

ORIGINAL ARTICLE

MEDICAL ETHICS: PERCEPTION AND PRACTICE

K. K .Mah and J. K. Candlish

Faculty of Medicine, University Kuala Lumpur Royal College of Medicine Perak, 30450 Ipoh, Perak, Malaysia

Corresponding Author

K .K .Mah

UniKL Royal College of Medicine Perak,

No. 3, Jalan Greentown, 30450 Ipoh, Malaysia.

Email: kkmah@unikl.edu.my

Abstract

Medicolegal cases continue to rise despite the establishment of medical ethics as a core component in the undergraduate medical education. This study sought to discover how senior medical students perceive medical ethics when they assume the roles respectively of doctor, patient and an immediate relative when facing ethical dilemmas. It also sought to discover the extent to which religion, cultural factors and their perceived severity of illnesses affects their judgements. Using multiple choice questionnaires, students were found to have assimilated universal ethical principles well, but paradoxically most students in the second phase of the enquiry, indicated that religion, cultural sensitivities and severity of illness will have a great influence on their decisions after they graduate.

Keywords: *Medical ethics, religion, culture, severity of illness*

Introduction

Medical ethics as a core component in the medical curriculum has been well established since the General Medical Council's (GMC) report on undergraduate medical education in Tomorrow's Doctors (GMC, 1993)¹ and subsequently the UK consensus statement on a model core curriculum for teaching medical ethics and law (GMC, 1998)². At the World Medical Association Assembly in 1999, a resolution was passed recommending that all medical schools include obligatory teaching of medical ethics and human rights³.

More recent advice by the GMC in Tomorrow's Doctors has placed greater emphasis on the assessment of learning outcomes of students as well as the training the trainers and teachers in medical education^{4, 5}. However it is still recognised that the teaching and assessment of this has remained suboptimal and various new models of teaching and assessments are needed⁶. The challenge now is to determine the effectiveness of our assessment methods. Are they reliable enough to predict that students have learnt what has been taught and will practise them in the future when confronted with ethical dilemmas?

In the Royal College of Medicine Perak, medical ethics appear throughout the five year programme. These consist of didactic lectures and informal sessions, mainly in small group discussions and in bedside teaching.

Assessment is limited to part question in an essay or an OSCE. In the light of the increasing number of medico legal cases in Malaysia⁷, it is timely for us to question whether students have truly learnt medical ethics as taught to them and will faithfully apply them in their future practice.

This present study, we believe, represents a novel approach to determine the effectiveness of our teaching methods in medical ethics, using what is often informally termed a '360 degree' approach.

It comprised two components, firstly to assess how students view medical ethics from three different perspectives, that of the doctor, the patient and an immediate family. The second component required the student to rate, on a Likert scale, how factors like religion, culture and severity of the illnesses will influence their decisions.

Materials and Methods

The subjects were 105 final year medical students in April 2012. They were requested not to discuss the questionnaires among themselves. There was no compensation for participation. The students were advised that they could withdraw from the study at anytime without disadvantage. Two multiple choice questionnaires (MCQ) for two different scenarios, one on obtaining consent for surgery and another on revealing confidential information, were provided, as below, enabling an assessment as to consistency of response.

Scenario A: (Obtaining consent)

A 70-year-old man has cancer of the stomach and needs surgery. He has a history of ischaemic heart disease. He is married and has two sons and two daughters. A consent is needed for surgery.

1. If you are the **DOCTOR**, from whom would you preferably obtain consent? Choose only **ONE** of the options.

- a) The patient.
- b) His wife.
- c) Any son.
- d) The eldest son aged 40.
- e) Any daughter.
- f) The eldest daughter aged 45

2. If you are the **PATIENT**, from whom do you think the doctor should seek consent? Choose only **ONE** of the options.

- a) Yourself- The patient
- b) Your wife.
- c) Any son.
- d) Your eldest son aged 40.
- e) Any daughter.

f) Your eldest daughter aged 45.

3. If you are **ONE of the IMMEDIATE FAMILY**, from whom do you think the doctor should seek consent? Choose only **ONE** of the options. (Immediate family consists of spouse(s), children, stepchildren, siblings.)

