ARTICLES

Sensitising intern doctors to ethical issues in a doctor–patient relationship

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Abstract

Introduction: *There is a felt need in India to influence the ethical behaviour of doctors by giving students formal education in ethics in medical colleges. Since internship is the interface between learning and independent practice, it is important to sensitise intern doctors to ethical issues in a doctor–patient relationship at this stage.*

Method: *Small-group interactive sessions featuring case-based scenarios that depicted the principles of the code of conduct, confidentiality, autonomy, informed consent and truth-telling were conducted for 45 interns. A pre-post multiple-choice question (MCQ) test and a post-session 5-station Objective Structured Clinical Examination (OSCE) were conducted.*

Results: *The results revealed a 36% increase in the MCQ scores and a satisfactory performance in the OSCE. The interns fared better in the stations related to confidentiality, the code of conduct and informed consent than autonomy and truth-telling. The post-intervention MCQ scores did not correlate significantly with the OSCE scores, thus highlighting the importance of independent knowledge-based and skill-based interventions. The feedback from the interns revealed that the intervention resulted in an increase in their knowledge of ethical principles and that it was likely to influence their future clinical practice. They opined that additional discussions and guidance at regular intervals would reinforce ethical practice further.*

Conclusion: *Interactive teaching using case-based scenarios and MCQs, followed by an OSCE, was effective in sensitising intern doctors to ethical issues in a doctor–patient relationship; however, more intensive and focused, continuous teaching should be planned for further enhancement of learning.*

Introduction

There has been a rise in unethical practices by doctors. These have been brought to light by the print and electronic media, and have given rise to an atmosphere of scepticism in society. Doctors are probably no longer considered noble professionals or healers who would always do the patient good. Rather, they are service providers, and the patients the service users. This change may have come about partly because of the corrupt and unethical practices of a few doctors, resulting in a loss of trust in the doctor–patient relationship (1).

While it may be expected that the principles of ethics would either come from within or that budding doctors would imbibe the code of conduct by following role models, in reality, today's medical students are unaware of the code of conduct and the general principles of ethics. A questionnaire-based study by Arun Babu T et al in Pondicherry, southern India, revealed that there were major deficiencies in medical students' understanding of medical ethics, especially issues pertaining to professional conduct, etiquette and ethics (2). A cross-sectional study in West Bengal, India, revealed that though medical students agreed that an awareness of ethics was important, their knowledge was deficient and there was no increase in their scores corresponding to additional years of medical education (3). Another study found that when medical students recorded the ethical issues encountered by them, the most common issues were related to ethics in medical education, professionalism, confidentiality, the doctor–patient relationship, informed consent and the doctor–peer relationship (4). Students may be either unaware of the code of conduct or the principles of ethics, or unable to translate the knowledge into actual practice.

To address these lacunae, in 2011, the Medical Council of India (MCI) released a document, "Vision 2015", which states that all institutes should have a foundation course in ethics (5). The MCI's document regarding regulations on graduate medical education also emphasises the importance of teaching ethics and professionalism across the entire MBBS curriculum (6). Recently, the MCI rolled out the Attitudes and Communication module, to be implemented in all medical colleges. However, as of now, only a few universities/colleges have a formal ethics curriculum, including St John's Medical College, Bengaluru, the Rajiv Gandhi University of Health Sciences, and the Maharashtra University of Health Sciences. The model practised in St John's Medical College involves instruction in ethics across the medical curriculum and reinforcement at the level of internship. The methods used are didactic lectures, seminars and clinical case discussions (7).

Various other methods of teaching and assessing the understanding of ethics and professionalism in the Indian

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context have been suggested. Those of teaching include interactive lectures, case vignettes, reflective exercises, feedback, portfolios, role models and art-based interventions, while those of assessment include multiple-choice questions, reflective/narrative portfolios, mini-clinical evaluation exercises, professionalism mini-evaluation exercises, the Objective Structured Clinical Examination (OSCE) and multi-source feedback (8).

