

# Teaching care-ethics

## Ética docente-asistencial

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### Abstract

Teaching care-ethics attends to situations derived from the involvement of patients in the medical training process. In comparison with ethics in clinical research, teaching care-ethics is as it was before World War II: it applies in a self-regulated manner the norms of medical ethics to educational problems with patients. The lack of specific ethical guidelines for teaching-care work is manifested, among other aspects, in weaknesses in the supervision and counseling of students during their clinical practices, which favors violations of the right to life and health of the population. It is proposed to consider the convenience of teaching-health care ethics committees, which protect and promote respect and guarantee the right to education in medical units.

*Keywords:* medical ethics, medical education, ethics committees.

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*As usual during my period of medical instruction,  
I was left in charge of everything without  
my knowing anything about anything.  
(Samuel Shem, *The House of God*)*

## **1. Introduction**

Teaching-care ethics refers to the study of morality in the medical education process in medical units; to the customs and norms existing in the teaching-care space, defined as the place where the processes of education and clinical care converge, and in which, characteristically, patients are an end in terms of medical care and also a means in relation to medical education.

The aim of this paper is to reflect on the ethical implications of patient participation in medical education. To this end, we first argue the need for teaching and health care ethics, then analyze its current state of development and, finally, we consider the teaching and health care problem from an ethical perspective.

## **2. The need and specificity of teaching and health care ethics**

According to Pérez Tamayo (1), the medical profession has three main tasks: clinical care, research and education. Each of these tasks has a moral (object of study) to which the corresponding ethics (science) is applied: clinical ethics or medical ethics proper, research ethics and teaching ethics. If the codes of ethics are considered as a product of applied ethics, it is clear that the ethics of teaching and health care is the one that lags furthest behind. In clinical and research, there are codes and there is a constant and permanent revision of them, which is still incipient in the teaching-care work; in the latter, there is a moment in which the problem is being recog-

nized (2) and some valuable ethical proposals are being put forward in this regard (3, 4).

The scarce development of the ethical study of teaching and health care work (5) stands out if compared to that achieved by clinical ethics and research ethics. It could be argued that teaching and health care ethics does not have its own object of study and that the values, principles, norms and deontological duties of teaching and health care are the same as those of clinical work. That is to say, that teaching and health care ethics is subsumed in clinical ethics and that, with knowledge of and attention to the latter, it is sufficient to develop ethical teaching and health care processes.

The mechanism through which teaching and care ethics is immersed in clinical ethics is medical authority and hierarchy: a medical student must always follow directions and obey orders from senior professors and physicians. It is assumed that, through hierarchy, the medical care of students is equal to that provided by professors and hierarchical superiors. This, on the one hand, helps to explain and justify abuse, violence and authoritarianism in medical education (6-9) and, on the other hand, hinders the development of teaching and care ethics.

Undoubtedly, clinical codes of ethics are in force and applicable to the educational work in medical units. It is not conceivable that teaching and health care ethics would violate or contradict clinical ethics. However, it must be recognized that medical education involving patients generates its own circumstances that require study and particular ethical codes. Clinical care involving only the physician and the patient is not the same as that in which one or more medical students are also present and in which the attending physician is also simultaneously a professor of medicine. Do patients need to be informed and authorize their participation in the medical education process? To what extent and under what conditions can medical students intervene in the medical care of patients? Should medical students (both undergraduate and postgraduate) assume responsibility for clinical care in medical units? These and

other questions can find general answers in existing values, principles, and codes of medical ethics. However, they reveal the existence of a specific context and the need for more specific and practical guidance when making decisions or developing policies in this regard. Hence the need to consider the specificity of the teaching-healthcare space and process and, consequently, of teaching-healthcare ethics.

