

## GMC: Medical ethics education conference

# Are we teaching students that patients don't matter?

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### Author's abstract

*Medical students may fear that their training leeches away the caring attitudes which attracted them to medicine. Some research suggests they are right. The medical school has a duty to support and encourage their values, but the reverse may happen. Students are taught about legal consent but not ethical consent. They may see or participate in concealment of medical mistakes and learn to practise deceit. The use of unconscious females for gynaecology teaching may encourage the wrong attitudes to patients. Trainee GPs may learn that the doctors' rights are more important than those of the patient. Measuring patients' views should be included in research protocols.*

The ethical education of medical students and young doctors is of prime importance to the public and it is just as important, from our point of view, as their formal medical training. The kind of people they are and the ways in which they are taught to behave are just as important to us as the fact that they can take out an appendix or deliver a baby. But the question is whose values are being taught? Unless there is continuous discussion and exchange of ideas between the profession itself and the teaching hospitals the information between them and the lay public and representatives of the lay public, such as community health councils, the values being taught may get out of step with what the community believes or what the community actually wants or understands. I have found that people who are in fact trying their best, albeit people with high ethical standards, have suddenly become very hurt by criticism of them, criticism which arose not because they were uncaring or unconcerned or did not have respect for their fellow men, but because things had moved ahead very fast in regard to how the public feel about the issues involved. Sometimes it is sheer technology that causes this. I recall when alpha fetoprotein screening was introduced by people who genuinely believed that by bringing forward this technology as quickly as possible they were benefiting patients, they were very surprised

when someone said: 'If I had known what you were doing when you took that blood test I would have refused'. It is simply because things are moving ahead so fast that doctors sometimes do not have time to think about what they are doing. So we must always have this debate. I know that many of you have been irritated by the sort of debates which take place in public and you think these are biased or not of the kind you would like. But it is far better that we have them even if we do not get everything absolutely right than that they should not take place at all.

What is really splendid to me is that medical students themselves are seeing the need for debate and the exchange of information with people outside the profession. Medical students in Oxford have, in fact, just asked that spending time with community health councils should be part of their training.

One of the things which has worried me in speaking to medical students in various parts of the country is that a number of them have come up to me afterwards and said: 'We are very worried. We do not like what is happening to us as people during the course of our medical training; because of the pressures, because of the things we are expected to do we feel ourselves turning into the kind of people we do not actually want to be. We can see what is happening to us but we feel we are powerless to prevent it. Certain ways of behaving are expected of us. Doing certain things is expected of us. We do not all think it is right but we have to get good reports. Sometimes we feel that our own values are being undermined'. Admittedly, the sort of people who are going to come and hear me talk are probably an atypical selection of the student population and the type of students who will come up afterwards and say that sort of thing are in an even smaller minority, but it worries me a great deal and it worries me because there is very good evidence in the literature that doctors' and nurses' values do change during the course of their professional training.

There was quite a good article recently in an American journal (1) about the growth of cynicism in medical students and a couple of years ago a very interesting study was done in the States when psychiatrists were no longer required to go through full internship before they became psychiatrists: somebody had the wit to compare those who had done

### Key words

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the full internship and those who had not (2). The ones who had missed out on some of the purely medical training were found to have greater empathy with patients, to be more sympathetic in psychotherapy, patients liked them better, and so on. I find this very worrying because young people – medical students and nurses – that I meet in medicine tend to be very caring and very concerned about ethical issues. When people bring those qualities of caring and concern to medicine they should be recognised; we should respect those qualities and support those who bring them, because those values will always be under pressure in areas of high stress and high workload. If we do not show in the way we treat young people that concern about ethical issues is something we value, support and respect in them; and if we allow it to be leached away during the course of their studies then I think we bear a very high responsibility.

When I ask medical students what they are taught about ethics they say: 'Well, you get the odd lecture but it is usually shoved in at the end somewhere'. They get the impression that it is regarded as very much a peripheral subject and they themselves are not entirely happy about that. They would be happier if it were a proper part of the curriculum, seen to be something which is regarded as important and which is valued by all their teachers, not just by somebody who comes along once in a while and does the formal ethics bit.

