Hidden influences on the moral growth of medical students – lessons from the medical English classroom

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Abstract

The paper showcases medical students’ morally-charged interpersonal experiences as recorded in a didactic experiment with control and experimental groups at a Romanian medical university (1st year compulsory English seminars). Data was obtained through classroom observations, testing, learning diaries, assignments and follow up questionnaire-based survey. Concurrent to the teaching/learning, we noticed how group dynamics seemed to impact students’ understanding and enactment of values considered important in the medical profession. The discussion focuses on experiential learning which is less explicit in the curriculum and less apparent in test scores, but still relevant in shaping the moral dispositions of future physicians.

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1. Research underpinnings

There is a fair degree of worldwide consensus that the good physician should adhere to and exercise high moral and professional standards, acting with respect, altruism, compassion, responsibility, integrity, collegiality etc. when interacting with patients and their families, as well as in working together with the other members of the medical team. Similarly, there is international agreement backed by legislation and implementation methodology for the integrated teaching of transferable competences such as respect for ethics throughout the curriculum.

At a declarative level, medical education institutions claim to be encouraging such attitudes and behaviours in students, but it is not always clear in what ways and/or to what extent this is being achieved. Moral growth is notoriously difficult to measure, control and predict, as negative circumstances may yield positive development and vice versa. Medical ethics courses are commonly found in curricula, but learning about ethics does not necessarily correlate with ethical behaviour.

The typical junior medical students are young adults whose advanced cognitive and metacognitive skills are still developing (especially with respect to one’s rapport to self, others, the world), as university life is filled with novelty, change, diversity and challenge. When measured against Lawrence Kohlberg’s 6 stages of moral development, it turns out that medical students may be in danger of “evolving” in the opposite direction, depending on (their understanding of) their experience in the morally-charged setting of medical school. Most people progress from reward/punishment-based moral thinking to self-interest and then mutual interest driven judgments, possibly
further on to group-welfare and societal oriented moral reasonings. A significant few such as Mahatma Gandhi or Martin Luther King reach the highest stage of placing universal human rights and principles at the core of one’s beliefs and choices in life. However, after a well intentioned start, some medical students may fall back on a thinking focused more on immediate self-interest, self-preservation and positioning in the system rather than exercising altruism, empathy, compassion and generosity. This is by no means a rule, for each individual is different, but researchers have pointed to the “hidden” curriculum of organisational patterns, social dynamics and ethos as a possible cause for detachment and even cynicism. For instance, students may forget about collegiality and fairness in their need for high multiple-choice test scores in order to secure a scholarship or state-funded tuition. Concurrently, explicit opportunities created and facilitated by the faculty within the formal curriculum for the open discussion and clarification of inherent dilemmas and challenges to the students’ thinking may be too few and far between.

In response to direct observations and research findings along these lines, medical universities have a wide range of potential measures to improve the curriculum and the students’ experience. Moral dilemma and case study discussion, role-play simulations, interdisciplinary team projects, guided reflection etc. may be used to teach medical ethics per se or integrate medical ethics features in other relevant courses (e.g. medical communication courses), as well as enrich the learning experience at lectures and seminars regardless of the discipline. The list of references at the end of the paper may help interested readers review current understandings of the moral education of medical students and, based on our own experience, authors respond positively to sharing ideas when contacted directly via the Internet (e.g. Schwartz et al., Self et al.).

2. Aims

On the whole, our 3-year PhD research project aimed to review the WHYs and experiment with the HOWs of integrating moral education in medical education beyond explicit medical ethics courses, e.g. in the medical language and communication curriculum. The general hypothesis was that language learning would not be affected negatively, while the effects on the students’ awareness, knowledge, skills and attitudes in the moral domain would be significant and beneficial.

In the process of conducting the research and subsequently, we have witnessed situations pointing to attitudes, behaviours, dilemmas and challenges that are relevant to medical students’ experience and development from a moral standpoint. Such non-quantitative “data” is showcased in this paper, seeking to shed some light on the hidden curriculum of social interactions experienced on a daily basis but not easily or often talked about openly.

