PERSPECTIVES

Supporting the Moral Development of Medical Students

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Philosophers who studied moral development have found that individuals normally progress rapidly in early adulthood from a conventional stage in which they base behavior on the norms and values of those around them to a more principled stage where they identify and attempt to live by personal moral values. Available data suggest that many medical students, who should be in this transition, show little change in their moral development. Possibly, this relates to perceived pressures to conform to the informal culture of the medical wards. Many students experience considerable internal dissidence as they struggle to accommodate personal values related to empathy, care, and compassion to their clinical training. Educational interventions that positively influence this process have established regular opportunities for critical reflection by the students in small groups. Other interventions include faculty development to enhance role modeling and feedback by clinical faculty. The author espouses more widespread adoption of these educational interventions.

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Third-year medical students in a small-group teaching session asked about getting permission from patients for "DNR" orders. Knowing glances passed among the students when one of the faculty members in the session said that DNR permission should be obtained without coercion. Several students said, "I've seen it done by saying things like 'You don't want them shoving a tube down your throat,' or 'Jumping up and down on your chest.'" The relief of the students was almost audible when several faculty members explained how to explore advance directives tactfully and sympathetically with patients.

Incidents like this one raise the important question of whether clinical training negatively influences medical students' ethical and moral development. Students in the often indifferent and sometimes seemingly hostile environment of the wards may feel pressured to relinquish their ethical values, presumably because considerations of such values might impair efficiency and hinder rapid decision making. We know that medical students begin medical school as young idealists.[1] But many commentators have characterized physicians coming out of training as cold and aloof.[2–6] This poses a major challenge to medical education. The moral development of medical students should be a chief focus, yet the transition from student to full-fledged physician is problematic for many. Evidence suggests that their moral development may be stunted, or even worse, students may experience moral regression.[7–14] This paper will examine recently published evidence on medical students' moral development and provide a theoretical framework for approaching the issue. My purpose is to suggest ways to support the students as they traverse the sometimes crooked pathway toward becoming morally and professionally mature and competent physicians.[15–17]

UNDERSTANDING THE PROBLEM

To gain an understanding of the ethical and value-laden issues affecting medical students as they begin their clinical work, one needs to hear their personal stories, honestly describing the many formative experiences encountered and told from the heart. In a few places, it has been possible for faculty to win the students' trust enough to gather narrative accounts of their experiences. My colleagues and I made numerous observations regarding third-year medical students enrolled in a "patient-doctor" course that shed light on the students' issues.[1,7,8,18,19] Others have made very similar observations.[9,10] The narrative methods employed are especially well suited to provide an understanding of complex and subtle phenomena like medical students' struggles to accommodate to their clinical work and simultaneously hold tight to personal moral values.[20–22] In their accounts, students described incidents that they themselves judged to be most important to their learning.

The students' narratives reveal widespread difficulties in accommodating or acculturating to what my colleagues and I have termed "ward culture."[1,8–12] Strongly empathic identifications with their patients pervaded medical students' narratives, to the extent they put themselves in their patient's shoes.[1] This was in contradistinction to the "ward team," whom the students found distant, less empathic, and perhaps less caring in their approaches to patients.[7-10,19] In many examples, students felt they were the only members of their teams who could

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or would relate to patients whom other team members considered too uncooperative, incommunicative, or hostile to make trying to communicate worthwhile.[7] Numerous students described reluctance to perform tests or procedures on dying patients who might not benefit from them. Other students seemed to feel that they had to choose between being their patients' advocates and fitting into the medical hierarchy, getting good grades, or becoming one of the team.[7–10,19] One student, hearing the attending physician say to a patient, "This is a teaching clinic, you must see the student," expressed the dilemma this way, "I was chagrined to find myself allied in the patients' eyes with the attending physician against just the type of patient I wanted to care for."[7] Such choices are difficult exactly because the students identify strongly with their patients.[1,7,8,19] So, a student choosing not to intervene over unnecessary testing or insensitive behavior by a house staff member might feel guilty and personally weak because of sacrificing his or her commitment to patient autonomy. But on a deeper moral level, the issue might be that the student failed a basic responsibility to care for someone he or she had come to know.

We previously characterized the underlying issue for the students as difficulty fitting into the ward team.[7] Others identified the underlying theme of medical students' narratives as conflicts with authority.[9,10] On rethinking the question of what is most problematic for students, I have formulated the hypothesis that, at its core, the issue is one of moral development—the students feel trapped between the need to live according to their moral principles and the many perceived pressures to suppress their principles in order to fit in as team members.

