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UNIVERSITY OF ZAGREB
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Ethical Issues Encountered By Medical Students During Their Education

GRADUATE THESIS



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ABSTRACT

Background: Ethical issues and concerns are becoming more and more important in everyday practice of physicians. The aim of this paper is to explore which issues students have encountered in different fields over the duration of their studies.

Methods: A hermeneutic method was used to analyse the essays of 19 students in their sixth year of medical studies. The essays were analysed to look for trends and patterns depicting various ethical themes they witnessed during their experiences. Attention was also given to students perspectives regarding each incident

Results: Ethical issues and prevalence of these issues were revealed. Ethical dilemmas that students were placed in, in various scenarios were also brought to light. There was comparison mainly between the more authoritarian and paternalistic approach shown by physicians towards patients and colleagues in certain countries. There was good evidence provided towards hierarchal systems in the healthcare setting, which also hi-lighted the pros and cons of hierarchy. There was a compelling viewpoint that pointed to the changing trends in Croatia from a paternalistic approach to a patient a one which respects patient autonomy.

Conclusion: This paper provided a useful insight into how students view medical ethics, as a set of values and a course. The results show that many students found that even before the study of the course medical ethics an innate set of morals was helpful and dictated their relationships with patients. There was also the opportunity to carefully examine students over all appreciation for a good set of morals and ethics as well as the importance of this example being set to them from early in their education.

1. INTRODUCTION

Medical ethics plays an important role in one's medical education and, later on, in one's medical career. Its study prepares students and physicians to be able to identify ethical problems and questions and in turn, analyse and solve them in a logical manner (Williams and World Medical Association. Ethics 2005).

To truly understand the concept of ethics one must first examine and understand in fine detail the core principles upon which this field has been built upon.
The four main cornerstones of medical ethics developed by Beauchamp and Childress in principles of biomedical ethics are autonomy, beneficence and non-maleficence and finally justice (Beauchamp and Childress 2009).
All of these principles require a conversation about the needs and desires of the patient or, in the case of justice, members of community. The principles are intended to guide. In the case of autonomy, we are required to determine the wishes of the patient in order to protect his or her autonomy. In the case of beneficence and non-maleficence, we are required to determine the patient's views of what does and does not count as goods to be pursued or harms to be avoided. In the case of justice, we are required to follow due process in order to determine just limits on health care that will be generally accepted.

The principle of autonomy is based on the Principle of Respect for Persons, which holds that individual persons have right to make their own choices and develop their own life plan. In a health care setting, the principle of autonomy translates into the principle of informed consent.

You shall not treat a patient without the informed consent of the patient or his or her lawful surrogate, except in narrowly defined exceptions (Garrett, Baillie et al. 2001). In order to affirm autonomy, every effort must be made to discuss treatment preferences with patients and to document them in the patients' charts. Informed consent is one of the most key components to autonomy of a patient and is a multifaceted concept that requires not only the patient to be assessed as being competent, that is understanding the consequences of the consent and capable of making a free choice. In addition they must not be pressured and free of coercion regarding making the decision. From the caring physicians point of view they must provide and make understandable necessary information for making a free, intelligent treatment decision and must make sure that the patient or surrogate understands the information. The only way to know if the patient understands the information is through reflective conversation with the health care provider. The health care provider must recommend what he or she takes to be the optimal option and is free to persuade, without pressuring, the patient of this option (Veatch 1997).

The process of informed consent as mentioned earlier is almost entirely reliant on a patients competence. Competence to make medical decisions requires that the patient know that he or she is authorising medical treatment and is able to understand effects of treatment, options in terms of health, life, lifestyle, religious beliefs, values, family friends, and all other factors bearing on treatment decision(Freeman and University College 1988). There is no easy way to determine incompetence except through the requirement that the health care provider spend time getting to know the patient and the patient's mind and understanding. There are several factors to take into

consideration during this process that being said one must remember that the most relevant factor when it comes to competence is the patients competence to make the specific treatment decision at hand (Beauchamp and Childress 2009). One must always remember that the fact that the patient has values different from the health care provider does not by itself prove the patient incompetent.

