**COMMENT**

**The ethics of teaching in medicine: A personal view**

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After thirty years of teaching in a medical college, I have noticed a paucity of discussion about the ethics of medical teaching so critical to developing and mentoring ethical doctors during their period of studentship. There is a general sense that the pedestal once occupied by the medical profession has begun to crumble. It has been buffeted by strong winds of change from outside – the higher legitimate expectations of the public in terms of honesty, trustworthiness, competence and accountability. It has also been eroded from within by scandal, malpractice and corruption (1,2,3,4,5) – the fact that these actions may represent a part of the medical profession does not matter. We reel with horror when the press and journals abroad (6) reveal the rot within, perhaps, not because we are unaware of it, but because the very idea of being exposed is singularly unpleasant.

The medical teacher has multiple roles that go beyond the traditional transmitter of knowledge, to an enhancer of the education process while being a role model, a facilitator of knowledge, an assessor, a planner and resource developer (7). As a role model, the medical teacher influences the attitudes, behaviour and ethics of medical students and helps cultivate professional values in them (8,9). Clinical skills, personality, and teaching ability are the three most important factors that students identify in an ideal role model while research activities and academic status were listed as less important (10). In this article, I focus on one aspect of how the medical profession, by devaluing the important task of teaching/educating, has contributed to its own demise.

One has only to read William Osler to marvel at the remarkable vocation of medical teaching; for, teaching in general and medical teaching in particular, is a ‘calling’ (vocal – vocation). As Osler would indicate –“I desire no other epitaph—no hurry about it, I may say—than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important work I have been called upon to do.” (11) Each of us will undoubtedly recall remarkable teachers that we had in medical college who inspired us and who were somehow, often intangibly, different. There is no excuse for the absence of learning in medicine – graduates once armed with a certificate to practice, will interact with the public with competence or incompetence, based on what they have imbibed in medical college. They will also embody, or not, the values of the medical profession that we and the public should take for granted – compassion and empathy in the face of visible and hidden suffering, humility when faced with the limits of knowledge and understanding, equanimity when confronted by the highs and lows of professional life, a passion for constant learning in the knowledge that the science of medicine is continuously advancing and changing, and a moral compass that allows us to choose right from wrong, or the greater good. These are colossal tasks for a medical educator. The easy “out” is to blame the current generation of students as uncommitted, superficial, of lower quality, unsuited to the medical profession, inordinately attached to their inanimate hand held devices and as a result, incapable of relating to the needs of ‘animate’ patients. The harder option is to look at ourselves in the mirror, as medical educators, and ask how much we have abrogated the role entrusted to us by following a policy of passivity that ‘hopes’ that medical students will “somehow” imbibe what is expected of them during their stay in medical college.

So why is medical teaching so undervalued? The typical trajectory of a medical teacher involves a period when they are deeply engaged with students as junior faculty – teaching is fun and interactions with students are valued and enjoyed. At some stage, the need to demonstrate ‘scholarly’ activity in terms of research projects and publications becomes acute, particularly since it may be linked to promotion. It does not help that at this stage people are often married, have young children and require a higher salary which would be guaranteed by promotion. At this stage, engaged teaching is a chore and an obstacle to a greater personal need of self advancement and students are part of that obstacle course – an easier option is to focus on research and allow teaching to proceed on ‘automated pilot’ mode. Once promotions have occurred and individuals have now moved to the status of senior faculty, individuals find themselves on committees, policy groups, and leadership roles. If successful in research – this becomes a roller coaster of its own. At this stage, teaching becomes an entity to be delegated to other staff for “their own good and experience” and for a “greater good” served by the individual in the other roles that they have adopted. It is pertinent to point out that during promotions, the evaluation of research can be very objective and complex (number and nature of grants, number of publications, impact factor of journals, citations, ‘h’ index etc.) in contrast to the evaluation of teaching which can be remarkably naive and simplistic (“How much do they teach?” “Are they good?”). There are two issues here. First, by teaching less as they become more experienced, medical educators deny the students access to the expertise that derives from experience – this is a huge wasted resource. They also in the process, buttress the view that teaching is not really that important. Second, the diminished value that teaching has in relation to research during promotions reinforces the notion that the latter is the “real deal” in academia. This promotes an “either -or” belief rather than a “both” commitment. Institutions feel under pressure to do research since this effects college rankings and public perceptions. This is unfortunate since the promotion of research in higher education has its own rationale which includes the generation of new knowledge and the translation of this knowledge for common good, among others. Thus, the higher status accorded to research by administrators on account of the preeminent place of research in the metrics of ranking (12) is detrimental both to teaching and to research, since the very *raison d'être* of research is reduced to a self serving exercise. This also promotes an adverse culture towards research including unethical practices such as gift authorship based on seniority or other factors (13), resort to predatory journals for publication (14), plagiarism (15) and other breaches of publication ethics.