THE EXTENT OF THE PROBLEM

Evidence using survey methodology documents that the issues defined above are widespread and generalized to many settings. In fact, data from several studies have shown little progression in moral maturity among medical students, compared to their peers in other settings,[11] and a survey of medical students confirmed that the majority feel their moral values are eroded during the clinical years.[12] Others showed widespread abuse of medical students by those in positions of power over them.[13,14] Residents also perceive unethical and unprofessional conduct among peers and others around them. In one survey, 74% of residents directly observed mistreatment of patients.[23]

THEORETICAL FRAMEWORK

We know a considerable amount about the moral development of young adults from the work of Lawrence Kohlberg, Carol Gilligan, and others.[24–27] Kohlberg used cross-sectional and longitudinal studies to observe how young adults and children reason about hypothetical ethical dilemmas.[24,25] More recent work largely confirms his general theory.[27] He described sequential stages of moral development. The ages at which individuals reached the different stages and the number of persons attaining the highest levels varied from culture to culture, but the sequence of stages remained the same.[24,25,27] Kohlberg described three general levels of moral development, which he named preconventional, conventional, and postconventional. According to his observations, the youngest children in the preconventional level determine right from wrong by avoiding punishment and cannot generalize beyond particular situations.[28] In later childhood and adolescence, persons can generalize and have a sense of self. In this so-called conventional level, actions are seen to be right if approved by significant others, such as parents, friends, or teachers. Receiving approval and exhibiting loyalty are important to persons in the early conventional substage. As they move to a higher substage within the conventional level, they develop a more abstract understanding of roles, obligations, customs, and authority figures. Here, persons may determine what is right according to a sense of duty.[24,25,27,28] Persons at this level generally adapt their behaviors to societal norms. They may do good in order to fit in.

Late adolescence and early adulthood are normally times of rapid growth for moral development, as demonstrated by studies of college and graduate students.[11] An important transition into the third or postconventional level, characterized by a substage in which individuals begin to define for themselves the moral principles that will guide their actions, occurs in some persons around this time.[24,25,27,28] They see moral principles as having validity apart from societal norms and authority figures. For example, such persons might define the rightness of an action in part by the principle of doing the most good for the most number of people. They might temper this approach by adopting a more basic principle of avoiding gross injustice to any one person or group. Only in young adults who have reached this level did Kohlberg describe moral reasoning where the choices that govern behavior are determined by moral principles. Kohlberg believed that only a few individuals attain a higher substage within this postconventional level of moral reasoning. Herein, the principles of human dignity and human rights are fully integrated into the personality and form the basis of a person's actions. Kohlberg thought, and data seems to confirm, that only the few persons at this highest moral substage would adopt, on their own, nonviolent civil disobedience as protest when their principles are violated.[24,25,27,28]

THE DEVELOPMENTAL CRISIS OF MEDICAL STUDENTS

Medical students in their clinical years are at an age when many should be early in their passage in the postconventional level where moral reasoning is based on principles.[11,27] My previous work shows that students in

their narrative accounts of events during training often describe attempting to operate from their moral principles or values.[1,7–10,29] Their ethical dilemmas involve possibly compromising principles. The terms they use in describing these dilemmas suggest that their discomfort results from perceiving themselves possibly regressing to the lower conventional moral level.[29] The students' tenuous toeholds in postconventional moral development seem threatened by the demands being made on them.

Supporting the medical students' moral development includes much more than encouraging them to think about ethical dilemmas. The students on the wards are confronted by demands for action. Philosophers have long known that behaviors and feelings are components of morality in addition to reasoning.[27,30] Ethical behavior integrates moral sensitivity (ability to recognize ethical issues), moral commitment (determination to do what is right), and moral behavior (skills at implementation), with moral reasoning (being able to weigh the rights of others and the principles at stake).[27,30]

At this point, one might consider the implications of Carol Gilligan's work on Kohlberg's theory. In studying female development, Gilligan emphasized the importance of "connection, care, and response" in morality, in addition to the approach emphasizing equality, justice, and rights advocated by Kohlberg.[25,31] Proponents of her view express the concern that morality built solely on justice emphasizes impartiality, and impartiality could promote aloofness and indifference.[32] Many scholars today, however, believe that the two moral orientations—justice and caring—are complimentary[27,31] My observations of students suggest that they perceive obstacles that undermine their care and compassion for patients as the chief moral problems that they face on the wards, less so hindrances that limit their ability to reason about ethical issues. Students embrace as their moral principles issues like openness, sensitivity to their patients, and understanding of their patients, as well as trustworthiness and willingness to take responsibility for the patients.[1,7,8,26,29,31–34] As I have previously pointed out, maintaining the caring orientation versus functioning on the clinical team becomes a fundamental moral choice for many students.[29,34] It follows that sensitivity, commitment, and behavior that constitute caring may outweigh moral reasoning, when it comes to defining the real-life ethical crises experienced by medical students. This may seem obvious, but until now, it has received only scant attention. It complicates medical educational approaches aimed at supporting the students, by requiring that any educational intervention provide for an integrated approach to morality, not confined to addressing moral reasoning alone.