Confidentiality is also an important factor.Confidentiality is one of the core duties of medical practice. It requires health care providers to keep a patient's personal health information private unless consent to release the information is provided by the patient (McHale 2002). Patients regularly share personal information with their health care providers. If the this information were not protected, trust in the physician-patient relationship would be broken which would result in patients being less likely to share sensitive information, which could negatively impact their care.

Autonomy by definition is the right to self govern or in medical practice one may interpret it as the right to accept or refuse treatment options for any of many reasons which have to then be respected by physicians. The other side of this argument looks at Paternalism which is acting without consent or overriding a person's wishes, wants, or actions, in order to benefit the patient or prevent harm to him or her (Loewy 1989). This however doesn't look at the whole picture, there are obviously certain caveats. Where in some instances a physician is forced to exhibit a certain degree of paternalism with that in mind we can look at paternalism from two standpoints; The first being strong paternalism in which there is the overriding of a competent patent's explicit wishes (American College of Physicians. Ad Hoc Committee on Medical, Kitchens et al. 1998). There is the false presumption that the caring physician has

independent knowledge of what is best for the patient whom should comply with the suggestions of the prescribing physician. The other being weak paternalism in which the physician will take steps for the benefit of an incompetent patient. This is justified in some cases in order to restore that person's competence, or in order to protect a confused patient from harm (American College of Physicians. Ad Hoc Committee on Medical, Kitchens et al. 1998). The latter view expressed brings to view a larger question of a physician performing actions he feels are in the best interest of a patient and takes the initiative to treat without consent and which brings up the point of beneficence vs non-maleficence.

The term beneficence connotes acts of kindness, charity and mercy. It is suggestive of unselfishness, altruism, humanity, and promoting the good of others (Schiedermayer 1998).The principle of beneficence is often simply stated as an obligation to act in ways that promote good. This can be expanded to include both the prevention and removal of harm as well as doing good. That is to say, we should act in ways that prevent harm, remove harm, and promote good. Beneficence is not simply the opposite of non-maleficence. Some would argue that while people always have a duty to do no harm, we don't always have a duty to help. However, in health care, there is an implied duty to help by virtue of the physicians relationship with the patient. This duty is both legally and morally based in that it is reasonable for patients to expect a professional caregiver to act in ways that will promote their health and well-being. On the other hand, there is generally a recognised limit to the level of service and sacrifice owed to a patient by any particular health care professional (Munson 2004). As with harm, the definition of good is difficult. The sheer number of ways one might

promote the welfare of another defies a complete description. If we look at welfare in the health care context, it is generally seen in terms of health and physical well-being. The following secondary principles fall under beneficence; prevent the infliction of needless pain, prevent killing others and preventing incapacitating others (Beauchamp and Childress 2009).

In simple terms, the idea is a wide one, but it is understood in broader terms in relation to ethical theory to effectively include all forms of action which are intended to benefit or promote the wellbeing of others. The language of a principle rule of beneficence refers to ones moral obligation to act for the benefit of another.

The principle of non-maleficence states that one should act in a manner that do not inflict evil or subject others to harm either physically, mentally or emotionally. Specifically, any harm that may be avoidable or intentional and malicious. There is also the implication of avoiding subjecting an individual to the risk of being harmed. It is important to point out that this principle can be infringed upon either intentionally or unintentionally. That is to say that there needn't be an intent to violate this principle. In fact, you don’t even have to inflict any harm. If you have consciously or unwittingly subjected a patient or colleague to unnecessary risk, you have violated this principle (Munson 2004). There are many types of harm ranging from physical and emotional injury to the violations of ones rights. In health care, the primary focus on harm relates to a narrower definition including disability, pain and especially death. However, harm can be very much be interpreted differently by various individuals, largely it depends on their own ideals and outlooks. A broader definition of the word harm is often required when it comes to ethical considerations.