As internship is the transition between learning and independent clinical practice, it would be an ideal time to sensitise budding doctors towards ethical practice. They should be made familiar with the principles of clinical ethics, and be able to put them into practice. As assessment drives learning, a teaching effort would be incomplete if the interns' learning was not assessed. Against this background, as a start, we thought of sensitising interns to ethical issues in a doctor–patient relationship (code of conduct, confidentiality, autonomy, informed consent, truth-telling) by means of an interactive, scenario-based teaching session. The session was preceded and followed by an assessment with multiple choice questions (MCQs). An additional evaluation was done by OSCE thereafter. The OSCE comprises a circuit of short stations, in which an examiner examines each student on a one-to-one basis while he/she interacts with either real or simulated patients. Each station has a different examiner. The students rotate through the stations, completing all of them. The OSCE has previously been found suitable for evaluating the ability of medical students and residents to address selected clinical–ethical situations (9). The OSCE, along with feedback, was planned with the dual purpose of assessing and enhancing learning.

Aims and objectives

The aims were to sensitise the interns to ethical issues in a doctor–patient relationship, using interactive teaching sessions featuring case-based scenarios; to assess their learning by MCQs and the OSCE; and to receive their feedback on the entire teaching–learning–assessment activity.

Methodology

Permission to carry out the project was obtained from the ethics committee of the institute. Twenty MCQs, which incorporated the five principles to be tested, were prepared. Ten questions were knowledge-based and 10 scenario-based, requiring the application of knowledge. Five OSCE stations, each depicting an ethical issue that was to be discussed, were prepared. These were the code of conduct, confidentiality, autonomy, informed consent and truth-telling. For each OSCE station, a resident doctor of psychiatry was given a case vignette and trained to enact the role of a patient (simulated patient). A write-up of the scenario, to be given to the intern at the time of the OSCE (OSCE instruction), was prepared. Checklists were prepared to assess whether the principles of ethics were followed during the intern's interaction with the simulated patient. These were designed to be rated by the resident doctor (acting as a simulated patient) at each station. In addition, the resident doctors were required to give the interns a global score out of five, on the basis of how well the situation was handled from the ethical point of view.

The MCQs and OSCE stations were reviewed and approved by three subject-experts. They were pilot-tested on a group of 13 volunteers (doctors from the psychiatry department) to ensure their feasibility, after which minor changes were made.

Every year, a batch of 150 intern doctors take turns to serve in the psychiatry department for 15 days as part of compulsory rotation. The project involved the intern doctors posted in the department of psychiatry, and was carried out in August and September 2014, in the first half of the interns' 12-month internship period. It was a one-day intervention, conducted in two batches of 23 and 24 interns, respectively.

In the first half, a four-hour interactive session, using case scenarios, was conducted for the interns on ethical issues in a doctor–patient relationship. The resource material for these sessions included the MCI's code of conduct document (10), the WHO Facilitator's Guide for teaching medical ethics to undergraduate students in the South-East Asia region (11), and the Medical Ethics Manual of the World Medical Association (12). The 20-item MCQ test was administered to assess the interns' knowledge of and attitude towards the topic before and after the intervention.

In the second half, the 5-station OSCE was implemented, with each intern having to interact with the simulated patient at each station one by one, for five minutes each. The interactions at the OSCE stations, time management and movement of the interns from one station to the next were supervised by a faculty member.

At the end of the OSCE, the interns were given group feedback on their performance. Their individual MCQ pre-test and post-test scores and the scores at each OSCE station were e-mailed to them, and specific feedback and clarifications were provided. The interns were also asked to fill up a feedback questionnaire on the teaching–learning activity. The data were analysed using Excel and the trial version of Statistical Package for Social Sciences, Version 16. The chi-square test and paired samples *t*-test were used as tests of significance. A p value of <0.05 was considered statistically significant.

