University of Leicester
School of Education
Educational Management Development Unit

PhD Thesis

MORAL DILEMMAS OF MEDICAL STUDENTS: A STUDY OF ETHICAL ASPECTS OF MEDICAL TRAINING

Submitted by: Edna Benshalom
Supervisor: Dr. Mark T. Lofthouse
October 2008
Abstract

This study examines the ethical reality of medical students, and ethical curricular aspects of medical school. The 'received curriculum' is analyzed using a combined interdisciplinary theoretical framework of 'Ethics' and 'Curriculum'. Defined in terms of students' experience of the curriculum, and the participants' perceived moral reality, the study was framed within a phenomenological-interpretive research paradigm. Content analysis of the 'narrative corpus' obtained by 38 open questionnaires addressed to sixth-year medical students, and by 21 interviews with medical students and senior faculty members, was conducted. Based on students' interviews, holistic 'ethical profiles' were produced and proved to be significantly informative.

The study showed that during their clinical training years, medical students cope with daily contextual moral dilemmas that relate to their culture and status and involve subtle, elaborately-calculated decisions. The students' authentic, reflective and analytical accounts of their ethical dilemmas, lead to the novel concept of students' 'moral awareness'. This increasing awareness of ethical dilemmas' complexity sheds light on an adult ethical-cognitive stage, characterized by pragmatic thinking focused on context, and by internalization of relativism and contradictions. The study further demonstrates the significance of students' experience for viewing and evaluating curriculum: the students, who perceived their ethics' 'received curriculum' in its totality, consequently offered important insights concerning ethical learning processes, thus enriching the 'traditional' medical school curricular thought.
Another new finding is the common understanding, exhibited independently by both students and faculty members, concerning 'modelling' and 'hidden curriculum' issues. Additionally, the study points out their mutual expectation for a more relevant ethical education in medical school, particularly the call for 'ward ethics' education, conducted by ethically-trained physicians.

Phenomenologically, the study elucidates a close relationship between the type of dilemmas students cope with, their ways of coping with the dilemmas and the type of 'ethics education' students and faculty members seek to promote.
# Table of Contents

**Chapter One – Introduction**

I. Background to the study

"A tale of two duties": medical education between "science" and "caring"

The Israeli Context:

   Medical care and medical education in Israel
   The Ben-Gurion University Medical School

II. Rationale of the study

Study's objectives

Conceptual framework

   Methodological considerations
   Research questions

**Chapter Two – Literature Review**

A: Curriculum Perspective


   Historic review: Setting the stage

      The 'Traditionalists'
      The 'Reconceptualists'

   Concepts of contemporary curriculum thought

      The total curriculum
      The view of curriculum as student experience based

2. Curriculum Trends: Medical School's View

Background - a century of conservatism and a decade of reforms
Chapter Three - Methodology

I. Introduction 67

II. Locating the Study 69

Theoretical context: conceptual and empirical framework 69

Methodological mapping 70

Qualitative-naturalistic research paradigm 71

Phenomenological tradition 71

Interpretive methodological approach 73

Narrative texts 74

III. Research Strategy 75

Open questionnaires as a research strategy 75

Interviews as a research strategy 76

Research course 77

IV. Data Collection Methods 79

Open Questionnaires 79

Sampling and administrating 79

Instrument development 79

Students Interviews 81

Sampling and administrating 81

Instrument development 81

Faculty Members Interviews 85

Sampling and administrating 85

Instrument development 85

V. Analysis 87

The double-approach choice 87

Cross-cases approach – content analysis 88

Within-case approach – holistic multiple readings 89

Analysis of data obtained by other research tools 91

VI. Validity of the Study 93
VII. Ethics

Chapter Four – Findings

Introduction
The structure of the 'Finding' chapter
Conceptual comments
Technical comments

Students' moral dilemmas
I. Construction of the body of dilemmas
II. Nature of the dilemmas
III. Typologies of the dilemmas
Typologies of the dilemmas as presented by the students
Typology of the dilemmas: the "responsibility continuum"
  "Reflection dilemmas"
  "Witnessing – optional reaction dilemmas"
  "Action dilemmas"

Coping mechanisms
I. Direct responses
II. Indirect responses
III. Alternative performance
  (a) Information to patients
  (b) 'Corrective behaviour'
IV. Resistance and protest
  (a) Refusal to perform
  (b) Complaints or formal protests
V. Consulting with others
'Silence'
I. Reasons related to students' status 130
II. Reasons related to medical school system and structure 133
III. Reasoning related to values and attitudes 135

Cynicism vs. Sensitivity 137
I. Students' attitudes during training 137
II. Implications for the future 143

Ethical learning processes – how do medical students perceive the acquisition of 'ethics education' 146
I. 'Modelling' as an ethical learning/teaching mean 146
   Negative models 146
   Positive models 148
II. Ways of ethical learning/teaching in medical school 150

A six years process: What was done in medical school on the subject of ethics 156
I. The medical school's emphasis on ethics 156
II. Chronological aspect 158
III. Students' perception of ethics courses 159
IV. Students' perception of the 'emotional processing' course 161
   Students' insights about the course – personal level 162
   Students' insights about the course – program level 163

Expectations for ethical training 166
Section I: Recommendations and suggestions 166
   Ethics in the ward 170
   Summarized quantitative data 171
Section II: Students' perception of themselves as seniors 172
Ethical reality of medical students – faculty members' interpretation

1. What are the moral dilemmas medical students cope with? 177
   I. Reflection dilemmas 177
   II. Witnessing: optional reaction dilemmas 178
   III. Action dilemmas 178

2. How do faculty members interpret the ethical processes of medical students? 181

Ethical curricular training processes – faculty members' interpretation 186

Faculty members view of ethical education 186
Desired vs. actual ethical training 190

Possible ways to overcome difficulties in providing the desired ethical training 195
   (a) Improvements of the existing ethical education 195
   (b) Changes of the existing ethical education 197

Chapter Five – Discussion 202

Preliminary Comments 202

The perceived moral dilemmas in medical students' reality 205
(I) Validation attributes of the findings 205
(II) Conceptual attributes of the offered typology 207
(III) The 'practicing' issue – an ethical challenge 208
(a) The perspective of practicing in "students' culture" 208
(b) "Laymen vs. professionals" aspect 213
Coping with moral dilemmas 216
Analysis and implications 216
Conceptual interpretive frameworks 220
(a) Students' status in medical school 220
(b) Morality in context 226

Learning processes of medical students, in regard to their ethical experience 234
'Modelling' – a resource of ethical learning process 235
Internal processes of ethics learning 238

The perceived ethical curricular processes in medical school 247
The 'total curriculum' 248
Mapping and assessing ethics curriculum 249
One course assessment 251
The effect of retrospective evaluation 253

Students' and faculty members expectations concerning 'ethics education' 256
Curricular/pedagogical level 256
Organizational-structural level 258

Chapter Six – Conclusions 263
I. Moral dilemmas of medical students: 264
II. Issues of morality 266
III. Issues of ethics curriculum/education in medical school 269
The study's contribution

From a theoretical perspective 273
From a methodological perspective 274

Recommendations for future research 275
Final comment – Epilogue 276

References 278

Appendices

Appendix no. 1 – Questionnaire i
Appendix no. 2 – Samples of Students' Questionnaires iii
Appendix no. 3 – Students Interview Schedule vi
Appendix no. 4 – Faculty Members Interview Schedule vii
Appendix no. 5 – Charts and Tables ix
Chapter One

Introduction

The purpose of this study is to examine the moral dilemmas of medical students – their ethical reality, experience and learning, and ethical curricular aspects of medical training.

The introduction presents two sections: I. Background to the study concerning relevant issues of medical education in general, and the Israeli context – Ben-Gurion University Medical School – in particular; II. Rationale of the study, that includes conceptual framework, study's objectives and methodological considerations.

I. Background to the study

"A tale of two duties": medical education between "science" and "caring"

Much has been written about the training of physicians, a universal issue going back to antiquity. A specific issue relevant to the present study is the ongoing conflict of modern medical education between two duties, a conflict that is at the base of many issues related to the study, such as scientific/academic vs. humanistic training (Lowery, 1993; Jolly and Rees, 1998).

The beginning of modern medical education is identified with the Flexner report (Flexner, 1910), that recommended the establishment of a university affiliated scientific framework for medical education. Although the report's main objectives of making medicine a scientific profession were accomplished, in retrospect, it can be seen as only the initial stage in a century of successive reports and proposals for reform. The realm of medical education has been characterized by a continuous paradoxical process of 'conservatism' (Bloom, 1988; Tosteson, 1990), together with a steady stream of commissions and reports of suggested reforms and change (Coles, 1993; Christakis, 1995). The main source of
tension seems to exist between two basic elements in the training of a physician: the scientific element of the profession with an ever-growing body of knowledge that needs to be acquired, and the humanistic element of the profession with the intention to train physicians that know how to take care of patients. Every proposal for a change inherently includes its contradiction. For example, the addition of humanities topics to medical education, as a response to one reform proposal, has increased the overload of the curricula from which nothing has been deleted, thus contradicting another recommendation (to lower the "overload" of courses) of the same reform (Regan-Smith, 1998).

Recommendations for improving the educational experience of medical students that began with Flexner, has continued to the present. Since the middle of the 20th century, at least 24 major reports advocating reforms in the US have been published (Christakis, 1995), as well as some major committees' recommendations in the UK, such as GMC's "Tomorrow's Doctor" (General Medical Council, 1993).

Throughout the numerous commissions and reports, several issues recur repeatedly. In 1910, the Flexner report in addition to making the basic scientific recommendations, recommended that (1) the basic science and clinical training be integrated throughout the four years; (2) active learning be encouraged; (3) the use of lectures and learning by memorization be limited; (4) students learn problem solving and critical thinking, not only facts; and (5) teaching emphasize that learning for the physician is a life-long endeavor. Coles (1993), reviewing reports from the UK, found that "there is a remarkable similarity between these reports" (p.58), while the two recurrent issues are that passive learning should be replaced by active, self-directed learning, and that the solution to medical education's problems resides less in syllabi but more in the teaching method employed. Christakis (1995), found the American reports to repeatedly encourage (1) better serving the public interest; (2) addressing physicians' workforce needs; (3) coping with the growing medical knowledge; and (4) increasing the emphasis on general practice. He also emphasized the remarkable similarity in the reports he reviewed:
"The reports have articulated a remarkably similar purpose of medicine, identified remarkably similar objectives of reform, and proposed remarkably similar reforms" (Christakis 1995, p.709).