Likewise, more than one level of harm may come into play in a situation. For example, a surgeon will cause a certain amount pain and suffering on a patient in order to save their life. The surgeon has inflicted one form harm in order to avoid a potentially worse fate. However, in all cases, we are prohibited from acting in ways that are likely to cause undue risk or needless harm. The following secondary principles fall under the principle of non-maleficence; Do not kill, do not cause needless pain and do not incapacitate others (Beauchamp and Childress 2009).

A question that frequently arises in the argument of beneficence vs non-maleficence is "whats the difference between the 2 principles?". An arbitrary answer to this question is that both principles rest on the fundamental importance of what is in the patient's interest. However, the difference between the principles rests on the character of the avoidance of positive harm and the demand for positive benefit.

There is no way to use these principles to make decisions in the abstract. A practitioner must take into consideration various social agreements about what is in the interest of the patient, the standard of care within the profession, what the patient or his or her surrogate, consistent with standards of informed consent, agrees to. With these qualifications in mind, we can assert that the least controversial treatment is one that accords with the interest of the patient, is consistent with the standard of care within the profession, is agreed to by the patient, consistent with his or her informed consent, and satisfies both the principle of non maleficence and beneficence.

When there is a conflict between the two principles, the principle of non-maleficence trumps the principle of beneficence. For example, if harvesting two good kidneys

from an almost but not quite dead man helps two patients on dialysis, we should not harvest the organs since doing so would violate the principle of non maleficence by harming the potential donor. Two good outcomes do not override the demand that we not harm patients (Beauchamp and Childress 2009).

A general principle of justice requires that we act in ways that treat people equally and justly. Actions that are prejudiced against individuals or a group of people arbitrarily or without a justifiable basis would be in violation of this basic principle. For example, two patients with the same medical need ought not be treated differently (Beauchamp and Childress 2009). This principle, though crucial, does not tell us what is needed or which specific needs are take precedence over others.

Of special concern in the health care context is the idea of distributive justice. The concept of justice refers to an equitable balance of benefits and burdens with particular attention to situations involving the allocation of resources. There are four specific principles of distributive justice (Munson 2004) that can be considered in situations involving the distribution of material goods and resources, especially those that are scarce. These principles are;

1.The principle of equality, which requires that all benefits and burdens be shared equally. The advantage to this concept of justice is that everyone is entitled to an equal share of available resources; however the principle becomes complicated when not everyone is perceived to deserve an equal share.

2. The principle of need, which suggests that resources should be distributed based on need so that those with greater need will receive a greater portion of the resource. In

theory, this supports the principle of equality in that everyone will end up with the same share of goods. A difficulty common to these two principles is the question of exactly what material goods and resources one is entitled to. Definitive agreement has not yet been reached in this society as to whether health service is such a good.

3. The principle of contribution maintains that persons should benefit in proportion to their individual contribution to society as a whole. Those who contribute more to the production of goods should receive proportionately more goods in return. In simple terms this is an example of you receive what you put in.

4. The principle of effort recognises the degree of effort made by an individual as the determining factor in the proportion of goods to be received. Obvious difficulties with these principles lie in defining the exact nature and impact of a contribution and accounting for the inherent differences in the outcomes of individual efforts regardless of the amount of effort expended.

Furthermore there are two specific categories that also fall under the umbrella of distributive justice (Noble 2007), and are also relevant in the healthcare context as well as leadership in healthcare. Procedural justice is the first of these. This requires processes that show no bias, and are both impartial and fair. There is an underlying necessity of due process when conducting disciplinary action against an employee or the manner in which a patient complaint is investigated. Procedural justice might also relate to how resources are allocated in situations where other relevant criteria such as need or effort are substantively equal.

