commentaries

The detrimental ethical shift towards cynicism: can medical educators help prevent it?

John G S Goldie

Oscar Wilde defined a cynic as 'one who knows the price of everything and the value of nothing.' In his paper 'Medicine and money: the ethical transformation of medical practice', which appears in this issue, Dr Salmaan Kershavjee reflects on an experience from his medical education. He uses the experience to illustrate his thesis that a detrimental ethical shift is occurring due to the unwanted permeation of economic considerations into medicine's core values.[1]

> *The task facing educators is … to help produce doctors who not only behave ethically, but are 'ethical doctors'*

Ethical decision making is integral to clinical decision making and many of the decisions doctors make involve value judgements. Doctors have to be aware of the all-pervasive nature of such value judgements and the extent to which their own values affect these decisions.[2,3] If they are to practise ethically, doctors, when analysing clinical situations, should be able to identify any inherent moral issue(s). To accomplish this, they need to know the range of moral concepts used frequently in ethical theory, and to be sensitive to variations in circumstances that change meaning in ethically sensitive ways. They should be aware of their own values and beliefs, those of each individual decision maker involved in the process of ethical decision making, and those of society in general.[4] In the case of Mr Desai, the patient from Dr Kershavjee's student experience, these processes do not appear to have been followed by the doctors who initially treated him. It is apparent that neither Mr Desai nor the other health care professionals concerned in his care had much involvement in the process of deciding whether to treat the complications of his end-stage liver disease. This is despite the trend in western health care towards recognising the importance of patient autonomy and patient–provider partnerships.[5,6] In making the decision about how to treat Mr Desai, the provider organisation's need to reduce costs would appear to have overridden the potential palliative benefits of albumin therapy. One would speculate about the personal values brought by these doctors to the decision making process. What influenced the development of such values?

> *Ethics should be addressed as part of the wider domain of professionalism*

Dr Keshavjee rightly acknowledges the reality of the need for rationing of health care and the benefits of the application of cost-effectiveness. However, he argues that the drive in US health care towards cost-effectiveness, often conflated with cost-reduction, has the potential to create a generation of doctors more concerned with reducing costs than with providing the best care for their patients. This situation is not confined to the US, as it is has the potential to occur in any health care system driven by market forces.

> *Addressing power imbalance is important when considering strategies to counteract the negative effects of the hidden curriculum*

He concludes that unless we help our students discern and understand the multiple factors involved in sound clinical decision making, we are in danger of producing doctors who could be viewed, according to Wilde's definition, as cynical. To counteract this detrimental ethical shift, I would go further and suggest that the task facing educators is not limited to producing students who can discern and understand the multiple factors involved in sound clinical decision making, but to help produce doctors who not only behave ethically, but are 'ethical doctors'.[7]

FOSTERING ETHICAL DOCTORS – THE CONSENSUS FORMAL CURRICULUM

Ethics should be addressed as part of the wider domain of

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professionalism.[5] There is consensus about the structure and process of ethics teaching within the medical curriculum.[4] As ethical decision making is integral to clinical decision making, ethics teaching requires to be integrated both vertically and horizontally in the curriculum. The ethical aspects of clinical decision making should be made explicit during clinical teaching. This requires clinical teachers to be directly involved in teaching ethics, a role for which many may feel unqualified. However, clinical teachers have the potential to act as powerful positive role models for their students. Empirical evidence has shown students to be more profoundly affected by role models than by formal coursework.[4]

Ethics teaching should not be undertaken exclusively by practising doctors, but should be multidisciplinary and interprofessional if it is to meet its broader goals. Patient contact should not be restricted to the clinical years of the curriculum as contact in the early years of medical school is important in students' ethical development.[4]

If students' perceptions are incompatible with the ability to make sound ethical decisions … is it possible to help them develop a frame of reference more conducive to good practice?

Students require knowledge of the range of moral concepts used frequently in ethical theory. Evaluation evidence suggests that small group, case-based teaching is the most effective format for formal ethics teaching.[8] A positivistic approach is not necessary as theory is often learned most effectively from its application. While it is important that all students cover a core ethics curriculum, the significance of students' personal ethics should be recognised.

FOSTERING ETHICAL DOCTORS – THE HIDDEN CURRICULUM

It is important to recognise the influence of the hidden curriculum, which probably impacts more on students' ethical development than does the formal curriculum.[7]

Salmaan Keshavjee's experience is an example of the hidden curriculum in action, which could have resulted in the transmission of cynical attitudes had the second team of doctors not challenged them. Positive role models have the potential to counter the negative influence of exposure to cynical doctor behaviour.