Results

1) MCQ scores

A total of 47 intern doctors (27 male and 20 female) enrolled themselves in this project and attended the interactive session on ethical issues in a doctor–patient relationship. Their MCQ scores before and after the intervention are summarised in Table 1. Their individual question-wise performance is summarised in Supplementary Table (i) [Available online from: http://ijme.in/articles/sensitising-intern-doctors-to-ethical-issues-in-a-doctor-patient-relationship/?galley=html]. The issues which were clear to most of the interns (more than 70%) before the intervention pertained to competence to give consent, telling the truth to the patient and reporting the

Table 1
MCQ scores (out of 20) of intern doctors before and after intervention (n=47)

Pre-test mean (%); SD	Post-test (%); SD	Gain in score (%)	t-statistic	p value
10.4 (52); 2.7	17.5 (87.5); 2.2	7.1 (35.5)	18.57	<0.05

SD: standard deviation

unethical conduct of another doctor appropriately. The issues which were unclear to most of them (more than 70%) related to the doctrine of double effect, maintenance of the records of indoor patients, the principle behind an advance directive, the shift of values from paternalism to patient autonomy and the protocol for breaking bad news.

There was an increase in the scores for all questions after the intervention. The difference was statistically significant in 17 out of 20 questions. The three other questions were related to competence to give consent, exposing the unethical conduct of other doctors, and giving non-useful treatment to the patient. The interns' concept of competence was clear even before the intervention; hence, a significant difference was not found. As for the exposure of the unethical conduct of another doctor, the number of interns who chose the option for how to report unethical conduct appropriately increased from 34 to only 36 after the intervention. The commonly held opinion was that one should talk to other doctors about it (*n*=9) rather than report it to the appropriate higher authority. In a question relating to a patient who insisted on getting a saline drip which was not really required, the interns chose to give a multi-vitamin tablet as placebo (*n*=10) before the intervention, and to tell her that her symptoms were imaginary (n=10) after the intervention.

2) OSCE scores

Of the 47 interns enrolled, two dropped out for unknown reasons and hence, 45 participated in the OSCE. Their OSCE scores according to the checklist and the global impression were added up and graded out of 10. The average OSCE scores at the five stations are shown in Table 2. The scores of the interns at the stations of autonomy and truth-telling (breaking bad news) were lower than their performance at the other three stations.

Supplementary Table (ii) [Available online from: http://ijme.in/articles/sensitising-intern-doctors-to-ethical-issues-in-a-doctor-patient-relationship/?galley=html] summarises the performance of the interns at each OSCE station, according to the checklists. The common drawbacks in the case of truth-telling (breaking bad news) were not assessing the patient's perception/information level (*n*=25), not addressing the patient's emotions (*n*=25), and not leaving scope for future discussion (*n*=41). As for autonomy, the weak points of most interns related to explaining the illness to patients (*n*=34), telling them about the need for monitoring (*n*=22) and the importance of taking medicines (*n*=23), and mentioning follow-up (*n*=24).

Table 2
Average station-wise OSCE scores of intern doctors (n=45)

Serial no.	Station (10 marks each)	Mean (SD)
1	Code of conduct	7.95 (1.86)
2	Truth-telling	6.20 (1.65)
3	Confidentiality	7.95 (1.54)
4	Autonomy	5.90 (1.30)
5	Informed consent	7.90 (1.81)

SD: standard deviation

3) Relationship between MCQ scores and OSCE scores

While analysing the correlation between the percentages of the post-intervention MCQ scores and the OSCE scores of the interns, a weak, non-significant correlation was found according to the Pearson's correlation test (r=0.2, p=0.18) (Figure 1,Table 3). This means that the increase in knowledge as reflected in the MCQ scores did not correlate significantly with the improvement in performance as reflected in the OSCE.