Finally, compensatory justice,which involves compensation for wrongs or harms that have been done. Damage awards to patients for malpractice or negligence are obvious examples of compensatory justice, along with damages awarded for discriminatory staff practices or fines levied for violations of legal or regulatory requirements. The salient point to be made here is that all resources whether abundant or scare must be and should be distributed appropriately so as not to waste valuable resource. Health care practitioners ought not to ration at the bedside (American College of Physicians. Ad Hoc Committee on Medical, Kitchens et al. 1998). The health care provider has a responsibility to be an advocate for the patient within the institutional setting in which he or she practices and beyond that has a larger societal responsibility, as citizen and as health expert, to be involved in establishing humane allocation policies at both the institutional and societal levels (Schiedermayer 1998). A classic example of allocation would be the use of the triage model in an ICU setting in a situation where there is a scarcity of beds. The problem facing the staff in such a case is how to bring about the greatest good in this situation of scarcity. Decisions should be based on medical need.

2. Medical Ethics' Teaching and Everyday Medical Practice

Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. As a scholarly discipline, medical ethics encompasses its practical application in clinical settings as well as work on its philosophy, sociology,history and theology. As such it is an integral part of the education of any student, intern or resident in the medical field. Ethics however cannot be exclusively taught to students only in the confines of a classroom. Knowledge is gained through experience as well as from reading literature. A physician with good ethical and moral conduct may not always be the most gifted physician in a team or hospital, but for the most part they will be one of the most respected in any healthcare setting. Appropriate ethical and moral conduct may very well determine the outcome of physicians career. As such it is vital that these principles are taught early to students and constantly reinforced during the learning period. In ethics students especially may witness events which they themselves may deem to be wrong or right, this inherent understanding of a situation is borne of experiences in the social setting. In fact students have been exposed to many aspects of ethical practice long before ever entering a classroom. Students are exposed to examples of clinician practice from the day they begin their clinical studies. This can range from anything between doctors and healthcare staff interactions with patients to the management of a hospital in a setting regarding allocation of resources. It is through such interactions where one may witness good and bad ethical practice. It is up to the teaching clinician and other members of the teaching staff to conduct themselves in an appropriate manner so as to set and example to their students and peers. Leading by example so to speak. Generally speaking lessons taught through such experience where one witnesses

events first hand make the most lasting impressions, either negative or positive. One of the major problems faced with this system is that students are exposed to both good and bad ethical practices before ever truly learning about and understanding the core principles behind what they have witnessed. This paper explores the experiences of 19 Students who shared their experiences of poor ethical conduct that they witnessed during their medical studies.

Ethical issues are usually more pronounced and in some cases obvious to those who are exposed to practice in a clinical setting. Students for many reasons are ideally placed to witness these transgressions so to speak. It is for this reason that the material used for this paper was written by students.

3.METHODS & ANALYSIS

3.1 Methods

The research into ethical issues encountered by medical students during their education was conducted by analysing 19 essays from 6th year medical students. These students were all enrolled in the University of Zagreb School of Medicine English program. The essays were written as part of the final exam for the subject Medical Ethics, which is studied in the 6th year of medical education. These essays were written on the topic "What are, for me, the main ethical issues that I have observed in my student days in medical practice?**".** Each essay focused on personal experiences of the students. Each individual also expressed their personal opinions regarding the issues as well as their own interpretations of their experiences. In some cases there were comparisons between different ethical practices in different countries but for the most part focused on experiences in Zagreb Croatia. After obtaining consent to use their essays their essays were analysed.

3.2 Analysis

The text was hermeneutically analysed using qualitative analysis methods. Each essay was analysed to look for trends and patterns that featured various ethical principles. The process that was used involved 3 main steps. Firstly a "naïve" reading (Mamhidir 2007) was conducted. This entailed an open minded view to each essay to provide a sense about the text, as well as a direction of the overall context of the text. The impression formed during the first reading was then used in the second step in which the "structural analysis"(Mamhidir 2007) of the text was conducted.

