

and spirituality and most importantly, by listening carefully to the language of my own body.

In all honesty, I have just begun to put the pieces of the puzzle together from the answers I found to questions like — What is a genetic disease? How do epigenetic factors influence disease progress? What is the role of nutrition, mental health, spiritual pursuits and societal factors in modulating disease onset / progression / regression? What is my role in my own healing? — in a way that is meaningful and beneficial to me. Up ahead, lies the task of leading a healthy life, sustainably and joyfully, and sharing my learnings in a responsible way. I have my hands full, so no complaints!

I am asked how I feel being a survivor of debilitating inflammatory diseases or how I fought them. I confess my approach is that of a learner. My medical journey taught me many a lesson, some of which I have shared here. This does not imply that I am a sage girl fighting the assaults on my immune system, on my being, with quiet calm and resilience; that is far from the truth. But the fact remains that I choose to give the student in me the upper hand always, which helps me cut through biases coming in the way of my healing. I dared to question and learn amidst pain and inner chaos, and continue to do so.

### Acknowledgments

*While the health solutions came from personal choices, making these choices needed support. And I did get plenty of support. My parents – mother, who never let me accept defeat even when the body was crumbling under the inflammatory burden, and father, who shouldered the financial burden of a very expensive medical journey. My husband – who loves me for what I am and gracefully accepts the scars from diseases I had before we met. My doctors – who empower me by being honest with their answers. My friends – who fuel my intellectual pursuits and inspire me to learn more. My students – who refine my questioning skills by asking their questions fearlessly. And above all, my spiritual guide and guru –*

*who lives as the voice of conscience inside me, prompting me to always be loving and compassionate in my ways, towards self and others.*

Here are some empowering resources that broadened my understanding of things.

### Resources

1. Myers A. *The autoimmune solution: Prevent and reverse the full spectrum of inflammatory symptoms and diseases*. New York: HarperCollins Publishers; 2017. ISBN 978-0-06-234748-0.
2. Enders G. *Gut: the inside story of our body's most under-rated organ*. New Delhi: Speaking Tiger Publishing Pvt. Ltd 2015.
3. Campbell T.C. *Whole: Rethinking the science of nutrition*. (2014) BenBella Books, Inc. Dallas, Texas. Epub ISBN 978-1-937856-25-0. Hardback ISBN 978-1-937856-24-3
4. Sapolsky R. *Behave: The biology of humans at our best and worst* London: Vintage, 2017. Epub ISBN 978-1-44-812978-2 version 1.0.
5. Svoboda R. *Prakriti: Your ayurvedic constitution*. (1988) Motilal Banarasisdass Publishers Pvt. Ltd., Delhi. ISBN 978-81-208-1840-8,
6. Frawley D. *Ayurvedic healing: A comprehensive guide* Delhi: Motilal Banarasisdass Publishers Pvt. Ltd, 1997. ISBN 978-81-208-1003-1.
7. Giri J, Jain P. *Sukham ayu: Cooking at home with Ayurvedic insights* New Delhi: Wisdom Tree' 2016. ISBN 978-81-8328-312-0.
8. Judith A. *Chakras: Seven keys to awakening and healing the energy body*. Hay House (India) Publishers Pvt. Ltd; 2016. ISBN 978-93-85827-21-1.
9. Goleman D, Davidson R.J. *The science of meditation: How to change your brain, mind and body*. (2017) Penguin Life, UK; 2017. ISBN 978-0-24-197569-5.
10. Pasukanna R. *Fingers as doctor: 108 Sutras of Mudra Science*. Kanna Foundation, 2014.
11. Sri Sathya Sai Baba. *The Vahinis*. A series of 16 books on spiritual living. Sri Sathya Sai Books and Publication Trust, Prasanthi Nilayam (India). The e-format can be accessed here.
12. Swami Venkatesananda. *The Yoga Sutras of Patanjali*. . Delhi: Motilal Banarasisdass Publishers Pvt. Ltd, 2008. ISBN 978-81-208-3351-7.
13. Gibran K. *The prophet*. London: Pan Books; 1991. ISBN 978-0-330-31972-0.
14. Manson M. *The subtle art of not giving a f\*ck: A counterintuitive approach to living a good life*. HarperCollins Publishers, 2016. Epub ISBN 978-0-06-245773-8 Version 04042018.
15. Tevelow J. W. *The connection algorithm: Take risks, defy the status quo, and live your passions*. Self-published by author; 2015. ISBN 978-0-692-39176-1.
16. Dover D. *The minimalist mindset*. Intriguing Ideas Press, USA; 2018. Epub ISBN 978-0-9986467-1-8 Version 2.4(D).

