Ethics and Communication

Does Students’ Comfort Addressing Ethical Issues Vary by Specialty Team?

Sarah L. Clever, MD, Kelly A. Edwards, PhD, Chris Feudtner, MD, PhD, MPH,
Clarence H. Braddock III, MD, MPH

Ethics education aims to train physicians to identify and resolve ethical issues. To address ethical concerns, physicians may need to confront each other. We surveyed medical students to determine if their comfort challenging members of their ward teams about ethical issues varies by specialty and what attributes of students and their teams contributed to that comfort. Compared to other specialties, students felt significantly less comfortable challenging team members about ethical issues on surgery and obstetrics/gynecology. We suggest that ethics education must address the atmosphere on ward teams and give students skills to help them speak out despite their discomfort.

KEY WORDS: medical ethics; ethics education; medical education; medical; undergraduate communication.

Foremost among the goals of medical ethics education should be the goal of producing physicians who can recognize, analyze, and resolve ethical issues. To accomplish this, ethics curricula have used case-based teaching of ethical principles during the preclinical years.1,2

Yet simply knowing the principles of medical ethics does not ensure ethical behavior. This realization has led to the development of a social and behavioral framework for ethics education, rooted in studies that document how medical education socializes students into their roles as physicians.3–5 This process of socialization has been called a “hidden curriculum,” in which students acquire attitudes and habits from the example of their peers and superiors in a training environment that can be tense, burdensome, and even abusive.6

Lessons learned from the hidden curriculum may affect whether or not students speak up when they witness ethical conflicts. They may learn from the response of team members that it is more expedient to keep quiet than to challenge team members regarding ethical issues. Failing to speak up, however, is disturbing from the perspective of their ethical development as physicians: “habits of reflection, character, and intervention need to be developed and exercised if they are to be ready-at-hand in the future.”7

To nurture these habits, those who design ethics curricula need to know under what circumstances and why students have difficulty challenging ethical issues and provide them with appropriate communication skills.8 One study has suggested the nature of dilemmas that students encounter in their clinical years: performing procedures; being a team player; challenging the medical routine; knowing the patient as a person; and witnessing unethical behavior.9 Another study has shown that students perceive ethical conflicts throughout their preclinical and clinical years.10 To our knowledge, however, no study has examined whether students’ comfort challenging what they perceive to be unethical behavior varies on different specialty rotations, or why students may have difficulties bringing up ethical issues.

As a guide in our own curriculum development, we sought to determine on which services medical students find particular ease or discomfort in raising ethical issues with team members, and what aspects of the team contribute to that difficulty. We hypothesized that students’ level of comfort challenging their team members about ethical issues might vary by the specialty on which they were rotating. We also postulated that certain features unique to the student’s role and the specialty determine students’ comfort in bringing up ethical issues.

METHODS

In May 1999 we surveyed 103 University of Washington third- and fourth-year medical students who attended an evening seminar on applying for residencies. The University of Washington Institutional Review Board approved the research protocol. At the beginning of the seminar students received an information packet that included an anonymous, uncoded survey titled “Ethics in a Short White Coat” (available at www.blackwellscience.com/jgi). No
Faculty representatives were present before or during the
time the students were in possession of the survey. At the
end of the seminar we collected completed surveys. One
week later, we sent a reminder e-mail to all participants
requesting that questionnaires be returned.

The questionnaire was adapted from one used to
evaluate the frequency and type of ethical concerns facing
third-year medical students. It asked students whether
they had encountered certain types of ethical situations,
using vignettes as examples; the vignettes represented the
range of issues that students have found troubling in the
past. For example:

I was on call with a resident who was swamped with
admissions. She asked me to see a patient and start his
IV. After two unsuccessful attempts, the increasingly
irritated patient snapped, “Do you know what you are
doing?” I wanted to stop, but I was worried that my
resident would think less of me for not succeeding, so I
tried again.

Approximately how many times, if at all, have you
done anything you thought improper for fear of a poor
evaluation?

We chose to use vignettes because no unambiguous
labels exist to describe the kinds of problems that the
vignettes depict. The vignettes therefore served to help
students remember specific situations they may have had
and to focus their recollection on the phenomenon of
interest. A separate section asked them to rate how
comfortable they were challenging members of their team
regarding ethical issues on different specialties (family
medicine, medicine, obstetrics/gynecology, pediatrics,
and surgery) on a Likert scale ranging from Very
Uncomfortable (1) to Very Comfortable (5). The question-
naire then asked the students to select as many
reasons as were applicable for their difficulties challeng-
ing team members (too low on the team hierarchy; too
much work for team to do; too large a team to raise
questions; too many ethical problems for team to deal
with efficiently; difficult personalities on team; and too
few chances to speak with attending) and rate how
important each reason was on a 3-point scale from “Very
Important” to “Not Important.” Finally, the questionnaire
asked students their age, gender, and the different
settings of ethics education they had had (medical school,
undergraduate, other graduate, self-study).

We calculated proportions to examine participant
characteristics (gender, age, number of settings of ethics
education), and the frequency with which they witnessed or
committed unethical acts. We calculated “comfort scores”
for each specialty by calculating a mean based on the level
of comfort indicated by each student for each specialty. To
control for multiple comparisons, we used a Bonferroni
corrected P value (.05/30 = .002). We used the paired
t test to compare mean level of comfort raising ethical
issues, using the psychiatry clerkship (because it had the
highest mean comfort score) as the reference. All analyses
were performed using STATA, version 6.0 for Macintosh
(Stata Corp., College Station, Tex).

RESULTS

Response and Demographics

Of the 103 surveys distributed, 76 were returned
(74%). All were suitable for analysis. Of the respondents,
51% were women and 81.1% were 30 years old or younger.
These demographics were virtually identical to those of the
students graduating in May 2000 at the University of
Washington, to whom this group of students would have
responded. The majority of students had had some
ethics education (93%); the median number of experiences
with ethics education was 2.

Ethical Environment

A majority (51%) of students reported witnessing what
they considered to be unethical acts during their clinical
years of training; 96% reported hearing derogatory com-
ments directed towards patients. Sixty-four percent re-
ported having done something themselves that they felt
was unethical.

Students’ comfort scores are shown in Figure 1. Mean
comfort scores for surgery and obstetrics/gynecology were
significantly lower than those for the other specialties
(mean values 2.62 and 3.12, P < .0001 for both when
compared to psychiatry).

The most common reasons students cited for their
discomfort in challenging ethical issues (rating them Very
Important) were “difficult personalities on the team” (44%);
“too low on the team hierarchy” (39%); “team was too busy”
(18%); and “too little time with attending” (15%).

DISCUSSION

Our data provide important information regarding the
degree to which students at the University of Washington
feel comfortable challenging ethical issues on the wards
and some insight as to why this occurs. As hypothesized,
on certain rotations they feel significantly less comfortable
than they do on others. They attribute their discomfort to
the presence of persons with difficult personalities on the
team and to being low on the team hierarchy.

Some aspects of our study bear consideration. Its
strengths include the size of the sample, the number of
surveys returned, and the uniqueness of the data it
contains. There may have been respondent bias, but its
directionality is uncertain: while it is possible that only
students who had “ethical complaints” returned the
survey, it is also possible that students who had particu-
larly bad experiences on the wards chose not to respond to
avoid thinking about those experiences. Our data cannot
detect whether students spoke up in spite or because of
their level of comfort. A degree of bias may have been
introduced by students’ perceptions of the “reputation” of