Here a coding technique was employed in which a word, or a short phrase that symbolically assigns a summative or salient attribute(Saldaña 2009) was looked for. Coding provided a detailed analyses of the text in order to explain the parts and validate or invalidate the initial understanding gained from the initial reading. The text was divided into meaning units that were then condensed, abstracted and structured into sub-themes and themes which were based upon various ethical issues such as autonomy, confidentiality, paternalism, disclosure, informed consent, justice, privacy, beneficence and non-maleficence.

A “comprehensive understanding”(Mamhidir 2007) was then developed based on the data from the initial naïve reading as well as the structural analysis. In addition to ideas formed during the previous phases pertinent literature was also taken into account.

4. RESULTS & INTERPRETATION

The analysis of all the essays during this process gave a useful insight into how situations are perceived by individuals. In some cases the students were writing about very similar situations that they were in, and formed different interpretations of the situation. Concurrently, there were also instances in which students who experienced seemingly different cases came to very similar conclusions.

Naturally when some of the students expressed their views they found it difficult on occasion to distance their emotions with the perceptions of the events that transpired. During this process one of the features that appeared turned out to be interpersonal relationships not only of physician and patient but also physician relationships with their peers and with students. Several ethical themes were recurring in the set of essays analysed as aforementioned. There was a special focus on the individual attitudes appreciation and point of views of each student. The results were divided in two separate sections major themes and sub-themes.

4.1 Major themes

4.1.1. Autonomy

This was a theme that occurred on several occasions in each essay, it was one of the most commonly mentioned and implied problem faced by medical students. In fact out of the 19 essays respect for patient autonomy was a main feature in more than half of the essays. There was a general consensus that the patients right to self govern was a critical part of healthcare that was in many cases lacking. This was especially apparent in the setting of the Croatian healthcare system. Interestingly, the students

who offered comparisons between the Croatian healthcare system and other countries such as Canada, the United Kingdom, Sweden and the United States, found that when it came to autonomy in these countries the patient was always put first. Patients in these countries had the final say of treatment plans and options after open and clear discussion with the physicians and other member of healthcare personnel. There was however a general acceptance as stated by most of the students that patients wishes should always govern the approach to treatment and treatment plan.

4.1.2. Beneficence & Non-maleficence

This was a theme that appeared in all of the essays submitted by the students and was the most commonly referred to example of poor ethical conduct. It was the key focus of 6 of the submitted 19 essays. The issues encountered or discussed regarding beneficence and non-maleficence also encompassed the widest range of events. One student focused on the pressure on health care physicians by members of the pharmaceutical industry to prescribe their drugs over other ones using monetary incentives. It was also noted that the student reviewed the literature of the drugs available. It was found that there was no significant advantage of the drug being pushed onto the doctor over other similar drugs available on the market. The other focuses of the students included but were not limited to the performance of unnecessary procedures on patients, the use of older techniques in surgery that resulted in longer healing processes and significantly more pain. There were some interesting arguments made in regard to views on beneficence and non-maleficence. the argument was made on several occasions that the two concepts are contradictory of each other. One student also expressed the notion that the only way to possibly

work in accordance of these two principles was simply to do nothing. However, there was an unanimous acceptance that if an action that inflicts harm on a patient is for the greater good of the patient then the benefits outweigh the negative aspect. This acceptance was especially true with regard to surgery and palliative care. There was however the feeling that in order for treatments to be in accordance with the best interest of the patient. The physician recommending the procedure or treatment would need to be up to date and be able to perform their duty by inflicting the least amount of necessary harm to a patient.

4.1.3. Justice

The adequate distribution of resource, as well as the treatment of individuals on an equal level regardless or race, gender, identity or sexual preference was a major theme mentioned in 13 of the 19 essays that were analysed. There was a theme in a paper that referred to the preferential treatment of the native race in the Canadian healthcare system over other ethnicities. In the Croatian setting the most frequent theme that appeared was the inadequate distribution of resources, especially in the ICU setting regarding allocation of beds to those that were generally not in need of a bed in the ICU. The view was many patients who are admitted to the ICU were in many cases found to have been sent from other departments. Beds were then occupied that would have been beneficial to other patients. A similar trend that was noted was that patients in the post ICU were often admitted due to connections had with members of the department rather than the specific need to be there.