## The ethics of teaching in medicine: A personal view

MARIO VAZ

Author: **Mario Vaz** (mariovaz@sjri.res.in), Department of Physiology, St. John's Medical College; Division of Health and Humanities, St. John's Research Institute, Koramangala Bengaluru INDIA

To cite: Vaz M. The ethics of teaching in medicine. *Indian J Med Ethics*. 2019 Jul-Sep;4(3) NS:221-6. DOI:10.20529/IJME.209.037

Published online on July 17, 2019.

Manuscript Editor: Nikhil Govind

Peer reviewers: An anonymous reviewer

© Indian Journal of Medical Ethics 2019

### Abstract

*While there is considerable literature on the teaching of medical ethics, much less has been written about the ethics of medical teaching. This article is a personal reflection on the latter. The devaluation of medical teaching, in part, but not only because of the difficulties of objectively assessing it, has serious ethical implications. Teaching, including medical teaching is a moral enterprise. The most serious consequence of inadequate medical teaching/learning is the graduation of incompetent and unethical*

*medical students. Medical teachers have multiple functions and are positive or negative role models to the students they teach. Senior faculty have a moral imperative to continue to teach while mentoring their junior colleagues. Faculty and institutions need to be aware of the ethical consequences of a hidden and null curriculum that is at odds with the values and goals of medical teaching. Remedial measures are needed; there are several steps that medical teachers and administrators can take to address this issue.*

The medical teacher has multiple roles that go beyond the traditional transmitter of knowledge, to an enhancer of the educational process while being a role model, a facilitator of knowledge, an assessor, a planner and resource developer (1). Along with this recognition of the medical teacher's multiple roles, are the paradigm shifts in medical education – from teaching to learning, and from teacher-centred approaches to student-centred approaches. As a role model, the medical teacher influences the attitudes, behaviour and ethics of medical students and helps cultivate professional values in them (2,3). Clinical skills, personality, and teaching ability are the three most important factors that students identify in an ideal role model, while research activities and academic status were listed as less important (4). In this article, I focus on one aspect of how the medical profession, by devaluing the important task of teaching/educating, has contributed to its own demise. The intent is not, however, to paint a picture of Stygian gloom. The new competency-based Medical Council of India curriculum that incorporates a spirally integrated course on attitude, ethics and communication (AETCOM), due to be implemented later this year, is an opportunity for medical teachers to review their roles and how best they can be ethical medical teachers (5).

One has only to read William Osler to marvel at the remarkable vocation of medical teaching; for, teaching in general and medical teaching in particular, is a "calling" (vocal – vocation). As Osler would indicate – "I desire no other epitaph—no hurry about it, I may say—than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important work I have been called upon to do." (6) Each of us will undoubtedly recall remarkable teachers that we had in medical college who inspired us and who were somehow, often intangibly, different. I was fortunate to go through a formal course in medical ethics when I was in medical college. However, the greater impact on me was what I observed of my medical teachers – a large number committed and sensitive to patient and student needs and what I would describe as generally good and genuine human beings.

