Meaning and value in medical school curricula


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Summary

Rationale, aims and objectives:
Bioethics and professionalism are standard subjects in medical training programs, and these curricula reflect particular representations of meaning and practice. It is important that these curricula cohere with the actual concerns of practicing clinicians so that students are prepared for real-world practice. We aimed to identify ethical and professional concerns that do not appear to be adequately addressed in standard curricula by comparing ethics curricula with themes that emerged from a qualitative study of medical practitioners.

Method: Curriculum analysis: Thirty-two prominent ethics and professionalism curricula were identified through a database search and were analysed thematically. Qualitative study: In-depth, semi-structured interviews were conducted with 20 medical practitioners. Participants were invited to reflect upon their perceptions of the ways in which values matter in their practices and their educational experiences. The themes emerging from the two studies were compared and contrasted.

Results: While representations of meaning and value in ethics and professionalism curricula overlap with the preoccupations of practicing clinicians, there are significant aspects of ‘real world’ clinical practice that are largely ignored. These fell into two broad domains: 1) ‘sociological’ concerns about enculturation, bureaucracy, intra-professional relationships,
and public perceptions of medicine, and 2) epistemic concerns about making good decisions, balancing different kinds of knowledge, and practicing within the bounds of professional protocols.

**Conclusions:** Our findings support the view that philosophy and sociology should be included in medical school and specialty training curricula. Curricula should be reframed to introduce students to habits of thought that recognise the need for critical reflection on the social processes in which they are embedded, and on the philosophical assumptions that underpin their practice.

**Keywords:** Professional values, philosophy of medicine, medical ethics, professionalism, medical curriculum, qualitative research

**Introduction**

Over the past 30 years, bioethics (or medical ethics) has become a feature of almost all Western medical school curricula, and many specialty training programs. A number of “core curricula” are now available to guide ethics teaching, providing educators with models that they can apply to their own settings. Like medical curricula more generally, these ethics curricula explicitly and implicitly promote a particular view of how medicine should be practiced—with, for example, ethical knowledge and skills, moral commitment and leadership, self-awareness, critical reflection, accountability and ‘virtue’. In other words, they present a particular representation of meaning and value in health care.

Curricula in ethics have been developed through a combination of empirical inquiry into practitioners’ moral and professional concerns and consensus building among bioethicists and educators. While these processes have generally been robust—as evident, for example, in the rigorous process undertaken recently to revise the UK Core Curriculum—there is always the possibility that standard curricula will miss important ways in which meaning and value are actually represented in contemporary medical practice. This is a problem because ethics curricula are unlikely to achieve their goals if they do not reflect all of the major preoccupations of practicing clinicians or adequately critique the concepts, ideas and values that underpin medical practice. Perhaps in recognition of this problem, exhortations regarding the teaching of medical professionalism have grown more numerous, and professionalism is now often taught alongside, or within ethics curricula. However, the professionalism movement risks the same error—a top-down, prescriptive approach that fails to connect with the ‘real world’ of day-to-day medical practice.

**Motivation for the study**

We became interested in this problem in the course of a qualitative research project, aimed at eliciting the values of practicing clinicians. It became evident in the course of this study that our participants tended to describe ethical and professional preoccupations that were not usually covered in standard ethics or professionalism curricula. To explore this issue further, we analysed a selection of curricula in order to determine what the “typical”
medical student or specialty trainee is likely to be taught to value in courses on ethics and professionalism. We then compared these findings to the results of our qualitative study in order to identify ethical and professional concerns that do not appear to be adequately addressed in standard curricula.

In this article, we will review published ethics and professionalism curricula, and the results of a qualitative study into the values underpinning medicine (more detailed accounts of the results have been, or will be, published elsewhere, including in this journal).\textsuperscript{14, 15} We then use this to identify the limitations of existing curricula and make some suggestions as to how ethics and professionalism curricula (and medical curricula in general) should broaden their philosophical reach and depth in order to respond to the ‘real world’ needs of students and doctors.

**Methods**

Our study consisted of two components—an analysis of current curricula in ethics and professionalism, and an analysis of data obtained in a qualitative study of doctors’ personal and professional concerns and expressed values.