When I discuss with them, for example, getting consent from patients, I find that the teaching they have received has been in a legal context. They have had lectures from someone from one of the defence societies about the value of getting patient consent, and so on. With due respect, teaching about what you can get away with in law, or what you are likely to be found out about, teaching about getting a bit of paper signed, is not ethical teaching about consent. That is something quite different. Of course the two overlap to a certain extent, but I am not happy about the fact that consent is primarily taught in a legal context and not in an ethical context. I think it gives the wrong attitudes to medical students. Of course a great deal of what they are taught comes not in formal lectures or classes or seminars but in observing the behaviour of those around them and what is done and what is not done. Confidentiality they are taught about early and it is very important, but what they are also taught very early on is that case notes are, above all, confidential from the patient, and this is an attitude which I am afraid patients are no longer willing to accept. It formed a very large part of the discussion in a recent World Health Organisation (WHO) working party I was involved in. The same feeling is coming very strongly from many other countries apart from the UK. If we are to share decisions and be primarily responsible for our own bodies and be regarded as mature people then how can medical students be brought up with this attitude towards us that we may not know about what is happening to us, and that information is to be doled out only in response to our

questions? We should be involved in all the decision-making and letting us know what is said about us is really part of an attitude of regarding us as responsible for ourselves and having respect for us as human beings.

I wonder if part of the cynicism which medical students learn is to do with the cover-ups which they see when medical mistakes are made? None of us in the lay community expects doctors to be perfect. We do not expect them never to make mistakes. We understand that even the best doctors will make mistakes occasionally, we hope not too often, and of course we always hope it is not us who will be on the receiving end. But a lot of respect for doctors is lost because of the way in which many doctors behave when a complaint, justified or unjustified, is made. More honesty would be better for patients and better for doctors too.

My concern about patients, particularly having dealt with so many families who have suffered bereavement, centres on the long-term development of something I saw written up in the *British Journal of Psychiatry* as morbid grief in people when certain issues related to their loss had not been resolved (3). These people had been unable to work through their grief, had been unable to reach a healthy resolution of their grief because they had been unable to find out the truth about the death of their loved one; some of them had turned to litigation as a result, solely to get peace of mind. Frankly this is an unhealthy ethical atmosphere for medical students to be brought up in. It is not one which I would wish to see my son or daughter surrounded by. I would not wish them to learn that you cover up mistakes, that you lie about them or that you do not tell on others you see lying about them.

As a member of an ethical committee I look at the medical problems and the research projects which are brought to us. It took us three years of very hard work to get a total reorganisation of the way the ethical committee was organised so that the committee actually met instead of merely circulating papers. There was very considerable opposition from some members of the medical profession to any alteration in the system. The view which I took and the community health council took, was that although we really had every confidence in the ethical behaviour of the doctors around us as individuals, the ethics committee had an important educational function to fulfil. In preparing his application to the ethical committee a young doctor wanting to do research has to give the information which he proposes to give the patient in writing and he has to state the discomfort the patient might undergo. It is a very interesting exercise to try and write such an explanation which is both easy to understand and honest. This is part of the training of young doctors which is extremely important and ethics committees which act as rubber stamps and do not do their job properly are not helping to educate doctors. Some of the comments which we have had to write on ethical applications which have been referred back have, I

think, come as quite a surprise to young doctors who simply did not realise they were not giving all the information they should have done.

I think the GMC cannot ignore the fact that the sheer pressure of work on medical students and young doctors may prevent them from having an opportunity to stand back and say: 'Where am I going? What am I doing? Where are we going as a profession? In what direction is this research leading us?' I do not care that all the distinguished people in this room probably worked very hard in their youth and worked a great deal harder than they think young doctors are working nowadays. I still think that particularly in this kind of profession, where there are enormous physical, emotional and intellectual stresses, we must provide time for people not only to do other things, but also to look at the broader context and implications of the work which they are doing.

The ethical education of young doctors is particularly important because of the context in which they work in this country, namely the National Health Service. It is important because patients do not have easily, as they do, for example, in France, the freedom to change doctors, to change hospitals or to change consultants. Therefore, if a trainee moves into general practice in a health centre, I have no doubt he is taught by an excellent general practitioner, but what does he learn about patients if he finds that within the health centre the doctors who are in different group practices have an agreement that patients cannot change doctors because it will be embarrassing for the doctors? That really does say something about your view of the patients' rights as opposed to your view of your own rights. I think those are not the right standards for doctors to learn when they are training in general practice, and yet it is something that happens.