There is no excuse for the absence of learning in medicine – graduates once armed with a certificate to practise, will interact with the public with competence or incompetence, based on what they have imbibed in medical college. They will also embody, or not, the values of the medical profession that we and the public should take for granted – compassion and empathy in the face of visible and hidden suffering, humility when faced with the limits of knowledge and

understanding, equanimity when confronted by the highs and lows of professional life, a passion for constant learning in the knowledge that the science of medicine is continuously advancing and changing, and a moral compass that allows us to choose right from wrong, or the greater good. These are colossal tasks for a medical educator. The easy "out" is to blame the current generation of students as uncommitted, superficial, of inferior quality, unsuited to the medical profession, inordinately attached to their inanimate hand-held devices and as a result, incapable of relating to the needs of "animate" patients. The harder option is to look at ourselves in the mirror, as medical educators, and ask how much we have abrogated the role entrusted to us by following a policy of passivity that "hopes" that medical students will "somehow" imbibe what is expected of them during their stay in medical college.

So why is medical teaching so undervalued? The typical trajectory of a medical teacher involves at least three distinct phases:

- i) the early period when they are deeply engaged with students as junior faculty – teaching is fun and interactions with students are valued and enjoyed;
- ii) a middle phase when the need to demonstrate "scholarly" activity in terms of research projects and publications becomes acute, particularly since it may be linked to promotion. It does not help that at this stage people are often married, have young children and require a higher salary which would be guaranteed by promotion. At this stage, engaged teaching is a chore and an obstacle to a greater personal need of self-advancement/ and students are part of that obstacle course. Thus, an easier option is to focus on research and allow teaching to proceed on "automated pilot" mode.
- iii) a later stage when promotions have occurred and individuals have now moved to the status of senior faculty. At this stage, individuals find themselves on committees, policy groups, and assume leadership roles. If successful in research – this becomes a roller coaster of its own. At this stage, teaching becomes an entity to be delegated to other staff for "their own good and experience" and for a "greater good" served by the individual in the other roles that they have adopted.

It is pertinent to point out that during promotions, the evaluation of research can be very objective and complex (number and nature of grants, number of publications, impact factor of journals, citations, 'h' index etc.) in contrast to the evaluation of teaching which can be remarkably naive and simplistic ("How much do they teach?" "Are they good?"). There are two issues here. First, by teaching less as they become more experienced, medical educators deny the students access to the expertise that derives from experience – this is a huge wasted resource. They also, in the process, buttress the view that teaching is not really that important. Second, the diminished value that teaching has in relation to research during promotions reinforces the notion that the latter is the

“real deal” in academia. This promotes an “either-or” belief rather than a “both” commitment. Institutions feel under pressure to do research since this affects college rankings and public perceptions. This is unfortunate, since the promotion of research in higher education has its own rationale which includes the generation of new knowledge and the translation of this knowledge for the common good, among others.

Thus, the higher status accorded to research by administrators on account of the preeminent place of research in the metrics of ranking (7) is detrimental both to teaching and to research, since the very *raison d'être* of research is reduced to a self-serving exercise. This also promotes an adverse culture favouring research, including unethical practices such as gift authorship based on seniority or other factors (8), resort to predatory journals for publication (9), plagiarism (10) and other breaches of publication ethics. So, are there ethical issues in the way we approach medical teaching? There are a large number of ethical issues that teachers encounter in any stream of education. These have been extensively discussed and relate to the classroom ambience, the learning experience, assessment of students, relationships in academia and in the responsibilities that teachers have to their students and colleagues (11). In my own discussion in this article, I use a Principlist approach to discuss the ethical issues of medical teaching.

The decision of senior medical teachers to withdraw from teaching cannot be considered *beneficent* (doing good) — this would require not only that in the process of withdrawing from teaching they do good for their colleagues (ie provide them with opportunities – although this motive is debateable) but that students also benefit by their withdrawal. The latter is possible if they were bad teachers to begin with, and their departure is seen as a boon by students rather than a loss. I would argue that this is not true for the majority of senior medical teachers – and, even if it were true, it would support the argument that the educative role of medical teachers has received lower consideration during promotions. The gradual reduction of teaching with increasing seniority in higher education has been documented in other countries such as Taiwan, where it has, in fact, been institutionalised (12). The decision of administrators not to see quality of teaching as a critical component for promotions or the actual work of medical faculty, cannot be considered *beneficent* — given the very purpose of medical colleges – to educate and train medical students.