**Curriculum analysis**

Ethics and professionalism curricula were identified through a database search (Medline, Web of Knowledge and Google Scholar) and an internet (Google) search using the search terms “ethics”, “bioethics”, “medical ethics” and “professionalism” combined with “curriculum”, “course”, “core curriculum” and “model curriculum”. Our goal was to find 1) prominent curricula that were likely to be used as models for other curricula and 2) a variety of curricula, including those designed for medical students and those designed for specialty trainees, and from a number of Western countries. In the course of our search, we identified a mixture of actual curricular documents, and descriptions of curricula in other published articles. We did not set any date limits on our search and we analysed all curricula that we identified. Others have carried out extensive systematic reviews,\textsuperscript{16} but we undertook a different approach, with a narrative analysis, and continued searching for curricula until thematic saturation had been reached—that is, no new curricular themes were emerging from our analysis. We analysed 23 curricula in total (Table 1).

*Table 1: refer to page 16 onwards*

**Qualitative study**

In this study, medical practitioners associated with the Sydney Medical School (Australia) were invited to participate in interviews. 22 people were approached, all agreed, 20 were available to participate. Sampling was purposive and was aimed at including both men and women and achieving maximum variation in age and specialty. There were seven women and thirteen men. Ages ranged from 28 to 76 (median 49), and years since graduation from three to 52 (median 26). Specialties included anaesthetics, general practice, internal medicine, surgery, ophthalmology, radiation oncology, psychiatry, emergency medicine, paediatrics and public health. Our goal in using this sampling strategy was not to examine
these sub-groups in depth or to identify subtle differences between sub-groups, but rather to ensure that we were not missing any major issues that might be obscured by interviewing only one ‘type’ of doctor. We continued sampling until thematic saturation had been reached—that is, no new themes were emerging from the interviews.

Participants were invited to reflect upon their perceptions of the ways in which values matter in their practices and their educational experiences. Interviews were semi-structured, with participants encouraged to reflect on episodes in their careers that had stayed in their minds because of their moral dimensions. They were also asked to talk about specific issues such as the cost of healthcare, the availability of health services, the appropriateness of the medical education program that they had received or were teaching, the place of evidence and research in medical education and practice, and the impact of role models and mentors. In contrast, participants were not asked specifically about ethics or professionalism as our interest was in how ethical and professional values permeated clinical practice.

Interviews were conducted by a medical practitioner and a psychologist, either together or separately. All interviews were anonymised with coded numbers used for each participant. Ethical clearances were obtained from the University of Sydney. We have withheld detailed demographic details of each practitioner to protect anonymity.

Transcripts were coded thematically. A process of dialectical empiricism was used to categorise the emergent themes into more abstract concepts, using constant comparison and reformulation of research questions and theories. Dialectical empiricism is a research technique for analysing qualitative data. It consists of iteratively generating and modifying research questions in the light of increasingly abstracted analyses of the data, until a degree of generalisation is reached that is determined by the nature and context of the study. The technique we use is modified from that described by VanLear. It is particularly useful because it encourages reformulation of research questions as emergent themes are seen to be important, without losing contact with the original purpose of the study. Agreement about themes, codes and categories were reached at regular meetings of the research group.

Results

The “ideal” ethics or professionalism curriculum

The contents of medical ethics and professionalism curricula are remarkably consistent, suggesting that core curricula have significant reach. Indeed, thematic saturation was reached after analysing fewer than five curricula. Most ethics curricula begin with an overview of moral philosophy or normative ethical theory—or at least making students aware that there is a body of philosophical scholarship that is relevant to medical practice. Most also emphasise the need to give students skills in critical and moral reasoning in order to deal with ethical dilemmas (identifying issues, clarifying issues and making decisions), as well as the necessary associated communication, argumentation and conflict resolution

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1 This might not be true for the ways in which curricula are delivered, but delivery was not the focus of our analysis.
skills. For the most part, however, ethics and professionalism curricula focus on substantive issues and are organised around a series of context-specific moral and professional quandaries, which are, in turn, understood with reference to a variety of guiding principles and concepts.

Clinical ethics forms the core of most medical school and specialty training ethics curricula, with a focus on the kinds of dilemmas that arise in particular clinical contexts (see table 2).