3. Methods

The effects of integrating moral education in the medical language and communication curriculum were researched by means of a didactic experiment. A compulsory series of 10 medical English seminars (= 20 hours) was modified based on CLIL / Content and Language Integrated Learning principles, by enhancing the language teaching with medical ethics contents and moral education techniques. The experiment was conducted in 2010-2011 on 1st year medical students at “Gr. T. Popa” University of Medicine and Pharmacy Iasi, following approval by the Research Ethics Commission of the university. 156 students were taught the same English language curriculum in two different ways, forming control groups and experimental groups. Through pre-testing, classroom observations, student learning diaries and emails, home assignments, test performance, final course evaluations and follow up, we collected evidence of language learning, shifts in awareness of medical ethics, moral thinking, intra- and interpersonal dynamics.

Of the 156 students, 80 formed the experimental groups and 76 the control groups. All were Romanian, ~19 years old, and most were female (typical demographics at Romanian medical universities today). Quantitative analysis included descriptive statistics, distribution and internal consistency coefficients, non-parametric tests and coefficients, Spearman correlations, ANOVA One Way and Repeated Measures with the help of SPSS 17.0.
Qualitative analysis focused on textual descriptions, reflections and answers provided by students and the observations of the author as teacher-researcher (also using Nvivo software).

4. Results and discussion

The quantitative data analysis confirmed most of the inferences subordinated to the general hypothesis (Ursache, 2011), but here we shall refer only to the results which may be linked to our direct classroom observations and what students shared about their experience interacting with each other, in order to gain more insight into influences on students’ development other than explicit instruction (e.g. group dynamics).

In a questionnaire-based survey conducted five weeks after the end of the experiment, the students were invited to express their agreement/disagreement on a 6-point Likert scale with statements about the course experience. Although there was no significant difference in the number of pre-existing relationships among students before medical school, the students in the experimental groups rated as significantly higher the contribution of the English seminars to the fostering of a positive group atmosphere, of collaboration as an alternative to individual work, and of students’ own willingness to provide help and support to others. They also reported more frequent instances of collaboration in other disciplines with colleagues from the English seminars, as well as more personal friendships emerging from the overall experience. Moreover, as results from other similar items in the survey focused on the intra-personal experience, the language course contributed less to the control students’ awareness of their own moral values, their thought processes in dilemmatic circumstances, and reassessment of their own prejudice and stereotypes. The non-parametric tests conducted to verify the differences noticed descriptively lead to coefficients significantly in favor of the experimental course experience, which is described next.

Throughout the semester, the preferred seating arrangement and spontaneous group dynamics were observed and recorded in the control groups compared to the experimental groups, where most of the activities implied pair/teamwork schemes facilitated by the teacher. We noticed how, when invited to sit anywhere in a classroom pre-arranged to allow all the students to face each other (in a semi-circle), some students sat very close together and with their backs towards other colleagues (sometimes the teacher, too), and other students were left isolated, with empty chairs in between. After a few seminars, it became obvious that students chose the same seats, creating the impression of “closed groups” versus “outsiders”. Passive participation and individual work patterns predominated in the control groups even when the possibility of working in pairs/teams was suggested (but not imposed). While a minority of students tried to impress with quick (and sometimes irrelevant) answers or display of advanced level of general English (occasionally interrupting), the others seemed to prefer to fade in the background and assume a passive role. In several sessions there was noticeable eye rolling, giggling and whispering which had a further inhibiting effect on students who were looking for affirmation but not (sufficiently) part of the “closed groups”. A few students seemed to actually want to be left alone. Well into the academic year, when the attendance list was called it was apparent that the students had not yet learned each others’ names, especially in the case of shy students. Last but not least, despite their undisputed intelligence and academic potential, some of the control groups often left their trash scattered throughout the classroom.