*Primum non nocere* (first, do no harm) is an ethical principle of ancient origin and embodied in the idea of *non-maleficence*. I argue that the current approach to medical teaching is indeed harmful. When senior teachers stop or reduce their teaching, students are often subjected to a large quantum of knowledge from enthusiastic junior faculty; much of which may be irrelevant. Senior faculty through their experience have the ability to sift what is needed from the vast tracts of information available to all, they are able to simplify without being simplistic, they can be open to being questioned

without feeling threatened, and, above all, they bring to their teaching a practical approach that comes with the experience that cannot be gleaned from books. An important aspect of this is the sharing of the lessons of life that extend beyond the framework of subject expertise. This is relevant because the “null curriculum” – which suggests to students that what is not taught is unimportant — needs to be carefully considered in terms of its impact on learners (13). The absence or reduction of these approaches could result in students seeing information as the goal rather than its application; detail and minutiae as preferable to a unified and integrated approach; adoption of a linear rather than a multidimensional method of reasoning; and theory superseding rather than being integral to practice. This, given the very nature of medicine – a science and an art, an imperfect science, a human science, is not merely non-beneficent, it is maleficent.

The intent is not to generalise about the qualities of senior or junior faculty but rather to decry the reticence with which many senior faculty continue to teach. There is the added factor of the “grunt” work – repetitious, boring work with little reward. Included in this is a range of activities such as invigilation, paper correction, repeated practicals, revision classes etc. It would be unreasonable to expect senior faculty to be at the centre of all activities; but it would not be unreasonable for senior faculty to acknowledge and appreciate this work done by junior colleagues and to mentor them through these processes. *Justice* in medical teaching is most visible in being fair and open to all students without prejudice or favour. This, unfortunately, has taken a beating over the years — the need to demonstrate “good results”, to ensure special favours to students who are sons and daughters of influential people, to be seen as being compliant to institutional authority and “needs” has resulted in many medical faculty being willing to barter their principles for immediate benefits. The teaching of ethics is unlikely to overcome these negative effects of the “hidden curriculum.” (14, 15, 16) In the process, teaching which is often seen as a “moral enterprise” (17) becomes the very means to undermine morality in our medical graduates. But there is more to the idea of justice; the role of the medical educator accords the opportunity to inculcate in students and junior faculty the principles of social justice so central to the practice of medicine. Thus, distributive justice is exemplified, for instance, by the way in which teaching loads and examination assessments are distributed among faculty. Participatory justice is typified in open, transparent and regular department meetings and meetings with students where all opinions are not only heard but openly expressed. Commutative justice is reflected in the policies of institutions not only emblazoned on their entrance walls as “Vision” and “Mission” statements but actualised from day to day.

One of the challenges of medical teaching is how to “pitch” one’s teaching – cater to the majority of the class and one might fail to inspire the “high performers” or leave the “low performers” behind. The utilitarian approach of providing the greatest benefit to the greatest number thus clearly has its limitations. The principle of *subsidiarity* requires medical

teachers to look for avenues to deal with these smaller numbers of students; both high and low performers. The new MCI curriculum incorporates two 4-week elective blocks at the end of the third year which can appeal to all categories of students. Student-led peer education programmes (18) may also serve the needs of “high performers” while sensitising them to the needs of others in their batch. Remedial classes have also been advocated in the new MCI curriculum for low performers and considerable thought needs to be given on how this can be done while minimising the problems of labelling and stigmatisation. In this context, how one deals with the issue is as important as what one does.

A medical teacher is required to maintain professional and ethical relationships with peers, students and others with whom they work. The teacher–student relationship may, however, often be adversarial resulting in intimidation, public shaming, and humiliation of students (19). Few institutions have a policy in place and there is a need to develop a professional code of conduct governing the student-faculty-medical college relationship. Such a code will ensure that roles and responsibilities of both students and faculty are clearly defined, boundaries delineated, and measures for redressal of grievances outlined, as has been done in some medical institutions, like the Johns Hopkins School of Medicine (20). It is also important for medical teachers to undergo some training on student relationships and not to model their behaviour on their own experiences of excessively hierarchical, sometimes abusive, and unquestioning teacher-student relationships which they may attribute to their current level of competence, expertise and success. There is at least some evidence that medical teachers are more likely to identify ethical issues in patient care rather than ethical issues in medical education, and that this can be improved with training (21).