Table 2: Clinical ethics topics

End-of-life care (e.g. withdrawing treatment, advance directives, euthanasia, transplantation), obstetrics and gynaecology (e.g. termination of pregnancy, assisted reproduction, embryo selection, contraception, sterilisation), genetic medicine (e.g. prenatal testing, pre-symptomatic screening, disclosure of test results to family members, germ line therapies, cloning), paediatrics (e.g. obtaining consent from minors, maintaining adolescents’ confidentiality, reporting child abuse), psychiatry (e.g. involuntary commitment and treatment, restraint), infectious diseases (e.g. immunisation, HIV testing) and emergency/intensive care medicine (e.g. treating the unconscious patient).

Students are encouraged, implicitly or explicitly, to analyse these dilemmas with reference to various philosophical, ethical and legal concepts and principles (see table 3).

Table 3: Ethical concepts and principles

- Benefit and harm,
- Autonomy, paternalism, consent (and its components such as information, voluntariness, understanding, competence, capacity, rationality, maturity), therapeutic privilege, best interests,
- Compliance and adherence,
- Veracity and disclosure,
- Privacy and confidentiality,
- Futility, double effect, ordinary/extra-ordinary interventions,
- Human dignity, personal integrity, respect for persons, vulnerability, agency, individual responsibility, human rights, public and private interests, sanctity of life, personhood and quality of life,
- Trust and accountability, and
- Reasonableness, fiduciary relationships, duty of care and negligence.

A second topic that features in many ethics curricula is what is now known as public health ethics, addressing issues to do with resource allocation, health promotion, population screening, and disclosure of medical conditions in the public interest. Again, public health ethics is explicitly or implicitly underpinned by the teaching of concepts and principles such as:

- Justice, equality, equity, needs, utility and benefit sharing,
• Individual and social rights and responsibilities,
• Individual, family, culture, diversity and pluralism,
• Advocacy and solidarity, and
• Discrimination and stigmatisation.

Education in professionalism (often delivered in conjunction with ethics teaching) generally entails teaching students about professional regulations, guidelines, standards, and codes and the health system in which they will practice. Students are also expected to gain the understanding and skills necessary to act as managers and leaders, be part of teams, manage conflicts of interest, manage their own and their colleagues’ stress and impairment, prevent and respond appropriately to medical error, manage the doctor-patient relationship (e.g. good communication, building trust, non-discrimination and boundary management) and engage in good academic (learning, teaching, supervision, research, and publication) practices. As with clinical ethics, teaching of professionalism is explicitly or implicitly underpinned by the teaching of concepts and principles such as professional virtues, trust, misconduct, medical error and clinical governance.

Most ethics and professionalism curricula emphasise the importance of cultivating desirable professional attitudes and virtues such as compassion, benevolence, honesty, courage, prudence, empathy, caring and commitment to learning, and ensuring that students graduate with demonstrable skills such as competently obtaining informed consent, admitting a patient involuntarily, transmitting sensitive information, giving bad news, identifying and using surrogate decision-makers and so on.

“Real world” ethical and professional preoccupations

Our interviews revealed a broad set of ethical and professional preoccupations, which can be categorised broadly into four categories: personal concerns; dyadic concerns; systemic, professional and organizational concerns; and epistemic concerns.

1. Personal concerns

a. Making authentic career decisions. A dominant theme throughout the interviews was the challenge of career decision-making—including the choice of medicine as a career—often with insufficient understanding

P12: [A medical career] can be very satisfying, but it’s a real life. It’s not a career, it’s more than a career if you want to do it well … it’s enormously frustrating and time consuming and exhausting, both emotionally and physically.

But making authentic career decisions was not always easy in the face of peer pressure, as P6 discovered when he chose rural general practice as a career.
P6: I decided I’d do rural general practice ... so I looked for ... the smallest hospital I could find to train...So I left [major teaching hospital], under a sort of lot of ‘you’re ruining your life, your life will be over’.

b. Managing personal stress. A theme that frequently emerged from our interviews was that of managing stress in the context of intense professional demands. The early years of medicine in particular were seen to be particularly intense.

P18: And [I had] a similar experience in neonatology ... in the middle of the night and four or five exchange transfusions. I was actually hallucinating ... I actually nodded off in a procedure, and had myclonic jerks, I thought ‘this is stupid’.

Events such as patient complaints could be a major source of personal stress.

P10: [Speaking about his wife, also a doctor] probably the most difficult period in her life was when there was a complaint about her medical care, and she just ... it knocked her for six and knocked her confidence.