Thus for decades, similar proposals have appeared concerning modes of learning/teaching, content of education and the nature of the profession. The variance lies in interpretations and articulations. For example: the most common proposals regarding the content taught at medical schools are to increase "generalism" (Christakis 1995, p.709). This is sometimes interpreted as ambulatory care clinical exposure, and sometimes as broader social science curriculum. The proposal to increase the amount of social science training in the curriculum is a prominent manifestation of the reports' articulated commitment to the notion of medicine as a "social good" (Christakis 1995, p.709), although what is considered to be social science has varied considerably over the years.

What accounts for this similarity, for the striking phenomenon that certain reforms are repeatedly suggested? There are at least three possible explanations:

1. It can be claimed that reforms are periodically and ritualistically articulated but with no intention to be performed. Sociologist Samuel Bloom (1988) argues that the history of "reform without change" in medical education is accounted by the fact that "Medical education's manifested humanistic mission is little more than a screen for the research mission, which is the major concern of the institution social structure" (Bloom 1988, p.294).

Bloom (1988) points out that the social structure of medical schools (i.e., decentralized power whose authority and status are determined by research productivity and grant funding) promotes research more than it promotes the education of the future physicians, which should be the primary mission of a medical school.

2. It can be claimed that problems with medical education are inherently irremediable. There are certain structural problems in medical education that are invariant (Christakis,
1995). For example, each report has to confront the problem of "explosion of information", and the fact that there will always be too much to know. However, several reports acknowledge that significant change in medical education has recently occurred and point out that in the past decade, new approaches such as Problem-Based Learning (PBL), community-based clinical teaching, and an emphasis on primary care have been incorporated into most medical schools' curricula (Jolly, 1998b). In addition, humanistic content as medical ethics and communication skills are included now in most medical school curricula (Regan-Smith, 1998).

(3) It can be claimed that the motivation for these reports is beyond their actual accomplishment, and lies in their symbolic, declared level of values and intentions:

"Both the similarity of the reports and their repeated promulgation may be seen to arise from the fact that the reports have two important functions other than their explicit one of reforming medical education: the affirmation of certain core professional values, and the self-regulation of the profession. The reports are all based on a consistently social vision of medicine and the medical profession. When the gap between what medical schools are supposed to provide their communities and what they actually provide is seen as having widened inordinately, an impetus to change emerges from within the profession. By espousing the realignment of societal needs with medical school objectives, the reports preserve the role of medicine within society. And since the health care needs of a society change with the passage of time, the impetus to promulgate reform proposals is ever present" (Christakis 1995, p.711).

The analysis presented above brings forward the conflicts that typify medical education in the 21st century. Medical educators continue to advocate and implement reforms in a struggle to articulate the role of medical education in society. This inherent conflict and challenge of medical education lies in the background of the present study that deals with ethical aspects of medical training. The Dean of Ben-Gurion University Medical School,
where this study has been carried out, describes in her own words the new, modern, relevant aspects of the old controversy:

"Medical education has always been a subject for both research and debate. Yet now more than ever, the challenge of preparing physicians in a dramatically changing world is enormous. The post-genomic era with its explosion of new information and amazing technology, demands a great deal of vision and innovation in order to equip our students with the appropriate faculties they would need as health care providers of the near future...However, unlike high-tech and bio-tech professions, medicine is still all about people. And the challenge of producing a well rounded, humanistic physician who really cares about people, their families, their community, who views them as a whole rather than a diagnosis and a medical treatment, is still the biggest challenge. It may indeed be bigger now than ever" (Ben-Gurion University of the Negev 2000, p.6).

The Israeli Context:

Medical care and medical education in Israel
The existence in Israel of a comprehensive national health insurance system (NHS) which provides full medical care to the population, serves as a general background to medical education. Both students and teachers are aware that fee-for-service is essentially a marginal pattern and most segments of the population expect and are entitled to full medical care, including medication and other expansive services, with minimal or no direct cost. Such a structure sets up systems of mutual expectations of deliverers and recipients of medical care, which differ from those prevalent in systems in which there is no medical insurance or incomplete coverage. Virtually all physicians in Israel work in salaried posts. Private practice exists and is growing, but it is still supplementary to the dominant system of medical care delivery in which there are organized settings of ambulatory or hospital care.
In structure and timing, medical education in Israel parallels the system of Western Europe which generally starts immediately following secondary school and lasts six to seven years. The main difference is that in Israel most students enter medical school not directly after secondary school, but after 2-4 years of compulsory army service. The academic type of secondary school in which most medical students have previously studied prepares them for the nationally administered matriculation examinations. About 40% of the age cohorts complete these examinations annually. Only those with a very high average in matriculations, and with a very high score in a psychometric-aptitude test may apply to medical school. Thus there is a highly competitive selection process even before an individual applies for medical school.

The Ben-Gurion University Medical School
The Ben-Gurion University Medical School (BGUMS), is located in Beer-Sheva, the capital city of the "Negev", the southern region of Israel. Israel has four faculties of medicine, of which that of Ben-Gurion University, established in 1974, is the youngest. From the way a former Dean of the school portrays its establishment it is clear that since the very beginning the school has been identified with a strong vision of the responsibility of the medical school to the community:

"In the early 1970's, two medical leaders joined forces in creating a new, fourth medical school which would redirect Israeli medicine. They realized that this goal could not be achieved in the existing medical schools due to the ingrained conservatism and behaviour patterns and, therefore, resolved to create new institution. The Negev region represented one of the last frontiers of Israel, and its university was not a conventional "ivory tower" institution, but one with a specific mission to interact with the Negev. It was only fitting that the new pioneering medical school be placed on the frontier in a people-oriented university" (Ben-Gurion University of the Negev 2000, p.10).
Accordingly, some of the original institutional objectives were:

1. To train physicians with awareness not only of their patients' medical problems but also of their psychological and social problems – in other words – the bio-psychosocial model of patient care.
2. To train physicians with a humane approach to patients.
3. To break down the barriers between the hospital and the community.
4. To train students who would see their role also as agents of change with respect to health care.
5. To blend the academic world with that of the community, in order to provide constructive interaction between the two.
6. To train physicians who would regard a career in primary care as respectable and desirable.

The BGUMS continues to hold to these objectives (Glick, 2005a), and is widely recognized as an innovative school with a special community orientation. However, there is a challenge in trying to combine the highest academic scientific standards with the training of humanistic physicians:

"Along with teaching and curricular innovations, we constantly aim to produce the professionally excellent, yet humanistic physician. From the unique selection process, through patient and community-based curriculum, to innovative non-cognitive learning experience, our students are repeatedly exposed to and internalize those values that machines and computers cannot provide" (Ben-Gurion University of the Negev 2000, p.6).

According to the school's self-accounts, a number of elements make the "Beer-Sheva experiment" unique: the process of student selection; the curriculum; student-faculty relations; early clinical exposure; and the administration of the physician's oath to the first year students.
1. Students' selection: As reported in the medical education literature (Antonovsky, 1987; Glick, 2005b), personal observation as well as experience clearly indicate that student's selection represents a vital step in the final physician product.

"The personality of most individuals is already formed when they enter medical school. Clearly inadequate were the existing Israeli selection procedures [in other medical schools, E.B.] which relied almost completely on matriculation examination grades and a psychometric examination, disregarding personal qualities. The school therefore decided to put a great emphasis on a semi-structure interview process whose goals are the identification of candidates with an interest in people, a high level of motivation and a record of past performance in helping others" (Ben-Gurion University of the Negev 2000, p.11).

Hence, interviewers of student candidates have been directed to look for nine major characteristics: personal integrity, empathy, tolerance of ambiguity, decisiveness, insight, intellectual level, community orientation, and a sense of social responsibility.

2. Curriculum: The curriculum itself places strong emphasis not only on basic sciences, but on behavioural sciences as well. The school emphasizes that there is no contradiction between humanism and excellence in science. The curriculum is a "spiral" curriculum. The four components of this spiral are: Basic Sciences, Behavioural Sciences, Clinical Medicine, and Public Health. They all form one vertical integrated system that are present at the outset and continue together throughout the three years of preclinical and three years of clinical studies in increased complexity. The curriculum is also integrated horizontally. Same year courses are designed to address the same clinical topics in an interdisciplinary approach and all revolve around exposure to patients, which begins on the first day of medical school.
3. Students' relations with faculty and participation in program: An additional difference between BGUMS and other institutions in Israel is the relationship between students and faculty. Major effort is expended in involving the student as a partner in both the learning process, and the planning and operation of the school:

"Overall, the atmosphere in BGUMS is non-competitive. Students have close relationships with faculty. Class size is small and learning is carried out in a relatively informal way. Faculty interact with each other in the multi-committee structure and the boundaries of the discipline are less emphasized. A common concern of all faculty is how to impart humanistic attitudes and values to students throughout the six years curriculum" (Friedman 1987, p.41).

Student representatives participate in the "faculty committee", "selection committee", the "yearly educational committees", and courses' debriefing sessions. Each course is followed by a "debriefing" in which students actively participate in a detailed analysis of the successes and failures of the course and in suggestions for change.

4. Early clinical exposure: One of the most prominent hallmarks of the school is the early clinical exposure, initiated from the first weeks of studies and continuing throughout the pre-clinical years in various forms. It is believed that early exposure imprints human and empathic attitude toward patients and paves the way for effective and personal interviewing techniques. When students are exposed to patients in their first year, they have almost no knowledge of disease processes or pathology and relate to the patient only in human terms, as one person to another. The student focuses on the impact of the illness on the patient and family and is then less preoccupied with the medical findings (Hermoni, 2005). The "clinical days" take place in a variety of settings, from primary care clinics to maternal and child health stations as well as the hospital, and this further de-emphasizes the hospital as the only health care setting. An integral part of the early clinical exposure is the pre-school summer course, where students visit various Negev communities to become acquainted with the society in which the medical school functions and learn from the community members their perception of the health care system in the region.
5. Physician's oath: A final unique feature is the administration of the physician's oath to the first year students, which occurs during the first weeks of studies, simultaneously with the awarding of diplomas to the graduating class. This process is intended to emphasize to the entering students that their role in serving humanity begins from their first day in medical school, rather than only after they graduate.

