Medical students and clinical ethics

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Teacher-clinicians are not always adequate role models

IN 2000, THE AUSTRALIAN MEDICAL COUNCIL highlighted the place of *clinical* ethics in the education of medical students.[1] A similar appreciation of its relevance has grown in the UK, North America and Europe.[2-4] Recently, a working group of the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools (ATEAM) produced a core curriculum for the subject[5] that encompasses the knowledge, skills and attitudes required for students to appreciate the range and complexity of ethical issues permeating medicine and the moral principles required to deal with them.

Who should teach ethics to medical students remains debatable, with some advocating a role for ethicists and others seeing the clinician as more appropriate. ATEAM argued that an optimal program embodies "multiple perspectives and multiple teachers".[5] As the working group put it: "Teachers of ethics can play an important role in modeling the very nature of ethics: the teaching process should be perceived as being emotionally supportive and academically encouraging, should be tolerant of multiple perspectives, should be interdisciplinary and should actively involve clinicians as code-instructors and as role models for students. This also underscores the responsibility of teachers to develop as an ethical community and be alert to, and respond to, unethical behavior among themselves."[5]

Clinicians who are specifically recruited to teach clinical ethics are invariably selected on the basis of their sensitivity and commitment to the ethical dimension of the doctor–patient relationship; they are likely to serve as appropriate role models. Regrettably, during the course of their training, students may encounter other clinicians who lack sensitivity and manifest a disregard of ethical principles. In a survey of Canadian medical students, half reported pressure to act unethically and 60% had observed unethical conduct in a clinical teacher.[6] Moreover, they had felt impotent in the face of these circumstances because of the teacher's intimidatory attitude.

Having taught clinical ethics for almost three decades and on three continents, I have compiled a body of evidence of clinicians demonstrating wholly undesirable qualities and behaviour to medical students. In the context of case-centred teaching programs in ethics, students are requested to observe ethical aspects of practice during their attachment to a medical or surgical unit and then select an experience which has provoked their curiosity, generated concern or affected them in some way. The narrative of this experience is shared with a group of fellow students, one of whom serves as a scribe. As a result of this process, I have files containing dozens of ethically challenging scenarios (Box 1).

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1: Examples of ethically challenging situations faced by medical students

- *The jocular doctor:* In an effort to introduce each patient in a clinic to the observing students, a consultant either joked about them or referred to an amusing quality in them. Although the content and tone were not malicious, the students wondered whether this did not undermine the principle of respecting the dignity of the person. The students were sensitised given their experience not long before of a pair of surgeons talking indelicately about an anaesthetised patient under their joint care.
- *The slanging match:* A group of students were unnerved when witnessing a feud between a consultant and a ward sister, conducted in the passage and well within earshot of the patients. The pair had virtually come to blows over the issue of truth-telling. The nursing staff were convinced that a patient with advanced cancer sought the truth about her prognosis, whereas the consultant was of the view that she would be emotionally harmed if given an explicit prognosis. The students felt immobilised in the face of the increasingly acrimonious exchange.
- *The scolding doctor:* During the course of a consultation, a patient complained of a burning sensation in her legs. The clinician briefly reassured her that this was of no consequence. The pain appeared to worsen, the patient becoming tearful and distressed. Expecting further reassurance by the doctor or cessation of the examination, the students were staggered to hear his litany of criticisms of the patient for her not exercising or eating adequately. Later in the staff office, the doctor complained further about the patient, seemingly insensitive to her suffering.
- *"All must palpate":* Having examined a patient with an abdominal mass who was obviously in severe pain, the doctor instructed all eight students in the tutorial group to palpate her abdomen after the ward round. Half the group felt so intimidated by the clinician's "overbearing personality" that they examined the patient despite her request for the process to cease. The others felt it disrespectful to impose on the patient, but then had to lie to the teacher that they had "felt the mass".
- *The "difficult" patient:* The patient screamed out in pain when the doctor examined her pelvis. The observing student was startled to hear the doctor then reprimand the patient for acting "hysterically" and losing control. Later, but still at the bedside, he explained to the student that she was a "difficult personality" and had always responded in this "exaggerated" way.