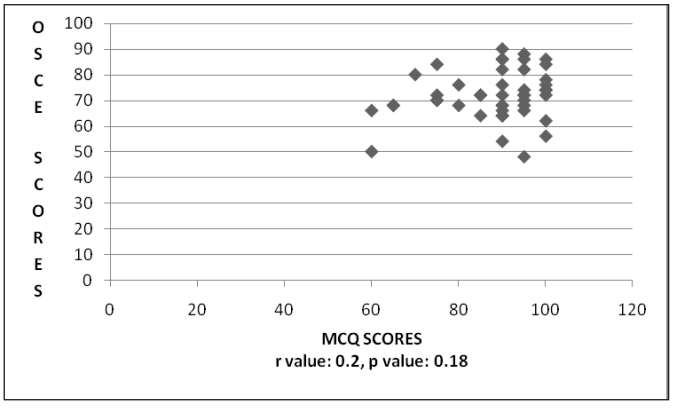

Figure 1: Correlation between post-session MCQ scores and OSCE scores

4) Feedback from intern doctors

The interns' feedback on the teaching–learning activity on a Likert scale is depicted in Figure 2. Almost all the intern doctors strongly agreed, or agreed that the topic was relevant to them, that the content was delivered in a clear manner and that they were satisfied. They strongly agreed/agreed that their knowledge, attitude and skill had improved as a result of the activity and that it was likely to influence their future practice. They also reported satisfaction with the MCQ- and OSCE-based assessment.

Some of the verbatim responses of the interns that brought out the essence of their feedback were as follows.

- *Interactive learning with case examples was very interesting.*
- *I seldom paid attention to issues like confidentiality and consent. I will be more careful now…*
- *Pre-assessment MCQs were a boost each time my attention was slipping.*
- *OSCE brought out my skills. I will be more comfortable now on in dealing with similar situations.*
- *Please include video demonstration of skills.*

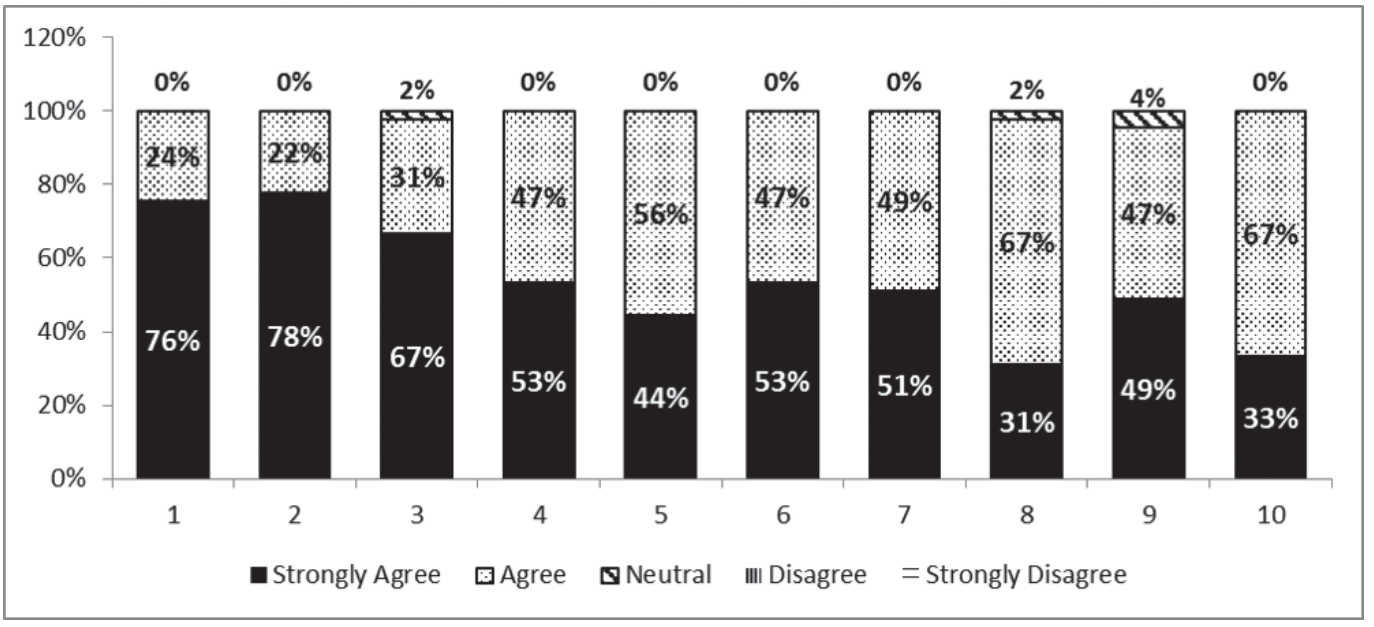

Figure 2: Feedback on teaching-learning activity by intern doctors (n=45)