There is a final point that I wish to make. The essence of clinical medical teaching occurs at the bedside of the patient – here the teacher focuses not only on the technical skills required of a medical graduate but on the human skills essential to a meaningful doctor-patient relationship. The discussion on the critical role of the committed clinical teacher is not new – William Osler wrote a spirited defence of the clinical teacher over a hundred years ago, and his observations are as pertinent now, as they were then (22). The bedside is also an ideal location for the teaching of medical ethics in real time and in very different circumstances to the environment of a classroom (23). Committed teachers see the inherent worth of educating students at the bedside. The focus on theory in medical colleges and the certification of graduates with incomplete medical and human skills is one of the gravest injustices the medical profession can inflict on society. In this sense, medical teachers are morally complicit when medical graduates treat patients incompetently, insensitively and unethically. Bedside teaching is not, however, without its ethical challenges, including those of patient dynamics, patient satisfaction and patient care (24). Specific ethical issues during the clinical teaching-learning process include the lack of respect for patients by medical students and non-disclosure of

their student status (25) and the role of the medical teacher in mediating between the patient and the student while trying to balance the interests of both parties – patient autonomy and learner needs. In the case of the latter, this includes issues of clinical history taking, physical examination and the performance of procedures under supervision (26).

There is a general sense that the pedestal once occupied by the medical profession has begun to crumble. It has been buffeted by strong winds from outside – the higher legitimate expectations of the public in terms of honesty, trustworthiness, competence and accountability. It has also been eroded from within by scandal, malpractice and corruption (27,28,29,30,31) – the fact that these actions may represent a part of the medical profession does not matter. We reel with horror when journals abroad (32) reveal the rot within, not because we are unaware of it, but perhaps because the very idea of being exposed is singularly unpleasant. Medical teachers are uniquely placed to stem this rot. In their hands are placed the future generations of doctors.

Some of the ways in which medical teachers can address the ethics of their teaching role include the following:

- Understanding that they are role models: their behaviour is constantly being scrutinised. Students often embrace what they see as positive attitudes and may reject, or sometimes unfortunately, embrace negative behaviours if they see some gain (32). Teachers must also be aware that students are quick to distinguish what they say from what they do and that a positive teacher-student relationship is a critical mediator in the hidden curriculum (19). The ongoing debate about how much ethics is taught or caught echoes the question posed close to 2500 years ago by Meno to Socrates in Plato’s Dialogue – “Is virtue something that can be taught? Or, does it come by practice?” (34)
- Accepting teaching and the facilitation of learning as an integral and important role: while clinical service and research are also integral roles of a medical teacher, the educative role cannot be relegated to the background–this is presumably why they have opted to work in medical colleges. We also need to be aware, and resist ethical breaches that teachers may encounter such as the lure of improper or biased grading of answer scripts, accepting gifts and favours from students, exposing students to embarrassment or disparagement, and inappropriate relations with students, among others (35).
- Keeping the student at the heart of the teaching–learning process. Their needs, apprehensions and difficulties need to be addressed. Lifelong learning needs to be cultivated (36) and teachers do this by being living examples of academic integrity – by preparing well for the classes and being abreast of their fields. We need to be open to being questioned and should see this as an opportunity rather than a threat. The facilitation of lifelong learning is an ethical imperative as knowledge grows and therapies change.



- Promoting academic honesty and ensuring that academic dishonesty, including among students, is reported and suitable action taken. Issues of academic dishonesty with students include copying, cheating, and plagiarism, among others (37).
- Recognising the bedside as the primary area where medical students are taught, not merely clinical skills, but the essence of patient-doctor communication, the necessity for respect, the identification of ethical issues with appropriate action such that it avoids or minimises moral distress in the patient, their family members and in the treating physician.
- Aligning medical teaching with health needs of national priority, since a primary purpose of medical education is to address the medical care delivery needs of the country (38). This will also widen the ethical outlook of students beyond doctor-patient interactions to doctor-community relationships and the importance of public health ethics.

