

## Valuing teaching and teaching values

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A quick review of some relevant medical codes in New Zealand reveals that there is a strong belief that doctors have a duty to engage in passing on the knowledge and practice of medicine to the next generation of doctors. For example, the New Zealand Medical Association (NZMA) Code of Ethics under 'Teaching' states:

Clinical teaching is the basis on which sound clinical practice is based. It is the duty of doctors to share information and promote education within the profession. Education of colleagues and medical students should be regarded as an ethical responsibility for all doctors.<sup>1</sup>

The Medical Council of New Zealand's (MCNZ's) document entitled *Good Medical Practice*, under the heading 'Scholarship' says:

Teaching, training, appraising and assessing doctors and students... An integral part of professional practice is teaching, training, appraising and assessing doctors and students, which is important for the care of patients now and in the future.<sup>2</sup>

Other codes of specific specialties express the same idea.<sup>3,4</sup> Both classical and modern versions of the Hippocratic Oath mention something recognisably similar.<sup>5,6</sup>

The Royal New Zealand College of General Practitioners (RNZCGP) website, under the heading 'Teaching the next generation' says:

Medical education is an important role of the College. Along with increasing numbers of registrars in training, more and more undergraduate medical education is occurring in community practices.<sup>7</sup>

Now there is a corollary to this duty to teach—a further concomitant duty, which is recognised in at least three of these documents. *Good Medical Practice* adds: 'If you are involved in teaching you need to develop the attitudes, awareness, knowledge, skills and practices of a competent teacher.'<sup>2</sup> The RNZCGP website continues: 'As a consequence [of the importance of medical education] many general practitioners and rural hospital generalists are developing teaching skills and expertise in medical education.'<sup>7</sup> In the Royal Australasian College of Surgeons' Code of Conduct it states that 'A surgeon will seek to maintain competence as a teacher and supervisor'.<sup>4</sup> In short, there is a clear recognition that, in order to fulfil the duty of educating their successors, current doctors who take part in teaching have a duty to learn to be good teachers. This duty will fall to any who engage in teaching, but in what follows we focus mainly on those who choose to pursue teaching within a university setting (though this does not necessarily mean in a university building).

It is assumed that university teachers have some research expertise to offer when they start their careers. Although this is limited to a PhD for most subjects, for medicine and other health sciences even this may not be an initial requirement. The

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The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

**THIS ISSUE:** Readers are invited to reflect on clinical teaching from an ethical perspective.

typical PhD is at least a foundation for learning to become a researcher. In contrast, the only knowledge of teaching comes from a set of ideas derived from observations made when being taught. These ideas have not been practised and the models of teaching they provide are solely founded on past experiences of what the new university teacher liked or disliked as a student. In other words, most are invited to apply to work in university teaching with 'no experience necessary'. Providing education beyond university—to junior colleagues for example—seems to be approached in the same manner.

Knowing something about a subject and recapitulating images of the classroom do not seem to be a sound foundation for something as important as providing young minds with a university education. Yet many in academic medicine seem to believe it is enough, even while there is good evidence that repeating certain cultural practices in medical teaching is inadequate for the new learner and the profession.<sup>8</sup> The inexperience of teaching faculty is partly caused by a widespread (though often tacit) acceptance that teaching, and learning to teach, are private activities. In contrast, all other areas of a medical teacher's work, including learning to research, are a collaborative and collective enterprise.

Doctors who opt to teach within universities need to think of the attributes that the institution requires of their graduates, and often these are conveniently ignored, both by teachers and paradoxically by the institution itself.<sup>9</sup> This convenient ignorance is a question of awareness of the required outcomes in the first place, and then a question of values. We firstly need our medical students to become good medical practitioners who have the skills and knowledge to practise. In addition, they are university graduates who must transcend training as they take their place in society and the world. In New Zealand, for example, university graduates are required by

law to become critic and conscience of society.<sup>10</sup> To do this they need more than attitudes, knowledge and skills in medicine. They need an education in values and valuing that takes them beyond their immediate profession. All university graduates potentially occupy positions of great influence in society and this privilege carries with it responsibility. It is society that supports their education in the first place and medical practice does not sit in isolation from a broader societal context. It is here that new medical practitioners, like all university graduates, conduct their lives.

