

# Medical education, palliative care and moral attitude: some objectives and future perspectives

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*Context* Adequate medical education has 3 interrelated aspects: theoretical knowledge, practical skills and the personal attitude of the doctor. The current emphasis on medical science diverts attention from the importance of the attitude aspect of medical education. We argue that the integration of palliative care into medical curricula can correct this imbalance between knowledge, skills and attitude. In our view, incorporating palliative care into medical training not only improves the quality of palliative care, but also contributes to the moral quality of the doctors being trained. To support our argument we emphasise the moral aspects of attitude. Moral attitude focuses on the capacity to respond to others in a humane manner and can be compared with the way a virtuous doctor acts. We show the crucial role this moral attitude plays

in palliative care and the surplus value palliative care education can have in general medical training.

*Perspectives* We suggest that clinical experience in palliative care, supplemented by reflection on narratives about chronically ill or dying patients and mourning or ageing processes, offers prospects for developing palliative care education. These perspectives can contribute to the transformation of the present 'hidden curriculum' of contemporary medical education, which implicitly shapes the student's moral attitude, into a future more explicit enculturation into the medical realm. Ultimately, this will improve health care as a whole.

*Keywords* education, medical; palliative care; curriculum; attitude; moral development.

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## Introduction

Recently, several authors<sup>1-4</sup> have argued that current education in palliative care in medical curricula is inadequate. An inventory of the state of affairs of palliative care education in the Netherlands revealed that palliative care is hardly a specific part of medical training.<sup>3</sup> In our own professional setting, the University Medical Centre in Nijmegen, there is discussion about whether an optional 4-week module on palliative care that is highly valued by students should be integrated into the general medical curriculum. In this paper we will discuss the advantages that integrating palliative care into the core curriculum of medical training can offer in educating the attitudes of medical students.

The *Oxford Textbook of Palliative Medicine*<sup>5</sup> specifies a series of learning objectives under the title 'Education and Training in Palliative Care'. The authors rightly claim that there is wide agreement about what

needs to be explored in palliative care medical education. Their list of objectives summarises – *inter alia* – the basic principles for enhancing palliative care education proposed by Billings and Block.<sup>6</sup> Other studies<sup>7,8</sup> discuss learning objectives that largely resemble those of the *Oxford Textbook*. These learning objectives for palliative care education should include exploration of:

- 1 death as a part of life and transcultural issues concerning death;
- 2 issues defining the decision for palliative care in a variety of clinical settings and the impact of that decision on both the patient's quality of life and health care costs;
- 3 the physical, psychological, social and spiritual impact of dying on patients and their families;
- 4 the control of pain and other symptoms;
- 5 psychosocial and existential support of patients and their families;
- 6 one's own attitude toward death;
- 7 communication skills, and
- 8 strategies enabling a continuum of care across a variety of inpatient and outpatient settings, particularly care in the home.

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### Key learning points

The emphasis on theoretical knowledge and practical skills in contemporary medical education diverts attention from the importance of the doctor's moral attitude, which is also an essential part of medicine.

Incorporating instruction in palliative care into basic medical education will improve the balance between knowledge, skills and attitude, and consequently enhance both the quality of palliative care itself, and the moral quality of the doctors being trained.

Gaining experience in a palliative care setting and using narratives that describe serious illness, ageing, death and grieving will help medical students both to recognise the humane dimensions of health care in general and palliative care in particular, and to refine their moral attitude.

The purpose of this article is to argue that structural attention to palliative care in the medical curriculum will enhance the personalities and moral characters of the doctors being trained. Adequate medical education is generally considered to have 3 interrelated aspects: theoretical knowledge, practical skills and the personal attitude of the doctor. Contemporary medical education, however, emphasises knowledge and skills and pays little explicit attention to what kind of person the doctor ought to be.<sup>9</sup> Although the personal attitude of the physician is of great concern in medicine as a whole, we argue that by putting more emphasis on palliative care in the medical curriculum, the balance between these 3 areas can be improved. Typically, palliative care is provided as an integral part of the care of all patients<sup>10</sup> and not by palliative care specialists. Although clinical areas like care of the elderly or primary care might claim to have the potential to educate students' attitudes, palliative care is also likely to enhance the attitude of the doctor-in-training. Physicians tend to see palliative care as epitomising the ideals of patient care, as has been mentioned in several studies of the provision of end of life care in general practice.<sup>11,12</sup> Although caring for dying patients does not obviously differ from patient care in general, Field<sup>12</sup> observed that dying patients were treated differently from other patients in a number of ways. At the end of their lives, patients receive more time and attention, and care seems to be

