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**Original research article**

# Role of Medical Ethics and Professionalism in Undergraduate Medical Education

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**Abstract**

**Background**: To Assess the role of Medical Ethics and professionalism in Medical Education and to assess the impact of teaching Medical Ethics and professionalism to Undergraduate students in new curriculum.

**Methods**: The present cross-sectional study was conducted among the 100 practicing doctors of Rajiv Gandhi Institute of Medical Sciences (RIMS), Adilabad. After taking the informed consent, the participants were given the semi structured self-administrative questionnaire which includes questions regarding the demographic details of the participants and questions regarding the ethics and professionalism in medical education. The data was entered in Microsoft Excel and was analyzed using SPSS version 21.

**Results**: Majority (60%) of participants completed their post-graduation. Mean duration of clinical practice is 17 years. Among the participants 50% were following ethical and professional behaviour sometimes, 28% of them were always following ethical and professional behaviour and 22% were not following ethical and professional behaviour. For the question regarding opinion about the ethical and professional behaviour of colleagues, 64% of the participants told that their colleagues always follows ethical and professional behaviour, 32% gave the opinion that their colleagues follow ethical behaviour some times and others told that their colleagues does not follow ethical and professional behaviour. Among the participants 62% were facing ethical issues once a week, 21% were facing once a month, 13% were facing once a year rest were not facing any ethical issues.

**Conclusion**: from our experience, it becomes clear that we have ignored the importance of ethics teaching in undergraduate medical curriculum. Participants in this study revealed that only 28 % were following ethical and professional behaviour in their practice and one of the major reasons found for unethical behaviour was workload. Seventy one percent of the participants told that, it is extremely important to teach about ethics and professionalism in the undergraduate curriculum. Majority (58%) of the participants told that, teaching ethics and professionalism in the new UG curriculum is going to cause high impact in the future.

**Keyword:** Medical Ethics, Professionalism, Undergraduate Medical Education, Medical curriculum

## Introduction

Medical ethics, the term dates back to 1803, is a combination of moral principles and values that are applied to take judgment in the practice of medicine[1]. Ethics is a broad term that covers the study of the nature of morals and the specific moral choices to be made. Normative ethics attempts to answer the question, "Which general moral norms for the guidance and evaluation of conduct should we accept, and why?"[2]. Some moral norms for right conduct are common to humankind as they transcend cultures, regions, religions, and other group identities and constitute *common morality* (e.g., not to kill, or harm, or cause suffering to others, not to steal, not to punish the innocent, to be truthful, to obey the law, to nurture the young and dependent, to help the suffering, and rescue those in danger).

Particular morality refers to norms that bind groups because of their culture, religion, profession and include responsibilities, ideals, professional standards, and so on. A pertinent example of particular morality is the physician's "accepted role" to provide competent and trustworthy service to their patients. To reduce the vagueness of "accepted role," physician organizations (local, state, and national) have codified their standards. However, complying with these standards, it should be understood, may not always fulfill the moral norms as the codes have "often appeared to protect the profession's interests more than to offer a broad and impartial moral viewpoint or to address issues of importance to patients and society"[3].

## The Fundamental Principles of Ethics

Beneficence, non-malfeasance, autonomy, and justice constitute the 4 principles of ethics. The first 2 can be traced back to the time of Hippocrates "to help and do no harm," while the latter 2 evolved later.

## Beneficence

The principle of beneficence is the obligation of physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the right of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger. It is worth emphasizing that, in distinction to nonmaleficence, the language here is one of positive requirements. The principle calls for not just avoiding harm, but also to benefit patients and to promote their welfare. While physicians' beneficence conforms to moral rules, and is altruistic, it is also true that in many instances it can be considered a payback for the debt to society for education (often subsidized by governments), ranks and privileges, and to the patients themselves (learning and research).

