

Teaching Students and Doctors
Clinical Ethics
(or, “Why do they always call us
when it’s too late?”)

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What I Will Address

- Query #1: Is there any evidence to support a benefit to teaching clinical ethics to students?
- Query #2: Is there any evidence to support a benefit to teaching clinical ethics to doctors?
- Conclusion

Questions

- Can we effectively teach medical ethics (clinical, legal, research, etc.) to students, post-graduates and practicing physicians so that they practice what we preach?
- Can we make students, post-graduates and practicing physicians more ethical doctors (if not more ethical persons)?

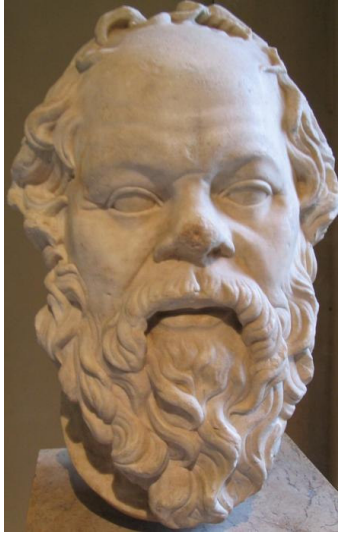
But, perhaps more fundamentally,.....



Some More Questions We Are Afraid To Ask

- Why do we teach ethics in medical schools (and sometimes beyond)?
- To whom should we teach ethics?
 - What should we teach?
- What do we hope to accomplish?
 - Have we met these goals?
- Should we even teach ethics at all?

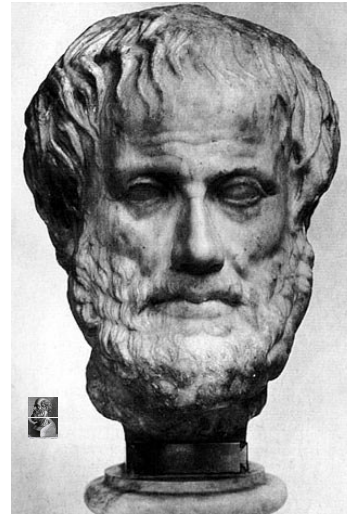
These Guys Could (supposedly) Really Teach Well



Socrates



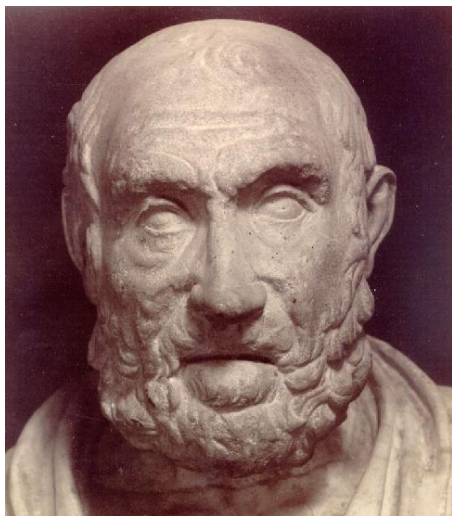
Confucius



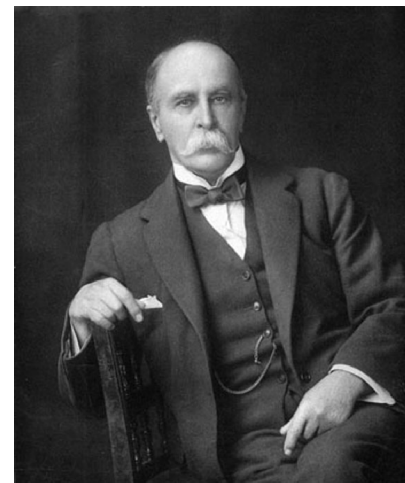
Aristotle



Mencius



Hippocrates



Osler

But, as they would all say, you
must start with good material
(or material that is good)

What Kind Of Students Are We Looking For?

- “The essential qualifications for admission to the Duke School of Medicine are intelligence, character, and integrity. We're looking for individuals who have compiled remarkable undergraduate records with clear evidence of leadership and scholarship, commitment to community service, and motivation for a career in medicine.”
- How do we choose these people? How do we “get it right?” How often do we get it right?

- Is there any way to evaluate the character of our applicants?
- If we discover that a student/resident is not of good character *after* admission, what should we do with him or her?
 - Remediation?
 - Warning?
 - Immediate expulsion?

A Quick Overview of the “Success” of American Medical Education

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are needed to see this picture.

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are needed to see this picture.

96% of entering students eventually graduate.

Fewer than 2% leave for academic reasons

Data from *Analysis in Brief* Vol. 7 (2), April, 2007 (AAMC)

10 Years of Data from Duke*

- 1000 students (100/class/year)
- 1 was dismissed and 6 administratively withdrew due to extended leave of absences or some other reason
 - Total = 7 students over 10 years
 - = 0.7%
- *Are we really that good at choosing students who will turn out to be good doctors???*

*Data supplied by M. Ellis, Registrar's Office, DUSM; 1 September, 2009

Are graduation rates a good measure of graduating good and right-acting doctors?