I believe an important contributing factor to the negative influence of the hidden curriculum is the misuse of power that often results from the hierarchical structures frequently found in medicine. The negative influence of the behaviour of role models such as the doctors initially treating Mr Desai is often reinforced by the misuse of power in the relationship between teacher and learner. Addressing power imbalance is important when considering strategies to counteract the negative effects of the hidden curriculum.

Students should also be given the real life opportunity to appreciate the relevance of macroethical issues such as cost-effectiveness, as issues pertaining to ethics education cannot be properly conceptualised in isolation from the broader social contexts in which they arise. The frame of reference used needs to be at the level of the organisation rather than at the level of the doctor–patient relationship.[7]

ETHICS EDUCATION – A DIFFERENT PERSPECTIVE

In considering how best to foster ethical doctors, we must bear in mind that students enter medical school with pre-existing perspectives, through which they will view their experiences and from which meaning will emerge. These meaning perspectives consist of specific values, assumptions and beliefs, often acquired uncritically in the course of childhood through socialisation and acculturation. This occurs most frequently during significant experiences with parents, teachers and mentors.[9] These processes have the potential to continue during students' medical education.[7]

Should final year students whose decision making processes are ethically flawed be deemed not competent to practise?

Students' meaning perspectives provide them with the criteria for judging or evaluating right and wrong and what is appropriate or inappropriate.[10] Values, assumptions and beliefs can be distorted or invalid, but few people question their basic assumptions about the world or are even aware of them. If students' perceptions are incompatible with the ability to make sound ethical and clinical decisions, is it possible to help them develop a frame of reference that is more conducive to good practice?

Transformative learning theory provides the basis for such an approach.[9,10] Successful transformative learning questions assumptions, provides support from others in a safe environment,

provides challenge, examines alternative perspectives and provides feedback. New assumptions are tested in the 'real' world or in discussion with others.[9,10] Learners' perspectives are potentially transformed into perspectives which are more 'inclusive, differentiating, permeable, critically reflective, and integrative of experience'.[10] Consequentially, the learner is empowered and becomes more likely to question a course of action that might compromise the core values of medicine.

It is important to identify students' perceptions on entry to medical school, and to evaluate change as they progress through the curriculum. Instruments such as the Ethics in Health Care Instrument[8,11] offer the potential to elicit student attitudes towards ethical issues on entry to medical school and to measure change as they progress through the curriculum. However, important value judgements will have to be made by medical educators when they are faced with final year students whose decision making processes are flawed in terms of their compatibility with consensus core values. Should they be deemed not competent to practise, in the same way that they would be if their decision making processes were flawed in terms of their evidence base? Or do we ignore the question as few instruments exist to formally assess this component of decision making? This is a subject for further debate.

REFERENCES

1 Keshavjee S. Medicine and money: the ethical transformation of medical practice. *Med Educ* 2004;**38**:doi: 10.1046/j.1365-2923.2004.01765.x.

2 Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 4th edn. New York: Oxford University Press 1994.

3 Calman KC, Downie RS. *Healthy Respect: Ethics in Health Care.* 2nd edn. Oxford: Oxford University Press 1994.

4 Goldie J. Review of ethics curricula in undergraduate medical education. *Med Educ* 2000;**34**:108–19.

5 Medical Professionalism Project. Medical professionalism in the new millennium: a physician's charter. *Lancet* 2002;**359**:520–2.

6 *Embracing Patient Partnerships.* [Theme issue.] BMJ 1999;319.

7 Hafferty FW, Franks R. The hidden curriculum, ethics teaching and the structure of medical education. *Acad Med* 1994;**64**:861–71.

8 Goldie J, Schwartz L, McConnachie A, Morrison J. Students' attitudes and potential behaviour with regard to whistle blowing as they pass through a modern medical curriculum. *Med Educ* 2003;**37**:368–75.

9 Mezirow J. *Transformative Dimensions of Adult Learning*. San Francisco: Jossey-Bass 1991.

10 Mezirow J. Contemporary paradigms of learning. *Adult Educ Q* 1996;**46**:158–72.

11 Goldie J, Schwartz L, McConnachie A, Morrison J. The impact of three years ethics teaching, in an integrated curriculum, on students' proposed behaviour on meeting ethical dilemmas. *Med Educ* 2002;**36** (5):489–97.

Quality improvement in medical students' education: the AAMC medical school graduation questionnaire

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For more than 2 decades, the Association of American Medical Colleges (AAMC) has surveyed students graduating from allopathic medical schools in the USA to obtain their perspectives on their medical school experiences and to collect data of special interest to the Association and its member institutions. During this period, each medical school has received an annual report summarising the responses of its students and comparing them to the aggregated responses of students from all US medical schools. The aggregated responses have provided a national perspective on the quality of medical students' education (as perceived by students).

Aggregated responses provide a national perspective on the quality of medical students' education

Approximately 14 000 students completed the graduation ques-

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