## Non maleficence

Non maleficence is the obligation of a physician not to harm the patient. This simply stated principle supports several moral rules – do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, and do not deprive others of the goods of life. The practical application of nonmaleficence is for the physician to weigh the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient. This is particularly important and pertinent in difficult end-of-life care decisions on withholding and withdrawing life-sustaining treatment, medically administered nutrition and hydration, and in pain and other symptom control. A physician's obligation and intention to relieve the suffering (e.g., refractory pain or dyspnea) of a patient by the use of appropriate drugs including opioids override the foreseen but unintended harmful effects or outcome (doctrine of double effect) [4,5].

**Autonomy**

The philosophical underpinning for autonomy, as interpreted by philosophers Immanuel Kant (1724–1804) and John Stuart Mill (1806–1873), and accepted as an ethical principle, is that all persons have intrinsic and unconditional worth, and therefore, should have the power to make rational decisions and moral choices, and each should be allowed to exercise his or her capacity for self-determination[6]. This ethical principle was affirmed in a court decision by Justice Cardozo in 1914 with the epigrammatic dictum, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"[7]. Autonomy, as is true for all 4 principles, needs to be weighed against competing moral principles, and in some instances may be overridden; an obvious example would be if the autonomous action of a patient causes harm to another person(s). The principle of autonomy does not extend to persons who lack the capacity (competence) to act autonomously; examples include infants and children and incompetence due to developmental, mental or physical disorder. Health-care institutions and state governments in the US have policies and procedures to assess incompetence. However, a rigid distinction between incapacity to make health-care decisions (assessed by health professionals) and incompetence (determined by court of law) is not of practical use, as a clinician's determination of a patient's lack of decision-making capacity based on physical or mental disorder has the same practical consequences as a legal determination of incompetence[8]. Detractors of the principle of autonomy question the focus on the individual and propose a broader concept of relational autonomy (shaped by social relationships and complex determinants such as gender, ethnicity and culture) [9]. Even in an advanced western country such as United States, the culture being inhomogeneous, some minority populations hold views different from that of the majority white population in need for full disclosure, and in decisions about life support (preferring a family-centered approach)[10].

Resistance to the principle of patient autonomy and its derivatives (informed consent, truth-telling) in non-western cultures is not unexpected. In countries with ancient civilizations, rooted beliefs and traditions, the practice of paternalism (*this term will be used in this article, as it is well-entrenched in ethics literature, although parentalism is the proper term*) by physicians emanates mostly from beneficence. However, culture (a composite of the customary beliefs, social forms, and material traits of a racial, religious or social group) is not static and autonomous, and changes with other trends over passing years. It is presumptuous to assume that the patterns and roles in physician-patient relationships that have been in place for a half a century and more still hold true. Therefore, a critical examination of paternalistic medical practice is needed for reasons that include technological and economic progress, improved educational and socioeconomic status of the populace, globalization, and societal movement towards emphasis on the patient as an individual, than as a member of a group. This needed examination can be accomplished by research that includes well-structured surveys on demographics, patient preferences on informed consent, truth-telling, and role in decision-making. Respecting the principle of autonomy obliges the physician to disclose medical information and treatment options that are necessary for the patient to exercise self-determination and supports informed consent, truth-telling, and confidentiality.

The universal applicability of these requirements, rooted and developed in western culture, has met with some resistance and a suggestion to craft a set of requirements that accommodate the cultural mores of other countries[11]. In response and in vigorous defense of the 5 requirements of informed consent, Angell wrote, "There must be a core of human rights

that we would wish to see honored universally, despite variations in their superficial aspects …The forces of local custom or local law cannot justify abuses of certain fundamental rights, and the right of self-determination on which the doctrine of informed consent is based, is one of them" [12].