While committed to good patient care, our participants acknowledged that attention to self-care could be just as important, both for their own good and for the good of their patients.

P4: I was getting a bit too connected. ... And [the consultant] ... came across me one day just feeling overwhelmed, and he said ‘You need two days off...’ And then I came back, and I was just a bit more considered and thoughtful about boundaries.

c. Achieving a work-life balance. Along similar lines, participants expressed concern about their difficulties in achieving a work-life balance. Some participants emphasised the lifestyle sacrifices they had made, and the profound effect this had had on them. A young doctor observed:

P15: I guess I see maybe my prolonged university study program, maybe that’s made me now in my 30s, not married, no children, maybe that’s delayed everything.

Others described the career sacrifices they had made in order to have time for family and other pursuits. A mid-career doctor found that her young family was now taking precedence over her ambitions to achieve eminence in surgery.

P5: I have really no more personal achievements to make that relate to my career. I feel I’ve achieved a reasonable amount. There’s lots of things more that I could have done, but I don’t think I’m going to do them, and I’m quite happy with that.
e. Managing enculturation. A more abstract preoccupation among our participants was that of the process of, and effects of professional and organisational ‘enculturation’. While they did not use this term specifically, they were all very much aware that medical school and subsequent specialist training had exposed them to a new culture. Participants were aware that they had passively absorbed aspects of the medical culture, such as the way in which clinical practice and research could be intertwined.

*P9:* I guess the other thing (even though I didn’t really probably quite click to it at the time) was the very academic intellectual approach, and particularly with the oncology people, the research being an intrinsic part of the day-to-day work.

They were also conscious of actively assimilating medical culture by seeking mentors, reflecting on other doctors’ (good and bad) practices, and learning to participate in medical discourse.

*P4:* I’ve actually also actively sought mentors. I didn’t realise that that’s what I was doing, but I did that over a long period of time, and I still do that in informal, and sometimes, formal ways.

Enculturation was seen as both a natural, inevitable process, and as one that needed to be navigated with care because it had the potential to compromise their capacity to practice with competence and integrity.

*P1:* From the system’s point of view, I think that the hospital training years were quite restrictive, and imposed maybe a set of values on me at that time that I haven’t thought I would have to contend with when I went into medicine.

2. Dyadic concerns

a. Relationships with patients. Many of our participants were concerned with establishing the ‘right’ interpersonal distance in the doctor-patient relationship. They clearly valued closeness, which entailed commitment to patient wellbeing, willingness to devote time to patients, attending closely to patients, building trust and promoting intimacy, and involving patients in collaborative decision-making. Doctors frequently expressed satisfaction at this feeling of closeness.

*P14:* it’s an iterative transaction between patient and the doctor. So I think that’s what I enjoy the most, you can see it in the patient’s eyes, you know that you’ve connected.

In keeping with this, our participants expressed concern about instances in their own, or others’ practice, when patients were treated disrespectfully or impersonally. But doctors
also described instances when they had found it difficult to maintain sufficiently clear boundaries, and spoke of their efforts to create the necessary distance from patients.

P19: The last year [of my training] I learnt to deal with those things a lot better and distanced myself. I still find it’s very difficult to... you take a lot of stuff from work home, and it’s hard to separate those things.

b. Advocating for patients. A number of participants described their distress at seeing patients being treated poorly, either because of the culture and system in which they were embedded or because of the values or personalities of the clinicians involved.

P1: I think there were people who ... weren’t good role models in terms of demonstrating wanting the best for their patients ... Those are the sort of people I felt uncomfortable working with, because their values of clinical practice were obviously different to mine.

In response to these upsetting events, several participants emphasised the importance of acting as advocates for patients.

P12: [A patient] was refusing surgery, and ...[another doctor’s] opinion was it was very important you actually cut off the care, because you needed to emphatically state that you were not agreeing with the decision ..., but ... in all of those cases I actually got more involved with them and tried to help them ...

3. Professional, organizational and systemic concerns

a. Managing medical resources. While deeply concerned about the quality of the doctor-patient dyad, and of the need to give individual patients the best care possible, our participants were also aware of the need to think about the health system and its limited resources.

