

BIOÉTHIQUE MEDICAL ETHICS BIOÉTHIQUE MEDICAL ETHICS BIOÉTHIQUE DEMOCRATIZATION OF MEDICAL EDUCATION IS NEEDED TO EFFECTIVE TEACHING OF BIOETHICS

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BACKGROUND

Despite a history in medical education spanning 2500 years, it has only been in the last 30 years that medical ethics has come of age by being formally included in medical curricula [1]. By 1990, medical ethics had become an integral part of the core curriculum in most American medical schools. At present, most medical schools in the UK include medical ethics as part of their formal curriculum [2].

This progress in the field in the North American and European contexts was attributed to a set of factors related to the development of the health system, moral development, and political development that took place at a more accelerated pace than in developing countries [3]. However, teaching of medical ethics has additional factors that affected its development and progress in both the developed and developing countries.

This article discusses the spectrum of factors that affect the teaching of medical ethics in developing countries, with emphasis on the kingdom of Saudi Arabia (KSA), in which the authors work. In particular, the authors introduce the concept of 'democratization' of medical education as a needed factor for effective teaching of medical ethics.

TEACHING MEDICAL ETHICS IN KSA

The need to teach bioethics (or medical ethics) to medical students has been well acknowledged [4]. Teaching medical ethics provides the student with the knowledge and skills needed to define, analyze and work on resolving the ethical issues that arise along with the provision of health care. It aims to improve the clinician's ability to provide better health care and not necessarily make a clinician with a virtuous character [4]. Apparently, this set of educational input (i.e. knowledge and skills) do not necessarily require a 'virtuous' doctor; however the patients, and the community in general, expect doctors to be role models in their attitudes to their patients.

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In Saudi Arabia there are more than 28 medical colleges (present and planned) mostly governmental (21/28); almost half of them were established in the last decade (1999-2009) alone [5]. However, less than half of them (12/28) teach medical ethics to their students, where the focus is not on medical/clinical ethics per se, but more on cultural Islamic judicial jurisprudence (*fatwa*) on medical issues, and not on proper Islamic bioethics. Medical students are only taught what different schools of Islamic jurisprudence say about this or that medical issue.

In a 2002 study that reviewed the current status of bioethics teaching in Saudi medical schools, Al-Umran and colleagues found that only 46% of respondents were satisfied with the current coverage of ethical issues in the formal curriculum; while 23% were unaware of the value of the subject. Unsurprisingly, the study concluded that there was inadequate formal instruction in medical ethics and lack of an optimal curricular model for teaching medical ethics at the undergraduate level [6].

Interestingly, there is no universal format of teaching bioethics even in countries where the practice of bioethics is flourishing, such as the USA [7].

Unlike the situation in US and Canadian medical schools, where the use of small-group case discussions is the primary pedagogic approach [8], most of the teaching methods of medical ethics in the traditional medical schools of the developing countries (including KSA) are based on passive delivery [9], i.e. lectures and seminars, mainly through PowerPoint presentations.

To a lesser extent, some ethical questions are being raised during the clinical rounds and briefly answered by the attending consultant, despite the evidence that interactive sessions that enhance participant activity and provide the opportunity to practice skills can effect change in professional practice and, on occasion, health care outcomes [10-11].

Moreover, there is reliance on summative assessments at the end of these courses, which makes students more inclined towards 'knowing by heart' than developing true critical thinking or moral reasoning skills needed to justify their answers.

WHAT IMPEDES THE EFFECTIVE DELIVERY OF ETHICAL MESSAGES TO THE MEDICAL STUDENTS?

Some factors that negatively affect teaching of medical ethics are global problems that were reported elsewhere in the world, while others are more local and confined to the KSA and countries of similar cultural structure.

First, there are the unmet expectations of medical

students in terms of their ability to provide the kind of health care they deem ethical. For instance, when seeing senior colleagues not treating patients well, or other health team members not doing enough for the patient's good, or most probably when patients and/or their families complaining of and not collaborating with the clinical team.

There is also the discrepancy between what is taught and what is practiced. Due to the lack of a consistent comprehensive syllabus, medical ethics is usually taught in general dogmatic broad terms like 'dedication to patients', 'doing your best to the patient', 'commitment to the code of ethics', etc. It is left to the student to interpret these terms accordingly. Indeed, different students have different perceptions, hence different interpretations. This is, consequently, reflected on the health care he/she provides to his/her patient.

The absence of clear guidelines on how to define, analyze and manage ethical issues as they appear makes them become ethical dilemmas that exert additional pressure on medical students.

There have been studies that examined the role of failure of faculty professors (or senior colleagues) as role models on the students' perception of ethical issues [12-13]. Moreover, the observation of, and participation, in unethical conduct may have detrimental effects on medical students' codes of ethics [14], as well as a delay of moral sensitivity in the course of medical education when clinical teaching and faculty behavior model values are at odds with what is taught in the classroom [15]. This situation is further complicated by the students' 'vulnerability' to oppressive behavior due to their position in the medical hierarchy [16], without adequate chances for debriefing, ethical deliberation, or reporting misconducts that their senior colleagues commit.

Consequently, the accumulation of these unresolved ethical dilemmas feeds the misbelief that ethics do not exist in real practice; hence medical students tend to repeat things their seniors did, which is most probably practicing more paternalism on the patients and more hegemony on other subordinate health team members.

