

The Ethics of Medical Education – The Ethical and Professional Issues in Teaching and Learning Medicine

Thamotharampillai Thirumoorthy, ^{1,2}*MBBS, FRCP, FAMS*

A search in the medical education literature is replete with articles on how to teach and evaluate professionalism and clinical ethics to medical students and residents. There are, however, fewer articles on the ethics of medical education discussing professional and ethical principles governing the student-faculty relationship, code of professional behaviour for medical faculty, and ethical issues. Additionally, articles on clinical training involving patients or ethical issues on medical education research and academic publication are scant. In this Editorial, I will confine the discussion to the student-faculty relationship and clinical training involving patients.

The Ethics of the Student-Faculty Relationship

There is significant literature on professional ethics code and conduct in the doctor-patient relationship (both in clinical care and medical research). However, relatively minimal is available on the student-faculty or resident-faculty relationship. Patients and the public expect doctors to be clinically competent, ethically proficient, display compassion, be professional and trustworthy. There is common understanding that similar to the quality of the doctor-patient relationship, the quality of student-faculty relationship is the consistently critical factor in determining a good outcome in education. The elaborate descriptions of the mutual obligations of the teacher and student in the Hippocratic tradition of medicine may not apply to modern medical education. Nevertheless, it is important for us in the profession to reflect on the central nature of this commitment for the sustainability of the medical healing traditions.¹ Today, this is reduced to a single line in the Singapore Medical Council (SMC) Pledge – “to give respect and gratitude to my teacher”.

The professional principles, practice and experience from the student-faculty-school relationship, the values upheld, roles modelled and the skills coached while in medical school, have significant influence in determining the type of physician the student will become. In today's medical education framework, most clinical faculty are adjunct and have many obligations that can conflict with the education

mission. This threatens the quality of the student-faculty relationship.

For a start, a professional compact or code of conduct governing the student-faculty-school relationship should be widely discussed, developed and applied. Applying equally to both students and faculty, the student-faculty-school compact is not just the usual honour code on academic honesty. It should seek to outline the principles, values, responsibilities and expected behaviours; and how they should be developed and what remedial actions would take place upon violation. Mutual respect and trust should be the defining core of such a compact.

The medical school governance, policies and practices should align with and promote the values and principles embodied of the student-faculty-school compact. The compact (when appropriately operationalised) would manage the commonly unaddressed ethical issues of moral distress among students, teaching by intimidation and shaming, breaching of boundaries and professional lapses among students and faculty. It is timely for an explicit declaration of the commitment to professionalism by faculty, students and the school. This is important as it forms a basis to the social contract with society, and in fulfilling the social accountability of medical schools and medical education.

The Ethics of Clinical Training Involving Patients

It is for the greater good of society that doctors are competent in diagnostic and therapeutic interventions before they are qualified as doctors and specialists. To achieve this clinical competence, medical students and residents need learning and coaching opportunities to practise critical, intimate examinations and invasive procedures on patients. Even the most proficient doctor has to have a first time with an invasive procedure on a patient.

At the same time, the individual patient seeking medical care may not directly benefit and even risk potential harm when medical students and residents are actively involved in their care of illness. Risks to patients, involving medical students and residents in their care, is an understudied

¹Duke-NUS Medical School, Singapore

²Centre for Medical Ethics and Professionalism, Singapore Medical Association, Singapore

Address for Correspondence: Dr Thamotharampillai Thirumoorthy, Duke-NUS Medical School, 8 College Road, Singapore 169857.

Email: gmstt@duke-nus.edu.sg

problem. All stakeholders in medical education agree that participation in medical education should be informed and voluntary. Patients are often inadequately informed of the participation of students and residents in their medical and surgical care.² It is common practice to provide little to no information regarding the role of trainees during the informed consent process for surgery. “Ghost surgery” is a term applied to the practice of allowing residents to perform procedures without specific consent of the patient. In contrast, most patients (87 to 96%) would prefer to be given information regarding the role of residents in their medical and surgical care.³ When there is adequate disclosure, an uncomplicated procedure, and a good relationship between the care team and the patient, patients are more likely to consent even if it’s the first time for the student or resident.⁴

It would be an irony to teach medical ethics of respect for patients’ welfare and autonomy when at the same time in the medical education and clinical training process, the very ethical principles and practices are inadvertently violated. The question is—how we, as the clinical educators, balance the greater good to society and future patients with that of benefit to current patients and the potential risk to the particular patient?

How do we then, as a profession, uphold the principles of medical professional duties and ethics in clinical training and medical education involving patients? This professional ethical dilemma needs to be addressed at all levels and not left unaddressed or at the bedside to be resolved. It is important that the challenge is addressed from the systems to the individual levels—the macro or societal level; the meso or hospital and institutional level; the micro or at the point of teaching with the patient.

There is no doubt medical education and clinical training on patients is an ethical and essential enterprise serving the welfare of society and patients. Informed consent, good relationships with patients, appropriate supervision of and preparedness of trainees are key ingredients in ensuring medical education meets professional and ethical standards.

Conclusion

Central to the medical professional culture of the pursuit of excellence, we have the means and the methods, and need only the will, leadership and governance to build a culture that moves medical education and clinical training on patients to the highest level of professionalism.

REFERENCES

1. Reiser JS. The ethics of learning and teaching medicine. *Acad Med* 1994;69:872-6.
2. Cohen DL, McCullough LB, Kessel RW, Apostolides AY, Heiderich KJ, Alden ER. A national survey concerning the ethical aspects of informed consent and role of medical students. *J Med Educ* 1988;63:821-9.
3. Porta CR, Sebesta JA, Brown TA, Steele SR, Martin MJ. Training surgeons and the informed consent process: routine disclosure of trainee participation and its effect on patient willingness and consent rates. *Arch Surg* 2012;147:57-62.
4. Santen SA, Hemphill RR, Spanier CM, Fletcher ND. Sorry, it’s my first time! Will patients consent to medical students learning procedures? *Med Educ* 2005;39:365-9.