

# Strengthening the role of ethics in medical education

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Some time ago my wife, a physician, overheard through the curtain of a patient's room what she described as the worst patient–doctor interaction she had ever heard. The resident came in, introduced himself for the first time and, within about a minute, without offering the patient a chance to say what she knew or how she felt, bluntly told the patient that she had a terminal illness and the best that could be offered was symptom control. Although I applaud the honesty of the message, the blunt and unfeeling way it was delivered raises the question of how we might prevent such encounters as an outcome of medical education.

The findings of an interesting paper by Johane Patenaude and associates, published in this issue (page 840), put this experience in context.<sup>1</sup> Using the Moral Judgment Interview, the authors found no improvement, indeed a slight deterioration, in moral reasoning in a cohort of 54 medical students who completed the interview in their first and again in their third year of medical school. As Patenaude and associates explain, the Moral Judgment Interview is based on Kohlberg's theory of moral development, which suggests that people develop sequentially through stages of moral reasoning; for example, from being motivated by threats of punishment, to a belief in the golden rule, to a sense of obligation to follow the law, to a personal commitment in the validity of universal moral principles (see Table 1 of their study). Moral reasoning is a precondition of ethical behaviour in medicine.

How can we strengthen the role of ethics in medical education? One way of course is to select, at the time of admission to medical school, students who are most likely to become ethical physicians. Would a test such as the Moral Judgment Interview serve this purpose? I have heard such proposals made in conversation (Dr. Bryan Magwood, Director, Medical Humanities Program, Faculty of Medicine, University of Manitoba, Winnipeg; personal communication, 2002), and no doubt there is some assessment of integrity and character in the student selection process. However, I am aware of little research on the reliability and validity of measuring moral reasoning on admission to medical school in relation to creating ethical physicians.<sup>2</sup>

A second way is to provide effective ethics training during medical school and residency training.<sup>3</sup> Approaches based on moral reasoning have an important limitation: they are only one piece of the puzzle. To address effectively the disclosure of bad news, informed consent, confidentiality, dishonesty, research ethics, end-of-life care, resource allocation and the like, the doctor must recognize situations

as an ethical dilemma; possess the relevant knowledge of norms, laws and policies; analyze how this knowledge applies to the situation at hand; and demonstrate the skills needed to communicate and negotiate this situation in practice. Moral reasoning is required, but the final common pathway is performance.

Evaluation of performance in ethics is a third way to strengthen the role of ethics in medical education. Obviously, the moment of truth in such evaluations is the actual patient–doctor encounter. The most valid evaluation measures, therefore, will be directed at these encounters. Some years ago my colleagues and I developed and evaluated the ethics OSCE (objective structured clinical examination) precisely because we were interested in performance.<sup>4</sup> However, the real action is at the bedside, not one step removed in an OSCE station. It will be important to evaluate not only attending physicians' assessments of the ethics and professionalism of students and residents but also the assessments by peers, nurses and, especially, patients and families. Although items related to ethics are beginning to show up on in-training evaluation reports (ITERs) across the country, to my knowledge the reliability and validity of these items has not been systematically evaluated.

About 2 years ago a group of medical students, working with the support of faculty, highlighted the fourth way to strengthen the role of ethics in medical education: create an ethical learning climate. The student-researchers found that nearly half of their fellow students reported clinical situations in which they felt pressured to act unethically.<sup>5</sup> Performance does not occur in a vacuum. Indeed, Patenaude and associates cite the "hidden curriculum" as a possible explanation for their findings. Creating an ethical climate requires cultural change: tapping into the "hidden curriculum," paying serious attention to role modelling in the learning environment and implementing policies and processes to ensure a learning climate conducive to ethical development. The University of Toronto and its affiliated teaching hospitals have developed guidelines for ethics in clinical teaching.<sup>6,7</sup> Research on implementation of these and similar guidelines elsewhere will be crucial.

This topic of professionalism has recently been addressed in the form of a physician charter.<sup>8</sup> Professionalism and professional behaviours are closely related to what I have been calling the role of ethics in medical education, and I do not see the benefit of distinguishing between these constructs. Most fundamentally, what is needed is the habit of mind of adopting and valuing the patient's perspective on unfolding medical events and creating a shared medical

experience with the patient. Every doctor, probably even the resident in the story at the outset, would say they practise patient-focused care. But if the resident were really doing so, his questions would have been, "What do you understand about your illness? What do you want to know? What is this like for you?"

We should not interpret the findings of Patenaude and associates as indicating that all medical students lack moral development and are unprofessional and unethical. Indeed, some of the highest levels of ethical and professional behaviour I have observed involved medical students and residents. However, the findings of Patenaude and associates remind us that we could go a long way to strengthening the role of ethics in medical education by admitting students who have high levels of ethics and professionalism in the first place, training for performance, evaluating bedside encounters for ethics and professionalism, including from the patient's viewpoint, and creating an ethical learning climate. Each of these strategies requires an evidence-based and continuous-quality-improvement approach. These strategies are likely applicable in every medical school in the world. To my knowledge, none of these strategies has been taken very far.

Almost 100 years ago Abraham Flexner placed medical education on a firm scientific and clinical foundation (even though his report had a devastating effect on minority medical schools).<sup>9</sup> It is time for a Flexner-like commission on strengthening the role of ethics in medical education that will complete the unfinished research agenda detailed here and ensure that the findings are implemented by every medical school in the world.

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