As competence is the first of the requirements for informed consent, one should know how to detect incompetence. Standards (used singly or in combination) that are generally accepted for determining incompetence are based on the patient's inability to state a preference or choice, inability to understand one's situation and its consequences, and inability to reason through a consequential life decision[13]. In a previously autonomous, but presently incompetent patient, his/her previously expressed preferences (i.e., prior autonomous judgments) are to be respected[14]. Incompetent (non-autonomous) patients and previously competent (autonomous), but presently incompetent patients would need a surrogate decision-maker. In a non-autonomous patient, the surrogate can use either a substituted judgment standard (i.e., what the patient would wish in this circumstance and not what the surrogate would wish), or a best interests standard (i.e., what would bring the highest net benefit to the patient by weighing risks and benefits). Snyder and Sulmasy[15], in their thoughtful article, provide a practical and useful option when the surrogate is uncertain of the patient's preference(s), or when patient's preferences have not kept abreast of scientific advances. They suggest the surrogate use "substituted interests," that is, the patient's authentic values and interests, to base the decision.

**Professionalism:**

Professionalism is a core competency for all healthcare professionals and is a subject of great interest within the academic community due to its vital importance in delivering the highest quality patient care

The core values of professionalism need to be delivered explicitly throughout the course of medical education, with more-complex subjects being introduced along the educational process[16].

The current wisdom suggests the following steps in teaching professionalism[17]:

- Setting the expectations
- Performing assessments
- Remediating inappropriate behaviors
- Preventing inappropriate behaviors
- Implementing a cultural change

The first step is to clearly define the expected behaviors for the institution and its affiliates, followed by the development of policies delineating the due processes: reporting channels, remediation processes, and follow-up. Both learners and teachers should receive a list of expected behaviors for which they will be held accountable with explanation of the consequences of acting inappropriately.

Beyond this initial orientation and the written documentation, the teaching of professionalism should be incorporated at all levels, and training should be offered in relevant topics such as conflict management, feedback, supervisory skills, and assessment. The cognitive material should include the value system of medicine, which must be internalized by all physicians during the long process of becoming professionals. This material, as mentioned earlier, should be introduced as early as possible, with an increasing complexity and should span both undergraduate and postgraduate education. Teaching the cognitive components can be facilitated through courses in the history of medicine with emphasis on how the concept of medical professionalism evolved. Instructions can be delivered in form of lectures to provide

frameworks, definitions and stimulate curiosity. Other forms of teaching are also helpful, small groups sessions may be used to explore personal interpretations and biases, whereas, problem-based learning or collaborative learning formats are believed to be very helpful in this regard[18]. These techniques might be augmented further by creating opportunities to participate in community service activities in which professional responsibilities are highlighted[19].

Focusing on the cognitive base alone is certainly not sufficient. Non-cognitive components are extremely important as well since professional identity arises "from a long term combination of experience and reflection on experience"[20]. Non-cognitive skills include among others: communication (language, empathy, integrity), collaboration (responsibility, respect, duty), and continuous improvement (recognition of limitations and motivation to improve). The student must be provided with stage-appropriate opportunities to experience the challenges faced by practicing physicians and to reflect upon these events in a safe environment so that the process of reflection becomes habitual. An extra effort must be made to ensure that all students have the opportunity to experience real or simulated clinical situations. When this approach is not feasible, small-group discussions involving case vignettes, video clips, narratives, role-plays or other educational methods may suffice. However, what students hear in the classroom may not make the most durable impression, it is what they see and experience in the everyday practice. Their faculty members, residents and fellow students act unintentionally or otherwise as "role-models" which shape their attitudes and harden their perceptions about the real expectations of the profession[21].

Role-models, who have an extremely important part to play in this process, must understand professionalism and be able to stimulate reflection on the pertinent aspects of professionalism being modeled. Unfortunately, negative role models do exist. They are responsible, at least partly, for the well-documented cynicism that can develop in some students. Interestingly, some of these negative role models come from sources other than medical community, e.g. the media; they may represent an important challenge to the students' professional development. Medical educators have to be aware of this and to deal with it appropriately as well[17]. Another hindrance to this process is the so called "hidden curriculum"; it usually impairs the students' ability to reflect upon their experiences leading them to distance themselves from patients more than is needed to maintain professional responsibility[21]. Identified elements of the "hidden curriculum" include among others: routines, rituals, symbols, institutional slang, control systems and power structures[22]. On the other hand, many positive reinforcement techniques have been suggested to improve the process; for instance, if a student was complemented by a patient or nursing staff on a professional behavior, the teacher should make sure this behavior is acknowledged in a meaningful way such as directly praising the student, listing the comment on the student evaluation tool, sending an e-mail to the clerkship director, or completing a praise card for exemplary behavior[23].

