TEACHING AND LEARNING ETHICS

Inappropriate attitudes, fitness to practise and the challenges facing medical educators

Demian Whiting

J Med Ethics 2007;**33**:667–670. doi: 10.1136/jme.2006.017947

The author outlines a number of reasons why morally inappropriate attitudes may give rise to concerns about fitness to practise. He argues that inappropriate attitudes may raise such concerns because they can lead to harmful behaviours (such as a failure to give proper care or treatment), and because they are often themselves harmful (both because of the offence that they can cause and because of the unhealthy pall that they may cast over relations between healthcare practitioners and patients). He also outlines some of the challenges that the cultivation and assessment of attitudes in students raise for medical educators and some of the ways in which those challenges may be approached and possibly overcome.

There is little doubt that in addition to the behaviours that people ought morally not to perform, there are certain attitudes that people ought morally not to have—for example, feelings of disgust in response to people of another race, or feelings of pleasure in response to other people's (undeserved) misfortunes. But in what ways might the possession of morally inappropriate or contemptible attitudes by a healthcare practitioner give rise to concerns over that person's fitness to practise? In this paper, I suggest several reasons. First, such attitudes may raise fitness-to-practise concerns because they can lead to harmful behaviours, such as a failure to provide proper care or treatment. Second, inappropriate attitudes are often themselves harmful (both in the offence that they cause and in the unhealthy pall that they may cast over relations between healthcare practitioners and their patients). I also outline a number of the challenges that the cultivation and assessment of attitudes in students pose for medical educators, and some of the ways in which these challenges may be approached and possibly overcome.

ATTITUDES

In this paper, I consider attitudes to include those non-cognitive states of mind—in particular, our emotions and desires—that are typically directed at other people (and/or their mental or physical attributes). I am also happy to allow, for the sake of argument, that our attitudes might include certain cognitive states—thoughts about another person's worth or value, for instance—although I believe that there is a genuine issue as to how such thoughts are to be properly conceptualised (see Blackburn[1], for instance, for the view that our evaluative thoughts are themselves expressive of our *non*-cognitive attitudes). All reference to attitudes in this paper should be taken to refer to a person's occurrent states of mind. Certainly we sometimes talk of people possessing particular attitudes, even when such attitudes seem not to be manifesting themselves. So, for instance, we might describe someone as having racist attitudes even when she is asleep and cannot be having the emotions, desires and thoughts that centrally constitute her prejudices. But whether or not we think that this is right way to describe things (so, should we say that the person who is asleep has prejudicial attitudes or only that she is *disposed* to experience such attitudes?), it is the states of mind to which a person is disposed, rather than the dispositions themselves, with which this paper is primarily concerned.

As I am interested in the question of how inappropriate attitudes may affect a healthcare practitioner's fitness to practise and the challenges this raises for medical educators, and because I believe these issues can be addressed without saying anything about how attitudes are initially acquired, I say nothing here about the interesting and important issue of initial attitude formation. Nevertheless, clearly some of the points that I make about how medical educators can encourage attitudinal improvements in students might be taken to cast some light on the issue of how inappropriate attitudes are initially acquired.

MORALLY INAPPROPRIATE ATTITUDES

If a person tells us that she feels a strong dislike for people from a particular racial or cultural background, then even if we judge that this person will never behave inappropriately—something which, of course, may be to her credit—are we still not likely to strongly disapprove of her attitude of contempt? The important point here, then, is that the attitudes that other people have and display towards ourselves and other people often matter a great deal to us (and in many cases as much as, sometimes more than, their behaviours), and it is for this reason, I suggest, that attitudes occupy a central part in our moral thinking. There are a number of ways in which an attitude might be thought morally inappropriate. First, it might be thought inappropriate when it is directed at an inappropriate object. So, for example, disgust felt in response to a person from a different ethnic or cultural background would normally receive our disapproval, as would normally a desire to hurt

Correspondence to:
Demian Whiting, Division of Primary Care, University of Liverpool, Whelan Building, Brownlow Hill, Liverpool L69 3GB, UK

Received 14 June 2006
Revised 13 October 2006
Accepted 16 October 2006

Abbreviation: OSCE, objective structured clinical examination

another person. Second, some attitudes—our emotions and desires, for example—seem inappropriate if they are directed at appropriate objects but are experienced too intensely. An example here might be a person who feels intense anger over a minor slight. And, finally, an attitude might be negatively evaluated if it expresses, or reflects, other inappropriate attitudes that the person possesses. So, for example, a person's failure to feel amused by another person's joke might be thought poorly of if that indifference reflects a callous disregard for the other person.