From the review of the "Beer-Sheva experiment" it is clear that BGUMS, like other medical schools all over the world, copes with the basic conflict of medical education, the challenge of maintaining a high standard of science and research as well as humanistic training of physicians. It is a school that competes with other medical schools over scientific and research prestige and selects students from among a highly qualified privileged population. Indeed, all kinds of reformatory and innovative changes the literature relates to (Jolly and Rees, 1998) – early clinical exposure, relations with the community in general and with community care-sites in particular, emphasis on primary-care training, declared ethics education objective – have existed in BGUMS for more than 30 years. Hence, the school definitely views itself as innovative and reformatory:

"Over the years, the medical school has become a world-leader of innovative concepts in medical education. The basic curriculum continues to emphasize strong scientific and technical skills combined with humanism, yet is constantly being analyzed and revised according to changing population needs and trends in science and medicine. The Faculty's model has been adopted at many other medical schools, both nationally and worldwide" (Ben-Gurion University of the Negev 2000, p.13).
II. Rationale of the study

Study's objectives

It is within this context of a medical school that is explicitly committed to educating humanistic physicians that this study examines the moral dilemmas of medical students – their ethical reality, experience and learning – during six years of training. The objectives of the study are twofold. The first is to identify and analyze the ethical reality of medical students including their conflicts and coping mechanisms, their moral development and attitude change and the implications and influence of their daily ethical experience. The second is to explore ethical curricular aspects of medical school such as learning processes, students' experience of the curriculum, expectations and suggestions for ethics teaching in medical school. The study of ethical coping processes of young people relates to the realm of ethics studies, and the study of ethics curricular processes in medical education relates to the realm of curricular studies. The concept of 'received curriculum' (Jackson, 1992) best reflects the combined perspectives, as it represents both the curriculum as a significant educational theoretical and practical concept, and the individuals that 'receive' the curriculum, the students that experience the training process.

Conceptual framework

In combining these two bodies of knowledge, "ethics" and "curriculum", the present study adopts conceptual frameworks from within each. This linkage effectively creates a unique relevant framework for studying the ethical reality in medical school through concepts originating from both educational curricular and moral development fields.

The study of ethics encompasses a wide variety of disciplines ranging from theories of philosophy to empirical behavioural sciences and ethical practical codes. The present study adopts two notions from the ethics conceptual-empirical field that basically relate to the way people construct their ethical identity (Blasi, 1993, 1995): (I) 'Morality in context' (Gilligan, 1982, 1986; Rest, 1986; Nisan, 1993, 1995; Libbieh et al., 1998), which
addresses the issues of individual decision-making and coping with contextual moral dilemmas in a person's life; and (II) 'Adult ethical-cognitive stage' (Perry, 1970, 1990; Kohlberg, 1981; Alexander et al., 1990), which addresses the developmental issues of ethical reasoning and conduct in adulthood.

The seminal article by Christakis and Feudtner (1993), that initiated the incipient research into medical students' moral dilemmas, highlights the relevance of the conceptual framework adopted by the present study:

"We contend that ethics presented as a moral theory or a set of principles can go only so far: personal problems, culled from the daily events of students' lives and rooted in the complex social situation in the ward, more thoroughly capture their consciences. It is in making decisions and living with their consequences that ethics ceases to be only a theoretical discipline and begins to become personal professional code of conduct" (Christakis and Feudtner 1993, p.254).

The study of curriculum can be interpreted narrowly or in a wider context. The present study adopts two notions from the curriculum field that basically relate to the way people experience their learning environment: (I) 'Total curriculum' (Schremer, 1996; Ariav, 1997; Marsh, 1997; Kelly, 1999), relates to the curriculum as the entire range of experiences that students encounter in a school or a program, including both declared and hidden elements. The notion of 'total curriculum', which views curriculum as a broad flexible interactive concept, emphasizes the heterogeneity and relativism of educational reality (Schremer, 1996), and acknowledges the importance of many stakeholders that take part in curricular processes (Lofthouse et al., 1995). (II) 'Curriculum evaluation as students' experience' (Mann, 1968; Willis, 1991; Eisner, 1992; Preedy, 2001) views the 'received curriculum' (Jackson, 1992), or what actually "ends up in the minds of students" (Lofthouse et al. 1995, p.11), as a valuable source of interpretation and evaluation of curricular aspects.

The relevance of the above concepts to the present study is apparent from a review of several British reports concerning medical education:
"A third recurrent issue in the British reports is that the focus of educationalists should be on learning rather than on teaching. Learning is not so much the matter of what the learners have been taught, but more concerned with the sense they have made of it" (Coles 1993, p.58).

The following chart summarizes the relations between the theoretical combined frameworks and the study's objectives:

Chart no. 1:
The conceptual framework of the present study
Methodological considerations

This study's concern is the medical students' ethical reality, focusing on the students' experience in medical school and their interpretation of this reality. Defining the study in terms of students' experience of the curriculum, and in terms of the perceived moral reality from the point of view of its actors, frames it within a methodological paradigm of qualitative-phenomenological-interpretive research.

The study makes use of two complementary methodological tools: open questionnaires addressed to a cohort of six-year medical students, and semi-structured interviews with 14 six-year medical students and seven faculty members who have taught them in medical school. The main purpose of the open questionnaires is to elicit the moral dilemmas students cope with and their patterns of consultations, whilst the main focus of the students' interviews is to elicit narratives about their coping mechanisms, conflicts, learning processes and ethical-curricular-personal insights and expectations. The interviews with faculty members focus primarily on their viewpoint concerning the ethical reality of their students, their own role as medical educators, and their view of ethical curricular aspects in medical school.

Validation and triangulation considerations lead this study to the adoption of three-tiered approach:

(a) 'Methodological triangulation' – the use of multiple methods to study a single problem or program. This study relied on open questionnaires and semi-structured interviews.

(b) 'Data triangulation' ('population triangulation') – the use of a variety of data sources in the study. Both medical students and faculty members of the medical school, that have a role in their training were interviewed.

(c) 'Theory triangulation' – the use of multiple perspectives to interpret a single set of data. In this study, the students' interviews are analyzed through two different research perspectives: holistic (within-case) perspective and content analysis (cross-cases) perspective, approaches representing two separate conceptual-theoretical frameworks.
Research questions

The key research questions of the present study are:

1. What are the perceived moral dilemmas and ethical conflicts in the medical students' reality?

2. How do medical students cope with their ethical reality? What strategies do students use for coping with ethical encounters?

3. How do medical students acquire and construct their ethical perceptions in the course of their medical training?

4. What are the perceived ethical-curricular processes in medical school?

5. What are the expectations of medical students and faculty members from the school curriculum and from themselves concerning ethical aspects of medical training?

The findings of the research are analyzed and discussed in an attempt to provide a broad picture of the ethical reality and ethical learning of medical students in medical school. Conclusions are presented regarding students' ethical world and ethical curricular aspects of medical education, as well as the research methodology and contribution.
Chapter Two

Literature Review

The present study examines various ethical aspects of medical students’ training. The review concentrates in two major fields of study (two perspectives):

A. The first perspective relates to the training-educational aspect, and thus is concerned with the study of curriculum. The curriculum domain encompasses a wide and diverse educational field; this review limits itself to several selective aspects of curriculum studies that are relevant for the present research, reviewing general conceptual aspects, and specific medical education aspects.

B. The second perspective relates to ethics, to morality in context –the way that students cope with ethical issues during their training in medical school, and the moral dilemmas and ethical reality they face.

The combination of the 'curriculum' and 'ethics' perspectives is relevant to a study that examines the 'received curriculum' of ethics – the ethical learning that has been acquired by medical students during their training process and as a product of the training reality and the program they experience. In the concept of 'received curriculum' (Jackson, 1992), the two bodies of knowledge of this research are embedded: on one hand, the curriculum as a significant educational concept and theory, and on the other hand, the individuals that 'receive' this curriculum, the students themselves, who personally experience the training process.

The review consists of two main parts. The first one – the curriculum perspective – serves as a conceptual framework for the research and is theoretical and conceptual in nature. The second one – the ethics perspective – that relates to the specific and actual objectives of the present research, reviews mainly models and empirical studies, and is contextual and situational in nature.
A: Curriculum Perspective: A Holistic Framework of an Educational-Training Program

Curriculum study is perceived in the present literature review as a critical analytical exploration of the curriculum as a totality. The present study is aimed at examining the ethical reality of a medical training program. In this review it has been chosen to adopt the perception of curriculum as the holistic experience offered by an educational/training program: the combination of multi-dimensional, multi-faceted curriculum – the 'manifest', the 'hidden', the 'taught', the 'learned', the 'formal', the 'non-formal', the 'enacted' and the 'experienced'. The conglomerate of curriculum aspects is the 'total curriculum', which is the actual, elusive 'received curriculum'.

The following sections in this chapter reflect the conceptual framework that has been chosen to represent the current theoretical trend of the curriculum field. In section 1, several key concepts in contemporary curriculum thought are reviewed. In section 2, several curricular aspects of medical education, relevant to the present study, are reviewed. Section 3 focuses on the concept of 'hidden curriculum' which is relevant to the curriculum perception that the present study adopts: the 'hidden curriculum' has been closely affiliated to topics concerning the learning and teaching of ethics, attitudes, values and norms (Jackson, 1992).

This review presents a broad approach to curriculum that characterizes current trends in the curriculum domain. Schremer (1996) has summarized some of the prominent developments in the field of curriculum: abandoning the search for one rational all-embracing theory, emphasis on heterogeneity and relativism of educational reality, acknowledgment that many stakeholders take part in educational process and a transition to phenomenological, interpretive forms of inquiry. The following section presents a brief historic review of this line of development, as well as two key concepts the present study adopts from curriculum studies – 'total curriculum' and the evaluation of the curriculum as students experience it.

Historic review: Setting the stage

A review of curriculum literature, (e.g., Marsh, 1997; Flinders and Thornton, 1997; Beyer and Apple, 1988) reveals two major forms of writing: (1) a narrowly focused writing concerned mostly with installation or evaluation of specific curriculum topics; (2) a more broadly focused form of writing, that is a late 20th century tendency, concerned with widespread investigations into curriculum philosophy and ideology. The recent trends in the curriculum domain, that has been “a field in foment” (Lincoln, 1992 p. 79), are the focus of this chapter, and the historic background serves merely to “set a stage for the discussion of newer and emergent traditions” (ibid, p. 79).

