheduled it. Part of the reason, he admits, is that he is afraid of what they might find.

Dr. Vargas joins, and the scribe begins recording. Sasha presents. She decides not to repeat his fear aloud in front of him at the bedside, and plans to raise it afterward. Near the end she says, “He hasn't gotten to his eye exam yet.” Dr. Vargas turns to Mr. Park: “That exam is how we protect your vision. Let's make sure it gets done.” She examines him, reviews his glucose log and his labs, adjusts his metformin, and the visit ends. Mr. Park's fear, and the reason the exam was never booked, were said only to Sasha, before the scribe was on.

Part 2: The draft

After clinic Dr. Vargas opens the AI draft to sign it and, as she does with her students, asks Sasha to read it with her. “You spent more time with him than I did. Tell me what the scribe got wrong or left out.” Sasha reads it against her handwritten notes and her memory of the visit. The history is well organized and most of the plan is right. Two things stop her.

6. **The eye exam.** Under health maintenance the draft reads: “Diabetic retinopathy screening: referral placed 7/2026; patient to schedule.” Both statements are true. But Sasha knows three things the draft does not say: the referral expired after 90 days under clinic policy and is no longer active; Mr. Park has not scheduled and, on his own account, will not without help; and the reason is fear, with a family history of diabetic blindness behind it. Nothing in the plan addresses any of this. If the note is signed as written, every future reader will see screening as in hand. No one renews the order, no one helps him book, and a man at real risk of losing his sight misses screening until someone notices, months or years from now. Sasha is also unsure whether his fear belongs in a clinical note at all.
7. **The statin.** The plan includes “Initiate moderate-intensity statin therapy.” A CDS card next to it shows the rule that fired (diabetes, age 40 to 75, cardiovascular risk reduction) and cites the ADA Standards of Care. The line was inserted automatically; statins were never mentioned during the visit, by Dr. Vargas or by Mr. Park. Sasha remembers his low-density lipoprotein (LDL) cholesterol as unremarkable and, even with the citation in front of her, cannot explain why a statin is indicated. She could say nothing and assume Dr. Vargas has it in hand. She could suggest deleting it. Or she could say that she does not understand it.

Part 3: The conversation

Sasha raises both issues.

8. The eye exam, as an observation with a proposed action: “The screening line reads as if it's handled. He told me he never scheduled it, so that referral has expired. And he told me why: he's afraid of what

they'll find. His uncle went blind from diabetes. I don't think he'll book it on his own. Could we renew the referral and ask the care coordinator to help him schedule?"

Dr. Vargas renews the order and messages the care coordinator. Together they rewrite the line: "Retinopathy screening: prior referral expired, not completed. Patient reports fear of findings (family history of diabetic vision loss) as the barrier; counseled; referral renewed; care coordinator to assist with scheduling." The fear is in the note not as color but as the reason screening lagged and the reason the plan now includes help.

9. The statin, as a gap she names: "The plan includes a statin, and we never discussed one with him. I also have to be honest: I don't understand the indication. His LDL looked fine to me. Can you walk me through it?"

Dr. Vargas explains that the recommendation is based on cardiovascular risk, not on the LDL value alone; the American Diabetes Association (ADA) recommends that, adults with diabetes aged 40 to 75 receive a statin for primary prevention of atherosclerotic cardiovascular disease which is why the CDS included the statin in the plan. The recommendation is sound. But it was never discussed with Mr. Park, so it cannot stand in a signed plan as "initiated." She changes the line to "Statin therapy indicated per ADA Standards; not yet discussed with patient; to review at follow-up call this week." Sasha writes herself a learning issue: read the relevant section of the current Standards of Care and bring questions to the next precepting session.

Dr. Vargas thanks Sasha for both catches. She says she will raise two patterns at the clinic meeting where the scribe pilot is being reviewed: the CDS placing undiscussed therapies into draft plans as if decided, and the scribe missing what patients say to students before the attending enters.

The case deliberately ends with the conversation going well: it models a functioning teacher-learner relationship, in which raising an observation and admitting a gap are ordinary professional behavior. The facilitator guide addresses the harder variant: what if the response had been dismissive?

Discussion Questions

10. Before Sasha says anything, the draft contains at least three points where professional behavior is tested. Identify them and say which element each tests: ownership of a decision the AI proposed; integrity of what the attending is about to attest to; or patient-centered care.

11. What does it mean to attest to a clinical note? In this encounter, what is Dr. Vargas's responsibility in signing, and what is Sasha's responsibility in the review she was asked to do? Where does the AI sit in that chain, if anywhere?

12. A clinical note serves several purposes: communication among clinicians, a medicolegal record, and increasingly communication with the patient. Using those purposes, decide what about Mr. Park's eye exam must be in the note, what may be, and what need not be. Does his fear belong? Then draft, in plain speech, how you would raise the problem with Dr. Vargas.