more patient-centred than elsewhere in medical practice.

In the first section of this article, we elaborate on the process of forming the doctor's attitude as an aspect of medical education comparable to the inculcation of theoretical knowledge and practical skills. Here we make a distinction between attitude and moral attitude. The next part of the paper concentrates on the contribution that teaching palliative care can make to attitude education within the medical curriculum. Finally, we will discuss 2 teaching methods that can enhance both palliative care education and medical training as a whole. These methods are frequently discussed in the literature, but in the Netherlands are rarely applied in medical education.

### Attitude and moral attitude

If we take a closer look at medical education, 2 aspects, i.e. theoretical knowledge and practical skills, of the conceptual trinity that make up an adequate education are rather easy to recognise and describe. Theoretical knowledge is acquired as (scientific) information that is presented to students in lectures and books. Practical skills are learned in practical courses and during hospital rotations. The education of student attitudes is far more difficult to recognise and describe. The problem is that it is difficult to understand what 'attitude' means. Attitude is a complex term. In this paper we primarily focus on the moral aspects of attitude.

The current psychological concept 'attitude' has been defined as 'a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object'.<sup>13</sup> This is a broad and rather abstract definition that does not make clear the fact that morality always plays an important role in the interaction between doctor and patient. Reflecting on the painting *The Doctor* (Sir Luke Fildes, 1891), Brody<sup>14</sup> argues that 'character and virtue are as important as knowledge and skills in describing the ideal family physician'. The basis of medical practice is more the maintenance of a network of human relationships than the application of scientific knowledge.<sup>14</sup> A virtuous doctor 'starts always with his commitment to be a certain kind of person, and he approaches clinical quandaries, conflicts of values and his patient's interest as a good person should'.<sup>15</sup> In terms of attitude, this means that the attitude of a doctor towards a patient is always a moral attitude which reflects the *personal* motivation and commitment of someone to act in the interest of *other people*. In contrast to the current psychological concept of attitude, moral attitude

focuses on the capacity of persons to respond to others in a particular situation in a *humane* manner, and it is this moral attitude which is exemplified by the virtuous physician.

Moral attitude is not about *what* people *do*, but about *the way* they act. Gastmans<sup>16</sup> argues that providing good care requires more than just the competent exercise of the various necessary cognitive and technical functions and skills. Providing good care is more than performing expert activity. Good care requires an inner engagement of the professionals involved. As Gastmans writes: 'Nurses derive their specific identity not only from the set of tasks that they perform but also from the way in which they commit themselves to the caring process'.<sup>16</sup> Moral attitude is thus closely connected with *the kind of person* someone is. By taking a closer look at the goals of medicine we will further illustrate what we mean by moral attitude.

The goals of medicine concern improving health, curing illness and, if this is not possible, caring for patients and helping them to live with the residues of their illness.<sup>17</sup> Health care professionals involve themselves in the lives of patients by offering them help to attain these ends. In *The Virtues in Medical Practice*, Pellegrino and Thomasma write: 'The good of the patient provides the architectonic of the relationship', and describe beneficence, as the guide to medical action, as 'grounded in the humanity of the persons interacting in the medical relationship'. In health care professionals, humanity appears in their personal capacity to respond to patients in a humane manner. This is what we mean by moral attitude. More than the psychological concept of attitude, the term moral attitude refers to the kind of person someone is. The moral quality of a person largely determines the moral quality of the actions called for in a particular situation with a specific patient. This moral view of medical practice is an essential component of any discussion of the importance of attitudes in medical education.