SUGGESTIONS FOR MEDICAL EDUCATION

Medical education *must* seek to promote the moral development of its students. Medicine, after all, is a moral profession. This will be complex, because individual students may be at different developmental levels and may respond differently to the challenges posed by beginning clinical work. Some may continue their moral development in spite of all adversity. Others with varying levels of comfort may accept the conventional morality of those around them. Some will express little interest in participating in educational activities that focus on personal values and medical ethics. These students may be those most in need of educational activities that may cause them to question their assumptions. In addition, the discomfort expressed by many students as they begin to be socialized into clinical roles is probably a hopeful sign. It may indicate that these students are struggling to keep their moral values alive. Available data suggest that a majority of students fall into this latter group and experience considerable personal difficulties in accommodating their moral values to the demands of clinical work.[7–11,19] Hence, they need to be supported. The educational process should create opportunities where they can learn from each other. They should also learn from faculty, who can set examples, help clarify the students' moral principles, and promote group norms wherein commitment to one's personal moral values is considered desirable. I believe that several aspects of medical education taken together might create an educational climate that positively influences medical students' moral development. These are critical reflection by small groups of students and faculty, role modeling coupled with feedback given by faculty on the wards, and faculty development to support all of the above.

Critical Reflection by Small Groups of Students and Faculty

Professional education ideally provides an alternation between opportunities for practical problem-solving by its trainees, wherein they learn the nuts and bolts of the profession, and regularly scheduled opportunities to reflect on the larger context and meaning of their work.[35–37] Reflective learning allows students to conceptualize and generalize their behavioral changes into their mental structure of knowledge, skills, and values.[35–37] In fact, it has been shown that learning by practice without the added component of reflection does not promote psychological growth.[38] A key to achieving deeply critical reflection supportive of moral sensitivity and commitment is that the students in their groups grow comfortable discussing their core beliefs, feelings, principles, values, and attitudes about patient care. Being able to talk openly and honestly about these issues and about cases that plague them leads the students to question assumptions, and clarify commitments to their core values and beliefs.[39–42] Once students feel comfortable disclosing their true feelings and beliefs, they can also receive peer and faculty support—the insight with consequent strengthen-

ing of their moral commitment that comes from knowing that one does not face difficult issues alone.

This reflective component may be missing from most medical students' clinical training, although several large-scale efforts regularly set aside hours for reflection by students and faculty in small groups.[1,9,10,18,19] Although lacking long-term outcomes, short-term studies demonstrated that educational interventions such as these positively influence students' understanding of moral problems and their behavior toward patients.[38,43–47] In one study, meeting in small groups for case-based discussions for only 20 hours by first-year medical students enhanced their growth in moral reasoning throughout medical school.[47] The more important challenge, however, is to enhance all components that contribute to moral behavior—moral sensitivity, commitment, and implementation, in addition to moral reasoning. For this purpose, I believe that successful efforts require a level of "safety" for students that allows them to be comfortable in disclosing their deepest commitments and innermost values in small group discussions and that such efforts should occur alongside clinical experiences. Some successful efforts of this type lasted for 1 year or longer.[18,19] Of note, part of the challenge in influencing students' moral development is that their dilemmas are not hypothetical.[7–10,29,48] They involve interactions with sick human beings, creating dilemmas that do require sensitivity, commitment, and the skills of implementation. Also, medical students' ethical dilemmas are often closely tied to maintaining caring versus other demands placed on them, such as making good grades, gaining approval of teammates, fitting into the hierarchy, or simply getting time off. These are weighed against the obligations that students feel to empathize with and care for their patients. For these types of dilemmas, critical reflection can place the students' realistic needs in perspective vis-a-vis patient care responsibilities.

Learning the communication skills of implementation is essential for a fully integrated ethical approach. Evidence also demonstrates positive behavioral changes from teaching patient-doctor communication skills using active, small-group learning methods.[43,49,50]

The carefully picked faculty members who participate in small-group, reflective teaching like that described in the opening vignette are generally positive role models — not only because they reinforce the legitimacy of empathy, compassion, and caring, but also because they develop strong bonds with their students that enable them to be effective role models. The small-group learning also has an impact on the faculty, through their tutorial discussions with the students. If, as seems likely, some faculty physicians regressed to the conventional moral level while in training, deep reflection on moral issues in the setting of a small group of colleagues and highly motivated students may well return them to the pathway whereby they rediscover and live by their personal moral values. However, small reflective groups are insufficient in themselves to promote the students' moral development, because the groups lack direct impact at the bedside, where patient care is being delivered.