### 3. Development of teaching and health care ethics

Despite the fact that medical education arises simultaneously with clinical practice, the application of ethics to teaching and health care is scarce and, in Mexico, it does not offer any support to the current regulations for the admission and permanence of medical students in medical units.<sup>1</sup> For example:

a) It does not consider the dignity of patients and omits the obligation to inform them about their intervention in medical education processes and ask for their consent to participate. The norms are based on the nineteenth-century vision of Dr. Eduardo Liceaga who, in 1887, when he was planning the construction of the General Hospital of Mexico, said that *the teaching of medicine, more than any other, must be essentially objective, it must be done on the sick, and all civilized nations have agreed that those who are assisted by public charity should be used for clinical teaching* (10).

b) It also underestimates the need to recognize and reward the teaching work of physicians assigned to the medical units; and

c) The regulations concerning resident physicians generate interpretative gaps that result in the undermining of their dignity and allow for work overloads that violate national laws and are incompatible with human health.

In addition to the fact that the regulations fail to consider the dignity and human rights of patients, resident physicians and me-

dical professors (11), questionable educational policies are implemented without ethical support, such as charging students for clinical training, without the patients being informed that they and their illness have been commercialized and that this constitutes a source of economic income for educational and health institutions (12).

It cannot be omitted that, although there is a lack of ethical support for medical education norms and policies, there are, albeit few, studies on ethics in the Mexican teaching and health care space (13-16). However, what stands out is that the academic production on the subject is reduced and has not integrated teaching and health care ethics as an area or discipline of study. Problems such as: the role of medical students during epidemics and natural disasters, mistreatment, professional burnout, dehumanization, suicide, addictions, violence and medical error, in interns, trainees and residents have a moral dimension that until it is recognized and considered can be resolved.

If one contrasts the development of teaching-care ethics with that of research ethics, one can appreciate the critical limitations and the few practical possibilities of the former. In brief summary: clinical research ethics, according to Diego Gracia (17), has three stages or periods of development. In the first, the clinic has a casual or fortuitous relationship between the medical act and clinical research; the only valid medical act is the one that has a clinical purpose (diagnostic or therapeutic) and is beneficial to the patient. The principle proper to this stage is beneficence and, fortuitously or by accident, that patient or the care he/she receives may contribute to medical knowledge.

In the second stage, research in human beings is considered an act valid in itself and independent of the medical act. That is, interventions on human beings can be aimed at generating knowledge, independently of the usefulness of the intervention for the patient, as long as it does not cause him/her harm. At this stage, medical ethics is applied to research, but it is insufficient or inadequate,

since physicians regulate themselves as to when, where and under what circumstances the values and principles of the clinic should be applied to research.

The third stage, or *autonomy*, is characterized by the direct application of ethics to research and its independence from clinical ethics. The autonomy of ethics applied to research arose with the first code of clinical research ethics (Nuremberg Code, 1947). The driving force behind the development and autonomy of research ethics stems from the events of World War II, in which the clear inadequacy of the application of clinical ethics to research and the self-regulation of physician-researchers became evident.

Compared to research ethics, teaching and health care ethics is between the first and second stages. Certainly, there are differences between countries and health institutions. However, these same differences show that there is no autonomy that is reflected in a universal code of teaching and care ethics. Let us look at the current state of development of teaching and health care ethics in the specific case of Mexico.

It should be remembered that a traditional model of medical education prevails in the country's teaching-care areas (18). That is, medical students (interns, trainees and residents) in medical units are simultaneously students and workers; they learn medicine while attending patients. It can be seen that the clinical and educational functions of the medical profession are confused and are, in practice, one and the same, just as clinical and research were in the beginning.

Certainly, medical students in medical units are officially «doctors in training» (Table 1) and, according to the respective regulations, must always be supervised and advised by qualified physicians or specialists while they are performing clinical work.

The recognition of supervision and mentoring of the clinical work of physicians in training is the implicit acceptance of the specificity and particularity of the educational process with respect

**Table 1.** Number and proportion of physicians by year and category. Mexico, 2012-2019.

Year	Contract physicians*	Medical personnel in training**	Total physicians in direct contact with patients	Physicians in training. Total physicians in direct contact with patients
2012	146,321	40,172	186,493	0.22
2013	152,423	42,294	194,717	0.22
2014	159,364	45,417	204,781	0.22
2015	170,129	47,873	218,002	0.22
2016	171,930	52,953	224,883	0.24
2017	173,374	55,660	229,034	0.24
2018	174,259	56,326	230,585	0.24
2019	177,062	58,396	235,468	0.24

\* General practitioners and specialists.