Case #1

- The first year class of medical students is taking an on-line test. Unbeknownst to the faculty, there was an error in the program such that about 25% of the monitors showed both the questions and the answers.
- The school has an honor code which demands that students be honest themselves and report dishonesty in others.
- The error was not reported for 20 minutes into the test; meanwhile those students with the aberrant displays continued to take the test (and get 100% correct answers!).
- The administration decided not to take any punitive action other than to remind the students of the honor code and administer a new test.

Case #1, cont'd

- The Administration stated that the students were members of the new “Millennium Generation”.
- Data has shown that these young men and women mature at a later age than their predecessors, thus we must take this into consideration when assessing personal responsibility for wrong actions (such as cheating).
- *However, this argument does not consider the impact of this delayed maturation on the ability of these students to engage in patient care and medical decision-making.*

Perhaps Not Surprisingly, Sometimes We Don't Get It Right

- Our students come from a long tradition of dishonesty and cheating in their prior academic institutions.¹
- And, we also know that prior behavior of this type can be predictive of latter unprofessional behavior:²

“As indicated by the responses to forced-choice questions for the engineering students surveyed, there is a relationship between self-reported rates of cheating in high school and decisions to cheat in college and to violate workplace policies; supporting our second hypothesis. Thus, this exploratory study demonstrates connections between decision-making about both academic and professional dishonesty.”

¹Vandehey M, Diekhoff G, LaBeff E. College Cheating: A Twenty-Year Follow-Up and the Addition of an Honor Code. *J College Student Develop* 2007;48(4):468-80.

²Harding TS, Carpenter DD, Finelli CJ, Passow HJ. Does Academic Dishonesty Relate to Unethical Behavior in Professional Practice? An Exploratory Study. *Science and engineering ethics* 2004;10(2):1-14

Papadakis, et al. (2005)*

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*Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. NEJM 2005;353(25):2673-82.

Papadakis,
2005, cont'd.

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Papadakis, et al (2008)*

“Performance during Internal Medicine Residency Training and Subsequent Disciplinary Action by State Licensing Boards”

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Maybe an Excellent Curriculum of Ethics Education, Taught by Faculty Who Uphold and Stand For These Ideals Themselves, Will Be Sufficient to Instill Principles of Right Action in Medical Students That They Can Then Use Throughout Their Careers.

Can Ethics Pedagogy Develop a Nascent Moral Sense in Students Within the Context of Clinical Medicine?

- Patenaude, et al.* looked at longitudinal development of the moral sense (using Kohlberg's Moral Judgment Interview throughout the years of medical school):
- *“Over the 3-year period, the stage of moral development did not change substantially (i.e., by more than half a stage) for 39 (72%) of the students, shifted to a lower stage for 7 (13%) and shifted to a higher stage for 8 (15%). The overall mean change in stage was not significant (from mean 3.46 in year 1 to 3.48 in year 3, $p = 0.86$); however, the overall mean change in weighted average scores showed a significant decline in moral development ($p = 0.028$). Temporal variations in students' scores show a levelling process of their moral reasoning. This finding prompts us to ask whether a hidden curriculum exists in the structure of medical education that inhibits rather than facilitates the development of moral reasoning.”*
 - ✓ This is similar to the findings from the US (Self DJ, Schrader DE, Baldwin DC, Wolinsky FD. The moral development of medical students: a pilot study of the possible influence of medical education. Med. Educ. 1993;27:26 - 34.)

This Problem Is Trans-Cultural*

- Asghari, et al. (Tehran University of Medical Sciences) examined moral reasoning in students before and after changing their ethics curriculum from a didactic, lecture-style to a small-group, case discussion style.
- Students' knowledge base was improved but there was no change in their moral reasoning.

*Asghari F, Samadi A, Dormohammadi T. Effectiveness of the course of medical ethics for undergraduate medical students. J Med Ethics Hist Med 2009;2(7).

An Alarming Finding from Croatian Medical Students*

- Using standard psychological scales of moral reasoning development and Machiavellianism, they surveyed 2nd year students (20 years old):
 - Most students demonstrated post-conventional levels of moral reasoning (Kohlberg level 5 & 6)
 - Women > men
 - Fairly high levels of Machiavellianism, described as “devious, manipulative people who are motivated only by their own self-interest”.

*Hren D, Vujaklija A, Ivanisevic R, Knezevic J, Marusic M, Marusic A. Students' moral reasoning, Machiavellianism and socially desirable responding: implications for teaching ethics and research integrity. Med Educ 2006;40(3):269-77.

How About Mentoring?

Surely, the value of excellent role models and teachers cannot be undervalued in developing the professional moral maturity and reasoning of medical students and post-graduate trainees?