13. The CDS inserted a statin recommendation that was never discussed with the patient, and Sasha cannot explain it. Compare her three options: say nothing, suggest deleting it, or name the gap. Which is the honest option, which is the safest for Mr. Park, and why are they the same one? What is the difference between a displayed citation and understanding?

14. A counterfactual: the note is signed as drafted, and Sasha notices the problems two weeks later while reviewing the chart. What are her responsibilities then, to the record (what does it mean to addend a note?), to Dr. Vargas, and to the system, if the scribe and the CDS are producing these patterns across many charts?

Facilitator Guide: PBL Case

Facilitator qualifications. A faculty member who is a content expert in clinical medicine; no AI expertise is required. The guide is written to be self-contained. Facilitators should be comfortable leading discussions about professional identity and about learner-supervisor communication, and should review the Session 2 materials on documentation review (omission errors) and the Session 4 materials on disclosure if unfamiliar.

Educational purpose. The case teaches three habits. First, verification and voice (Objective 5): an AI draft can be literally accurate and still omit the thing that matters, and the professional response is a specific, respectful observation with a proposed action. Second, ownership and epistemic humility (Objectives 1 and 2): the statin moment asks the student to resist automation bias, to recognize the limits of her own knowledge, and to act on both by naming the gap rather than hiding it. A displayed citation on a CDS card is not understanding, and an undiscussed therapy cannot be attested to as a decision. Third, patient-centered focus (Objective 3): what Sasha heard alone with the patient is the only reason the omission is caught, and the fix is an action for the patient (renew, help schedule, counsel), not a richer narrative for its own sake. The case is also an integrity case in the exact sense defined in the lecture (Objective 4): whoever reviews a draft owes the signer an honest account of what is wrong and what they do not understand.

Suggested group size and timing. Groups of 5–7 with one facilitator. 35 minutes: ~5 minutes reading, ~25 minutes on the five questions, ~5 minutes closing debrief. The case is intentionally rich; if time is short, prioritize Questions 3 and 4; they carry the case's two central moments.

Q1: Three decision points (model answer)

15. Ownership of an AI-proposed decision: a statin that no one discussed with the patient sits in the plan as if decided. Signing it would make the CDS, not a clinician, the author of a therapeutic decision (automation bias, from the lecture).
16. Integrity of attestation: the draft describes retinopathy screening in terms that are true but inert; the referral has expired and nothing is planned. Signing without correction attests to a plan that does not exist.
17. Patient-centered care: the patient told the student the real barrier to screening. If that stays with the student, the system never acts on it.
18. **(Also acceptable: cognitive offloading.** Had Sasha not kept her own record of her time with Mr. Park, there would have been nothing to check the draft against.)

Q2: Attestation and responsibility (model answer)

To attest is to confirm that the note is accurate and to take professional responsibility for it. Dr. Vargas owns the attestation and, with it, the note's accuracy toward Mr. Park. Sasha's responsibility is narrower but real: when asked to review, she must share what she learned from the patient, say what she believes is wrong, and say what she does not understand. Silence in a review is a choice. Institutions vary in how they label student participation in notes; students should learn their institution's documentation policy. The AI has no place in the chain of responsibility. It drafted; it did not decide, and it cannot attest (AI as a tool, not a team member, the curriculum's through-line).

Q3: What belongs in the note, and how to raise it (model answer)

Must be in the note: that screening has not occurred, that the prior referral expired, and what is being done about it (renewed referral, scheduling help, counseling). These serve every purpose of a note: the next clinician needs to know screening is open; the record must reflect the actual plan; and the patient, reading his note, should recognize his own situation. May be in the note: the barrier, stated briefly and respectfully (fear of findings; family history of diabetic vision loss), because it explains why screening lagged and why

the plan now includes help. Need not be in the note: a narrative of the patient's emotional life beyond what bears on care. Reasonable clinicians disagree about how much of the patient's story a note should carry (Charon's narrative medicine on one side, the medicolegal minimalists on the other). The point for students is to decide from the note's purposes, not from habit or from what the scribe happened to capture.

Scripts: a good one names the specific problem, its consequence for the patient, and a proposed action, as shared problem-solving. For example: “The screening line reads as if it's handled. He told me he never scheduled it, so the referral has expired, and he's afraid of what they'll find. Could we renew it and get him some help booking?”

Q4: The statin, automation bias, and epistemic humility (model answer)

Saying nothing forwards a therapy on the tool's authority rather than anyone's understanding, and lets an undiscussed decision stand as decided: that is automation bias in its plainest form. Suggesting deletion substitutes ignorance for the tool's reasoning and could cost the patient an indicated therapy; the recommendation is correct, since in diabetes at this age statin therapy is recommended on cardiovascular risk rather than on an LDL threshold, and by ADA criteria age and diabetes alone meet it (other guidelines add an LDL or 10-year risk threshold). Naming the gap is honest about the limits of her knowledge (epistemic humility, a professional-identity element from the lecture), keeps a clinician in charge of the decision, and surfaces a second problem she might otherwise have missed: the therapy was never discussed with the patient, so even a correct recommendation cannot be attested to as initiated. The displayed citation did not make the decision; a clinician who understands it, and a conversation with the patient, do.