\*\* Interns, trainees and residents.

Source: Own construction based on: Secretaría de Salud. Health personnel by year National [Internet]. 2019. Available from: [http://sinaiscap.salud.gob.mx:8080/DGISGenerarTabla?titulo=Personal\\_de\\_salud\\_por\\_a%F1o&href=/tablero/recursos\\_en\\_salud/personal\\_de\\_salud/Entidad/2007-2019\\_personalDeSalud\\_Entidad.xlsx&ruta=/tablero/recursos\\_en\\_salud/personal\\_de\\_salud/Entidad/2007-019\\_personalDeSalud\\_Entidad.xlsx&hoja=Nacional&adicionales-Titulo=NACIONAL](http://sinaiscap.salud.gob.mx:8080/DGISGenerarTabla?titulo=Personal_de_salud_por_a%F1o&href=/tablero/recursos_en_salud/personal_de_salud/Entidad/2007-2019_personalDeSalud_Entidad.xlsx&ruta=/tablero/recursos_en_salud/personal_de_salud/Entidad/2007-019_personalDeSalud_Entidad.xlsx&hoja=Nacional&adicionales-Titulo=NACIONAL)

to the process of medical care. However, the fact that they establish the obligatory nature of supervision and counseling of physicians in training does not mean that they are complied with. Moreover, the norm does not establish any sanction for those who fail to comply with this mandate, leaving it up to professors and physicians hired by the medical unit to decide whether or not to supervise the students. This amounts to self-regulation in terms of enforcement. On the other hand, there is evidence that points to the need to elaborate a code of teaching-healthcare ethics and mechanisms to promote and ensure compliance with it.

#### 4. Teaching and health care problems

In Mexico, the inadequacy of ethical self-regulation of the teaching and care process has been widely documented. The National Human Rights Commission (CNDH) has been providing continuous evidence for more than 20 years. The first specific recommendation on the subject made by the CNDH dates back to 1997 (19). In total, in 2020, the CNDH made eight recommendations to the authorities of the Health sector for violations of human rights of patients in medical units that were attended by unsupervised medical students. The 2020 recommendations are in addition to the 29 already made in the same sense in the lustrum 2015-2019. During this period, the recommendations to the Health sector for not supervising students doubled with respect to those of the 2010-2014 period, and increased fourfold with respect to those of the 2005-2009 five-year period.

In addition to the specific recommendations, there are three general recommendations that point to medical students and the educational process in medical units as a cause of human rights

**Tabla 2.** Number and percentage of recommendations made by the National Human Rights Commission according to five-year period. Mexico, 1995-2019.

Lustrum	Total number of recommendations	Recommendations to the Health sector		Recommendations in which medical students are involved	
2000-2004	257	43	16%	5	12%
2005-2009	312	44	14%	7	16%
2010-2014	415	80	19%	14	17%
2015-2019	401	113	28%	29	26%
TOTAL	2020	353	17%	66	19%

Source: Own construction with data from the CNDH. Available from: <http://www.cndh.org.mx/Recomendaciones>



violations. *General Recommendation No 15/ 2009, On the right to health protection* (20), refers that the lack of supervision of medical students was one of the main causes of the 11,854 complaints received from the health sector between 2000 and 2009; *General Recommendation 29/2017, On the clinical record as part of the right to information in health services* (21), and *General Recommendation 31/2017, On obstetric violence in the national health system* (22), reiterate the lack of supervision of medical students as a cause of violation of patients' human rights.

According to the CNDH, the rights most violated by the lack of supervision of medical students in teaching-assistance spaces are the right to life, to access and protection of health, right to a life free of obstetric violence and right to access to health information. Certainly, the objective of the recommendations issued by the CNDH regarding the non-repetition of cases and violations of human rights is not being fulfilled and they highlight the need for a code of conduct for teachers and health care workers, beyond self-regulation, and the need for bodies to guarantee and monitor compliance.