P5: ...the budget is limited, and it’s not even just about the budget, it’s about the appropriateness of doing everything to everyone. And I make, and most colleagues make, those decisions every single day.

b. Managing bureaucracy. While aware of the need to take systems into account, all of our participants expressed frustration at the bureaucratisation of medicine. This frustration stemmed in part from the ways in which bureaucracy could stand in the way of good patient care, and their powerlessness to make things better.
P8: ...every year we used to lobby to change the hospital policy to call residents to do blood cross-matching after hours ... So I used to have to make representations to the hospital CEO about this, and he said to me one day ‘You know, every year you elect a new representative, and by the time they work out what needs to be done, they’ve moved on’.

Frustration also stemmed from the perceived lack of respect accorded to doctors by health service administrators and managers.

P17: I’m really, really sceptical about governance. But I think my concern is mostly about the way it’s delivered, in that it tends to be delivered in quite a patronising way ...

c. Professional relationships and medical politics. It was not only bureaucrats who could be the source of inter-personal friction, as relationships with other doctors could be equally fraught. Bullying by senior doctors was a common theme among our more junior participants (and others reflecting on their early years).

P10: And there was a culture at [Hospital X] ... it was a harassment sort of culture: intimidation, yelling, and real stripping down.

Many of our participants were concerned about lack of respect for their departments or specialties.

P16: We’re a bit understaffed because of various things, and I think our department has hit a very low point, and it’s seen as dysfunctional by ... a lot of other people in the hospital.

Competition and conflict were also causes for concern, and needed to be managed authoritatively.

P7: .You find that there’s camps that are warring, fighting for control and that ... and I was asked by both, ‘Whose side are you on?’ by both sides ... And I said ‘Neither’. And they said ‘Well if you’re not on my side, you’re against me’. And I said ‘well fine’.

d. Relationships with the public. As well as being concerned about lack of respect from managers and colleagues, our participants expressed concern about negative public perceptions of medicine.

P13: There is little respect for politicians, the church leaders, and doctors ... I think a lot of people would prefer to speak to their kind, friendly bus driver, than their rushed GP, who doesn’t seem to give a damn about them ...
Negative portrayals of medicine in the general media were seen as a particularly important cause and manifestation of lack of collective respect.

*P1: This is going to sound really a bit lame, but um, I'd like to see better recognition for the good things in our system, instead of you know, constantly whinging about some of the infections in the states, and the bad things that happen...*

### 4. Epistemic concerns

**a. Making wise decisions.** A key epistemic preoccupation to emerge from our interviews was how to employ knowledge wisely. Difficult clinical decisions were important to our participants because they affected others’ lives, and were potentially a source of painful, even if instructive, regret.

*P15: Things that I’ve done? The things that I remember are the cases that I’ve done the wrong thing and it’s awful. You just feel sick, just terrible.*

Importantly, decisions were central to our participants’ identities as doctors—over time, they came to see themselves as doctors who made certain kinds of decisions. This was, in turn, related to their natural temperaments and inclinations.

*P19: Naturally I think I am much more of an activist, a more intuition driven person, I impose these rules so I don’t get too unsafe with my practice.*

**b. Using the right kinds of knowledge.** Closely related to their interest in the process of decision-making was our participants’ concern with the need to balance two kinds of knowledge. On the one hand, they were aware of the importance of making decisions based on their knowledge of the workings of the body, or the probabilistic knowledge of evidence-based medicine (EBM).

*P8: Well I think [EBM is] one of the great revolutions of medical practice. I think it’s truly Copernican in its scope ...*

But our participants were equally concerned about their capacity to integrate technical decisions with the world of values, relationships and individual and cultural preferences. Balancing these two kinds of knowledge (and associated decision-making) was seen as an important challenge.

*P9: I think the preferences and attitudes and values of the person who is the patient, they are obviously critically important. And I think drawing that EBM picture with the...*
evidence and the person’s circumstances and their preferences ... I think that’s actually quite a good model.

...It’s so hard, because at a macro level I think it actually is very scientific. But I think when you look at the individual bits and pieces of it, it can seem much less so because there are so many other considerations on a patient to patient basis.

c. Conforming to professional standards of practice. Closely related to our participants’ ambivalence about EBM was their ambivalence about adhering to professional guidelines and protocols.