The status of medical ethics is at its low in the poor and developing countries where the government hardly takes care of population health.[24] Corporatization of medical education, medical practice, and drug manufacturing has already made its negative impact, where poor patients are made to undergo seemingly life-threatening medical procedures (newer drug, newer invasive prosthetic devise, transplant and plastic surgeries) for the sake of monetary benefits. Medicine, ethics, and law should have their practical place in undergraduate medical curriculum for preparing medical practitioners to act ethically and legally. Physician-patient relationship will be symbiotic only when ethical and legal concerns are properly addressed. To address all these challenges national medical commission in our country recently

introduced AETCOM module in new undergraduate curriculum. This study was undertaken to assess the impact of implementation of teaching medical ethics and professionalism in the new curriculum, to understand the challenges in implementing it and to take corrective measures for better implementation.

**Aims & objectives:**

1. Role of Medical Ethics and professionalism in Medical Education
2. To assess the impact of teaching Medical Ethics and professionalism to Undergraduate students in new curriculum.

**Methodology;**

A cross sectional study was conducted to assess knowledge, attitudes and practices of medical
ethics among the doctors working in Rajiv Gandhi Institute of Medical Sciences, Adilabad.
A total of hundred doctors were included by using convenient sampling. The doctors were included from all departments and included from house surgeons to professors.
After explaining the purpose of the study, informed consent was taken. Those who were willing to participate were included in the study. The data was collected by using a self - administered semi structured questionnaire.

Questions on demographic data, knowledge regarding medical ethics and professionalism, opinion on implementation in new undergraduate curriculum were included in the questionnaire. The questionnaire was prepared and validated. Institutional ethical committee permission was obtained prior to collection of data. The data was entered in Microsoft exel and was analyzed using SPSS. The results were tabulated and presented using descriptive statistics. The questionnaire is presented in Appendix 1.

**Results:**

**Table 1: Demographics characteristic of study participants**

| S.no | Characteristic | Category | Frequency | Percentage |
|---|---|---|---|---|
| 1 | Age groups | 21-30 | 39 | 39% |
| | | 31-40 | 27 | 27% |
| | | 41-50 | 18 | 18% |
| | | 51-60 | 11 | 11% |
| | | 61 and above | 5 | 5% |
| 2 | Gender | Male | 42 | 42% |
| | | Female | 58 | 58% |
| 3 | Designation | Professor | 9 | 9% |
| | | Associate professor | 14 | 14% |
| | | Assistant professor | 21 | 21% |
| | | Tutor | 16 | 16% |
| | | Medical officer | 4 | 4% |
| | | Intern | 36 | 36% |
| 4 | Qualification | MD/MS | 60 | 60% |
| | | MBBS | 40 | 40% |
| 5 | Years of experience post M.B.B.S | More than 25 years | 11 | 11% |
| | | 16 to 25 years | 12 | 12% |
| | | 5 to 15 years | 26 | 26% |

| | | | | |
|---|---|---|---|---|
| | | 0 to 5 years | 15 | 15% |
| | | Nil | 36 | 36% |

A total of 100 doctors working at RIMS, Adilabad were included in the study with a 100% response rate. The socio demographic characteristics of the participants are summarized in Table 1. The mean age of the participants was 32.70 ± 10.26 years, and 58 % were female participants. Majority (60%) of participants completed their post graduation. Mean duration of clinical practice is 17 years.