Finally, there is another quite unique challenge to delivering medical ethics courses in our setting, which is the dominance of *fatwa* on the consultations in the health-care provision in KSA, as well as many other Muslim countries.

The scholars' judicial approach to ethical issues usually tends to abstract the raised ethical questions/issues from moral reasoning exercise into a distinctive judgment on whether the issue in question is permissible (*halal*) or not (*haram*).

This does not only minimize the room for ethical deliberation but also shifts the responsibility of taking the decision from the healthcare team-patient communication into the hands of the religious scholars, who are more or less outsiders and do not follow the implications of their *fatwa*.

WHAT IS MEANT BY DEMOCRATIZATION OF MEDICAL EDUCATION? AND HOW TO ACHIEVE IT?

Democratization of medical education is a process by which medical education becomes more engaging to medical students as stakeholders and active participants in the decision making process in their medical schools. Students should no longer be only passive recipients of information (and orders) of their teachers, and they should take an active part in the generation and utilization of any ethical knowledge and skills they acquire.

The bottom line is to develop forums in which the students can practice the freedom of reflection, moral reasoning, and self-expression. It is for every institution to choose how to implement this according to what best fits its context.

Democratization strategies should aim at empowering the medical students as moral agents and as decision makers. They should be encouraged to freely select their representatives in the faculty's managing/directing board with an adjusted right to vote. Moreover, the medical school should set a role model in academic transparency where the students know their academic rights (including freedom to practice social activities) and have a mechanism of appeal should they face any disciplinary decisions.

From the academic perspective, interactive learning methods should be adopted in a safe learning student-centered environment, involving multiple ways to apply problem-solving methodology like problem based learning (PBL) and the SPICES model developed by Harden and colleagues [17]. Individual participation is enhanced by small-group teaching. Ethics teaching should start early (from first year) and progress from concrete cases to more abstract and theoretical considerations of the moral, legal, psychological and philosophical aspects of the subject.

In addition, students need to be trained to express themselves and communicate with patients by using communicative teaching methods like narrative ethics and standardized patients for instance. Lastly, students need to train themselves to learn how to work in team and acknowledge other health care team members. This is best achieved by multidisciplinary ethics education, where medical and paramedical students learn to study together as a basic step to work together in the future.

HOW WOULD DEMOCRATIZATION OF MEDICAL EDUCATION IMPROVE THE TEACHING OF BIOETHICS?

The (positive) effect of democratization of medical education on teaching ethics remains a set of assumptions, which need to be studied in a more systematic way, by proper research methods. However, we believe that democratization of medical education as proposed by this article can achieve better moral development through moralization of the medical education process and context, as follows.

In terms of the process, positive involvement of medical students in the teaching process through peer education, group leadership, presentations, etc., will give them the sense of ownership, leadership and literally the freedom from the negative impact of hierarchy. This will allow them to be in a position to 'practice what they preach' and express the characteristics they want to see in their role models and to be able to become/act as role models themselves, at least for their peers. Such an involvement in the educational process would help them to have their expectations (regarding learning bioethics) heard, and probably included in the curricula. On the other hand, it will also refine these expectations to be more realistic.

Medical students who have their voices heard through established channels will be adapted to communication with their colleagues and patients, particularly gaining the skill of listening to others. Their contribution to the decision making process (through the faculty or committees boards) will help them have more reasonableness and rationality in making their future decisions regarding patients.

Multidisciplinary ethics education, as a part of multidisciplinary medical education, will prepare medical students to communicate and collaborate with other non-physician colleagues in the healthcare team. This is assumed to reduce the problems related to hierarchy and power gradients among the team, especially in a PBL setting that enforces collaboration among the team to reach a solution of the problem being discussed.

CHALLENGES AND POSSIBLE SOLUTIONS

Democratization of medical education is not free from challenges, especially in the context of less developed countries.

Educational institutions are not found in vacuum. They are affected by the surrounding culture, traditions and regulations, which may work as antagonist factors to institutional democratization. Its advocates and activists may be putting themselves and positions at stake, especially with the overall discretion from using political terms like 'democracy' and 'democratization'. However, a gradual approach that is confined to the academic setting would minimize such threats.

The special sensitivity regarding the Islamic scholars' role in ethical issues is already being handled. There are annual conferences all over the Muslim world where doctors and scholars meet, discuss and decide on the novel ethical issues.

KFMC faculty of medicine, among other Saudi medical schools, is teaching an 'Introduction of Islamic rules on health-related issues' to medical students.

Lack of awareness and lack of qualified trainers in teaching ethics could be solved by collaborative programs with international centers found in the US and Canada. Such collaborations are welcomed and funded by major bioethics grants' providers like US National Institutes of

Health (NIH), the Fogarty International Center (<http://www.fic.nih.gov/>), the Wellcome Trust (<http://www.wellcome.ac.uk/Funding/Biomedical-ethics/index.htm>), the Greenwall Foundation (<http://www.greenwall.org/guidebio.htm>), and others.

CONCLUSION

The current approaches to teach medical ethics in Saudi Arabia, among other developing countries, are facing many challenges that impede, or sometimes reverse, the delivery of ethical messages to medical students.

They need to be reviewed in terms of content and context. Democratization of medical education is one approach that would help in achieving the expected and needed goals of teaching medical ethics to medical students. However, this approach needs to be implemented gradually, and its implications need to be thoroughly assessed through proper research methodologies.

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