The 'Traditionalists'
The model that has become, in essence, the paradigm of curriculum field has been articulated by Tyler (1949). Although its declared purpose was synthesizing nearly all the previous developments, it was largely a behaviourally oriented, procedural model (Flinders and Thornton, 1997), known as the 'means-ends approach' (Kelly, 1999), or the 'technical production perspective' (Posner, 1988). The Tyler model has provided a view of rationality in curriculum studies. Critics of Tyler and his followers (as reviewed by Marsh, 1997) have claimed that the educational process is complex, dynamic and unpredictable and should not be reduced to a one-dimensional, pre-defined articulation of objectives. The call of Schwab
(1978) to see educational practice as an integrated part of theory, has enabled new research directions whose starting point is reality and not theory (Shonmann, 1995). The processes that produced this criticism have been characterized by Pinar (1975) as "reconceptualists".

The 'Reconceptualists'

The 'reconceptualization' movement that represents the paradigm shift in curriculum study, is an umbrella term referring to a diverse group whose common bond has been a set of assumptions that view curriculum and curriculum theory in a larger social, historical and cultural perspective (Pinar, 1992). As reviewed by Marsh (1997), some of the main principles used by 'reconceptualists' in their theorizing endeavors could be defined as:

1. The centrality of the individual – "the individual is the chief agent in the construction of knowledge; he/she is a culture creator as well as culture bearer" (ibid p.271).
2. Experience as the basis for meaning.
3. Different discourses and methodologies – "new language forms are needed to bring out new meanings and insights about curriculum" (ibid p.271).

The 'reconceptualists' most important contributions to curricular thought have been the demonstration that curriculum is not a neutral or value-free entity (e.g., Apple, 1986), that knowledge cannot be separated from human interest (e.g., Lincoln, 1992) and that there is an important need to expose bias and power relations hidden in the curriculum and in broader conceptions of schooling (e.g., Jackson 1968; 1992).

This criticism shares a common belief, that most curricular theories have been too narrow and have failed to adequately grasp aspects of curricular process that have profound meaning for educational outcomes and for individuals – teachers and students alike – who experience the process (Marsh, 1997). Jackson (1992) has traced a definitions shift over the decades going from "fixed course of study" terminology to broader terms such as "learning opportunities" and "experiences which a learner encounters". Thus, it might be argued that these shifts in definition over the decades represent "conceptual progress".
(Tanner and Tanner, 1980; Marsh, 1997). Some concepts related to this progress are analyzed in the next section.

Concepts of contemporary curriculum thought

Contemporary curriculum theory has put an increasing emphasis upon both individualization of teaching and learning as informed by rigorous phenomenological and autobiographical/biographical research, and upon the lived experience of students (Ariav, 1997). As the present study deals with students' ethical reality and experience within a training-educational program, it adopts two notions from the curriculum field that basically relate to the way people experience their learning environment: (1) 'total curriculum' that relates to the curriculum in a wide context (Schremer, 1996; Ariav, 1997; Marsh, 1997; Kelly, 1999), and (2) 'curriculum as students' experience' that views students experience as a valuable source for curriculum interpretation, understanding and planning (Mann, 1968; Willis, 1991; Eisner, 1992; Preedy, 2001). Those notions are now examined.

The total curriculum

Two dimensions characterize contemporary curricular perceptions – the inclusiveness of multiple aspects of education in the term curriculum, and the contextual view of curriculum. Three orientations can be traced, that differ in the scope of totality and the contextual component. The three orientations are articulated from the least broad one to the broadest:

(a) Curriculum is everything: The most widespread and common perception of totality (Kelly, 1999) is two fold: it relates to the curriculum as the entire range of experiences that students encounter, and refers to the curriculum as the whole program of an educational institution. Kelly (1999) has suggested that any definition of the curriculum should include at least four major dimensions: the intentions of the planners, the implementation procedures, the actual experiences of the students, and the “hidden learning that occurs as by-product of the organization of the curriculum, and indeed, of the school” (ibid, p. 7). This inclusive perception of the curriculum is concisely defined
by Marsh (1997): "curriculum is an interrelated set of plans and experiences which students complete under the guidance of a school" (p.5). These broad perceptions of the curriculum, identify the types of issues which the study of curriculum currently addresses.

(b) Everything is the curriculum: a less common perception (Jackson, 1992) that views curriculum everywhere, not restricted to school and schooling. This even broader view has claimed that every institution, organization, or group has a curriculum. Curriculum is interpreted metaphorically as separated from school life, and is altered to a term that means 'human influence'. Cremin (1976), for example, writing about the educative function of the home and other institutions outside the school, has declared that "Every family has a curriculum, which it teaches quite deliberately and systematically over time. Every church, synagogue and employer has a curriculum" (ibid, p.22).

(c) Curriculum is a life story: an interpretive perception (Connelly and Clandinin, 1987) that relates to contextual-rich course of life narratives as the curriculum. Clandinin and Connely (1992) have cited the Oxford English Dictionary (OED) that defines "curriculum" as: "a regular course of study or training" and as "curriculum vitae, the course of one's life, a brief account of one's career", and have given precedence to the second meaning of the OED definition:

"Teachers and students live out a curriculum; teachers do not transmit, implement or teach a curriculum and objectives; nor are they or their students carried forward in their work and studies by a curriculum of textbooks and content, instructional methodologies and intentions. An account of teachers' and students' lives over time is the curriculum" (ibid, p.5)

Clandinin and Connelly (1992) have maintained that this narrative-contextual perception of curriculum should be reflected in the language used by educators. For decades the word curriculum has emphasized formal courses and programs of study, and was related to functional language and terms such as 'objectives', 'vertical and horizontal integration', 'sequence', 'units' and so on. Clandinin and Connelly (1992) have suggested softening this
technical means-ends language with personal and experiential terms, if curriculum should be more of "curriculum vitae".

All three perceptions share a basic belief that views curriculum as an open-ended system, as a broad, flexible interactive concept (Ariav, 1997). One aspect of this view has been the realization that all experience is necessarily situational and contextualized (Geertz, 1973), that there is no privileged position outside of experience from which to achieve a free and independent (i.e., non-contextualized) perspective. An additional aspect of this view has maintained that "the power of rhetoric is crucial in determining the superiority of one view over another" (Jackson 1992, p.11), thus implying that there is no definition of curriculum that will endure for all times and places. Another realization, that many stakeholders take an active part in influencing curricular processes (Lofthouse, 1995), has added yet another dimension to the contextually complex understanding of curriculum. Thus, it has been suggested by many (Schremer, 1996) to view the term 'curriculum' as a code term of the specific meaning it has in a certain circle and a certain context, and not as a permanent universal term.

The perception presented above, that views curriculum as a notion that embraces wide contextual experiences of students in an educational environment, is compatible with the present study objectives and conceptualizations.

The view of curriculum as student experience-based, and curriculum evaluation from student experience perspective

Originally arising from the thought of Dewey (1938), student experience has been recently advocated by many sources (e.g., Goodlad, 1984; Cuban, 1992; Eisner, 1995). Dewey (1938) has clarified the concept of 'learning experience' by setting forth the idea that experience involves the interaction of the individual (internal conditions) with the objective (external conditions). Similarly, the idea of curriculum as the students' experience, views experience as exposure to the external side – the environment (the overt activities which student undertake) and to the internal side (beliefs, attitudes, feelings, which student hold).
Apparently, student experience of the curriculum has not received much attention from educators, neither in conceptual work, nor in empirical research, for the following possible reasons (Erickson and Shultz, 1992; Kelly, 1999):

1. **Theoretical orientations**: Immediate student experience, especially in the sense of a combination of its socio-cultural, emotional, and cognitive aspects, has not been a central construct in teaching and learning orientations and assumptions.

2. **Technical difficulties**: When concerning student experience, students themselves are the ultimate insiders and experts. However, there are methodological problems of research of student experience that relate to the time and memory gap between the experience in school years and the accounts in adulthood. In any case, these obstacles are not so relevant to the present study of adult students’ experience.

3. **Systematic silencing of the student voice**: Students in schools are in a one-way position relative to adults, or to teachers. Schools are hierarchical organizations that by nature do not promote critical thinking (Posner, 1988; Dole, 1993). As Giroux (1988), among others, has observed education for critical reflection would require fundamental change in the ways curriculum, teaching, and learning are organized in schools.

The absence of the student voice is double in nature, both in the practice of school life – the curriculum, and in discussion-deliberation of it:

"The literature is rich in exploration of concepts of learning. The predominance of a discourse on learning rather than the learner reflects the relative powerlessness of learners in discussions about teaching and learning. School students are rarely involved in any meaningful way in making choices about the teaching and learning they will receive" (Lumby 2001, p.5).

In spite of that powerlessness, students’ views are very much in line with the new paradigms of learning, which assume a central part for learners and promote partnership
and dialogue. Theoretical foundations of learner-centered conception are: "developmental and humanistic ideas asserting that learners are active constructors of their own minds consciously ‘actualizing’ their own identities" (Silcock and Brundrett, 2001, p.41). Two bodies of theory compose the conceptual framework that underlines the view of curriculum as student experience: Constructivism and Humanistic ideology. Constructivism is a theory asserting that knowledge is not passively received but actively built up by the cognizing subject, who is acting upon a given experiential base (Von Glaserfeld, 1992); Humanistic writers, such as Rogers (1983), believe that giving learners responsibility for their own learning will lead to their ‘self-actualization’ – “that self-concept transformation which turns learners into fulfilled individuals” (Silcock and Brundrett 2001, p.41).

The reliance of curriculum perception as student experience on fundamental educational theoretical frameworks, such as Humanism and constructivism, seems promising. Schubert (1982), for example, has counted ‘experimentalism’ as a major mode of thought having profound implications for curriculum (interpreting it as ‘apprenticeship mass’). However, the concept of curriculum as experience, has never emerged as dominant in practice (Marsh, 1997) and “rarely does the curriculum signify possibility for the student as an existing person, mainly concerned with making sense of his own life-world” (Greene 1997, p.137). This gap is a challenge for many studies in this field, including the present study.

Curriculum evaluation is a complex process that relates to alternative interpretations of curriculum concept (Preedy, 2001). Thus, as curriculum can be conceived in various ways, it can be evaluated in consistency with any of these interpretations. When curriculum is conceived as a course of studies, it is evaluated in terms of how logically it is arranged. When curriculum is conceived as the activities which students undertake in schools, it is evaluated in terms of the utilitarian results of these activities. When curriculum is conceived as students’ experience, evaluation relates to the ability of the evaluator to apprehend the overall situation adequately and fully.