Administrators of medical colleges also have an important role to play. They need to:

- recognise and evaluate teaching as an integral part of the professional development of medical teachers and the promotion process. While the objective evaluation of teaching will continue to be a challenging prospect, various methods have evolved to allow for inputs from all the stakeholders involved (39).
- rationalise the distribution of time across the broad roles of those working in medical colleges (teaching, research, clinical service) so that this does not become the prerogative of the individual but rather institutionalised as policy. In so doing, institutions must recognise that various permutations of time allocation exist in models abroad, which allow institutions to recognise the inherent worth of individuals having greater capabilities in one or more these broad roles.
- be aware of the implications of the 'hidden curriculum' – the fact that students learn from organisational structure and organisation, even if this not intended. There is thus a need to align the hidden curriculum with what is professed in the formal curriculum (13).

The word doctor has its root in the Latin word '*docere*' (to teach). It is time that medical teachers embrace this professional obligation (40).

## Acknowledgements

Olinda Timms and Manjulika Vaz for their comments on the manuscript and the reviewer for very thoughtful insights and suggestions.

## References

1. Harden RM, Crosby J. AMEE Guide No 20: The good teacher is more than a lecturer - the twelve roles of the teacher. *Med Teach*. 2000 Jul; 22(4):334-47.
2. Ray S. Role models. *BMJ* 2010 Mar 31;340:c1572.
3. Branch WT, Jr, Kroenke K, Levinson W. The clinical educator: present and future roles. *J Gen Intern Med*. 1997 Apr;12:1-4.
4. Wright S, Wong A, Newill C. The impact of role models on medical students. *J Gen Intern Med*. 1997 Jan;12(1):53-6.
5. Medical Council of India. Competency based under graduate medical curriculum. New Delhi; MCI;2018[cited 2019 Feb 6]. Available from: <https://www.mciindia.org/CMS/information-desk/for-colleges/ug-curriculum>
6. Sokol DK. William Osler and the jubjub of ethics; or how to teach medical ethics in the 21st century. *J R Soc Med*. 2007 Dec;100(12):544-6
7. Prathap G, Gupta BM. Ranking of Indian medical colleges for their research performance during 1999-2008. *Annals of Library and Information Studies*. 2011 Sep; 58:203-10.
8. Bavdekar SB. Authorship issues. *Lung India*. 2012 Jan-Mar; 29(1):76-80.
9. India targets Universities in predatory- journal crackdown. *Nature* 2018 Aug 28;560(7720):537-8.
10. Juyal D, Thawani V, Thaledi S. Rise of academic plagiarism in India: Reasons, solutions and resolution. *Lung India*. 2015 Sep-Oct; 32(5):542-3.
11. Keith-Spiegel P, Whitley Jr. BE, Balogh DW, Perkins DV, Wittig AF. *The Ethics of Teaching: A Casebook*. 2nd Edition. New York: Psychology Press. Taylor and Francis Group, 2010.
12. Chen CY. A study showing research has been valued over teaching in higher education. *Journal of the Scholarship of Teaching and Learning*, 2015 Jun; 15 (3):15-32.
13. Lehmann LS, Sulmasy LSS, Desai S, for the ACP Ethics, Professionalism and Human Rights Committee. Hidden curricula, ethics, and professionalism: Optimizing clinical learning environments in becoming and being a physician: A position paper of the American College of Physicians. *Ann Intern Med*. 2018;168:506-508
14. Rajput V, Mookerjee A, Cagande C. The contemporary hidden curriculum in medical education. *MedEdPublish*. 6. Doi:10.15694/mep.2017.000155.
15. Lempp H, Seale C. The hidden curriculum in undergraduate medical education: Qualitative study of medical students' perceptions of teaching. *BMJ* 2004 Oct 2;329 (7469):770-3.
16. Gauffberg EH, Batalden M, Sands R, Bell SK. The hidden curriculum: what can we learn from third-year medical student narrative reflections? *Acad Med*. 2010 Nov;85(11):1709-16.
17. Caslib, Jr. BN. On the nature of ethics for teachers. *Philippine Social Science Review*. 2014) 66/1:67-90.
18. Ten Cate O, Durning S. Peer teaching in medical education: twelve reasons to move from theory to practice. *Med Teach*; 2007 Sep; 29 (6): 591-9.
19. Haidet P, Stein HF. The role of the student-teacher relationship in the formation of physicians. *J Gen Intern Med*. 2006 Jan; 21(Suppl 1): S16-S20.
20. Johns Hopkins School of Medicine. Guidelines for Conduct in Teacher/Learner Relationships. Johns Hopkins Medicine website. Date unknown [cited 2019 Feb 8]. Available from: <https://www.hopkinsmedicine.org/som/students/policies/relationships.html>
21. Chiapponi C, Dimitriadis K, Özgül G, Siebeck RG, Siebeck M. Awareness of ethical issues in medical education: an interactive teach-the-teacher course. *GMS J Med Educ*. 2016; 33(3):1-12.
22. Osler W. Sir William Osler: On full-time clinical teaching in medical schools (re-published). *Can Med Assoc J*. 1962 Oct 6; 87(14): 762-5. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1849650/>
23. McCarthy MW, Fins JJ. Teaching clinical ethics at the bedside: William Osler and the essential role of the hospitalist. *AMA J Ethics*. 2017 Jun;19 (6):528-32.
24. Sturman N. Teaching medical students. Ethical challenges. Reprinted from Australian Family Physician 2011 Dec; 40 (12):992-5.
25. Jagsi R, Lehmann LS. The ethics of medical education. *BMJ* 2004 Aug 7;329 (7461):332-4.
26. Kalantri SP. Ethics in medical education. *Indian J Anaesth* 2003 Nov-Dec; 47(6):435-436.
27. Kane S, Calnan M. Erosion of trust in the medical profession in India: Time for doctors to act. *Int J Health Policy Manag*. 2017 Jan; 6(1):5-8.
28. Kumar R. The leadership crisis of medical profession in India: ongoing impact on the health system. *J Family Med Prim Care* 2015 Apr-Jun; 4(2):159-161.
29. Mahajan V. White coated corruption. *Indian J Med Ethics*. 2010 Jan-Mar [cited 2019 Feb 6];7(1):18-20. Available from: <https://ijme.in/articles/>