Now, it is sometimes objected that attitudes cannot be morally inappropriate, because states of mind are generally not things that we have direct (or voluntary) control over and it is sensible to talk about moral *criticism* or *blame* only regarding matters that we have direct control over. But here two things should be said. First, although we may not have direct control over our attitudes, we are often able to exert indirect forms of control over them—so, for example, we may be able to voluntarily cultivate or suppress our attitudes—and it might be plausibly held that this is all that is needed in order to be blamed or criticised for our attitudes[2 3] (see also papers by Robert Adams[4] and Angela Smith[5] for the view that responsibility doesn't require *any* kind of control). But, second, even if it were the case that criticism requires direct control, this does not mean that our attitudes cannot be morally evaluated. This is because, as a number of philosophers have pointed out, whereas right and wrong are properties of actions and states of mind, blame attaches to *agents*.[6–8] It would therefore be perfectly sensible to hold that even if someone is not to be criticised for her attitudes—on the grounds that attitudes are not voluntary states of mind—those attitudes may still be the wrong attitudes for her to possess.

MORALLY INAPPROPRIATE ATTITUDES AND FITNESS TO PRACTISE

How, then, might morally inappropriate or contemptible attitudes raise concerns about fitness to practise? The first way is by threatening to have a negative effect on a healthcare practitioner's behaviours. There are at least two ways in which a person's attitudes might do this. To begin with, an inappropriate attitude might affect behaviour by causing a distorted or inadequate understanding of the relevant features of the clinical situation. The point here is that attitudes play an important role in determining the kinds of things that attract our notice or attention. So, for example, a healthcare practitioner who is unconcerned about the emotional well-being of her patients may as a result of that attitude fail to notice aspects of the patients' situation—for instance, behaviours that indicate that her patients are in distress or pain—that are necessary to provide appropriate care (and that a more sensitive or empathetic practitioner would normally pick up on). And, second, inappropriate attitudes can affect behaviours, by affecting desire or motivation. If I feel repelled by particular groups of patients (for instance, elderly patients, or patients with learning disabilities, or patients from certain ethnic or cultural backgrounds), then even though I may recognise the nature of my professional and moral obligations in respect to such patients, I may still find myself insufficiently motivated to behave towards them in the appropriate or optimal way.

Now, it might be held that we cannot simply infer from the fact that a person has inappropriate attitudes that she will behave inappropriately. This is because a person who is aware of her attitudes and is sufficiently concerned about them may often be able to prevent them from interfering with the way that she practises. So, for example, a healthcare practitioner who is sufficiently disturbed by her own racist attitudes and feelings may, out of a strong sense of disapproval for those responses, be able to muster the strength to behave in a way that is not suggested by those attitudes, or may be able to successfully suppress those attitudes so they do not threaten to affect her behaviour. I think that this is right and, therefore, I agree that it does not follow from the fact that a healthcare practitioner has inappropriate attitudes that she will behave unacceptably. Nevertheless, it would be clearly mistaken to think that people's attitudes never interfere with their behaviours. This is because people are not always able to suppress their attitudes or act in ways that are contrary to what their attitudes suggest, and in some cases people may not even be able or willing to recognise in themselves the presence of inappropriate and disruptive attitudes.

The second reason why morally inappropriate attitudes may raise fitness-to-practise concerns is that such attitudes can themselves be a direct source of harm to patients. If I know that my doctor feels deep disdain for or indifference to me, then even if I think that my doctor will behave appropriately, I am still likely to feel greatly offended and disturbed by the contemptuous attitude. And I would suggest that at least part of the reason why such attitudes do so disturb and offend us is that most of us have a need to matter to other people—indeed, our own sense of self-worth and value will often crucially depend on it—and our not mattering to others will often be evidenced or demonstrated by their emotional disdain or indifference (on this point see Blum, 1980, p150).[9] Moreover, that attitude of my doctor is likely to poison or adversely affect my own feelings towards the doctor, thus undermining my desire to seek the doctor's attention or help and, thereby, the quality of the care that I am potentially going to receive. And, of course, we might expect both these ways in which attitudes can give rise to harm—that is, both through the offence or upset and through the deterioration of relationship that those attitudes may cause—to be of particular concern in areas of care where we find heightened emotional sensitivities and vulnerabilities in patients (as might be the case, for instance, where patients are facing grave uncertainty or a poor prognosis). This is because it is when patients are most vulnerable that the need for appropriate shows of attitude from healthcare practitioners will be most acute and when the display of a contemptuous attitude towards a patient is likely to be most damaging.