The first modern statement to argue that curriculum evaluation is, in fact, educational criticism dealing with the experiences of students was made by Mann (1968). Willis (1991)
has described the art of educational criticism as “qualitative evaluation”. Qualitative curriculum evaluation is consistent with, and partially developed (in its modern form), from such sources as phenomenology, hermeneutics and critical theory. It aims at: “expanding reflective human understanding of specific educational situations and promoting moral action within these situations and their social contexts” (Willis, 1991).

Another angle of curriculum evaluation has been advocated by Eisner (1992), asserting that understanding school experiences depends more on understanding the quality of the journey (the process of education) than its destination. The process evaluation approach has been followed since by many:

“Process evaluation focuses on the perspectives and interpretations of the participants on qualitative rather than quantitative data, taking a subjective phenomenological stance, rather than a ‘rational’, quasi-scientific one. It acknowledges multiple realities – the different groups and individual stakeholders construct different meanings of the curriculum in the light of their own contexts, values and perspectives” (Preedy 2001, p.94).

A significant implication of ‘process curriculum evaluation’ is the emphasis on students experience as a source of information. Preedy (2001) writes that this dimension has been much neglected and should receive more attention. Colleges, universities and further education units put a greater emphasis on student perspectives (Shackleton, 1989; Chikering, 1990; Loothhouse, 1995), due to the fact that young adults are regarded as partners for consultation and as autonomous individuals that can choose their educational/training sites. Preedy (2001) has suggested basic arguments for the promotion of students’ involvement in curriculum evaluation: (a) the right of individuals to ownership of their world; (b) benefits to the system – accurate feedback supplied by responsible informants; and (c) benefits to the students – promotion of motivation and development of reflective skills. A strong argument has also been made for curriculum evaluation to be: (1) informal, case-particular, holistic and responsive (Hardie, 2001); (2) descriptive and illuminative rather than prescriptive and directive (Kelly, 1999).
Three elements of curriculum evaluation that are relevant to the present study are embedded in the current trends that have been presented: the centrality of process evaluation, the focus on the participants of the educational situation, and the qualitative approach of inquiry.

One of the main themes of the following section, that reviews selective issues of curriculum in medical school, is concerned with clinical training, a field that is based on students' experience (apprenticeship model) as a basic curricular source.
2. Curriculum Trends: Medical School's View

For a long period of time, from about 1920-1960, medical curriculum study and practice have been characterized by a stable and isolated existence, free from outside interference, including educational theories' influences (Jolly, 1998a): "Medicine had become one of the most active professions with the most passive of pedagogies" (p.22). However, changes in the social and economic climate and attention to patients' rights, as well as developing concepts of adult and professional education now penetrating medical schools, have changed this isolation and resulted in a growing field of medical education curriculum study. Reviewing the medical training curriculum is beyond the scope of the present study. However, specific aspects of affiliation between general curriculum issues and medical education are reviewed in this section. Aspects of 'ethics education' in medical school are discussed shortly in section 3 (The 'Hidden Curriculum'), and broadly in section 6 (Aspects of Medical Students' Ethics).

Background – a century of conservatism and a decade of reforms

The most notable curricular trends that have played a role in medical education in the 20th century are associated with two reports from its first and last decades. The first one is the review by Flexner (1910) in the USA, that had effectively determined the course of medical education as academic and scientific in nature, while the second one is the publication, in the UK of the document Tomorrow's doctors by the GMC (General Medical Council, 1993), representing contemporary processes of curriculum change.

The Flexner report (1910) resulted in a comprehensive increase in the emphasis on scientific, single discipline oriented, predominantly laboratory-based studies in the medical curriculum (Tosteson, 1990). However, the objective of making medicine a scientific profession and its educational implications have attracted waves of criticism since the late 50th (Merton et al., 1957; Becker et al., 1961) until the present (Bloom, 1988; Coles, 1993; Lowry, 1993; Regan-Smith, 1998):
"Some of the educational consequences of the 'overstuffed' and often poorly taught Flexnerian curriculum where non-thinking is the rule, are well known and include overloaded and overwhelmed students who learn by rote memorization, who are brutalized and desensitized by clinical training, and who as housestaff practice inhuman medicine" (Regan-Smith 1998, p. 506).

Despite the failure of most earlier attempts at fundamental curriculum re-orientation (Bloom, 1988), only the 1980s and, especially, the 1990s have proved to be a time of reappraisal in medical education, with calls for reforms throughout the world (Towle, 1998). This restlessness has led to "curriculum ferment" (Towle 1998, p.5), resulting in attempts to reform the curriculum in the majority of the US and Canadian schools (Jonas et al., 1992). Similarly in the UK, a consensus view of the need for change in undergraduate medical education has developed, and all medical schools in the country have been reviewing their curricula (Whitehouse et al., 1997).

Major representations of this 'curriculum ferment' can be traced in:

1) The Association of American Medical Colleges’ report ‘Physician for the twenty-first century (AAMC, 1984), which emphasized that communication, patient autonomy, and doctor-patient relationship must underpin the whole educational process (Rees and Jolly, 1998).

2) The GMC (General Medical Council) report (1993), that have highlighted the overburdened curriculum, with undue emphasis on the passive acquisition of facts that are soon forgotten, as a major area for reform (Towle, 1998).

3) A national inquiry in the UK conducted by the King’s Fund Center on 1990, aiming to establish guidelines for redesigning undergraduate curriculum (Lowry, 1993).

These reports and the literature around them have defined goals and objectives and have examined medical training in view of current learning and curriculum theories. The goals that have been declared in the various reports have emphasized the acquisition of general competencies and the principles of medicine: the promotion of lifelong, independent
learning; integration between basic, social, and clinical science; early clinical contact; a better balance in the curriculum between curative and preventive medicine; an inclusion of wider aspects of health care, such as legal or economic issues; and multi-professional team work.

A manifestation of this 'curriculum ferment' is described in its intensity: "The evolution in attitudes towards the quality of education has been dramatic" (Rees and Jolly 1998, p.246). About twenty years ago the curriculum emphasized and assessed retention of factual knowledge and appeared to have no clearly defined objectives or philosophy. Also, "the concept of curriculum design was virtually unknown" (Jolly 1998a, p.21). In contrast, the medical education world of the last decade has been rich with systematic approaches to curriculum designs and with the concept of creating a rationale for medical education (e.g., Lowry, 1993; Whitehouse, 1997; Jolly and Rees, 1998; Peyton, 1998). It seems that medical education has been progressively perceived as an education process. The emphasis has not been only on the medical aspect of medical education, but also on the educational aspect of it.

One of the concerns of medical education literature is with clinical training, that focuses attention to a fundamental problem: it is difficult to relate to clinical training, although being central in medical education programs, from curriculum point of view. However, much of the implicit and explicit learning in medical school occurs in clinical settings, where formal curriculum does not exist. Aspects of clinical training are discussed below.

**Clinical training – curricular aspects**

The concept of 'clinical experience' has been the driving force behind the later stages of medical training (Downie and Charlton, 1992; Lowry, 1993; Jolly, 1998b). Clinical education, that can be described as a mixture of formal teaching with informal experiences (Downie and Charlton, 1992) basically includes a combination of elements like: bedside small group tutorials, ward rounds, independent student-patient contact (interview,
examination, and written summary) and classroom discussions (Peyton, 1998). Hence, it could have been expected that the objectives of such a central domain of medical education would be defined and documented. However:

"Until very recently, most of the educational literature dealt with the educational process chiefly in terms of characteristics and activities of the teacher, rather than with the objectives, length, structure, or function of the period of clinical attachment. In these studies of clinical teachers the worth, and hence the purpose, of the clinical experience is frequently assumed to be self-evident" (Jolly 1998b, p.177).

Correspondingly, criticism of clinical education has usually not been pointed at its goals, but at the process or outcomes of it (Lowry, 1993). Towle (1992), for example, asked 51 senior clinicians to identify the objectives and the value of clinical rounds. The most significant agreement was about problems associated with clinical teaching (workload, time availability and so on) and much less on the central objectives of the rounds (except for physical examination and the detection of physical signs). It seems that the historical development of medical education that has been linked to a system of patronage and apprenticeship, might be accountable for making clinical experiences so 'self-evident', as "the main training value of these clinical years comes largely from the result of personal contact between 'master' and 'acolyte'" (Downie and Charlton 1992, p.136).

Another notable aspect of clinical exposure that might be related to apprenticeship, or 'modelling' has been the substantial variation in the nature of clinical attachments between schools. Moreover, it has often been difficult to know what is the precise educational experience for students even within one medical school (Dacre, 1988; Downie and Charlton, 1992), as described in strong words by Jolly (1998b):

"Hence two students nominally attached to 'medicine' might nevertheless have completely different educational experiences. Such haphazard experience is widely reported. The problem with clinical education as currently construed is that the
The apprenticeship system has left a legacy of an ideology but not the means to implement it". (p.180)

Apart from the enormous variability, some prominent problems that relate to clinical education have been documented:

1. **Contents of instruction** – some observational studies of ward rounds (cited in Jolly, 1998b) have found that teaching has been frequently unconnected with patient care, clinical skills, doctor-patient communication, or management, and "discussion often focused on minutiae, or on esoteric scientific aspects of the case" (Jolly 1998b, p.183).

2. **Quantity of instruction** – Much research (cited in Jolly, 1998b) questions the amount of instructional activity that actually takes place in clinical environment.

3. **Quality of instruction** – Evaluation studies have shown clinical teaching to be "perfunctory", while "students were sometimes humiliated on the wards and teaching was often cancelled" (cited in Jolly 1998b, p.184).

In spite of the above-mentioned problems, students apparently do emerge from medical school, as physicians, with the knowledge, skills, and attitudes enabling them to practice medicine, so it can be deduced that there are educational outcomes which are being gained through learning experiences (Downie and Charlton, 1992). Not so much is known about these experiences, since the research tends to concentrate on what the medical teacher does, rather than on the processes students encounter.