**Table 2: Participants following Ethics and professionalism in their practice**

| S.no | Characteristic | Frequency | Percentage |
|---|---|---|---|
| 1 | Following always | 28 | 28% |
| 2 | Following some times | 50 | 50% |
| 3 | Not following | 22 | 22% |

Among the participants 50% were following ethical and professional behaviour sometimes, 28% of them were always following ethical and professional behaviour and 22% were not following ethical and professional behaviour

**Table 3: Participant's opinion about their colleagues following Ethics and professionalism**

| S.no | Opinion | Frequency | Percentage |
|---|---|---|---|
| 1 | Following Always | 64 | 64% |
| 2 | Following some times | 32 | 32% |
| 3 | Not following | 4 | 4% |

For the question regarding opinion about the ethical and professional behaviour of colleagues, 64% of the participants told that their colleagues always follows ethical and professional behaviour, 32% gave the opinion that their colleagues follow ethical behaviour some times and others told that their colleagues does not follow ethical and professional behaviour

**Table 4: Incidents of unethical behaviour faced by the study participants in their personal life**

| S.no | Incident | Frequency | Percentage |
|---|---|---|---|
| 1 | Prescribing unnecessary medication | 34 | 34% |
| 2 | Cuts in the lab | 12 | 12% |
| 3 | Not explaining the patient condition properly | 11 | 11% |
| 4 | Taking high charges | 10 | 10% |
| 5 | Improper patient care | 9 | 9% |
| 6 | Negligence | 8 | 8% |
| 7 | Improper referral | 6 | 6% |
| 8 | Claiming charges in government hospitals | 4 | 4% |
| 9 | Irresponsible behaviour | 3 | 3% |
| 10 | Reckless attitude | 3 | 3% |

The participants narrated different situations in their personal life where they have experienced unethical and unprofessional behaviour as mentioned in the above table (Table 4). Majority (34%) faced the situation where they were prescribed unnecessary medication, 12% faced unnecessary lab tests, 11% faced communication regarding patient was not correct followed by other situations.

**Table 5: Frequency of ethical issues faced by the participants in their practice**

| S.no | Characteristic | Frequency | Percentage |
|---|---|---|---|
| 1 | Once a week | 62 | 62 % |
| 2 | Once a month | 21 | 21% |
| 3 | Once a year | 13 | 13% |
| 4 | None | 4 | 4 % |

Among the participants 62% were facing ethical issues once a week, 21% were facing once a month, 13% were facing once a year rest were not facing any ethical issues

**Table 6: situations where ethical issues faced by the participants in their practice**

| S.no | Situation | Frequency | Percentage |
|---|---|---|---|
| 1 | During emergency care | 67 | 67% |
| 2 | No clarity | 18 | 18% |
| 3 | Not always possible to tell truth | 15 | 15% |

Sixty seven percent of the participants faced ethical dilemma while giving emergency care, 18% had no clarity about the ethical issues and 15% faced difficulties in telling truth to the patients.

**Table 7: Reasons for unethical behaviour of study participants in their practice**

| S.no | Reason | Frequency | Percentage |
|---|---|---|---|
| 1 | Work load | 86 | 86% |
| 2 | No autonomy as intern | 9 | 9% |
| 3 | Telling about death of patient | 5 | 5% |

Al most all participants told that heavy work load is the reason for un ethical and un professional behaviour.

**Table 8: Ethical and professional behaviour behaviour in other professions**

| S.no | Profession | Mean percentage | Standard deviation |
|---|---|---|---|
| 1 | Spiritual organizations | 64% | 33.2 |
| 2 | Police | 50 % | 24.9 |
| 3 | Film industry | 49% | 27.2 |
| 4 | Business people | 47 % | 23.6 |
| 5 | Judiciary | 46% | 29.1 |

For the question regarding the professional and ethical behaviour of other professions other than health care participants told that spiritual organizations have highest 64% ethical behaviour followed by police, film industry, business people and judiciary.