Do inappropriate attitudes that fail to cause offence or deterioration of the relationship between healthcare practitioner and patient, or that do not threaten to lead to harmful behaviours, raise fitness-to-practise concerns simply on the grounds that those attitudes are morally contemptible or inappropriate? For example, should a doctor who has racist (or ageist or sexist) attitudes, but who never allows them to interfere with her practice or even to be communicated to her patients, still be judged unfit to practise? It is not clear to me how the healthcare practitioner's fitness to practise can be an issue in such cases, as the patient is in no way being harmed or violated by the presence of those attitudes. Of course, there may be reason for thinking that the *healthcare practitioner* is suffering some kind of harm or loss in possessing such attitudes (whether the practitioner realises it or not)—say, because they prevent the person from living a fully flourishing human life—but it is not clear why *her* loss here should be at all relevant to the issue of whether she is fit to treat or attend to patients.

Above, I have outlined types of circumstances in which morally inappropriate attitudes raise fitness-to-practise concerns. To conclude this section, first, I should emphasise that the potential harm of having an inappropriate attitude must be judged to be sufficiently severe to cast doubt on the healthcare practitioner's fitness to practise. After all, it is clear that we all experience some attitudinal defects—various prejudices, short

temper, less than ideal levels of empathetic ability, and so on—and in many cases those attitudes will be noticed by others and will to some degree affect our behaviour. But although this may be undesirable, it seems clear that a certain measure of inappropriate attitude will have to be tolerated if we are not to potentially bar all healthcare practitioners from clinical practice. Second, I suggest that there are mitigating circumstances where an inappropriate—and perhaps highly upsetting—attitude may be taken to be no indication of the healthcare practitioner's overall fitness to practise. This may be the case, for instance, where a person's responses are understandable consequences of the intense but unusual pressures that she is working under and, therefore, cannot be taken to be an indication of how the healthcare practitioner normally reacts to patients. In such a case, although we may want to encourage the person to remove herself from the situation temporarily, I think we should not take such displays to be a reflection on her overall fitness to practise.

CULTIVATING AND ASSESSING ATTITUDES IN MEDICAL STUDENTS

I have said something about why inappropriate attitudes may raise concerns about fitness to practise. Now, if that is the case, there would seem to be good reason for medical schools to put measures in place that will help the development or cultivation of better attitudes where current attitudes are thought to be lacking. And, moreover, there would also seem to be good reason for medical schools to ensure that measures are in place to reliably assess attitudes in students (and to ensure that those whose attitudes are judged to be sufficiently harmful or offensive are identified and given remedial support, or, if necessary, prevented from progressing further in their studies). So, let me first say something about the challenges facing educators in relation to the development of attitudes in students.

To begin with, I take it that for reasons of privacy and beneficence, any attempt to develop better attitudes in students should be done on an informed and consensual basis. Students should be encouraged to reflect on the appropriateness of their attitudes and to engage in behaviours that might lead to an improvement in attitude. They should not, however, be *compelled* or *required* to change their attitudes. That would seem to constitute over-meddlesomeness with a person's psychological life, and could potentially lead to significant psychological harm or distress. Of-course, students might be required to ensure that their (inappropriate) attitudes do not negatively affect how they behave towards patients, but that is not the same as requiring students to alter the attitudes themselves.

Encouraging changes or improvements in attitudes in ourselves and others does constitute a notoriously difficult challenge. In part, this is because attitudes are not things that people can normally give up or change at will. We cannot realistically hope, then, that students will automatically be able to improve their attitudes if they are simply encouraged to reflect critically on them (although reflecting on the appropriateness of an attitude will clearly still have some important part to play, as this will help to inform students of which attitudes may need working on). But, still, a number of things can be said about how changes in attitude may be encouraged. In some cases, changes in attitude may come about with changes in the way students view or conceptualise patients. For instance, by helping to increase students' awareness of the anxieties and fears that patients may often have, we might expect to find in many cases an increase in sympathetic responses to patients. Or, by challenging possible misconceptions about particular ethnic or cultural groups of patients, we may hope to often find a reduction in prejudicial attitudes. In such cases, we might expect medical educators to use teaching methods that seek to challenge, or improve on, the thoughts that underlie a particular attitudinal response. This might involve, for instance, requiring students to reflect on the likely consequences of their behaviours for patients. Or, for example, it might require students to research and discuss the nature and extent of the anxieties that many (possibly, vulnerable) patients experience—where this exercise might itself be usefully informed by asking students to reflect on occasions when they were patients, or on occasions when they (or a close relative, perhaps) were emotionally vulnerable.