It can be safely said that within the process of clinical training, a process defined by "immense sophistication and complexity" (Downie and Charlton 1992, p.113), curriculum issues, dealing with ways of teaching and learning, need to be addressed. Moreover, an assessment of students' contribution to and responsibility for their own learning processes is most significant in medical training, and needs further research and elaboration:

"Perhaps most important of all, as curriculum planners and teachers we need to be able to trust our students and trainees more than perhaps we do. They are adults. We must recognize them as such. Our efforts should be directed toward creating the
conditions needed for effective learning, that is by contextualizing the educational events we arrange and by supporting our learners in their learning. Nothing more is needed. Nothing less will do” (Coles 1988, p.80).

The learning-teaching process in clinical training appears to be mostly informal, unstructured and situational. The concept of the 'hidden curriculum' that relates to this informal, implicit, unintended type of learning is reviewed in the following section.
3. The 'Hidden Curriculum'

For the past several decades the concept of the 'hidden curriculum' has played a central and significant role in curriculum studies (e.g., Jackson, 1968; Apple, 1975; Martin, 1976; Gordon, 1988; Vallance, 1991). The suggestion that there might be something called a 'hidden', 'unintended', 'unwritten' or 'unofficial' curriculum has occasioned a lot of discussions and debates. The concept of the 'hidden curriculum' has enabled the curriculum domain to include the totality of experiences provided in educational programs: whether academic, socializational, vocational, or individualistic in orientation; whether experienced in classrooms or not; whether cognitive or emotional and attitudinal in focus. The relevance of the 'hidden curriculum' concept to the present study lies in its inclusiveness, its ambiguity and its intuitive association to the acquisition of norms and values. This section begins with the presentation of the theoretical framework of the 'hidden curriculum', as an educational concept in general. It then turns to review the 'hidden curriculum' conceptualization and implications within the framework of medical school in particular, with an emphasis on the link to ethical aspects of the medical training.

**Conceptualization perspectives**

One of the dominant trends in Western thought has been the search for what lies behind appearances (Gordon, 1988). However, it is only since Philip Jackson's *Life in Classrooms* appeared in 1968, in which the term 'hidden curriculum' was coined, that a significant debate developed among curriculum theorists and educators with respect to the implicit and tacit aspects of teaching and learning. Jackson (1968) claimed that children learn in school to live in a crowd, to be always exposed to evaluation of their actions by others, and to be subordinate to institutional power and authority. A number of other writers in the 1970's have identified various aspects of the 'hidden curriculum'. Dreeben (1976) focused on "what is learned in schools" as a function of the social structure of the classroom and of the teacher's exercise of authority. Kohlberg (1970) identified the 'hidden curriculum' as related to moral education and the role of the teacher in transmitting moral standards. Snyder (1971) saw the 'hidden curriculum' as the implicit messages that are transmitted
unconsciously, and in some sense illegitimately, to the students. Apple (1975) argued that the 'hidden curriculum' reinforces the basic codes and rules of an institution. Social critics have used the 'hidden curriculum' as a polemic tool — according to Reimer (1971), 'hidden curriculum' can be identified and accounts for schools' reinforcement of class structure, and Illich (1971) saw the schools as promoting dominant myths of modern culture through the 'hidden curriculum'.

The 'hidden curriculum' refers to learning outcomes that are either unintended by the teacher (or the school in general) or are intended, but not openly acknowledged to the learners (Martin, 1976). Gordon (1982) has classified the various definitions of the 'hidden curriculum', maintaining that in both radical and mainstream literature on the 'hidden curriculum' one can identify three different kinds of definitions: (a) those which focus on school learning outcomes that can be divided into two groups — academic learning, associated with the 'manifest curriculum', and non-academic learning (e.g., values, attitudes, social skills), associated with the 'hidden curriculum'; (b) those which focus on school environment, that can be divided into cognitive environment, associated with the 'manifest curriculum', and the physical/social environments, associated with the 'hidden curriculum'; (c) those which distinguish between two modes of influence — a conscious, deliberate influence, associated with the 'manifest curriculum' and unconscious unplanned influence, associated with the 'hidden curriculum'. Another classification (Vallance, 1991), has emphasized the degree of intention, which resembles Gordon's (1982) 'mode of influence'. The idea of an escape from intention, as expressed in terms of unintended consequences, unintended learning, or unintended messages, is dominant in much of the work on 'hidden curriculum' (e.g., Martin, 1976; Gordon, 1982; Jackson, 1992).

Perhaps the most important contribution of the concept of a 'hidden curriculum' resides in its invitation to researchers to look at education, teaching, and schooling in an interpretive fashion. To study a 'hidden curriculum' requires a broad view, and acknowledgment that researchers are not quite certain what the variables are. Such a perspective accords well with the increased emphasis on meaning in social action since the early 1970s (Musgrave, 1997) and with the general tendency in curriculum research toward qualitative,
ethnographic or interpretive studies (Jenkins, 1992). No wonder that within the intellectual climate of interpretive research, the 'hidden curriculum' has reached a point of conceptual acceptance (Jackson, 1992).

The 'hidden curriculum' in medical school

Conceptual framework
Since the introduction of the concept of 'hidden curriculum' to the field of education and to the curricular planning debate and research, the term has been periodically mentioned and referred to in medical education literature (for example, Marinker, 1974; Haas and Shaffir, 1987). However, the concept has not become an integral part of the discussion about medical education until it was introduced by Hafferty and Franks (1994), who have captured the 'hidden curriculum' as a broad concept of the concealed transmission of medical culture, along with the formal curriculum.

Hafferty and Franks (1994) initiated the discussion about 'hidden curriculum' in medical ethics instruction, and since then the concept has been used in the broader context of medical norms and professionalization (Papadakis, 1998). Hafferty and Franks (1994) claimed that formal instruction in medical ethics does not take place within a cultural vacuum. Most of what medical students internalize in terms of values, attitudes, beliefs, and related behaviours, is transmitted not through the formal curriculum but via a more latent one, a 'hidden curriculum' (Hafferty and Franks, 1994), that is concerned more with replicating the culture of medicine than with the teaching of knowledge and techniques (Haas and Shaffir, 1987). In fact, what is “taught” through this 'hidden curriculum' can often be antithetical to the content and goals of those courses that are formally offered (Hafferty and Franks, 1994).
The 'hidden curriculum' operates along various dimensions: pedagogical, personal and organizational:

"Within the classroom, a hidden curriculum accompanies formal instruction in a variety of ways. Instructors in biochemistry, immunology and pharmacology transmit not only information about metabolism, cytomegaloviruses, and drug biotransformation, but also messages about the nature of science, including the presence (or more correctly the absence) of uncertainty and ambiguity in scientific work. Unwittingly, case reports may convey images that perpetuate gender, racial, ethnic, cultural, or disability stereotypes. Stories, jokes and personal anecdotes, whether told by faculty or by fellow students, all function as part of the oral culture of medical training and thus as an influential part of the educational process (Hafferty and Franks 1994, p.865).

Moreover, the 'hidden curriculum' is not dependent upon social factors to convey its messages (Feudtner and Christakis, 1994). Valuable information about the "nature of things", is embedded within the structure of medical work and the learning environment. A common example is the message that is transmitted to students when a priority is given in school to work-plans and schedules, sometimes at the expense of the clinical needs of patients (Hafferty and Franks, 1994). Another example might be the message sent to medical students by the criteria for faculty promotion that give much credit to scientific excellence, and not necessarily to humanistic approach to patients (Hundert et al., 1996). Hafferty (1998) combines the concept of 'hidden curriculum' to medical school culture:

"The hidden curriculum highlights the importance and impact of structural factors on the learning process. Focusing on this level and type of influence draws our attention to, among other things, the commonly held "understandings", customs, rituals, and taken-for-granted aspects of what goes on in the life-space we call medical education. This concept also challenges medical educators to acknowledge their training institutions as both cultural entities and moral communities intimately involved in constructing definitions about what is "good" and "bad" medicine."
Finally and perhaps most important, this concept asks educators to recognize medical education as a cultural process and therefore as something that is constantly buffeted by external forces and by problems of internal integration” (ibid, p.404).

Related concepts and terminology variations
Hundert (1996) took the concept of the 'hidden curriculum' one step further. He identified the 'informal curriculum', as a subset of the 'hidden curriculum' that happens outside classes and hospital rounds:

"The informal curriculum happens every time the student or resident is not in a class or on rounds, making it virtually everywhere and unavoidable, two characteristics that account both for its power and its complexity" (ibid, p.625).

The informal curriculum involves learning at the level of interpersonal interactions that take place outside formally identified learning environments: in the elevator, the corridor, the lounge etc. (Hundert et al., 1994). The concept of the ‘informal curriculum’ also helps medical educators to better address and assess the importance of role models in the learning that takes place at all levels of medical training (Hafferty, 1998). The ‘informal curriculum’ can either support or oppose the stated goals of the ‘formal curriculum’, and it is much harder to investigate than the formal curriculum (Papadakis, 1998). To analyze the content of the informal curriculum, investigators have tape-recorded hundreds of hours of informal interactions between students and house staff (Hundert et al., 1994). Hundert and his colleagues (1994) suggested that the most important thing learned from all these taped interactions is that the ‘informal curriculum’ is informal only in the sense that the rules are not written down and the teaching does not happen in classrooms or in wards rounds. Nevertheless, it is governed by a set of rules.

The concept that medical education is composed of dimensions other than the formal curriculum appears in several recent articles and conference proceedings (e.g., Hundert et
al., 1996; Hafferty, 1998; Papadakis, 1998). Terms concerned with this concept are used interchangeably, so that different uses of terminology can be found: 'formal curriculum' is sometimes called the 'declared curriculum' (Marinker, 1997), the 'recommended curriculum' (Stern, 1998), the 'explicit and intended curriculum' (Hafferty, 1998). The terms 'hidden curriculum' and 'informal curriculum' have been defined distinguishably by Hafferty and Franks (1994) and Hundert (1996) as has been stated, but the use of the terms is often mixed (Hundert et al., 1996; Marinker, 1997; Wear, 1998), and there are other terms that describe the same phenomena, such as 'incidental curriculum' (Friedman Ben-David, 2000), or 'implicit curriculum' (Hafferty, 1998). Hafferty (1998) has related to the main alternating terminology by specifying the common elements:

"Although concept labels and core definitions can vary by author, the notion of a multidimensional learning environment embraces at least three interrelated spheres of influence: (1) the stated, intended, and formally offered and endorsed curriculum (e.g., the "this is what we do" curriculum); (2) an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students (the informal curriculum); and (3) a set of influences that function at the level of organizational structure and culture (the hidden curriculum)") (ibid, p.404).