Interns, trainees, and residents (23-25) also expressed the need for greater supervision and counseling during their clinical practice, and most of them (>50%) acknowledged having made clinical errors (diagnostic or therapeutic) due to lack of counseling during clinical practice. This points to the maleficence of the educational processes in the teaching-healthcare space in various Mexican states and other countries (Table 3).

Beyond the numbers, the opinion of medical students in the medical units (Table 4) and patient testimonies such as: *...I still remember how traumatic my labor was in the [...]; I was treated as exactly that, an object of study, rather of practice; several residents went through me until I finally refused to continue being outraged* (26), highlight the need for teaching-healthcare codes of ethics that limit or, ideally, suppress maleficent educational processes.

**Table 3.** Percentage of interns according to Mexican state or country and response to the corresponding item.

Item	Veracruz N = 477 (2019)	Zacatecas N = 155 (20 19)	Nayarit N = 40 (2020)	Costa Rica N = 55 (2020)
My professors in the medical unit [always] attended (in person or remotely) effectively the doubts I had during the medical care processes in which I participated.	26	21	55	49
My professors in the medical unit [always] had adequate working conditions to fulfill their educational function.	13	15	42.5	29
My professors or tutors at the Faculty of Medicine [always] were aware of my academic development in the medical unit.	12	8	12.5	11
[Always] I received supervision during my healthcare activities from the staff of the medical unit. 1	19	14	40	20
[Always] I received adequate feedback on the tasks I performed.	15	15	27.5	22
[Never] I made diagnostic or therapeutic errors due to lack of academic supervision during the assistance activities that I carried out in the medical unit.	31	25	35	49
[Never] I made diagnostic or therapeutic errors due to lack of clinical skills.	26	19	35	31

Source: Unpublished information from the Observatory of Medical Education and Human Rights.

**Table 4.** Comments of medical students on their professional training in medical units. Mexico and Costa Rica, 2019-2020.

I believe that the head of teaching of such unit should have been more aware of the needs of the students, since on many occasions we are treated without dignity and they forget that we are also human beings. (Internal-Veracruz-378)
I think [...] the academic authorities should be more vigilant. (Intern-Veracruz-141)
[...] Our head of hospital teaching has not taken pains to advise us or protect our interests [...]; He is only interested in looking good with the heads of service, at the cost of us having rotations, which do not correspond to us at that time. (Resident-Veracruz-135)
[...] Take care of the actions of those assigned due to sexual harassment towards internal companions. (Internal-Zacatecas-117)
Lack of support from the educational institution. They never supervised us or were aware of what we did. (Internal-Nayarit-30)
[...] They only see us and use us as «those of us who take out work», and the academic part has been lost almost entirely, and it is a pity because afterwards the doctors who have already graduated complain that our training is not adequate. Intern-Costa Rica-8)

Source: Unpublished information from the Observatory of Medical Education and Human Rights.

## 5. Discussion and conclusions

During the last few years, it has been emphasized that medical education should incorporate medical ethics in curricula and programs. The World Medical Association reaffirmed in April 2021 the 1999 resolution, which states that *the teaching of medical ethics should be a compulsory subject and a vetted part of the medical curriculum of every medical school* (27). This has been done, which contrasts with the little development of teaching and care ethics. Surely any student in the final years of medical school can mention the fundamental principle of medical ethics: first do no harm. However,

many future physicians will also learn during their training process in medical units that this principle is nothing more than a statement. They themselves, while receiving formal courses with the do-no-harm message, were exposed, on the other hand, in what is the hidden curriculum (28), to performing clinical procedures under unfavorable and high-risk conditions for patients.

In order to overcome the nineteenth-century perspective of the role of patients in medical education, it is necessary to promote the development of guidelines and codes of teaching and health care ethics in the country and to encourage every medical unit with medical students to have a teaching and health care ethics committee to guarantee their application and compliance. The right to health of the population and the right to education of medical students in medical units require it.

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## **Bibliographic notes**

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