A very different approach might be needed, however, in those cases where a student's understanding of her situation is deemed to be in good order but her responses are nevertheless still thought to be lacking in some way. So consider, for instance, the case of a student who is aware of a patient's distress and anxieties but who fails to be sufficiently moved by them. In such a case, cultivating better attitudes cannot be about challenging the person's thoughts or perceptions of her situation (as these are assumed to be in good order), but would rather seem to be about trying to help effect changes in that person's affective or conative sensitivities—for instance, that person's disposition to emotionally respond to her (well-formed) thoughts and perceptions in the way that she does. (For further discussion of the limitations of the cognitive approach to treating inappropriate and dysfunctional emotions, see Whiting, 2006.[10]) It seems to me that in such cases we might have to rely on 'non-cognitive' forms of intervention if we are to hope for changes in attitudes. So, for example, in some cases we might find that encouraging certain forms of behaviour towards patients—where this might be helped by clinical tutors modelling and explaining appropriate behaviours (see Burack *et al*, 1999, p54)[11]—will succeed in feeding back to, and directly effecting changes in, the attitudes that the student possesses and displays (see Adams, 1985, p14).[4] In other cases, encouraging students to spend time in places where appropriate responses are likely to be elicited—for instance, in areas of care where students have to engage with patients who are feeling very anxious or who are in great discomfort—might gradually lead to a general improvement in how students react to patients (see Blum, 1980, p195).[9]

There will, of course, be occasions when it will not be possible to cultivate more appropriate attitudes. This may be the case where the existing attitudes are deeply entrenched, or where the student is not prepared to participate in activities that are, in part, aimed to effect attitudinal improvements. In such cases medical educators will need to decide whether the presence of any inappropriate attitudes raises fitness-to-practise concerns. It may be that although a student has undesirable attitudes, they are not significant enough to cast doubt on the student's overall fitness to practise—as, for example, where the student is aware of, and appropriately responsive to, the presence of those attitudes. But in some cases an inappropriate attitude cannot be ignored—for instance, where the student is unable to exert sufficient control over her inappropriate attitudes—and it is therefore judged that patients are at risk of significant harm. In such cases the student clearly cannot be deemed fit to practise.

The preceding discussion does lead to the question of how medical educators might assess whether the possession of an inappropriate or contemptible attitude is likely to give rise to fitness-to-practise concerns. Now, clearly such an assessment has to consist in more than assessing students' recognition of attitudes that are likely to raise fitness-to-practise concerns, as a student may recognise that an attitude is likely to be harmful or offensive, for instance, but still possess and display that attitude. Neither do forms of assessment that require students to reflect on and discuss the attitudes that they possess and display in clinical situations seem sufficient. This is not to say that there is *no* place for such forms of assessment. In our own

medical school (based in the University of Liverpool), for instance, third-year students are now required to provide reflective portfolios at the end of their first clinical rotation. These portfolios include short and structured reflections on behaviours and attitudes that students have observed in themselves or other healthcare practitioners. So, for instance, students are asked to complete a structured reflective document in which they identify an event that raises ethical and professional concerns; discuss how various parties were affected (where this might include, for instance, discussion on how a display of an uncaring attitude impaction a patient's well-being); discuss in some detail the ethical and professional issues raised by the event; and outline an appropriate plan of action or response to the event observed. We believe that such exercises help students to develop skills in identifying and responding to relevant behaviours and attitudes. Moreover, such portfolios give assessors an indication of behaviours or attitudes that might be putting people at risk of harm. The worry, however, is that medical educators cannot rely *solely* on such forms of assessment, as not all students will be able or willing to identify in themselves attitudes or behaviours that raise fitness-to-practise concerns.

Assessors need to be able to reliably detect attitudes displayed; the point of the above discussion was to suggest that this cannot be guaranteed by simply asking students to identify inappropriate attitudes or to provide reflections on their attitudes. One way in which attitudes might be more reliably detected is by using objective structured clinical examinations (OSCEs). Examinations of this type do not seem to present the same problems as the approaches to assessment so far discussed, as they are based on assessors' observations of attitudes and behaviours displayed, not students' own observations. I think that there is little doubt that an OSCE approach can indeed be a helpful assessment tool. This is because a student might display behaviours in an OSCE station (simulated healthcare scenario) that provide some (if not conclusive) evidence of attitudes that raise fitness-to-practise concerns. Nevertheless, an OSCE approach does present some significant problems. The primary concern is that because of the artificial nature of an OSCE station, students will not necessarily display the types of attitudes that they would in an actual clinical setting (see Ginsburg *et al*, 2000, pS9).[12] It is also unclear how an OSCE approach could accommodate the large number of observations that would need to take place if we are to sufficiently minimise the risk of examiners misinterpreting attitudes displayed. Moreover, different attitudes are likely to be elicited in very different (clinical) contexts (in caring for older people as opposed to mental healthcare, for instance), and therefore, in order for examiners to reliably detect attitudes that raise concerns about fitness to practise, numerous OSCE stations would have to be organised to represent various clinical environments or patient groups—a requirement that raises substantial logistical concerns. Consequently, it seems to me that although OSCEs might, again, go some way towards providing evidence of attitudes that raise concerns, they also cannot be solely relied on.