The concepts of both the 'informal' and the 'hidden curriculum' stand in contrast to that of the 'formal curriculum'. Namely, it is widely assumed that there is a fundamental distinction between what is being formally taught and what is being actually learnt. Hence, the term 'hidden curriculum' is used as the generic term for the curriculum that is not the formal one. It is clear from the literature that the concept of 'hidden curriculum' has been accepted as an existing common phenomenon in medical training, in particular in the field of ethics education and professionalization process. For example: Stern (1998) found contradictions between the 'recommended curriculum' of medical values, examined through content analysis of curricular statements and documents, and the 'taught curriculum', identified through naturalistic observations and audio-taping of internal medicine ward teams; Wear
(1998) analyzed the implicit and explicit implications of "white-coat ceremonies" — a recent phenomenon in medical schools, emphasizing that such a symbolic ritual is a curricular event.

The words of Marinker (1997), that refers to British medical education and to various documents of the 'declared' curriculum, describe this understanding well, as he has concluded that the chasm between the formal curriculum and the hidden one is inherent to medical education:

"The 'declared curriculum' is written in earnest and elegant prose and is taken very seriously in the Virtual Medical School. The 'hidden curriculum' is beyond the control of the GMC; it is written in the bricks and mortar and memories of the Actual Medical School; it is more expressed in the inflexions of our voices and the looking of our eyes, than in anything you can take down and use in evidence. The 'hidden curriculum' is captured, fixed and made manifest in how doctors actually set about the task of medicine" (ibid, p.297).

It is equally clear that there is a need for a further research in that direction, research that uses various methodologies (Hundert et al., 1996) penetrates new domains (Hafferty, 1998), and raises the question "what are the fundamental values and messages being created and transmitted in any curricular and non-curricular event" (Hafferty 1998, p.404).

The centrality of the 'hidden curriculum' in educational and ethical processes in medical school, as presented in this chapter, leads to the next section of the review, that focuses on medical school’s ethical processes from the perspective of medical students’ ethical reality, during their training program.
B. Ethics Perspective: Aspects of Medical Students’ Coping with Ethical Reality in Medical Education

This perspective of the literature review focuses on issues of ethics related to students of medical school. A prolonged professional training is part of the experience of a large number of young people in modern society, young people who are – physically and in most social respects – fully adult (Jarvis, 1997). Young adults, in a certain professional stage of their lives, are facing numerous personal situations and encounters that concern various aspects and meanings, including the aspect of ethics and moral implications. Students’ ethical reality in medical school is the focus of the present research. Three topics that relate to students’ coping with their ethical experiences are reviewed, proceeding from the broader view to the narrower – from the field of ethical decision-making of individuals in general, to the area of cognitive and ethical processes of adults and students in particular, to the specific subject of ethical confrontations of medical students. Thus the subjects of the present study are perceived first as persons, then as young adults, and lastly as medical students.

Three sections are presented within this perspective: section 4 is concerned with the coping mechanisms, in regard to contextual moral issues and moral decision-making. Various theoretical perceptions of moral behaviour and development are presented, along with models that analyze processes of moral decision-making and their methodological-conceptual implications. Section 5 aims at understanding the processes of adult cognition, the epistemological and ethical development of young adults, particularly students, in their studies and training stages. In section 6, the moral confrontations of medical students during their training are reviewed, mainly according to students’ own accounts. The empirical context of the present research is presented in this last section.
4. Morality in Context: Individuals Coping with Ethical Issues

The present study is interested in the ethical reality of individuals and their coping mechanism in moral situations. Therefore, the relevant topics, derived from the world of 'ethics' studies reviewed below, are concerned with human aspects of moral decision-making and behaviour. First, approaches to moral growth and development, which relate to broad learning/psychological theories, are presented, since human morality study was perceived as a form of human learning. Second, as the concepts of cognition and behaviour are dominant factors in the presented theories, two theoretical models that integrate moral reasoning and behaviour are addressed. Finally, conceptual methodological paradigms that view moral cognition and behaviour as integral components of identity and self are discussed.

Theories of moral growth and development.

Three psychological theories have dealt extensively with the phenomenon of human morality, each explaining it in distinctly different ways.

1. Cognitive-development theory – The cognitive developmental approach was pioneered by Piaget (1965), and had been further developed by psychologists such as Kohlberg (1969), Perry (1970) and Damon (1984). Piaget contributed to the cognitive development approach in two ways: First, by suggesting that the human learner is a stimulus-seeking entity, not learning entirely through conditioning; Second, by offering a framework of clearly discernable stages or structures of thought. The general thesis is that human beings’ moral development proceeds in a stepwise sequence, through the various stages of moral reasoning. The best known theory of cognitive-moral development has been developed by Kohlberg (1969, 1981), who has identified five stages of moral reasoning and judgement.

2. Social learning theory – This second view of moral development is derived from the empiricism of Locke and the behaviourism of Watson and Skinner. This view tends to look at human nature as a relatively 'blank slate' upon which society leaves its mark.
The individual acquires moral and other social learning by two methods: direct teaching, and learning through modelling or imitation. The terminology used by the social learning theory is specific: "Since social learning theorists are uncomfortable with words such as 'moral' and 'ethical', they substitute their own term: 'pro-social'" (Ryan 1991, p.739). Moral behaviour, like the rest of learning processes, is a matter of shaping someone's behaviour until it conforms to the shaper's, presumably society's, desire. While the developmentalists focused on thought, the social learning theorists focused on action or behaviour.

3. **Psychoanalytic theory** – A third approach to moral development has been the Freudian psychoanalytic approach. It is based on a view of human nature as driven by irrational impulses, that must be controlled. Society's agents, typically parents, must intervene early, to introduce restraints and to conform behaviour. As a theory of moral development, the great strength of the psychoanalytic view is that it is rooted in a total view of personality. Psychoanalysis has brought to the front stage the process of identification, and the development of a personality construct that controls the moral behaviour (the 'superego'), functioning as a conscience.

These three theories represent the theoretical background in the context of which the discussion of human moral choices, decisions, actions and reflection takes place. It has been commonplace for reviewers of morality to state that cognitive-developmentalists study thinking, psychoanalytic psychologists study affect, and social learning psychologists study behaviour – and to assume that cognition, affect, and behaviour are basic processes and distinct elements, each having a separate track of development. However, the next paragraphs of this section present an integrative perception of morality.

**'Morality': Reasoning and action**

'Morality' can be interpreted in diverse and multifaceted meanings. In the present review's context the term 'morality' is referred to, following Frankena (1970), as a social value, that relates to how people cooperate and coordinate their activities in the service of furthering
human welfare, and how they adjudicate conflicts among individual interests. Or, in other words, "the crux of morality is doing what you know is right. However, there are problems in both knowing what is right and in doing what is right" (Rest and Narvaez, 1994, preface p.x).

While the above-reviewed theories are related to moral growth and development, the approaches discussed below attempt to capture integratively moral aspect of behaviour and reason. Two such approaches are presented: "The four component model" (Rest, 1986); and "Moral balance" model (Nisan, 1993, 1995). As the two models are concerned with moral decision-making, they are relevant to the present study that examines moral decisions of individuals, decisions that combine reasoning and action.

'The four component model'
Rest (1986) has argued that 'morality' should be captured as a complex, integrated model that combines cognition, affect and behaviour. Rest (1986) offered a model starting with the question: "when a person is behaving morally, what must we suppose has happened psychologically to produce that behaviour?" (p.3). The model suggested by Rest (1986) has been since elaborated in Rest and Narvaez (1994) and Rest et al. (1999), and includes the following components:

1. **Moral sensitivity** – interpreting the situation: the person must be able to make some sort of interpretation of a particular situation in terms of what actions are possible, who (including oneself) would be affected by each course of action, and how the interested parties would regard such affects. Moral sensitivity is the awareness of how our actions affect other people. It involves the imaginary constructing of possible scenarios, and knowing cause-consequence chains of events in the real world; it involves empathy and role-taking skills.

2. **Moral judgment** – judging which action is morally right/wrong: the person must be able to make a judgment about which course of action is morally right (or 'fair' or 'just'), thus labelling one possible line of action as what the person ought to do in that situation. This component judges which line of action is more morally justifiable.
3. **Moral motivation** – prioritizing moral values relatively to other values: the person must be able to give priority to moral values above other personal values. Deficiencies in this component occur when other values such as self-actualization replace concerns for doing what is right.

4. **Moral character** – having courage, persisting in a moral task, overcoming distractions, implementing skills: the person must have sufficient perseverance and ego strength to be able to follow through his/her intention to behave morally.

It appears that in a research context, an abundance of the empirical research on morality has concentrated on components 1 and 2 (Rest et al., 1999), mainly by posing theoretical dilemmas and ethical vignettes to subjects. However, there is significantly less research regarding the measurement or empirical testing of component 3 and 4 (Rest et al., 1999), as these are much more difficult to explore.

These four components represent the processes involved in the production of a moral act. The four components are not presented as four virtues that make up the ideally moral person, but rather as major units of analysis used for tracing out how a particular course of action has been produced in the context of a particular situation.

**'Moral balance' model**

The 'Moral balance' model has attempted to explain moral decision-making, perceiving morality as a central component of identity. The model suggested that people calculate some sort of moral balance for themselves on the basis of all their morally significant actions within a given time span. This moral balance is compared to a personal standard of 'minimal morality', which the individual defines as personally obligatory, and from which he is not willing to allow himself to descend. When faced with a moral conflict, one not only evaluates the planned action, but also one's moral balance, in accordance with one's acceptable level of morality that is part of his identity and self-concept. Nisan (1993, 1995) pointed out that persons do not only pursue moral motives, but also specific ego interests that appear legitimate to them and are weighted against moral obligation. In a moral conflict, a person has to choose among moral interests and potentially conflicting ego
interests (Rest, 1986). According to the 'Moral Balance' model, the decision depends on which of the conflicting interests have greater relevance for the identity of the individual (Nisan, 1993, 1995).

A comparison between the models reveals common distinctions: (a) there are certain preconditions for a moral action - moral sensitivity, selection of a moral relevant rule, a decision concerning personal moral responsibility and a decision concerning actual action in a certain time; and (b) the two models assume non-linear connections between reason and behaviour components, thus advocating the holistic interactive approach to moral decisions and ethical identity.