Opinion statements in feedback:

1. The topic of ethical issues in a doctor–patient relationship is relevant to us.

2. The content was delivered in a clear and appropriate manner.

3. I am satisfied with this teaching–learning activity on the topic.

4. My knowledge on the topic has increased as a result of this activity.

5. My attitude towards ethical issues in a doctor–patient relationship has improved after the activity.

6. This activity helped in enhancing my skills in handling ethical issues in a doctor–patient relationship.

7. This activity is likely to influence my future practice in handling ethical issues in a doctor–patient relationship.

8. I am satisfied with the MCQ-based assessment done on the topic.

9. I was comfortable with assessment by OSCE

10. I am satisfied with the assessment done by OSCE

- *This learning is likely to influence my future clinical practice.*
- *We need a platform to discuss and continue to learn the principles of ethics and related laws.*

Discussion

There was a statistically significant increase in the interns' knowledge of various principles of ethics, as reflected in their MCQ scores. Their knowledge regarding competence to give consent, truth-telling and exposing the unethical conduct of another doctor was good even before the intervention. They may have learnt about these matters by reading, formal and informal interaction with teachers, or observing role models during their medical curriculum.

However, most of them were not aware of the doctrine of double effect, the duration for which indoor patients' records need to be maintained, the principle behind advance directives, shift of practice from paternalism to patient autonomy and the protocol for breaking bad news.

The scores improved for all the questions after the intervention (average increase – 35.5%), which means that while ethics is popularly believed to be only "caught", it can also be "taught". In the question-wise analysis, however, there was no significant difference in the question related to reporting the unethical conduct of another doctor. While the MCI states that it is the duty of every doctor to expose the unethical conduct of another (7), whistle-blowing gives rise to certain apprehensions in India. Though 34 of the 47 interns agreed to appropriate reporting of the unethical conduct of another doctor even before the intervention; only two more agreed after the intervention. The reluctance to speak out may be due to fear of being harassed, fear of disciplinary action against oneself, and fear of possible undue damage to one's career prospects. Doctors who raise such concerns probably do not feel protected enough (13). Another opinion that did not change significantly after the intervention pertained to giving intravenous saline to a patient who actually did not need it. This probably shows a lack of awareness of somatoform illness and of the undue preference for placebo treatment in such cases. A survey of medical interns in New York revealed that those who were aware of the use of placebo would consider using it for suspected factitious pain, for patients with a history

of substance abuse or psychiatric illness, or those whose complaint had a suspected psychiatric component (14). There are important ethical considerations involved in the use of intravenous saline as a placebo medication for somatoform illness. These include deceiving the patient, wasting resources and depriving the patient of the appropriate treatment. The intervention did not have any significant success in driving home these points.

The OSCE scores of the interns ranged from 5.9 to 7.95 out of 10. Their performance was significantly better in the stations related to the code of conduct, confidentiality and informed consent than autonomy and truth-telling (breaking bad news). Autonomy is a concept that dominates modern ethics. However, the minds of budding Indian doctors are perhaps still coloured by the tradition of paternalism in the doctor–patient relationship. The notion that the doctor knows what is best for the patient and the patient must comply seems to influence their belief system and practice, knowingly or unknowingly.In this context, a comparative study between Malaysia and India revealed that though the Indian doctors were aware of the concept of autonomy, the practices chosen by them reflected medical paternalism. The doctors' opinions played a substantial role in clinical decision-making in India (15).

The interns also probably found it difficult to break bad news. This could be because the doctor may worry about how the patient would react to the bad news and handle the situation. It could also reflect the doctor's own anxiety about breaking the news, and his/her helplessness about how to deal with the situation. A qualitative study was carried out in Mumbai, India to learn about the perspectives of interns on the communication of bad news to patients. The interns mentioned that the main obstacles in the way of communication were time constraints, language barriers, personal fears, patients' illiteracy, crowded wards with no privacy, and lack of training (16). Thus, it seems that more focused and exclusive training is required to cultivate expertise in breaking bad news.