Closing the gap: a good answer names a concrete plan (read the relevant Standards of Care section, log it as a learning issue, bring it back to the preceptor). Facilitators should say explicitly that honest uncertainty plus a plan is a strength in a learner.

Q5: The counterfactual discovery (model answer)

The record: correct it now, with an addendum to the signed note (dated, signed, preserving the original) and, more urgently, the referral renewed and the statin conversation actually held. The patient's need sets the timeline.

Dr. Vargas: tell her directly and promptly; she signed the note. The framing is the same collaborative observation as in Question 3.

The system: a tool that inserts undiscussed therapies into plans, or a scribe that misses what patients tell students, belongs with the institutional owner of the tool (the clinic's pilot review, clinical informatics, or safety reporting), raised through Dr. Vargas or directly. Correcting one chart fixes one patient; reporting the pattern protects the rest. Silence has its own weight.

Common pitfalls

19. **Keep the focus on habits and systems, not fault.** The scribe recorded what it heard; the CDS applied its rule; Dr. Vargas runs a sound teaching workflow and responds well. The case is about the habits that make this environment safe, not about who erred.
20. Students may treat the good outcome as unrealistic. Acknowledge it directly: the case models the relationship working because that is the norm being taught. Then ask the harder variant aloud: if the response had been dismissive, what then? (Answer: the patient's need still stands; persistence through another channel, such as a clerkship director or the tool's institutional owner, framed on the patient, not the conflict.)
21. Students may drift into re-litigating whether AI scribes should exist. Redirect: the tool is in the environment; the question on the table is what professional behavior looks like inside that environment.

22. Do not let Question 3 collapse into “document everything.” The purposes of the note, not completeness, decide what goes in.
23. **Do not let the barrier become a stereotype.** Mr. Park's fear and his difficulty with paperwork are facts about one patient, not about a population. If students generalize (“patients like him don't follow up”), redirect to the system question: what would have helped this patient complete screening, and whose job was it to notice he had not?

Equity note for facilitators. Two features of this case bear on equity without being its subject. First, the information that saved the screening came only because the student had time alone with the patient; in clinics where that time is scarce, and for patients who hesitate to volunteer fear, the omission goes uncaught. Second, Session 3 reviews evidence that speech recognition performs worse for some dialects and non-native speakers; an ambient scribe may miss more of what some patients say. The professional habit taught here, verifying the draft against what the patient actually said, matters more for those patients, not less. Raise this only if the group has covered Session 3.

Workflow context. This fictional clinic specifies that the student sees the patient first, the scribe starts when the attending joins, and the attending reviews and signs the draft. These are case assumptions, not universal rules about scribe licensing or student participation. Institutions differ in preceptorship structure, recording consent, student documentation, and attestation. The cited preceptor materials and student OSCE study offer examples; apply local policy when adapting the case.

Evaluation plan

24. Level 1 (reaction): three-item exit poll after the session (clarity, relevance to clerkships, intent to use one behavior).
25. Level 2 (learning): the six Session 5 MCQs administered as pre-work and again at the end of the session; Question 5 maps to this case.
26. Level 3 (behavior): at 4 to 6 weeks, a two-question follow-up asking whether the student has raised an AI-related observation with a supervisor or verified an AI output before acting on it, and in what situation.

Closing debrief prompt: “What is the one habit from this case you will carry into your first clerkship, and what will make it hard to keep?”

Sources for the note on the workflow

27. **UMass Chan Medical School.** Longitudinal Preceptorship Program (LPP) preceptor packet. https://umassmed.edu/globalassets/office-of-undergraduate-medical-education-media/vista-lpp/lpp-ilm/lpp-preceptor-packet.pdf
28. **University of Houston College of Medicine.** Longitudinal primary care preceptor orientation. https://uh.edu/medicine/faculty-affairs/documents/lpc-orientation-preceptors-with-narration.pdf
29. **The Cavalier Daily.** U.Va. Health cuts scribe hours as AI documentation tools expand across Health System. October 2026. https://cavalierdaily.com/article/2026/10/uva-health-cuts-scribe-hours-as-ai-documentation-tools-expand-across-health-system
30. **Yale School of Medicine.** How ambient AI scribes impact medical students. August 18, 2026. https://medicine.yale.edu/news-article/ambient-ai-scribes-impact-medical-students/
31. Impact of an ambient AI scribe on medical student Objective Structured Clinical Examination notes: nonrandomized clinical trial. JMIR Med Educ. 2026. doi:10.2196/88264
32. **American Academy of Family Physicians.** Updated E/M documentation rules good for preceptors. AAFP News, February 16, 2018. https://www.aafp.org/about/news/20180216studentdocumentation