On the topic of racial discrimination there was also a pattern by which certain doctors showed their frustrations with patients of Roma descent, as well as patients in summer

who didn't speak the language well as they were visiting tourists. That being said there were a few contradictions here as well that showed that some students who experienced similar situations with different ethnic groups also stated that there was no discrimination shown towards the patients. This is an example of students in similar situations that interpret the situation in different ways.

4.2 Sub-themes

4.2.1. Informed consent

As discussed earlier a vital part of patient autonomy is to provide the patient with all necessary information pertaining to their case, in order to obtain their consent to perform a procedure. This sub theme was the most positively written about and discussed out of all the ethical concerns discussed in all papers. Regarding informed consent only in 4 essays did it state that patients were bullied so to speak into providing their consent for treatment. 2 cases involved surgical treatment and the other case was regarding chemotherapy for a tumour and 3 were part of examination. Informed consent was also mentioned in one of these essays and an example was provided to show an appropriate discussion with a patient that involved an open dialogue between the physician and patient. In the essays in which there was a mention of informed consent the general consensus was that physicians both in and out of Croatia look to disclose information to a patient and ask for a signed and written consent on a course of action. There was also a general comprehension with regard to the importance of obtaining consent. One student looked to shed light on this by suggesting that the reason that this was considered of the utmost importance

was largely due to physicians wanting to avoid lawsuits against them which are in general commonplace in North America. Another student simply stated that with the advent of modern technology and the internet patients are more aware and have access to information regarding therapeutic options which leads to an open discourse with physicians, thus facilitating the process of obtaining consent.

4.2.2. Paternalism

Paternalism discussed and defined earlier under autonomy, was a theme that appeared in 7 of the reviewed essays. Of the 7, three of them were referred to the same case, a physician whom was teaching a class and informed a patient that the students would be learning how to perform a physical examination on her. They suggest that the physician did not ask the patient for permission or as if it was acceptable for students to be present.

The other references to paternalism included a patient who was informed that she would begin with chemotherapy immediately the day she received a diagnosis of having a tumour. However 6 of the 7 mentions of paternalism were pointed to the physician simply informing patients that students would be performing physical examinations on patients, or physicians themselves performing physical examinations on patients without asking first. But by telling the patient to get undressed and commencing the examination. All the students that referenced paternalism in their essays expressed their disdain towards the actions of the physicians in question. From this though every student did say that through witnessing what was in their estimation such appalling behaviour, they were taught how Not to deal with patients.

4.2.3. Confidentiality, Disclosure & Privacy

Confidentiality is one of the core duties of medical practice. It requires health care providers to keep a patient's personal health information private unless consent to release the information is provided by the patient (McHale 2002). Confidentiality was mentioned in only one of the essays where a student states that she was allowed to take patient medical files home. The student also makes a mention that the files she was allowed to take home listed patient details. The files were provided for research purposes but also contained patient data and information not pertinent to the field of her research. Privacy and disclosure were themes scarcely mentioned and were only referred to twice in all the essays. Students attitudes towards patient data and information were very rarely touched upon. Nonetheless when mentioned, it was understood that information regarding patients was to be kept private and not discussed with others that had no relevance to the case at hand.