The initial patterns were the same in the experimental groups and there were similar instances during the semester, but as the weeks passed the difference in overall attitude and atmosphere became substantial and apparent. All the sessions with the experimental groups involved pair and group work getting students to move around, get to know each other and help each other. Attention was paid to making sure shy students were not left behind and that they all had skills or information which were valuable to the group in relation to the task. There was substantial reflection in action and on action focused on the experience of collaboration and the students were often invited to say which values important to the medical profession had been practised during the seminars.

With the experimental groups, we noticed how some students with a lower level of general English compensated through a positive attitude and team building gestures beneficial to the groups’ progress in completing the tasks. Also, there were instances when shy students paired up with less inhibited colleagues, being more comfortable speaking with 1-2 people at a time (which is also closer to everyday conversation patterns). In fact, on several occasions it was demonstrated that quiet and withdrawn students may have good ideas and solutions which they are willing to share if made to feel safe and respected. One student suffering from speech impairment was patiently listened to and subsequently became a much valued member of her group.
In the experimental groups, notes were left behind by students saying "THANK YOU for this 2h!! I think is the greatest seminar of the college! I like the way we interact and share the work!! It’s a great method and would like to learn more about how I can apply this way, ideas to myself." or "I also learned that respect is essential and that you can disrespect someone without even meaning/knowing it." There were numerous oral and written comments about how the seminars helped with overcoming the fear or speaking in public or feeling at ease in an otherwise competitive group of people. The students’ learning logs contained comparisons between the course experience and feeling like in a family, being thus able to build friendships. Repeatedly, students commented on their initial preference for independent, solitary work being challenged by having enjoyed and gaining appreciation for teamwork. However, even if most of the descriptive self-evaluations mentioned teamwork positively, a couple of students doubted the authenticity and transferability of that to the very competitive way in which medical education is organised.

Last but not least, it is worth mentioning that the connections built within the experimental groups went beyond the boundaries of the course. There were reports and evidence that students from the experimental groups helped each other stay updated instead of concealing information from each other, studied together, got involved in additional elective courses and extra-curricular/volunteering projects (also in the following years), and some seminar groups remained in close contact up to today even as certain students switched series or quit medical school to embark on a different career path.

5. Conclusions

Our research can be qualified as both applied and involved (being about, with and for), closely linking the researcher, the subjects and the context with a view to enhance the impact of education in action and through reflection. Granted, the one-semester experiment was not fully successful in discouraging attitudes such as superiority, selfishness, prejudice, individualism among junior medical students who were, on the whole, highly capable, motivated and hard working. However, it has documented and demonstrated how the same students may welcome and benefit from the opportunity of exercising respect, tolerance, mutual support and cooperation when learning about medical communication in a morally and ethically enriched way.

When faculty pay attention not only to the curricular contents to be taught but also to the affective climate, encouraging reflection and discussion about the HOW as well as the WHAT of medical education (e.g. addressing group dynamics issues), students learn experientially to value and enact altruism, empathy, teamwork, generosity within and beyond their immediate academic pursuits. Such attitudes and behaviours are essential to thoughtful and compassionate medical practice, but they cannot be acquired through taking notes in lectures or tested through multiple-choice questions during the preclinical years, when students’ moral values and dispositions are still undergoing development.

In what concerns the medical language and communication curriculum, a strict concern for specialized language instruction, however justified, is not enough to fulfill the brief of a discipline which should transcend its boundaries of specificity by subscribing to an outcome that can only be defined in a holistic, integrated fashion (e.g. the “good” doctor). The deeply (trans)formative mission of medical education, in particular, is underpinned by the essentially moral contract between society and medicine. Consequently, we see it as legitimate and justified to formulate questions which challenge and aims which enrich language courses with (meta)cognitive, affective and behavioral learning objectives conducive of the medical graduate’s ability to engage in professional and moral conduct.

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