- a) The patient.
- b) His wife.
- c) Any son.
- d) The eldest son aged 40.
- e) Any daughter.
- f) The eldest daughter aged 45.

Scenario B: (Revealing confidential information)

A 70 year- old man from a rural village had some blood tests done. These revealed that he had leukaemia. A few days later a family member came to collect the results. The patient is married and has two sons and two daughters.

1. If you are the **DOCTOR**, to whom would you prefer to give the results? Choose only **ONE** of the options.

- a) The patient.
- b) His wife.
- c) Any son.
- d) The eldest son aged 40.
- e) Any daughter.
- f) The eldest daughter aged 45.

2. If you are the **PATIENT**, to whom do you think the doctor should give the results? Choose only **ONE** of the options.

- a) Yourself (the patient)
- b) Your wife.
- c) Any son.
- d) Your eldest son aged 40.
- e) Any daughter.
- f) Your eldest daughter aged 45.

3. If you are **ONE of the IMMEDIATE FAMILY**, to whom do you think the doctor should give the results? Choose only **ONE** of the options. (“Immediate family” consists of spouse(s), children, stepchildren, siblings.)

- a) The patient.

- b) His wife.
- c) Any son.
- d) The eldest son aged 40.
- e) Any daughter.
- f) The eldest daughter aged 45.

It will be noticed that a great deal of imagination was demanded, but the participants seemed to have no difficulty in that respect.

In the second phase of the process, the students were required to select, on a Likert scale, whether the factors (i) ethics taught in medical school (ii) religious beliefs (iii) cultural values and (iv) the severity of disease in question would influence the manner in which they would obtain consent for surgery and how they would impart confidential information.

The concepts surrounding (i) and (ii) were held to be self-explanatory but ‘cultural values’ were explained in terms of ethnicity, nationality, family influences, and experience of life.

Results

The results for scenarios A and B above are in **Table 1**. Surprisingly, the figures for the two were absolutely identical. A substantial section of the student population thought that laboratory or other results could be communicated to the wife, who would also be competent to give consent. Commendably, however, the majority held that the patient must be the vehicle for consent and the recipient of test results. The results for the second phase of the investigation are shown in **Tables 2 and 3**.

The concepts of consent and the disclosure of information are quite different but it can be seen that the students respond virtually in an identical manner to both. It is also clear that the ethics taught in medical school have strong competition from perceptions of the severity of the disease and to some extent from religious beliefs.

Table 1: Obtaining consent for surgery and revealing confidential information. Percentages of responses from 108 students.

Choice of donor of consent and recipient of results	As doctor	As patient	As relative
The patient.	99	96	77
His wife.	1	3	19
Any son.	0	0	0
The eldest son, aged 40.	0	1	4
Any daughter.	0	0	0
The eldest daughter, aged 45.	0	0	0

Table 2: Obtaining consent for surgery (Scenario A), percentage of responses.

	No influence	Somewhat influenced	Neutral	Moderately influenced	Greatly influenced
Ethics taught in medical school	0	6	13	39	42
Your religious beliefs	6	9	34	28	23
Your cultural values	7	16	43	28	6
The severity of the disease.	2	5	15	30	48

Table 3: Revealing confidential medical information (Scenario 2), percentage of responses.

	No influence	Somewhat influenced	Neutral	Moderately influenced	Greatly influenced
Ethics taught in medical school	0	4	15	34	48
Your religious beliefs	6	6	44	25	18
Your cultural values	8	9	51	27	5
The severity of the disease.	2	6	15	28	49

Discussion

In the first component of the assessment, when students assumed the role of a doctor or a patient, they seemed to be aware that obtaining consent for surgery should overwhelmingly be a matter for the doctor and the patient. This is an indication that students have comprehended the medical ethics taught to them in the traditional way. The fact that if one is a relative, then consent and reception of results might devolve upon the wife (the 19% response in **Table 1**), is slightly perturbing but the students might have assumed that in many cases the husband might be too old, or too mentally impaired, to understand consent.

