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Closing the gap between professional teaching and practice

A policy can help protect students from being asked to behave unethically

Papers p 709
Personal view p 743

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Learning to be a doctor can be uniquely rewarding. Unlike other undergraduate study, clinical medicine has a practical edge such that students can directly experience the relevance of their academic work through their educational contact with patients. They also have the privilege of experiencing the range of human intellect, emotion, achievement, and failure embodied in the patients from whom they will learn. Finally, their positive interactions with patients reinforce the altruism that brought many of them into medicine. At its best, medical education can make students feel good about themselves and what they are learning, as well as preparing them for good professional practice. But if a gap exists between their clinical teaching and what they know and feel to be morally right the effects can be disastrous.[1]

Once their clinical training begins medical students are subject to high levels of stress, and some do not respond well. This is hardly surprising: their youth and immaturity leave them emotionally unprepared for experiences of illness, suffering, and death. The emotional price of clinical training can be enormous, and this price can be raised still further by the professional values of their educators. Too much focus on confidence in decision making, for example, may make it difficult to respond constructively to students' distress or even to recognise it before it poses a serious psychological and educational threat.

Even when teaching is of high coherence and consistency, students may experience stress. When, however, there is a discrepancy between what students are taught about good ethicolegal practice and what they experience on clinical firms[2 3] anger, disillusionment, and cynicism may follow.[4] Two papers in this issue catalogue gaps between principle and practice that may arise—for example, physical examination of patients for purely educational reasons without consent (pp 743, 709).[5 6] Students may respond by having their worst fears confirmed about hypocrisy within the profession that they have chosen to join. Others—probably the bad doctors of the future—will have their immaturity reinforced and conclude that they do not have to take professional or personal ethics seriously.

One thing is clear. Unless patients can exercise the right to reject the preferences of their clinicians they can draw no effective personal boundaries between themselves and these preferences.[7] For patients to exercise the "partnership in care" so publicised by the current government they must have some power to match that of their partner clinicians. The only power they can exercise is that which is guaranteed by their rights to informed consent, to confidentiality, and to be otherwise treated with respect and courtesy.[8] Any reluctance on the part of clinical teachers to incorporate such respect into their professional practice devalues good ethicolegal teaching.

One way of dealing with the potential gap between ethicolegal teaching and clinical behaviour was developed in 1996 at St Bartholomew's and the Royal London School of Medicine and Dentistry. Our students insisted that the only way to correct the

Policy on the rights of patients in medical education

For educational activities not part of clinical care:

- Patients must understand that medical students are not qualified doctors (and not "young doctors," "my colleagues," or "assistants").
- Clinical teachers and students must obtain explicit verbal consent from patients before students take their case histories or physically examine them, making sure they understand the primarily educational purpose of their participation.
- Clinical teachers and students should never perform physical examinations or present cases that are potentially embarrassing for primarily educational purposes without the patient's verbal consent—including for the number of students present. When individual students are conducting such examinations a chaperone should usually be present.
- Students should never perform any physical examination on patients under general anaesthetic for primarily educational purposes without patients' prior written consent, which should be placed in the notes. Patients who are otherwise unconscious or incompetent must be involved in primarily educational activity only with the explicit agreement of their responsible clinician and after consent from parents (children) or consultation with relatives (adults).
- Clinical teachers should obtain patients' explicit verbal consent for students to participate in treatment (suturing, taking blood, delivering babies, etc.). Procedures not requiring immediate supervision should be undertaken only if there is recorded evidence of competence.
- Students must respect the confidentiality of all information communicated by patients in the course of their treatment or participation in educational activity. Patients should understand that students may be obliged to inform a responsible clinician about information relevant to their clinical care.
- Clinical teachers are responsible for ensuring that these guidelines are followed. If students are asked by anyone to do the contrary, they must politely refuse, referring to these guidelines. Encouraging students to ignore these guidelines is unacceptable.