The poor correlation between the post-intervention MCQ scores and OSCE scores may suggest that the two tested different areas of ethical knowledge and application. It also possibly suggests that an increase in knowledge need not be parallel to an improvement in performance. It may be so because in addition to a knowledge of the various principles of ethics, one needs to have effective communication and interpersonal skills to execute the ethical principles in day-to-day clinical practice. This implies that any teaching–learning activity on ethics should include both knowledge-based and skill-based activities. Also, while the OSCE does measure the actual performance of interns in a given situation, it remains an artificial, standardised setting, and the real-life scenario may be quite different. The possibility remains that the interns might have performed differently if there were no time constraints, if the patients were real patients, and if there was nobody watching them. The ideal way to test ethical performance would be to have assessments based in the work-place, such as mini-clinical evaluation exercises (Mini-CEX), professionalism–mini-evaluation exercises (p-mex), reflective portfolios, and multi-source feedback.

The feedback from the interns revealed that they were satisfied with the interactive teaching, and found the group discussion based on case scenarios very interesting. The findings of a study that looked into students' perceptions of instruction in ethics were similar. Regarding the format of teaching, the majority of students preferred lectures with break-out sessions (60%), followed by small-group discussions only (37%). Only 3% of the students preferred individual problem-solving with virtual campus support, ie no formal teaching (17).This means that a vast majority of medical students agreed to the need for formal teaching of ethics.

While the need to educate medical students on ethics has been felt, there are several difficulties in trying to achieve this goal in the Indian setting. Some of these difficulties include the absence of a compulsory course on bioethics, the lack of a uniform, need-based ethics curriculum and the extreme shortage of medical teachers trained in bioethics (18). In spite of these problems, guidelines have been proposed on designing an ethics curriculum and it has been suggested that education on ethics be incorporated in medical education across all the years, and not be restricted to a single department (19). Recently, a curriculum has been proposed for introducing ethics education into the medical curriculum in India. This includes several innovative teaching–learning and assessment methods at various levels (20).It has also been suggested that ethics should be taught as a practical subject, and the curriculum should aim at making the students aware of ethical problems and dilemmas, teaching them the mechanisms of decision-making and informing them about the existing ethical guidelines and safeguards (21).

The intern doctors who participated in this project had not been exposed to any other ethics programme in their medical curriculum, and this project was an attempt to inculcate in them the principles of ethics in a doctor–patient relationship; and it turned out to be an effective way of sensitising them. The interactive sessions with MCQs addressed the knowledge part, while the OSCE, followed by feedback, addressed the performance and enhanced the educational impact of the intervention.

However, the ideal way to impart education on ethics would be to have an ethics programme spread across the entire medical curriculum, with reinforcement at multiple levels.

Limitations

The project covered a small group of interns and can be generalised, at the most, only to the population from which it was derived.

It was only a one-time intervention in the teaching and assessment of ethics. It would have been worthwhile to find out whether the interns retained what they had learnt at the end of the internship, but such an assessment was

Table 3
Correlation between post-session MCQ and OSCE scores

		MCQ	OSCE
MCQ	Pearson correlation	1	0.202
	Sig. (2-tailed)		0.183
	n	45	45
OSCE	Pearson correlation	0.202	1
	Sig. (2-tailed)	0.183	
	n	45	45

not made because the interns were posted in various other departments and busy preparing for entrance examinations for postgraduate courses.

The OSCE was conducted immediately after the teaching–learning session. To change one's attitudes or practices, one needs some time to understand the information, reflect, evaluate oneself and make important decisions. To facilitate this process, a continuous platform for ongoing discussion and feedback may be required. This small intervention did sensitise the interns, but it remains to be seen how, in the absence of such a system, it would influence their future clinical practice.

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Any submission of very similar work: *No submission has been made for publication. However, the work was presented at the 5th National Bioethics Conference at Bengaluru, in the form of a poster.*

Institute where work was done*: Department of Psychiatry, Government Medical College, Surat*

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