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A Similar (Pessimistic) View from the UK*

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Perhaps not surprising, with mentors
like this fellow:

Top Psychiatrist Didn't Report Drug Makers' Pay

By GARDINER HARRIS

Published: October 3, 2008 (NYT)

“One of the nation’s most influential psychiatrists earned more than \$2.8 million in consulting arrangements with drug makers from 2000 to 2007, failed to report at least \$1.2 million of that income to his university and violated federal research rules, according to documents provided to Congressional investigators. The psychiatrist, Dr. Charles B. Nemeroff of Emory University, is the most prominent figure to date in a series of disclosures that is shaking the world of academic medicine and seems likely to force broad changes in the relationships between doctors and drug makers.”

Case #2

- A well-known and highly regarded surgeon, a faculty member who received an outstanding teacher award, operates on a 69 year old woman who is a Jehovah's Witness and has signed a release consent to forgo blood transfusions, even if it means her death.
- There is an operative catastrophe and she exsanguinates in the OR. When she is brought directly to the ICU her hemoglobin is 2.5 gm/dL.
- The surgeon refuses to accept her prior wishes (to which he agreed) and wants to transfuse her.

This Discussion Has Not Included those Doctors Engaged in Research

- Standard misconduct (plagiarism, fraud, theft, etc.)
- Rampant conflict of interest
- Performing clinical research disguised as clinical care to avoid regulations
- Etc., etc., etc.....

Judging from the news reports, our efforts to teach the ethics of scientific conduct and research, have made little difference over the past 25 years.

Child Psychiatrist to Curtail Industry-Financed Activities

By PAM BELLUCK

Published: December 30, 2008 (NYT)

“A prominent Harvard child psychiatrist will curtail activities financed by the drug industry while Massachusetts General Hospital investigates his failure for years to disclose the consulting fees he received from drug makers. The psychiatrist, Dr. Joseph Biederman, a world-renowned and controversial researcher on childhood mental illness, has agreed to stop participating in speaking engagements and other activities paid for by pharmaceutical companies, and also to stop his work on industry-financed activities within the hospital. That includes clinical trials that are under way at the hospital.”

etc., etc., etc.....

Case #3

- A 3rd year medical student is doing her research project in the lab of a prominent professor.
- She took her data and published a paper without her mentor's knowledge or his name on it.
- The problem was discovered after she had graduated and was doing a residency.
- Her "punishment" was to withdraw the paper with a correction published. She was allowed to complete her residency.

Some Cautious Conclusions

- The point is that these data suggest that even good mentors, the kind of doctors we looked up to when we were in school, the ones about whom we said “I want to grow up to be a doctor like her”, don’t really matter.
- The antiquated and irrelevant nature-nurture debate aside, by the time you get to medical school we may not be able to make all that much of difference in your long-term, stable moral reasoning.
- Perhaps we need to get much better at detecting these problems in applicants and students. Rather than engaging in Herculean efforts to remediate these students, perhaps we should just accept the fact that not everyone we accept should be a doctor: our admissions officers, as good as they are, are not perfect.
- ***ETHICAL PEOPLE MAKE ETHICAL DOCTORS***

Doctors & Ethics and Clinical Practice

- Do we teach students how to think ethically when faced with a dilemma, and do students learn and then incorporate this into practice?
- Or, do we teach students the “rules”?
 - ☛ Those who take the right action simply because it’s the right action, benefit from such instruction.
 - ☛ Those who obey the rules because they are afraid of the consequences of not doing so, may not personally benefit, but society does.
 - ☛ Those who don’t care about the rules may only become better “cheaters”.

Utilization of Clinical Ethics Consultation Services

- If we are not be so good at making or training ethical doctors, shouldn't we be getting more ethics consults?
- I think one of the main problems (and challenge) is that we are now producing doctors who think they are ethical and thus don't need help (unless they are desperate).
- Ethics Consults are considered as qualitatively different than other consults (such as a Cardiology or Infectious Disease consult); doctors readily admit their lack of specialty knowledge in fields in which they do not concentrate. But Ethics is something we all know; it is part of being a doctor qua doctor. It would be akin to asking for an empathy consult.

Case #4

- A first year resident in Pediatrics, a graduate of a top-ranked medical school, wrote a single author paper while a medical student that was published in major American medical journal.
- After he started his residency it was discovered that this non-fiction article was actually about 50% fiction.
- He was required to write a letter to correct the public record, undergo some training on academic misconduct and continued in his training undisturbed.

Some Final Thoughts

- The practice of medicine is maintained as a contract or compact with society;
- In return for taking care of patients irrespective of who or what they are (hopefully), doctors are relatively free to be a self-regulating monopoly;
- A vital constituent of the “self-regulating” part is the duty to ensure that doctors are honest, respectful of patients privacy, autonomy, etc.;
- *How good a job are we doing ensuring that we are living up to our end of the deal?*

The Responsibility of Medical Schools

- Do as good a job as possible evaluating the *character* of applicants *before* acceptance.
- Understanding that we have relatively limited knowledge about applicants' character before admission (perhaps as compared to their academic potential), we must make the commitment to their future patients and society to not graduate students whose character does not meet the high standards we espouse.