The student dilemma

A recurrent theme in these scenarios is the students' powerlessness either to challenge the clinician or to intervene on the patient's behalf: "How can I, when placed at the very bottom of the hierarchy, voice my disapproval?" … "How can I come to the aid of patients when I am not directly responsible for them and this could be construed as acting beyond my remit?" … "How can I inform the Dean given that my

quandary may well be divulged to the clinician himself?" Although these sorts of questions have been posed many times, I have always found it difficult to provide a rational response. After all, any advice to take action could well place students in professional jeopardy.[7]

When asked what factors inhibit students from speaking out, fear heads the list. Teacher-clinicians exert a strong influence over the student's future. They may be examiners or a source of references. Another commonly cited factor is the dominance of a professional culture which makes it taboo to question the clinical or professional conduct of a senior colleague. Mention is often made of an ethos whereby doctors should protect one another, especially in the face of a censorious environment and a siege mentality regarding the legal profession. Students note that "whistle blowing" is frowned upon and that the discloser of "medical secrets" is often ostracised.[8]

Students may not always feel confident that their critical reaction to an unethical clinician is justified: "Perhaps I am not able to tease out all the aspects?" … "Surely consultants with much more clinical experience and knowledge than myself must know what they are doing." … "Perhaps it *is* the best way of dealing with the situation."

Other factors are probably rationalisations to justify retreating from a potential confrontation. For instance, are students justified in levelling criticism when they themselves may act unethically in the future, whether deliberately or inadvertently? Leeway is also given to the common plight which doctors, especially junior staff, face — working under great pressure with limited resources. Is it not understandable that a doctor may sometimes, in a state of frustration or fatigue, fail to maintain optimal ethical standards?

Finally, questioning a consultant's *clinical* decision is akin to a student asking a teacher to clarify an objective position, but raising questions about an *ethical* judgement may penetrate more deeply and imply an attack on the personal qualities of the clinician. In minor instances, issuing this challenge may not seem worth the offence it may cause. In extreme cases, where a student surmises that a teacher is habitually unethical by dint of inherent deficiencies, the corollary may follow that "Such doctors unfortunately do exist and we have no choice but to tolerate them".

If a series of teachers fail as ethical role models, students may well become disillusioned with their chosen profession. Instead of having an eager, energetic approach to medical life, they may become cynical and embittered. If insufficient good role models are available, students may miss the opportunity, at a formative period in their development, to enhance their own ethical capabilities.

Students are well placed as members of an observant, intelligent peer group to contribute to the promotion of ethical standards by raising issues with their teachers. By not speaking out, avoidable patient distress may persist. The distress may be amplified by a sense of disillusionment that the "next generation" of doctors merely imitates the undesirable behaviours of their seniors. Students' acquiescence could be seen to maintain the status quo.

James Dwyer[7] captures the essence of the problem: "… the failure to speak up in certain situations is a failure of learning *and* caring." Moreover, the risk prevails that moral sensibility becomes eroded.

Suggestions for change

Given the adverse repercussions of negative ethical role modelling, I have sought the views of student groups over recent years as to how they may act. What follows is the product of these discussions.

The cardinal change required is to remove the taboo on students "speaking up". Dwyer[7] encapsulates this appositely by calling on students to subscribe to the Socratic maxim *primum non tacere* ("first, do not be silent") to fulfil their responsibilities to patients, colleagues and the medical profession. Abolishing the taboo depends on a number of overlapping factors. Altering the nature of the teacher–student relationship is paramount. The traditional hierarchical character of not only that association but of all the tiers of medicine embodies so many limitations that it ought to be ditched at the earliest opportunity. A more equitable link, similar to a partnership, is bound to be much more rewarding to both parties by permitting everyone to learn from each other's perspective.[9] Here, the teacher must obviously modify well-entrenched habits and come to regard students as creative and curious. The learning process can be so much richer when it encompasses this interactive quality.

The host environment, whether it be a hospital, a clinic or general practice, is another crucial variable in enabling the student to raise ethical questions. An institution whose ethos encourages ethical enquiry and is open to the challenge of optimising clinical care will listen carefully to the student's voice.