Developing the Clinical Faculty: Role Modeling and Feedback on the Wards

Role modeling is often cited as *the* method for teaching students ethical behavior conforming to professional standards. Studies of role modeling suggest that students and residents identify most positively with faculty who are enthusiastic and love their work, as well as those whose clinical skills and teaching abilities are judged highly competent.[51–55] Fortunately for moral development, teaching psychosocial skills is also perceived by learners as excellent faculty role modeling.[55] Negative faculty role models can be particularly malinfluential.[56] Students identify negative role models as faculty who are dissatisfied with their careers and have poor interpersonal interactions with patients and others.[56] These data support the accepted educational principle that the example set by a faculty member influences students more strongly to the extent that he/she establishes positive relationships with the students. Other educational principles for enhancing the effectiveness of role modeling include establishing mutual learning goals (allowing the teacher to highlight behaviors that are being modeled) and providing accurate feedback on the modeled behaviors.

Providing good feedback may be problematic as applied to moral education. A recently published observational study of attending physicians' responses to problematic behaviors by residents on the wards suggested that many teachers' responses to moral lapses are ineffectual.[57] Faced with behaviors that attending physicians had said would be unacceptable, their most common response was silence (an apparently baseless assumption that residents would interpret silence as disapproval).[57] Other responses included appealing to the residents' self-interest or "medicalization" (an entreaty to establish more positive patient relationships in order to enhance one's efficiency as a doctor).[57] These responses may trivialize the moral aspects of residents' behavior. Rarely, if ever, was honest feedback given regarding behavior by residents that faculty members described as uncaring or unprofessional.[57] A dilemma related to these observations possibly concerns the perceived needs of the teachers to maintain collaborative relationships with their trainees.

The dilemma posed for teachers, who fail to respond directly to suboptimal ethical behavior but wish to maintain good relationships with their trainees, is reminiscent of the medical students' dilemmas described in the introductory sections of this paper. Although teachers may verbalize a principled stance toward ethical dilemmas in private conversations, in practice many, even the majority, appear to actually function at the conventional level of moral development.[57] They appear to place team approval and the social norms developed informally on the wards above their moral principles. This is an observation that

certainly compounds the difficulty of effectively supporting the medical students and suggests that teachers as well as students are still developing morally, consistent with the belief that moral development is a lifelong task. So, to support students' moral development, we will need additional activities that both complement and improve role modeling, feedback, and ultimately, moral development by the faculty. Critical reflection accomplishes the former; faculty development may provide the latter.

Faculty development programs offer solutions to some of the difficulties pointed out above.[58] But missing from faculty development programs is sufficient emphasis on moral education. The experiences of the students documented above,[7–10,19] and observations of faculty failing to address ethical issues on the wards,[57] suggest that medical school faculty need to understand the theories[24–27] and the special relevance of fostering an integrated approach that incorporates compassion and caring into medical students' work with patients.[26,27,29,30,32,34] The clinical faculty may profit from large-scale faculty development efforts modeled after the programs that used small-group reflection.[18,19] In these programs, the faculty had opportunities to participate in reflective discussion groups of their own, where their values and attitudes could be clarified, and peer support be provided for dealing with difficult ethical decisions. We now know that such decisions include providing honest but nonjudgmental feedback to students and residents whose attitudes or behavior may at times be suboptimal.[59] Because ward culture itself may be inhospitable to empathy and mature moral functioning, and since the informal curriculum of the wards discourages critical reflection and personal awareness,[60,61] enhancing professional and moral development in medical students ultimately requires creating a new, more positive and supportive ward culture.[35] A necessary step appears to be supporting the moral development of the faculty.

SUMMARY

I believe that good clinical practice cannot be separated from professional and ethical behavior that depends on moral maturity. Though the years of young adulthood are a life stage in which students should rapidly grow in moral maturity, available evidence suggests that current clinical training, by focusing so narrowly on the biomedical aspects of medicine, may inhibit many medical students' growth as moral agents. I have provided illustrations to support this hypothesis and connected this evidence to the framework of theory provided by our most influential philosophers whose life's work has been the study of moral development.[24–28] We do not have longitudinal studies that show to what extent physicians, whose moral development may have been arrested early in clinical training, naturally later regain their empathy and compassion, and grow as moral agents. Perhaps many do, but some do not. I have suggested a 2-pronged approach combining small-group, reflective learning for medical students with enhanced faculty development of faculty role models to further this crucial but until now neglected aspect of medical education. Perhaps my suggestions sound idealistic and overly ambitious, but after all, are we not obligated to ensure that our students are supported in their efforts to maintain their caring and attentiveness to moral issues? This, I believe, is intrinsic to medical education.

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