### Moral attitude in medical education and palliative care

Medical education cannot simply be understood as the transmission of medical, biological and epidemiological information and the acquisition of the necessary practical skills. Medical education necessarily influences the moral identity of the student. Medical training is 'a process of moral enculturation' into the medical community.<sup>18</sup> This process of enculturation is usually not explicitly expressed in the formal curricula of medical schools. It is reflected in what is called the 'hidden curriculum'. During medical education students

become socialised. They adopt and internalise new values, attitudes and rationales about what is important in practising medicine and how to be a good doctor. Medical training makes students reconstruct their former picture of medicine.<sup>19</sup> The reconstruction of the student's view of the medical world is not an explicit objective of the formal curriculum but an implicit result of being part of the medical community. Personal experiences, stories about patients' experiences, casuistry, doctors and teachers functioning as role models, and the explicit content of the curriculum all mould the students' way of committing themselves to (future) patients. Medical training gradually and covertly cultivates the moral attitude of the doctor *in spe*. A problematic consequence of this more or less unconscious enculturation of medical students is the aforementioned imbalance in the trinity of adequate education. The emphasis on theoretical knowledge and practical skills distracts attention from the doctors' moral attitude. Several authors have pointed out the crucial role of the professional's moral attitude in palliative care.

Randall and Downie,<sup>20</sup> for instance, state that palliative care gives need to be morally developed persons. Much of the success of a doctor, nurse or other health care worker depends on their relationship with each patient. The nature of that relationship depends, in part, on the patient's perceptions of the helper. That is why it is important that the judgements made by a health care professional are not just the product of a technical, scientific mind, but also of a humane and compassionate spirit. The success of a caregiver in palliative care depends on his or her perceptiveness about the patient, and reciprocally, the perceptions of the patient are determined by the apparent commitment of the caregiver.

In a similar vein, Bradshaw<sup>21</sup> mentions the dangers of developments such as the rationalisation of care for terminally ill patients in the UK and its reduction to a bureaucratic routine. She asks whether medical science should be the only basis for terminal care. Medicine is an effective tool to control symptoms and pain, but it is not the only weapon in the arsenal of palliative care. Medical science has always been and will continue to be a vital component of palliative care, but it is now becoming an increasingly dominant component. Bradshaw wonders whether the original ethic of humane care for the dying can have a place in preventing the reduction of palliative care to purely medical treatment. Although she realises that acquiring the necessary knowledge and skill is important, she states that: 'the quintessential heart of palliative care is the kind of compassionate people involved in it'.

Our thesis, that explicit education in palliative care offers medical schools a clear and interesting way of directing attention to the doctor's moral attitude, is also supported by medical educators. Barnard *et al.*<sup>22</sup> point out the importance of the preclinical years of medical education in preparing students to provide optimal care for patients near the end of life, as well as for patients in general: 'The foundations for excellence in end of life care that are laid in the preclinical years are also the foundations for excellence in general medical practice' and 'a curriculum that optimally prepares students to give excellent care near the end of life will best prepare them to become excellent physicians in all aspects of medical care'. Obviously, palliative care education fits very well with the aims and agenda of general medical education.

Moreover, from the perspective of the widely accepted WHO definition,<sup>23</sup> it seems reasonable to conclude that adequate performance in palliative care practice requires engaged caregivers who are capable of acting in a personal and attentive way.

The WHO defines palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards death as a normal process;
- neither hastens nor postpones death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness, and
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

In our view, it is imperative to integrate palliative care into the medical curriculum. This is dictated by the fact that every caregiver must be able to provide palliative

care. The inclusion of palliative care in medical training will also contribute to the education of the moral attitude of doctors. In the next section we will focus on 2 ways of including palliative care education in the medical curriculum.

