EDITORIAL

Is Ethical Development Impeded in Young Doctors?

Young doctors undergo a rite of passage. Though some egregious stresses—for example, the every-other-night call schedule—have been relaxed, it remains plain that the passage traversed by doctors in training is an intense, at times, wrenching socialization into a world that for most "outsiders" would be distressing. From the third year of medical school until the end of residency training, usually 5–7 years, young physicians are up to their elbows in human suffering, vulnerability, fearfulness, deformity, and dying. Perhaps, not surprisingly, doctors' coping with these experiences takes the form of banding together, developing an "us versus them" mentality, and an "insiders" language. Their humor is often sarcastic and cynical. Similar reactions are common to most humans in intensely stressful environments.

Yet, society and the profession hold high expectations of physicians, in some ways just the opposite of what I describe above. Expectations include that physicians should always be compassionate and respectful of patients, hold high ethical standards, and place patients' welfare above their own. It follows that the moral development of physicians needs to progress hand-in-glove with their becoming technically proficient. In this expectation, human nature butts heads with high ideals.

The paper by Clever et al. published in this issue of the *Journal* characterizes students at the beginning of their rite of passage.[1] The authors readminister a questionnaire developed by Feudtner and Christakis[2] and seven years after their original publication, demonstrate that the majority of medical students continue to hear derogatory comments directed toward patients and to witness or do actions felt to be unethical. The authors determine that the most important reasons students fail to challenge these "unethical" events are "difficult personalities on the team," and "being too low in the hierarchy," reasons reflecting their rocky period of socialization into the current clinical climate.

In a related study, Parsons et al. examine medical students' perceptions of humor and slang.[3] Their qualitative study includes too few subjects to draw conclusions regarding how students progressed during the year they were observed and interviewed, but provides rich insights into their feelings as they teetered on the verge of going from "outsiders" to "insiders" on the medical team. The students at this stage were able to identify with patients' perspectives, but at the same time, they exhibited an "insiders" understanding, namely that of the interns and residents. We see students hold on to their personal values (about a patient being made fun of, for example—"I feel badly about laughing about... it just seems like a really difficult situation to be in"). But they sympathize and begin to identify with the frustrations of the house staff ("Having just finished a month of being that tired and sleep deprived, and being up all night for really stupid things, I can see where the frustration comes from." "It's unrealistic to think they're not going to say insulting things to a patient at times and laugh about it."). A most insightful comment describes the residents, "They are wonderful and very humane people, but they inevitably adopted the ... terminology regardless of whether they thought it was good or bad" (This refers to use of the term "gomer" by residents).

So, what do we conclude from this? We see good people thrown into an impossibly stressful environment sometimes behaving badly and using "dark" humor that is disrespectful of patients. Indeed, the above quote suggests that such language often contrasts with the behavior of the young doctors when face-to-face with actual patients. Close examination of their humor reveals an underlying element reflecting painful experiences of the doctors—"gomer" and "brick" convey feelings of hurt and helplessness on the part of caregivers of these unwittingly difficult patients. Nevertheless, we know that this humor generally sets a poor example for medical students. At times, it gets completely out of hand. Hence, inappropriate humor, together with the information emerging from Clever et al's paper, poses a huge educational problem.

The entire scenario (disrespectful language, ridicule of patients, medical students feeling that they are coerced into marginally or sometimes flagrantly unethical practices) flies in the face of the moral values of the profession. In these and similar papers, we see medical students at the point of entering, if not being submerged, in the process of becoming doctors.[1,3–8] They join a team of interns and residents in the murky environment of the acute hospital ward. What comes next after the students are actually socialized into being house officers is not so well described. However, their adolescent-like humor and behavior reflects a lower level of moral functioning than one would hope for from physicians, or expect from persons at their stage of adulthood.[9] We don't know in how many cases this regression is a permanent, versus a transitory, delay in moral and professional development.[9] The two studies published in this issue of the *Journal* do not provide answers to this question. But it would seem highly prudent to apply counter-measures to improve the ethical environment for medical training. We must search

for remedies to reconcile human nature under stress with our professional expectations.

Although clear evidence shows that interventions of various sorts improve matters,[9] the evidence is insufficient to show which interventions or combinations thereof are most effective, as well as their preferred timing, scale, and permanence. At this point, I suggest that we in medical education proceed by mounting a variety of efforts and documenting their impact. The chief focus of such efforts might be assisting the students and residents to participate effectively in medical care without suppressing their ethical values or losing touch with the idealism that attracted them to medicine. A larger issue, never to be lost sight of, is changing the culture or hidden curriculum of the medical wards into a more humanistic environment.

Clever et al. think that students should be supported in learning to confront possible unethical behaviors.[1] (One technique: rather than directly challenge a superior's actions, teach students to say they don't understand why things are being done in a certain way. This approach is less confrontational for someone "low" in the hierarchy). Parsons et al. suggest reducing sleep deprivation and other stresses on young physicians, providing "ethical debriefings" for medical students, and educating the interns and residents to be better role models.[3] We and others have created small-group sessions for critical reflection by medical students, which allow them to clarify and place their experiences in perspective in a safe, supportive environment.[5,10] This type of educational process seems to me to be highly effective, an opinion supported by some evidence.[11] I have also observed anecdotally in my thirty-year career that interns and residents seem more and more willing to participate in exercises designed to impart patient-doctor communication and teaching skills. Hence, teaching positive role modeling to interns, residents and perhaps faculty seems highly promising. In sum, we are making slow progress, but we should apply ourselves more diligently to those aspects of medical education that address the human dimensions of care, still far too neglected in medical training programs. — **William T. Branch, Jr., MD,** *Grady Memorial Hospital, Emory University School of Medicine, Atlanta, Ga.*

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