- white-coated-corruption/?galley=html
30. Chattopadhyay S. Corruption in healthcare and medicine: Why should physicians and bioethicists care and what should they do? *Indian J Med Ethics*. 2013 Jul-Sep;10(3):153-9.
  31. Nundy S, Desiraju K, Nagral S., Editors. *Healers or Predators? Healthcare corruption in India*. New Delhi: Oxford University Press; 2018.
  32. Berger D. Corruption ruins the doctor-patient relationship in India. *BMJ*. 2014 May 8;348:g3169.doi: 10.1136/bmj.g3169.
  33. Supe AN. Medical ethics and medical education: some thoughts. *Indian J Med Ethics*, 1998 Jul-Sep;6(3):79-80. Available from: <https://ijme.in/articles/medical-ethics-and-medical-education-some-thoughts/?galley=html>
  34. Plato. *Meno*. Translated with an introduction by Benjamin Jowett. The University of Adelaide Library. University of Adelaide, South Australia, 2014. eBook.
  35. Singh A. Ethics for medical educators: an overview and fallacies. *Indian J Psychol Med*. 2010;32(2):83-6.
  36. International Federation of Medical Students' Associations. IFMSA Policy Statement. Global Policy on Medical Education. Adopted by the 65th March Meeting General Assembly, St. Paul's Bay, Malta, March 2016 [cited 2019 Feb 6]. Available from: [http://ifmsa.org/wp-content/uploads/2016/05/2016MM\\_PS\\_Global-Policy-in-Medical-Education.pdf](http://ifmsa.org/wp-content/uploads/2016/05/2016MM_PS_Global-Policy-in-Medical-Education.pdf)
  37. Whitley BE, Keith-Spiegel P. *Academic dishonesty: an educator's guide*. Mahwah, New Jersey: Lawrence Erlbaum Associates; 2002.
  38. Thomas G. Medical education In India – the way forward. *Indian J Med Ethics*. 2016 Oct-Dec;1(4) NS:200-2. Available from: <http://ijme.in/wp-content/uploads/2016/11/2152-5.pdf>
  39. Berk RA. Using the 360° multisource feedback model to evaluate teaching and professionalism. *Med Teach*, 2009; 31:1073-80.
  40. British Medical Association. *Doctors as Teachers*. Board of Medical Education. 2006.Sep[cited 2019 May 14]. Available from: [https://warwick.ac.uk/fac/sci/med/study/ugr/mbchb/societies/slime/products/teaching/doctors\\_as\\_teachers\\_bma\\_sept\\_06.pdf](https://warwick.ac.uk/fac/sci/med/study/ugr/mbchb/societies/slime/products/teaching/doctors_as_teachers_bma_sept_06.pdf)