## Two means of educating moral attitude

Several experiences with student participation in a hospice during medical training show that students consider experiencing palliative care practice a welcome and very valuable contribution to their education.<sup>24,25</sup> These empirical studies support a recent plea<sup>26</sup> to integrate clinical experiences in palliative care into the core curricula of medical schools. Moreover, according to Block and Billings,<sup>26</sup> gaining some experience in care for the dying can 'help young physicians learn to tolerate a degree of intimacy and personal engagement that other aspects of medical training may subvert or undermine'. Consequently, both professionals and patients throughout the health care system can benefit from the integration of experience in palliative care into the medical training programme. However, prudence is called for. Working in palliative care can be stressful and students must be well supervised and given adequate emotional support if this integration is to be successful.

Another method that can contribute to moral attitude in caring is the use of the humanities in medical school. Health care practitioners are confronted daily with the complex interplay of the generality of the disease in question and their unique, individual and emotional response to it. Narrative art forms such as novels and films can help them understand that interplay in 3 separate, but interlinked, ways.<sup>27</sup> Literary examples give insight into common patterns of response. Narratives can provide insight into individual differences and may help to produce a feeling for ambiguity. Reading literature also can enrich the language and thus the thought processes of health care practitioners.

Beyond these 3 more or less cognitive and affective characteristics, novels (or narratives in general) also serve as moral guides for living a good life.<sup>28</sup> Experiences with humanities courses in medical education<sup>29-32</sup> support these suggestions. While Hampshire and Avery<sup>30</sup> recommend the study of medicine in literature as an option for those who are interested, Finlay<sup>31</sup> and Downie *et al.*<sup>32</sup> suggest an integration of the humanities into the medical curriculum. On the basis of anecdotes from final year students' tutors, Finlay<sup>31</sup> noted the emergence of a different type of graduate in Wales: the tutors

remarked on the students' 'ability to show compassion and to communicate effectively, their understanding of the gravity of medical decisions and their insight into human suffering'. Kirklin et al.<sup>33</sup> successfully used a humanities course to explore the impact of cancer on the lives of patients, families and professionals. By offering the student the chance to stand back and reflect on their professional task, the humanities module allowed the student 'to access the wealth of human experience that is embodied in the arts' and informed and directed them 'in their search for the wisdom and the humanity to fulfil their role as clinicians'.<sup>33</sup> On the basis of these educational experiences it seems reasonable to conclude that using narratives to dramatise the experiences of chronically ill or dying patients, the loss of a beloved family member or friend, or the inevitability of ageing or death, will not only lead to the provision of better palliative care, but will also result in a generally more humane medical practice.

## Conclusion

A medical student's journey through medical school may be compared with Dante's medieval journey through the *Inferno*.<sup>34</sup> This analogy does not mean that medical education is a hell, but rather that attendance at medical school involves the same tasks that Dante had to accomplish during his trip, as described in the *Divine Comedy*. Dante's first task involves learning God's laws. This task is accomplished through studying case histories of sin and having occasional lectures from his companion Virgil on their way down through Purgatory. The second task involves the emotional reactions of Dante to the sufferings and mutilations that human souls undergo in hell. He has to learn to deal with the misery he meets on his way down. These 2 tasks are identical to the double task that confronts medical students in that 'they must learn about disease and how to treat it, but they must also retain the capacity to feel, deeply, the suffering they encounter without being overwhelmed or incapacitated by it'.<sup>34</sup> 'Learning about disease and how to treat it' refers to knowledge and skills, and 'the capacity to feel without being overwhelmed' refers to the moral attitude of the student as it is put forward in this article. As we have indicated, the latter seldom forms an explicit part of contemporary medical education, but is embedded in a hidden curriculum that socialises students during their progression through medical school.

Education in palliative care can transform the hidden curriculum into a more governed and explicit

enculturation of future doctors into the medical community. In particular, experience in palliative care for every student and exposure to the appropriate narratives during medical training offer serious prospects for developing a profound education for humane, rather than merely technical, palliative care. Ultimately, this will improve health care as a whole. Unfortunately, there is little empirical understanding of the relationship between the education of palliative care givers, the practice of palliative care and the personal qualities or moral attitudes that are needed in care for the dying. This relationship should therefore be a topic for future empirical and philosophical research in palliative care.

## Contributors

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