So are there ethical issues in the way we approach medical teaching? I use a Principlist approach to discuss this. The act of senior medical teachers to withdraw from teaching cannot be considered *beneficent* (doing good) - this would require not only that in the process of withdrawing from teaching they do good for their colleagues (i.e. provide them with opportunities – although it is debateable about whether this is used as a convenient excuse) but that students also benefit by their withdrawal. The latter is possible if they were bad teachers to begin with and their departure is seen as a boon by students rather than a loss. I would argue that this is not true for the majority of senior medical teachers– and, even if it were true, it would support the argument that the educative role of medical teachers has received lower consideration during promotions. The decision of administrators not to see quality of teaching as a critical component of promotions or the actual work of medical faculty, cannot be considered beneficent - given the very purpose of medical colleges – to educate and train medical students. *Primum non nocere* (first, do no harm) is an ethical principle of ancient origins and embodied in the idea of *non-maleficence*. I argue that, on the contrary, the current approach to medical teaching is indeed harmful. When senior teachers stop or reduce their teaching, students are often subjected to a large quantum of knowledge from enthusiastic junior faculty; much of this may be irrelevant. Senior faculty through their experience have the ability to sift what is needed from the vast tracts of information available to all, they are able to simplify without being simplistic, they can be open to being questioned without feeling threatened, and, above all, they bring to their teaching a practical approach that comes with experience that cannot be gleaned from books. An important aspect of this is the sharing of the lessons of life that extend beyond the framework of subject expertise. The absence or reduction of these approaches could result in students seeing information as the goal rather than its application, detail and minutiae as preferable to a unified and integrated approach, adoption of a linear rather than a multidimensional method of reasoning and theory superseding rather than being integral to practice. This, given the very nature of medicine – a science and an art, an imperfect science, a human science, is not merely non-beneficent, it is maleficent. The intent is not to generalise about the qualities of senior or junior faculty but rather to decry the reticence with which many senior faculty continue to teach. There is the added factor of the “grunt” work – repetitious, boring work with little reward. Included in this is all manner of activities such as invigilation, paper corrections, repeated practicals, revision classes etc. It would be unreasonable to expect senior faculty to be at the centre of all activities but it would not be unreasonable for senior faculty to acknowledge and appreciate this work done by junior colleagues and to mentor them through these processes. *Justice* in medical teaching is most visible in being fair and open to all students without prejudice or favour. This, unfortunately, has taken a beating over the years – the need to demonstrate ‘good results’, to ensure special favours to students who are sons and daughters of influential people, to be seen as being compliant to institutional authority and ‘needs’ has resulted in many medical faculty being willing to barter their principles for immediate benefits. The teaching of ethics is unlikely to overcome these negative effects of the “hidden curriculum.” (16, 17, 18) In the process, teaching which is often seen as a ‘moral enterprise’ (19) becomes the very means to undermine morality in our medical graduates. But there is more to the idea of justice; the actions of medical educators accord the opportunity to inculcate in students and junior faculty the principles of social justice so central to the practice of medicine. Thus, distributive justice is exemplified, for instance, by the way in which teaching loads and examination assessments, are distributed across faculty. Participatory justice is typified in open, transparent and regular department meetings and meetings with students where all opinions are not only heard but openly expressed. Commutative justice is reflected in the policies of institutions not only emblazoned on their entrance walls as “Vision” and “Mission” statements but actualized from day to day. One of the challenges of medical teaching is how to “pitch” ones teaching – cater to the majority of the class and one might fail to inspire the ‘high performers’ and also leave the ‘low performers’ behind. The utilitarian approach of providing the greatest benefit to the greatest number thus clearly has its limitations. The principle of *subsidiarity* requires medical teachers to look for avenues to deal with these smaller numbers of students; both high and low performers, and this needs to be addressed without stigmatization. In this context, how one deals with the issue is as important as what one does.

A medical teacher is required to maintain professional and ethical relationships with peers, students and others with whom they work. The teacher –student relationship may however often be adversarial resulting in intimidation, public shaming, and humiliation of students (20). Few institutions have a policy in place and there is a need to develop a professional code of conduct governing the student-faculty-school relationship. Such a code will ensure that roles and responsibilities of both students and faculty are clearly defined, boundaries delineated and measures for redressal of grievances outlined as has been done in some medical institutions (see 21, for example). It is also important for medical teachers to undergo some training on student relationships and not to model their behaviour on their own experiences of excessively hierarchical, sometimes abusive, and unquestioned teacher-student relationships which they may attribute to their current level of competence, expertise and success.

There is a final point that I wish to make. The essence of clinical medical teaching occurs at the bedside of the patient – here the teacher not only focuses on the technical skills required of a medical graduate but on the human skills essential to a meaningful doctor-patient relationship. The bedside is also an ideal location for the teaching of medical ethics in real time and in very different circumstances to the environment of a classroom (22). Committed teachers see the inherent worth of educating students at the bedside. The focus on theory in medical colleges and the certification of graduates with incomplete medical and human skills is one of the gravest injustices the medical profession can inflict on society. In this sense, medical teachers are morally complicit when medical graduates treat patients incompetently, insensitively and unethically. The new competency-based curriculum of the Medical Council of India (23) which incorporates an AETCOM programme (attitudes, ethics and communication) within it is a new opportunity for medical teachers to review and put into practice the ethical dimensions of their calling.

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