## The 14<sup>th</sup> World Congress of Bioethics: Some personal reflections

ALASTAIR V CAMPBELL

### Abstract

*These reflections on the 14<sup>th</sup> World Congress of Bioethics in Bangalore stem from the author's personal and family connections with India and from his participation in all fourteen of the world congresses since the foundation of the International Association of Bioethics in 1992. The very wide scope of the meeting could be seen in two ways, as confusing and chaotic, or as richly diverse and enlightening. Emphasising the latter aspect, this paper argues that the powerful emphasis on health for all and on care for the marginalised in society has a crucial lesson for the bioethics community worldwide.*

### Introduction

I may be in the unique – or at least, unusual – position of having attended all fourteen of the World Congresses, since the inaugural one in Amsterdam in 1992. Moreover, I was fully involved in the planning and delivery of two of them – In London in 2000, and in Singapore in 2010. In light of this, and of the fact that I have also served as the President of the IAB, perhaps I am well placed to assess the impact and importance of the Bangalore Congress.

There is another relevant factor to mention by way of introduction. My family has very strong links with India. My grandfather, Thomas Vincent Campbell and my grandmother,

Florence Campbell, were medical missionaries in the rural area north of Madras (now Chennai), and they founded a hospital which exists to this day. My father and mother met and married in Madras – Dad was a Professor of English at Madras Christian College. My brother and two sisters were born in India and spent the early years of their childhood there. Thus, India is in my blood, as it were, though I did not manage to visit it for any length of time until 2012, when I gave a series of lectures in different cities in South India, and was able to visit the Campbell Hospital in Jammalamadugu. On the wall there is a picture of my grandfather, 'TV' Campbell, honouring him as the founder of the hospital. But to me, the much more important connection is with my grandmother, Florence, who is not even mentioned! Yet she was one of the earliest women medical graduates in Britain and she did outstanding work as a doctor in India, most especially with women and children in the rural communities. I have visited India several times since that first tour, and have participated in several National Bioethics Conferences. Hence, these reflections on the World Congress, held in conjunction with the Indian National Bioethics Conference, are obviously coloured by my fascination with this vast country, by my deep admiration for my Indian friends and colleagues, and by my awareness of the major problems and challenges which have to be confronted in this setting.

### Scope

As with all other world congresses the scope of this meeting was very broad, although the overarching theme was justice in health care – 'health for all'. This broad scope was clearly inevitable given the fact that Bioethics itself is extremely diverse, and that in order to ensure a viable number of participants a wide range of papers have to be accepted, provided they are up to a reasonable standard academically. The result is, of course, a dizzying set of parallel sessions, with

Author: **Alastair V Campbell** (alastairandsally@gmail.com), Director Emeritus, Centre for Biomedical Ethics, National University of Singapore, SINGAPORE.

To cite: Campbell A. The 14<sup>th</sup> World Congress of Bioethics: Some personal reflections. *Indian J Med Ethics*. 2019 Jul-Sep;4(3) NS:226-8. DOI:10.20529/IJME.209.027

Published online on May 16, 2019.

© Indian Journal of Medical Ethics 2019