**Table 9: when to teach the ethics and professionalism**

| S.no | When | Frequency | Percentage |
|---|---|---|---|
| 1 | During Under Graduation | 94 | 94% |
| 2 | After Under Graduation | 4 | 4% |
| 3 | Before Under Graduation | 2 | 2% |

Ninety four percent of the participants gave the opinion that, ethics and professionalism should be taught during under graduation.

**Table 10: Importance of ethics and professionalism in the UG curriculum**

| S.no | Importance | Frequency | Percentage |
|---|---|---|---|
| 1 | Extremely Important | 71 | 71% |
| 2 | Very Important | 13 | 13% |
| 3 | Somewhat Important | 14 | 14% |
| 4 | Not important at all | 2 | 2% |

Seventy one percent of the participants told that, it is extremely important to teach about ethics and professionalism in the undergraduate curriculum.

**Table 11: Impact of teaching ethics and professionalism in new UG curriculum**

| S.no | Impact | Frequency | Percentage |
|---|---|---|---|
| | High | 58 | 58% |
| | Moderate | 27 | 27% |
| | Low | 19 | 19% |
| | No opinion | 6 | 6% |

Majority (58%) of the participants told that, teaching ethics and professionalism in the new UG curriculum is going to cause high impact in the future.

**Table 12 : Suggestions regarding the implementation of teaching ethics and professionalism in new UG curriculum**

| S.no | Impact | Frequency | Percentage |
|---|---|---|---|
| 1 | Require standard teaching material | 71 | 71% |
| 2 | Require more sensitization for medical teachers | 17 | 17% |
| 3 | Need separate course for medical teachers | 6 | 6% |
| 4 | No suggestion | 6 | 6% |

Seventy one percent of the participants told that, there should be a standard teaching material for teaching ethics and professionalism

**Discussion:**

A review of medical ethics education, conducted in 2004, recognized that there are two overlapping views regarding the purpose of teaching medical ethics: (1) to create virtuous physicians and (2) to provide physicians with a skill set for analyzing ethical dilemmas[25]. Nevertheless, a consensus regarding the importance of the medical ethics curriculum has been established in the medical community[25-27].

In this study, among the participants only 28% were following ethical and professional behaviour & similar findings were noted in a study conducted among physicians in Manipur,

India, revealed that more than half of the respondents (54%) were unable to recall any of the contents of the Hippocratic Oath[28]. In the current study seventy one percent of the participants told that, it is extremely important to teach about ethics and professionalism in the undergraduate curriculum. Studies conducted in Barbados[29] and Northern India[30] revealed similar findings, where 100% and 85% of participants respectively agreed that medical ethics should be taught in medical school.
However, in the present study 54% of participants told that current teaching of ethics and professionalism is not adequate. A study from Nepal found that 50% of the students felt that ethics teaching in Nepal was not adequate[31].

In this study Majority (58%) of the participants told that, teaching ethics and professionalism in the new UG curriculum is going to cause high impact in the future. A recent study on the effect of integrated medical ethics curriculum on 1st-year students from Singapore also revealed similar findings from the subject group and that the ethics teaching and assessment in medical education resulted in significantly greater receptiveness toward ethical codes of profession and had better critical thinking and clinical ethical competency[32].
In the present study seventy one percent of the participants told that, there should be a standard teaching material for teaching ethics and professionalism and similar opinions were given in few studies[33]

## Conclusions

In conclusion, from our experience, it becomes clear that we have ignored the importance of ethics teaching in undergraduate medical curriculum. Participants in this study revealed that only 28 % were following ethical and professional behaviour in their practice and one of the major reason found for unethical behaviour was work load. Seventy one percent of the participants told that, it is extremely important to teach about ethics and professionalism in the undergraduate curriculum. Majority (58%) of the participants told that, teaching ethics and professionalism in the new UG curriculum is going to cause high impact in the future.
Seventy one percent of the participants told that, there should be a standard teaching material for teaching ethics and professionalism. Implementation of teaching on medical ethics is, therefore, important in undergraduate medical curriculum in this medical college

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