If we are to address the limitations of an OSCE approach, I believe that we may have to turn to clinical tutors to make longitudinal observations and assessments of attitudes in diverse and actual (not simulated) clinical settings (see Ginsburg *et al*, 2000, pS9).[12] This approach to assessing attitudes does not raise the same logistical or resource concerns raised by an OSCE approach, and there is no problem of artificiality. There is some evidence to suggest that clinicians—who are clearly best placed to evaluate attitudes in clinical settings—are often unwilling to report or discuss with medical students problematic behaviours and attitudes.[11 12] This concern might possibly be met largely by carefully explaining to clinical tutors the reasons why attitudes need to be evaluated and discussed with students and by ensuring that adequate training and support are provided. (See Burack *et al*, 1999, p52[11], who cite lack of training and the belief that corrective feedback in this area would generally be counter-productive as two of the reasons for clinicians' reluctance to assess and discuss attitudes observed with students.) Now, if that is the case—and clearly more empirical work needs to be done in this area—then I believe that the use of longitudinal observations by clinical tutors may indeed have a crucial role to play in the assessment of attitudes.

My own thinking is that medical schools will ideally consider adopting all of the forms of assessment outlined above. One reason for this relates to compilation of evidence: the more observations that take place of a student's displays of attitude, the better the picture we can build of that student. Moreover, having different assessment methods in place will help to ensure that attitudes that may not be picked up by one method (as a result, say, of one of the potential limitations with that method outlined above) may be picked up by a different one. Finally, of course, each of the methods may play an invaluable role in helping students' professional and personal development. The use of reflective portfolios, for instance, can help students to develop skills in identifying and responding to problematic attitudes that they might possess. And clearly each of the assessment methods discussed above enables assessors to provide useful feedback to students.

CONCLUSIONS

Much more will need to be said on the question of how attitudes are to be best cultivated and assessed, and clearly any proposed method of cultivating or assessing attitudes in students would need to be rigorously tested and empirically validated. But if we are to endorse the view that attitudes are an important part of our assessment of a healthcare practitioner's fitness to practise, then it is incumbent on medical educators to discuss, devise and test strategies for cultivating and assessing them. Here I seek to give reasons why attitudes may raise fitness-to-practise concerns. I also outline some of the challenges posed by the task of cultivating and assessing attitudes in students, and some of the ways in which those challenges may be approached and possibly overcome.

ACKNOWLEDGEMENTS

I would like to thank Margaret Hammond and two reviewers for their comments.

Competing interests: None.

REFERENCES

1 **Blackburn S**. *Ruling passions: a theory of practical reasoning*. Oxford: Clarendon Press, 1998.
2 **Sankowski E**. Responsibility of persons for their emotions. *Can J Philos* 1977;**7**:829–40.
3 **Oakley J**. *Morality and the emotions*. London: Routledge and Kegan Paul, 1992.
4 **Adams R**. Involuntary sins. *Philos Rev* 1985;**44**:3–31.
5 **Smith A**. Responsibility for attitudes: activity and passivity in mental life. *Ethics* 2005;**115**:236–71.
6 **Sinnott-Armstrong W**. 'Ought' conversationally implies 'can'. *Philos Rev*, 1984;**93**:249–61.
7 **Stern R**. Does 'ought' imply 'can'? and did Kant think it does? *Utilitas* 2004;**16**:42–61.
8 **Whiting D**. Standing up for an affective account of emotion. *Philosophical Explorations* 2006;**9**:261–76.
9 **Blum L**. *Friendship, altruism, and morality*. London: Routledge and Kegan Paul, 1980.
10 **Whiting D**. Why treating problems in emotions may *not* require altering eliciting cognitions. *Philos Psychiatr Psychol* 2006;**13**:237–46.
11 **Burack J**, Irby D, Carline J, *et al*. Teaching compassion and respect: attending physicians' responses to problematic behaviours. *J Gen Intern Med* 1999;**14**:49–55.
12 **Ginsburg S**, Regehr G, Hatala R, *et al*. Context, conflict, and resolution: a new conceptual framework for evaluating professionalism. *Acad Med* 2000;**75**(Suppl):S6–11.