4.2.4. Hierarchy

During the process of reading the essays during the naïve reading a word that was used in 13 of the 19 essays was hierarchy. It was always used to describe a situation where a student felt that they were witnessing something untoward, but felt that they had no right or means to question the offending physician. The attitude towards this was one which was disliked by students. It was mentioned mainly in regard to experiences in the Croatian setting. The explanation given by the students was that the senior doctor above them felt as though they were all knowing. In addition to this there was a suggestion that the hospital setting is arranged according to rank and that

students were at the very bottom of that ladder and in many cases were made to feel that they were at the bottom of the pile. In contrast to the Croatian setting there were some comparisons offered from Sweden, the United Kingdom and North American settings. In these regions there was also an existing hierarchy that students were made aware of however there was no intimidation factor and in fact speaking out against actions considered inappropriate is encouraged. This however was not a hard and fast rule in the essays, there was an example of a situation in the UK that a student experienced. The student was observing a procedure in which the physician made an error and denied it. The student was asked about this by a senior physician in the presence of the offending physician. The student stated that they felt pressure in the situation to support the physician who made the mistake for fear of a stigma that may have been attached if they said that there was an error committed. The attitude of the students towards a structural organisation of a hospital setting garnered the widest range of responses. On one hand they respected that there was a need for organisational structure in a healthcare setting. They felt that it brings order to have more experienced physicians with better skills ranking higher than less experienced ones. However the students took issue to the fact that in many cases individuals with higher rank felt that they are above everyone below them. There was a sense that these physicians felt more powerful than others and that to challenge them broke an unwritten law of camaraderie. In situations where there was open dialogue between all parties the universal feeling was very much in favour of having a hierarchal setting.

5. DISCUSSIONS & CONCLUSION

5.1Discussion

It may be noted that many examples discussed in the results may paint a negative picture of the ethical practices witnessed by students in Croatia. This idea though however could not be further from the truth. Through reading the articles and via personal experience it is clear to see that there is an evolution taking place. Ethics and appropriate ethical conduct are becoming more common in the work place. To fully comprehend attitudes and in some cases morals of individual physicians and physicians as a whole in a given population, one must first study the culture and society of a region. Doctors were once considered to be above the common man; Intellectually, morally, and in the eyes of society at large (Jonsen 2000). This perception is still in place today in certain regions of the world. However it is changing, and with time, ideally there will be more uniformity in ethical practices across the globe.

The field of medical ethics is vital for all professionals involved in a healthcare setting. Unlike physics or chemistry, medicine is not a pure science. It is both an art and a science, and those two things are interdependent and inseparable, just like two sides of a coin. The importance of the art of medicine is because we have to deal with a human being, his or her body, mind and soul. To be a good medical practitioner, one has to become a good artist with sufficient scientific knowledge (Panda 2006).

Even thought the principles, cornerstones and foundations of this field may be taught

in a classroom or workshop. True understanding of the field may only be gained through experience, conversation and interaction.

It is the responsibility of teachers, professors and physicians that are all involved in the learning process to remember that teaching students is not merely about a transference of knowledge. It includes a holistic approach that seeks to instil in their students a sense of moral standing, moral courage and principles by which future physicians can abide.

Beckman and Lee suggested that;"Inexperienced clinical teachers are often controlling and non-interactive"(Beckman and Lee 2009). In many of the cases that were reviewed in the publication of this paper it showed that truly the opposite was true. There were numerous examples of even the most experienced clinical teachers exhibiting traits that are non-conducive to a holistic learning environment.

5.2. Conclusion

There is a misconception that the study of medicine is all about disease and understanding disease processes. Medical ethics as a subject is not perhaps taken as seriously as it should be, not only by physicians and teachers who may ignore that it their duty to educate students and more broadly society through their actions. It is my opinion that as a principle the field and subject of ethics should begin to be taught continuously through the learning process of every student in medicine.

It is not always the most skilled physician that commands the respect of his or her peers and subordinates. The physician who views their patients as human beings and

treats them with the dignity that they should be afforded will always be given an immeasurable amount of respect.

The definition of health is that formalised by the World Health Organisation (WHO) over half a century ago; “a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.”(Grad 2002). This definition includes social well being, and very often the simple act of acting towards a patient with morals and respect will aid the healing process in a non quantifiable manner.

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