For these reasons, medical teachers should not go about the education of others in an unexamined way. At present there are professional standards that are rigorously defended in medicine, but more relaxed and limited when it comes to teaching medicine. What seems to be missing is awareness of the values impact that teaching has, and that values are a part of becoming an accomplished teacher. Students will learn values from those who teach them, whether these are a deliberate or an unconscious part of the transaction. Values are learned in the classrooms and in informal teaching situations. They are reflected in all the choices that teachers and students make and affect their thinking and actions.<sup>11</sup>

Of course there are medical teachers who recognise the largely amateur situation of teaching and go to great lengths to educate themselves and others. Some in the profession have a strong value for teaching and carefully research this as a subject and will publish the results of their inquiries at conferences and in journals (for example *Medical Teacher*, *Teaching and Learning in Medicine*). In these situations, teaching becomes less private and this community of medical teaching researchers clearly value their own development and that of others. Sometimes this group prefer medical education research to medical disciplinary research. And some do both. Their

example demonstrates that the often-used 'lack of time' argument for not developing teaching is open to contestation. It seems that some medical teachers cultivate their teaching whereas others decide to focus on different aspects of work. These are value decisions and, for some, teaching is not a highly valued part of practice. However, there is a dilemma here in as much as the commitment to develop teaching requires an interest, or perhaps even a love of subject. For some, loving the subject of their own teaching practice may not appeal, but the expectation of a commitment to improving teaching practice exists nonetheless.

With these thoughts in mind, a values code for medical teaching may serve as a guide to the profession. It could look something like this:

#### *Teachers in medicine will:*

1. recognise that their own values will be influential in the education of medical students and junior doctors
2. understand that the development of their own attitudes, awareness, knowledge, skills and practices as a teacher all require sound value decisions; part of professional competence is to continually refine such values
3. accept that teaching improvement, like all other parts of a health practitioner's work, requires a lifetime's commitment
4. be accountable to the profession and society for their own and their students' value choices and actions; these include specific values relating to ethical choice and moral judgment
5. feel obligated to make teaching inquiries public. Learning about teaching should not be done in isolation, but through sharing knowledge in a supportive community of teachers. In this way teaching becomes a scholarly activity worthy of a university.

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## BOOK REVIEW

## The Good Doctor: What Patients Want

Ron Paterson

Review by **Susan J Hawken**

In *The Good Doctor: What Patients Want* Professor Paterson puts the spotlight on the doctor through the lens of the patient. He writes for all involved in health care—patients, doctors, advocacy groups, policy makers and educationalists. He challenges us all to take action on an individual and collective level to ensure that doctors are competent—that is, ‘good enough’.

The book is divided into four parts with each focusing on an important aspect of his argument.

Firstly, he outlines what an ideal doctor is and carefully references this to good quality research in the area. He goes on to describe the reality in the New Zealand health context describing the ‘problem doctor’. This is achieved predominantly through cases he was involved in during his time as Health and Disability Commissioner, but there is also reference to international cases. The third part explores barriers holding back change that would help to address the competence of doctors. This includes examining what he sees as the key components—undemanding patients, overburdened doctors, reluctant regulators, medical culture and legal constraints. This section was interesting and the commentary on medical culture insightful.

Finally he provides a prescription for change, and includes an overview of the re-certification procedures in North America

and the UK that was informative. Although acknowledging primary care’s innovation in the past, he lays down a specific challenge to general practitioners by stating that PHOs should be publicly publishing comparative quality information down to the level of individual practices.

Overall his argument is very well constructed, it is easy to read, and well referenced. It is challenging and there may be a sense of disquiet around the issue of collecting and sharing our own quality performance data with regard to care of our patients. The key issue highlighted though was that surely as a profession we can honour our commitment to professionalism by addressing issues of competence in ourselves and others in a rigorous, systematic way that assures the public they are in good hands.

I would recommend this thought-provoking book. Maybe we need to be initiating more conversations with patients about what they do want to know about doctors, contributing to the debate on how best to address actual practitioner performance, and taking some action.

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