In medical training ethical teaching cannot be divorced from something which happens on the shop floor, that is to say, on the ward or in the operating theatre. It was, in fact, the Patients Association which finally got the Department of Health to produce a circular, many years ago, saying that patients have the right to refuse to be used as teaching material and that they must still be treated even so and should not be penalised for so refusing. I would remind you that that was fought against very hard by some teaching hospitals. I regard that as important, not just because of the importance of patients' rights but because if students are being taught that way good doctors will not be the result. What is taught thereby is that patients are things to be used, not people with rights of their own. Nevertheless, we see that doctors are still taught gynaecological examinations on unconscious patients who have not consented. I think that is wrong for patients, but it is just as wrong for doctors because again what they are learning is that patients are there to be used and it is, in fact, I think a very bad way of teaching examination technique because you are not getting the feed-back from the patients on how it is being done and their reaction to it. The American

method of using, as it were, professional or volunteer patients is very much better. But in obstetrics how are young doctors being taught? In some maternity hospitals a bell rings and they rush in to do a delivery, particularly if it is twins or something interesting. Then another bell rings and everybody crowds into the room to watch. What are we teaching them? Yes, we are teaching them how actually physically to deliver a baby, but what are we teaching them about the attitude to the patient? In my view the ethical teaching of obstetrics, as well as good practical teaching of obstetrics, means getting to know the woman during pregnancy, sitting with her throughout labour, learning about her views on pain relief, not having pain relief, or the right to refuse pain relief, and so on.

I think that at the moment many doctors are feeling anxious about the public debate and criticism of what is happening in the medical field. I really do not think they need to be anxious. They only have to be a little more open. They only have to say to medical students: 'We cannot, in fact, practise good medicine without knowing what the patients think and what they feel about us and that is how we are going to do it'. But this is equally important in research. Young doctors feel they have to do some research. They have to get some publications done in order to get on, in order to be successful. When I look at some of this research I find first of all it is astonishingly shallow in that it is geared to short-term results without any provision for long-term follow-up. But I also find often no adequate assessment of what the patients thought of the treatment or the drug or what was being done to them has been built into the research and I think there are many areas in which one cannot do good research without including that. I think this is why some doctors, or the profession itself, has landed in trouble and has faced public criticism. If students and young doctors were taught that gathering, in a properly organised way, patients' views to be fed into the research method was essential they would learn not only how to do better research but also that respect for the patient as an individual and for the patient's view was something that as doctors they were automatically required to think of. Unfortunately, when we – lay people – ask more questions doctors respond by becoming irritable and see it as threatening. They should try not to, but should rather try to see it as lay peoples' attempt to be responsible for themselves, to share decision-making with doctors. I can only say that the more I have learned myself, through reading medical journals, books, and so on, the more respect I have had for people who practise medicine well, whether in general practice or in hospital. My respect for them has increased, not decreased and those who have welcomed debate and shared decision-making are the kind of people I would like to be teaching medical students.

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the doctor's own responsibility for the updating of his or her knowledge and for his or her own lifestyle. We deal also with more general issues including the allocation of resources, the role of private practice, medico-legal proceedings, the doctor and patient in research, the role of the doctor in relationship with the media, the doctor in politics, the doctor as a teacher and the doctor as an agent of social change. The base of knowledge can be acquired through didactic lectures but the formulation of personal values occurs in the clinic and at the bedside.

This complicated syllabus may be divided into four more simple areas: the doctor and his patient, the doctor and himself, the doctor and the profession and the doctor and others.

At St George's Hospital Medical School there are four didactic lectures. The core of each of these lectures is, respectively: decision-making; confidentiality; the viewpoint of a patient in teaching, treatment and research (given by somebody who has recently been a patient); and, fourthly, the misuse of medicine. In addition there is an annual medical ethics lecture, which takes place in the evening, when an outside speaker of repute lectures on a topic of his or her choice.

A number of areas are covered in our small-group work, including the teaching of interviewing skills, at the beginning of the clinical course, and we try to use this time as an opportunity for students to become more sensitive about the dynamics of the dialogue

between the doctor and the patient. We also try to encourage the student to understand what it is like to be a severely disabled person in today's world.

Debates take place, particularly in psychiatry, where such issues as the sanctity of life, autonomy and self-determination are very carefully prepared and hotly debated.

In terms of examination the first ethics question appeared in the psychiatry paper in our Finals in 1983.

In conclusion, we believe that ethics cannot be imbibed solely through the process of osmosis; osmosis will, of course, continue to happen but we cannot rely on that as a total learning exercise. Neither do we want medical ethics to become an unpopular and unexamined sub-specialty in the medical school. We feel it must be taught and learned using the whole range of educational technology. Above all, we must raise the awareness of all clinicians and teachers to the need to make the ethical implications of their subject an intrinsic part of the knowledge required. The best way of doing this is, we feel, to increase the sensitivity to ethical issues at a postgraduate level: at our conferences and postgraduate meetings, do we discuss and debate the ethical issues with which we are wrestling and in particular are we prepared to expose our uncertainties and our inadequacies to the juniors and to the medical students? If the ongoing process of medical education contained an ethical sensitivity, we would have the confidence and sense of urgency to hand this on to those who are just starting in medicine.

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