However, when they assume the role of an immediate relative, the question of who should provide consent for surgery becomes cloudy. Only 77% felt that the consent should derive from the patient. The role of the spouse and the eldest son becomes important to the extent of 19% and 4% respectively. This puts in doubt the above conclusion that the students had absorbed the accepted ethical precepts.

In the second phase (**Tables 2 and 3**) component, there is further bemusement. Assuming the results of question 1 and question 2 in scenario A are the products of high-quality teaching in medical ethics and that the students have fully understood them, one would expect that religious beliefs, culture and severity of the disease should have no impact in decision making with regards to consent taking for surgery. On the contrary 23%, 6% and 48% respondents respectively indicated that such factors do play a role in their decision with respect to consent.

The results from Scenario B, wherein students had to assume the different roles with regard to revealing of confidential information, are almost identical to results of Scenario A (which is why no attempt at statistical analysis was made). This would infer that there is consistency in the way students approach these two issues, although

they may be thought perverse in the light of the responses detailed in **Table 1**.

Thus how do we reconcile the fact that almost all students are able to provide acceptable responses to the questionnaires but falter when they consider the severity of diseases, as well as religion and cultural values, with less than 50% indicating that taught ethics would be the most important determinant of decision making.

Shumway & Harden (2003)⁸, opined that student become skilled at passing tests, particularly the multiple choice type. So possibly in our exercise, Scenarios A and B, were skilfully answered according to expected requirement, but when confronted with a range of choices as in the Likert scale, students allowed their imaginations to run freely.

Since this group was about to graduate, concern is raised about how they will actually behave in their professional lives. In fact, studies have shown that values, religious and cultural differences do greatly influence the decisions doctors make when faced with ethical dilemmas^{9, 10}.

Larger multicentre studies are required to determine whether such trends exist in other universities. There is urgency in view of the increasing numbers of medico legal challenges, despite the well developed ethical curriculum and assessment methodology following the first edition of the GMC report on undergraduate medical education in *Tomorrow's Doctors*¹.

Conclusion

Teachers should not assume that whatever ethics they have taught and assessed will be practised by the students. Some students may provide teachers with 'expected answers' just to pass examinations rather than learning the information as a whole.

Teachers must be aware that in reality, students' decisions on ethical dilemmas may be influenced by other factors like religion, culture and perceived severity of the illnesses being treated. Teaching and assessment methods may need to be re-examined in this light.

Acknowledgement

The authors would like to thank the final year students of 2012 for voluntarily participating in this survey. We also would like to thank University Kuala Lumpur, Royal College of Medicine Perak for allowing us to conduct this survey.

References

1. General Medical Council, London (1993): *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*.
2. Consensus Statement by Teachers of Medical Ethics and Law in UK Medical schools Teaching medical ethics and law within medical schools: a model for the UK core curriculum. *J Med Ethics* 1998; 24: 188-192.
3. 51st Annual General Assembly of The World Medical Association 1999. http://www.wma.net/en/40news/20archives/1999/1999_04/ (Retrieved 27.07.2013)
4. General Medical Council, London (2003): *Tomorrow's Doctors*.
5. General Medical Council, London (2009): *Tomorrow's Doctors*.
6. Lakhan, SE, Hamlat E, McNamee T. & Laird C. Time for a unified approach to medical ethics. *Philosophy, Ethics, and Humanities in Medicine* 2009; 4:13.
7. Kassim, PNJ. Medical negligence litigation in Malaysia: Whither should we travel? *Journal of the Malaysia Bar* 2003; XXXIII: 14-25.
8. Shumway J M & Harden RM. (2003) AMEE Guide No. 25: The assessment of learning outcomes for the competent and reflective physician. *Med Teacher* 2003; 22(6): 569-584.
9. Padel AI. Medical ethics in religious traditions: A study of Judaism, Catholicism, and Islam. *J Ind Med Assoc* 2006; 38: 106-117.
10. Tsai, DF. Ancient Chinese medical ethics and the four principles of biomedical ethics. *J Med Ethics* 1999; 25: 315-321.