The student may contribute to this spirit of ethical openness in at least two ways. Firstly, questions about ethical aspects of a clinical situation should be raised respectfully, avoiding judgementalism or personal denigration. Secondly, students should take care to broach delicate matters, which may well involve patient care, in a suitable setting. Thus, if distressed by an encounter between doctor and patient, they should refrain from questioning the teacher until in the private surroundings of the tutorial room.

In proposing these two requirements of students, we have depicted them as individual protagonists. They may hesitate to raise an issue lest they are "out on a limb", their views stemming from an idiosyncratic source. Students would

2: Principles from the Australian Medical Students' Association Code of Ethics — preliminary draft

Medical students should:

- respect the needs, values and culture of patients they encounter during their medical training;
- never exploit patients or their families;
- hold clinical information in confidence;
- obtain informed consent from patients before involving them in any aspect of training;
- appreciate the limits of their role in the clinical setting and in the community;
- respect the staff who teach and assist them in their clinical training;
- when involved in clinical research adhere to the ethical principles in the appropriate national and international guidelines;
- maintain their personal integrity and well being.

therefore do well to ventilate their concerns to their fellows and then share the task of questioning the clinician.

The advantage of fellowship can be reinforced by reference to a code of ethics. A draft code for medical students published in 2002 by the Australian Medical Students' Association is an exemplary document comprising eight principles (Box 2), each of which is elaborated upon and clarified in a series of annotations.[10] In the event of an experience with a negative role model, students can readily compare what they have observed with corresponding principles in their code. This comparison can then embolden them to challenge the teacher.

If students experience difficulty because the teacher resists their enquiry they may feel helpless. The third annotation of Principle 6 of the AMSA code anticipates this by stipulating that: "When medical students experience difficulty with staff, they should discuss this with their academic mentor or supervisor." This is sound advice, although the student may be reluctant to follow it lest he or she be labelled a "whistle blower". Again, the notion of "security in numbers" applies. Fellow students who share a concern would no doubt find it easier to raise this as part of a group with a clinical dean or clinical supervisor.

Conclusion

No matter how comprehensive and systematic the teaching of medical ethics, the acquisition of relevant skills and the cultivation of desirable attitudes will take place mainly in the clinical arena and be influenced by doctors who model an appreciation of the myriad ethical questions that pervade medical practice. Role models of good ethical conduct will always loom large in guiding the student to acquire a sense of moral integrity.[11] Clinician-teachers share a duty to do all they can to expedite the process. Negative modelling is a destructive force which has no place in the learning environment. We all have a responsibility to confront and eradicate it.

References

1. Australian Medical Council. Goals and objectives of basic medical education. Guidelines for assessment and accreditation of medical schools. Canberra: AMC, 2000.
2. Teaching medical ethics and law within medical education: a model for the UK core curriculum. *J Med Ethics* 1998; 24: 188-192.
3. Jennett PA, Crelinsten GL, Kinsella TD. Advanced training in biomedical ethics: a curriculum in clinical specialty programmes. *Med Educ* 1993; 27: 484-488.
4. Holm S, Nielsen EH, Norup M, et al. Changes in moral measuring and the teaching of medical ethics. *Med Educ* 1995; 29: 420-423.
5. Braunack-Mayer AJ, Gillam LH, Vance EF, et al. An ethics core curriculum for Australasian medical schools. *Med J Aust* 2001; 175: 205-210.
6. Hicks LK, Lin Y, Robertson DW, et al. Understanding the clinical dilemmas that shape medical students' ethical development: questionnaire survey and focus group study. *BMJ* 2001; 322: 709-710.
7. Dwyer J. *Primum non tacere:* An ethics of speaking up. *Hastings Cent Rep* 1994; 24: 13-18.
8. Morreim EH. Am I my brother's warden? Responding to the unethical or incompetent colleague. *Hastings Cent Rep* 1993; 23: 19-27.
9. Kushner TK, Thomasma DC, editors. Ward ethics. Dilemmas for medical students and doctors in training. Cambridge: Cambridge University Press, 2001.
10. "Draft" code of ethics, 2002. Australian Medical Students' Association. Available at: http://www.amsa.org.au/flash/about/publication/document/misc/policy/AMSA_ethics.PDF (accessed Nov 2002).
11. Paice E, Heard S, Moss F. How important are models in making good doctors? *BMJ* 2002; 325: 707-710.

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