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distressing ethicolegal practice of some of their clinical teachers was by creating a policy to underline the rights of patients asked to participate in educational activities separate from their clinical care. They argued that, aside from reminding teachers of their duties as medical educators, a policy would also help students to question, if not decline to participate in, activities that they know to be unacceptable. Students helped draft the policy, which was then adopted by the school and later improved and endorsed by the subject panel in ethics and law applied to medicine of the University of London (see box). Since then it has encouraged independence of thought and action in the face of moral injustice, exactly the values about which there has recently been so much positive discussion in the wake of scandals in Bristol and Alder Hey.

The General Medical Council should adopt a policy of this kind as it is consistent with many of the council's principles of good practice. Were it to be rigorously enforced throughout the United Kingdom abuses of both patients and students of the kind described by Hicks et al[6] and West et al[5] would be consigned to history. Equally, a refusal of institutions to tolerate such abuses would send a message to students that becoming a doctor is about more than learning clinical science.[9] It requires the development of the moral character necessary for hospitals and medical schools to become sanctuaries of respect for human rights and dignity. Making clear to students that attitudes and behaviour that have so damaged the reputation of doctors no longer have a place in medicine is an important step in alleviating stress among students. It will also help to ensure that the students of today will be proud rather than distressed that they have chosen to be the doctors of tomorrow.

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Thromboprophylaxis after replacement arthroplasty

Anticoagulants are more effective than aspirin

Venous thromboembolism remains the greatest single threat to life during the extended postoperative period after total hip arthroplasty.[1] Several prophylactic measures are currently used, including elastic stockings and intermittent pneumatic compression to reduce stasis, and aspirin or various forms of anticoagulation to counteractact hypercoagulability. Evidence for the effectiveness of these different forms of prophylaxis varies from large multicentre trials in thousands of patients to small single centre studies, and there is no clear consensus on the best form of prophylaxis.

Thrombosis is less likely if venous stasis is minimised, and this is the rationale for the use of elastic support stockings and raising the foot of the bed. These passive measures have been used for years, and, though they help prevent venous thromboembolism, they are not sufficiently effective on their own after major joint replacement. Nevertheless, intermittent pneumatic compression of the legs in 500 patients undergoing hip replacement reduced the overall rate of deep vein thrombosis to 5%, with a 1% incidence of pulmonary embolism.[2] This compares favourably with a 50% incidence of deep vein thrombosis in patients given no prophylaxis.[3]

The efficacy of foot pumps was compared with anticoagulation in a randomised study, and the results in terms of preventing deep vein thrombosis were comparable.[4] Pumps are used to promote venous return and do not carry the risk of bleeding complications, but they tend to be cumbersome and, more important, difficult to use outside hospital. This constraint is relevant since there is evidence that optimal thromboprophylaxis after major joint surgery should continue for at least 10 days, and some would argue four to six weeks.[5 6] This means that prophylaxis must continue after patients have left hospital, so effectively it becomes a choice between aspirin or anticoagulant therapy.

A recent large multicentre study (PEP study) examined the effect of aspirin as a prophylactic agent against venous thromboembolism in patients who had fractured their hips.[7] A reduction of about a third in the incidence of venous thromboembolism was found in patients given aspirin compared with placebo. In contrast, in a subgroup of 4000 patients who had undergone hip or knee replacement aspirin showed little benefit over placebo: in both groups there were eight cases of pulmonary embolism and no significant difference in the incidence of deep vein thrombosis (26 in the placebo group, 22 in the aspirin group).

Unfortunately the PEP study did not include a group of patients given anticoagulants. Its results are, however, consistent with those reported from seven small studies in which aspirin was given to 419 patients. Here the overall prevalence of deep vein thrombosis was 52%, while in 655 control patients in 13 trials it was 51%.[3] These findings are in striking contrast to the results in 20 trials in over 3000 patients given low molecular weight heparin after arthroplasty, in which the overall prevalence of deep vein thrombosis was 15%.[3] Thus the ability of aspirin to prevent

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