P4: I’m wonderfully delighted that our current graduates are so well trained in evidence based medicine, and I think they all do apply the evidence based learnings on an individual level, but I think the proliferation of guidelines and the attitude to them, is perhaps just 10 or 15% too far, a more slavish adherence, and I do worry that there are so many guidelines and so many bits of paper that we’re expected to read and assimilate, and it is too much.

P16: I suppose some of the very switched-on consultants and the ones that are really smart and using evidence-based medicine every day, and they can quote all the different papers, and the sensitivity and specificity of things. So there’s a couple of consultants I can think of who operate like that, and they’re very kind of protocol-driven or study driven. And they’re very good at what they do in terms of diagnosing the patient and managing the patient. However, I think they may lack a bit of interpersonal skills in having sympathy and connecting with the patient on a different level.

A younger participant expressed some anxiety about whether or not her clinical practice was in line with that of more experienced colleagues.

P15: I don’t think I give more lines of chemo than other people ... Maybe some would stop a bit earlier, maybe some would keep going, but I don’t think I necessarily do more or less than the typical.

Discussion

It is clear from our research that while representations of meaning and value in ethics and professionalism curricula overlap with the preoccupations of practicing clinicians, there are significant aspects of ‘real world’ clinical practice that are largely ignored. As important as they are, therefore, the topics found in standard ethics and professionalism curricula are not necessarily the issues of most concern in day-to-day practice.
Areas of overlap, which appeared in both ethics/professionalism curricula and interviews, were primarily related to personal concerns—making good career decisions, managing stress, and achieving work-life balance—and dyadic and systemic concerns—balancing closeness and distance, advocating for patients, and managing medical resources. These findings from participants across the spectrum of specialties are similar to those of Ellsbury et al, who examined competing professionalism values in community-based physicians.18

But there were also several themes in our data that are rarely, if ever, emphasised in standard ethics or professionalism curricula. These fell into two broad groups. The first were concerns about enculturation, bureaucracy, intra-professional relationships, and public perceptions of medicine. The second group included a number of epistemic concerns—about making good decisions, balancing different kinds of knowledge, and practicing within the bounds of professional protocols. While some would argue that such epistemic concerns do not really belong in an ethics or professionalism curriculum, in fact these issues have a strong moral component in that they are both about being a ‘good’ member of a profession and about making the ‘right’ kinds of judgments for patients. Indeed, it could be argued that it is unethical to practice a medicine that is not informed by the right kind of knowledge and decision-making, however these might be defined.

Another general theme that emerged from our research was ‘balance’—achieving a work-life balance, balancing altruism and self-concern, balancing closeness to and distance from patients, balancing their commitment to individual patients against their commitment to the health system with its finite resources, and balancing evidence, pathophysiology and epidemiology and knowledge of patient values and preferences in their clinical reasoning. It is, therefore, noteworthy that the virtues such as balance and moderation do not appear in the standard ethics curriculum—except in the context of balancing ethical principles.

These disconnections between existing ethics and professionalism curricula and our participants’ accounts of their practice and professional values do not suggest that the contents of standard curricula are unimportant or irrelevant to clinical practitioners, but they do suggest that curricula may not reflect the full range of ways in which meaning and value are represented in medical practice.

This is significant because a major purpose of ethics and professionalism education is to make visible the “hidden curriculum”19-21—that is the “cultural mores that are transmitted, but not openly acknowledged, through formal and informal educational endeavors.”22 p440

The concern about the hidden curriculum is that it conceals both undesirable and desirable values and behaviours, rendering them inaccessible to either criticism or praise. If sociological and philosophical topics of relevance to practitioners are excluded from curricula, they are more likely to remain “hidden”, to the detriment of both practitioners and patients.

A number of scholars have suggested that the philosophy and sociology of medicine (beyond applied moral philosophy) should be included in medical curricula on the grounds that this may assist medical students to develop a “reasoned, critical, reflective approach to medicine” and deal with uncertainty.22, 23 We believe that our data supports this view because our participants’ concerns were broadly sociological (concerned with, for example, enculturation, identity, power, and (de)professionalization) and epistemic (concerned with decision-making, evidence and achieving a balance between different kinds of knowledge). Concepts that might usefully be introduced to students would therefore include social hierarchies, social boundaries, enculturation, power and authority; health, disease, benefit, risk and the purposes of health care; and knowledge and evidence. As one participant commented: I often think back to a lecture that we had in med school, about the sick role. I
don’t know whether we give a lecture on that any more ... It’s probably gone, it should go back. But it’s fundamental isn’t it, because that’s a line that people cross when they come into the doctor’s surgery, with what might be otherwise seen as a social issue or a personal issue (P1).

While it is beyond the scope of this article to address exactly how medical sociology and philosophy should be taught, we believe it would be important both to introduce sociological and philosophical concepts in abstract terms and ground them in personal experience, in keeping with the elements of the learning cycle: concrete experience, observation and reflection, the formation of abstract concepts, and testing in new situations.24 To achieve this, we would suggest a broad reframing of the ethics/professionalism curriculum, along the following lines.

First, students could be taught that medical practice is infused with moral and professional quandaries—that is, with situations in which there may be (at least) two choices, each of which may be morally or professionally required, neither of which may override the other, and each of which may carry a morally relevant outcome.25-28

Second, students could be shown how to look beyond the types of ethical quandaries that are commonly presented to students in formal curricula in order to recognise that ethical concerns may also stem from conflicts between the personal and professional ‘interests’ of the doctor and the needs of their patients; between the conventions of medical culture—including those about knowledge—and the preferences of the doctor or patient; and between the values embedded in clinical practice and the values embedded in bureaucratic and organisational approaches to patient care.

Third, students could be reassured that the goal of ethical reasoning is not to come up with the one right answer, but rather to strive—in the tradition of virtue ethics and virtue epistemology—for phronesis, prudence and a moderate or dialectical approach to approaching ethical dilemmas. This approach would be consistent both with our participants’ natural inclinations to try find balance, and with the recent—albeit controversial—revival of virtue ethics and virtue epistemology within medical ethics.14, 29-31

To help students grasp the reality that there are no simple solutions to moral and professional quandaries, they could be formally introduced to the concept of ‘reflective equilibrium’ i.e. to the idea that moral reasoning involves reflecting upon a set of considered moral judgements, a set of moral principles that explicate their moral judgments, and a set of relevant background theories.32-35 This overall approach, which is consistent with what DePaul32 has referred to as a “radical wide reflective equilibrium”—emphasises the need for ethical reasoning to be informed not only by theory (ethical, epistemological, sociological, etc), but also by empirical inquiry, personal reflection on one’s formative moral experiences, and personal intuitions stemming from formative experiences. It is also consistent with learning theory, which emphasises the importance of starting with the learner and facilitating the natural learning cycle in which concrete experience stimulates observation and reflection, the formation of abstract concepts, and testing in new situations.24

What we are suggesting, therefore, is that already overcrowded ethics and professionalism curricula should be reframed, rather than extended. The goals of this would not be to provide students with a simple tool for solving ethical and professional dilemmas, but rather to introduce them to the infinite complexities of clinical life, and to habits of thought that recognise complexity, uncertainty and the need for ongoing critical reflection and moral engagement with peers and mentors.
### Table 1: Ethics/professionalism curricula that were analysed

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<td><a href="http://www.mcc.ca/pdf/cleo.pdf">www.mcc.ca/pdf/cleo.pdf</a></td>
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<td>UNESCO Bioethics Core Curriculum</td>
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<td>unesdoc.unesco.org/images/0016/001636/163613e.pdf</td>
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<td>International Federation of Medical Students’ Associations (IFMSA) and European Medical Students’ Associations (EMSA). European Core Curriculum - the Students’ Perspective</td>
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<td><a href="http://www.educmed.net/pdf/documentos/bolonia/eccsp.pdf">www.educmed.net/pdf/documentos/bolonia/eccsp.pdf</a></td>
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<td><a href="http://www.bcm.edu/ethics/students">www.bcm.edu/ethics/students</a></td>
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<td>University of Bristol</td>
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<td><a href="http://www.bristol.ac.uk/social-community-medicine/centres/ethics/courses-programmes/">www.bristol.ac.uk/social-community-medicine/centres/ethics/courses-programmes/</a></td>
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**Specialty training curricula**

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<td>Department of Family Medicine, University of Manitoba</td>
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<td>Royal College of Radiologists</td>
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<td><a href="http://www.ncbi.nlm.nih.gov/pubmed/19008085">http://www.ncbi.nlm.nih.gov/pubmed/19008085</a></td>
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**Surveys of curricula**

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References