**Conceptual methodological implications**

The complex perception of actual ethical coping of individuals, that has been implied in the non-linear integrative models, leads to conceptual, methodological questions concerned with ways to study these phenomena: How are moral and non-moral questions to be demarcated? Who is to determine the boundaries - philosophers or empirical researchers? Is morality defined by an a priori conceptual decision, or by inference from empirical evidence?

Empirically, for some (e.g., Kohlberg, 1981), morality is to be defined from the top down, by deduction from a meta-ethical perspective or from the highest stage of moral development, represented to research subjects in universally articulated dilemmas. For others (e.g., Gilligan, 1982), morality is to be defined from the bottom up, i.e., by induction from what the interviewed subjects in a research actually say concerning their understanding of morality. The first approach has been rather widespread in the empirical ethical studies in medical schools, using virtual hypothetical ethical dilemmas and vignettes as research tools (e.g., Baylis and Downie, 1991; Self and Baldwin, 1994; Savulesco et al., 1999). The second approach claims that an empirically minded researcher can only grasp the nature of morality by eliciting the subjective stance of the individual, thus using
interview techniques as research tool (e.g., Gilligan, 1986; Brown et al., 1988; Brown et al., 1989; Gilligan et al., 1990; Tappan, 1990; Brown and Gilligan, 1991). The present study adopts the second approach: (I) conceptually, by defining a moral dilemma according to the involved person's own definition (Blasi, 1993, 1995), with no judgemental hierarchy of ethical dilemmas, and (II) empirically by using interviewing techniques (see: 'Methodology').

Another raised conceptual/methodological issue is whether morality investigation should focus on moral action (or behaviour, or conduct) as the ultimate and indisputable criterion of an adequate moral functioning. Blasi (1993, 1995), has argued that it is no less important to understand the various ways by which the moral values and beliefs are integrated in the personality. It is true that real moral integration is expressed by behaviour, but not necessarily in each individual act that has moral implications. Therefore, a more valid examination would be a study of how a person manages his life in the long run. The integration of morality in the personality can be seen not only in behaviour but also in reactions of a person to his own behaviour through feelings like remorse or guilt, through mechanisms such as reflection, and through concrete attempts to correct damages and rehabilitate his values. However, This offered wide framework of viewing morality as part of holistic identity (Blasi, 1993, 1995) is difficult to examine and research. Complexity and ambiguity are intrinsic characteristics of any human morality aspects that are intended to be studied, so that strategies of inquiry should correspond to the nature of the domain studied (Gilligan et al., 1991). Hence, the present study adopts the above-presented approach of examining morality in the course of a relative long period of time, and as part of a person identity reflecting self choice and values.
5. Adult Cognition: Epistemological and Ethical Development in Adulthood

The present study's concern is with the ethical implications of medial training for the young adults participating in it. Discerning epistemological-intellectual development of adults is an essential step towards understanding ethical processes in adulthood. Epistemology is a branch of philosophy that is concerned with the nature of human cognition. Epistemological development is the development of knowledge and knowing, the development of ways in which the individual understands and/or constructs the meanings of his existence. From the 1970's there has been an inclination among psychologists to put the concept of 'knowledge' in the front stage of research. In this sense it is seen as a reaction to behaviourist theory that focused on stimulus-response relations and has viewed the organism, the mind, as a 'black box' that has not enabled empirical study (Hofer and Pintritch, 1997). A study of adult cognition attempts to understand how knowledge of the world is developed by adults and young adults and how they attribute meaning to their experience.

Piaget (1965) who named his stages model of intellectual development of children 'genetic epistemology', defined 'formal-operations' as the last stage of development that occurs in adolescence. 'Beyond Piaget' school of thought (Commons et al., 1984) argued that the sequence of cognitive development extends into adulthood, and shares the conviction that by ending the stages of cognitive development in adolescence, "Piaget truncated development conception of both adulthood and cognition" (Commons et al., 1984).

Alexander et al. (1990) summarized some common characteristics of adult cognition:
1. Transition to understanding the relativistic nature of knowledge
2. Acceptance of contradiction as part of reality.
3. Integration, perceived as a process of dependency between variables or coordination between various points of view.
4. Pragmatism and a focus on context.
Nisan and Applebaum (1995) concluded that uniqueness of adult cognition lies not in hypothetical processes but in daily, ordinary, practical decision-making, where life pragmatics require a move from abstract solution to a choice of action. In the following paragraphs, several models of epistemological development are reviewed, in an attempt to shed light on the variability in the positions of students in relation to knowledge and knowing, and to issues of commitment, interactions and responsibility.

**Perry's model of intellectual and ethical development**

In a model known as 'Perry's Scheme', Perry (1970, 1990) has constructed a direct relation between cognitive and intellectual development and the development of ethical reasoning. The study used a longitudinal paradigm in which students in Harvard University were interviewed several times during their studies about their experiences of learning and thinking and about their interpretations and understanding of them. After validation of the open interviews, Perry and his colleges articulated a scheme of intellectual and ethical development that originally included nine stages, which later have been condensed to four meta-stages: dualism, multiplicity, relativism and commitment. The 'Perry's scheme' is composed of 'positions' and 'transitions' and not of 'stages', but as in Piaget's cognitive development theory (1965) and in Kohlberg's moral reasoning development theory (1981), 'positions' have represented a sequence of hierarchical stages, while 'transitions' occur through a dynamic of 'disequilibrium':

- **Dualism**: A polar view of the world, division of meaning into two realms – good vs. bad, right vs. wrong etc. Right answers exist somewhere for every problem, authorities know them and deliver them.
- **Multiplicity**: Diversity of opinions and values is recognized as legitimate in areas where right answers are not yet known. Opinions remain atomistic and no judgment can be made among them so 'everyone has a right to his own opinion', 'none can be called wrong'.
- **Relativism**: Diversity of opinions, values and judgment derived from coherent resources, evidence, systems and patterns, allowing for analysis and comparison. The individual perceives knowledge as contextual and relational, and starts to realize the need to choose and strengthen his commitments. The transition from
'relativism' to the next position is especially difficult, because of the tendency to perceive relativism and decision-making as contradictory.

- **Commitment:** An affirmation, choice, or decision (career, values, politics, personal relationships) made in the awareness of relativism. Students are confronted with the paradox of establishing values and perceptions in an epistemological context of relativism and doubtfulness. Typical conflicts that student have accounted: certainty vs. doubts, idealism vs. realism, inner choices vs. external influences, action vs. contemplation etc. (Perry, 1970, 1990). In this stage, young adults (e.g., students) understand that conflicts of that kind do not resolve easily, as one of them is cited: "now I know that I'll never know how many times I'm going to be confronted" (Perry 1990, P.97). It seems that the development that has been traced in college students achieving this last position is 'age-free'.

Perry has pointed out the problematic distinction between two types of moral relativism. In the position of multiplicity there are many right answers to moral problems, and the individual does not feel the need to choose among them. However, in contextual relativism – even if there is no objective rightness (in the sense of being context-free), some answers and some ways of thinking seem more suitable than others. Similarly, Gilligan et al. (1990) have distinguished between two kinds of post-conventional moral reasoning:

- 'Post-Conventional Formal' (PCF): the relativism issue is solved by a logical system – solutions are inferred from concepts like 'social covenant' and 'natural justice';
- 'Post-Conventional Contextual' (PCC): the criterion for the adjustment of moral principles is shifting from an objective truth to the 'most suitable', and can be based only on the context of the dilemma itself.

Belenky et al. (1986) have constructed a cognitive-ethical model for 'women's ways of thinking' in which stages stretch from 'silence' to 'received knowledge', 'subjective knowledge' and 'procedural knowledge', and finally to 'constructed knowledge'.

The models of Perry (1970, 1990) and Belenky (1986) have influenced an abundance of studies of epistemological development. A representative example would be that of
Baxter-Magolda (1992) that distinguished four stages: 'Absolute Knowing' – authorities have all the answers; 'Transitional Knowing' – realization that authorities do not know everything; 'Independent Knowing' – raising the questions about the origins of knowledge and legitimization to personal opinions; and 'Contextual Knowing' – an ability to create individual perspectives by judgment of evidence within their framework. The reviewed models of epistemological development show a similar developmental process: starting from an obedient, inflexible, non-compromising position, going through transition positions of knowledge expansion and flexibility, until reaching the position of personal relativistic and contextual knowledge. Knowledge and knowing, become less public and more personal, and are involved with commitment and responsibility.

The combination of understandings inferred from the previous section ('human morality') about the complex holistic nature of moral decision-making, and understandings inferred from the present section ('adult cognition') about the relativistic contextual nature of cognitive and ethical processes, pave the way to review the next subject: the exposure of medical students to moral decision-making in the contextual setting of their medical training.
6. Moral Dilemmas of Medical Students – Aspects of Medical Students’ Ethics

This section focuses on the moral issues relating to medical students. It opens with a background that briefly discusses two related topics: ‘attitudes change’ during medical school and 'ethics teaching' in medical school. Then, the emerging field of moral dilemmas in medical training, which is the major interest of the present study, is reviewed. Then, several interpretive conceptual frameworks, potentially applicable for theorizing the students' moral dilemmas are presented in question formats. Finally, implications of the review to the present study are discussed.

Background – ethical related topics in medical education.

‘Attitude change’ during medical training

It has been generally accepted (Flaherty, 1985) that the goals of medical education emphasize the student's development in three spheres: knowledge, skills, and attitudes. Since Merton's et al. (1957) comprehensive analysis of medical education, medical educators have paid increasing attention to the processes whereby students acquire attitudes and values in keeping with the role of physician:

"Medical education is a professional socialization experience that involves not only the acquisition of knowledge and skills but also, and perhaps more important, the acquisition of attitudes, values, and a sense of ethics" (Wolf et al. 1989, p.19).

Many studies have examined attitudes and attitudinal related issues, such as the alteration of students' outlooks (Eron, 1955; Hass and Shaffir, 1987; Rest and Narvaez, 1994), their desensitization to certain moral issues (Hebert et al., 1992; Self and Olivarez, 1996), and even problems associated with medical students stress and abuse (Silver, 1990). Out of the many student attitudes, none has evoked more interest and controversy than the issue of cynicism, since Eron's (1955) 'classic' publication: "The effect of medical education on
medical students' attitudes". Eron's most quoted finding (based on Likert-like scales) is the increase in cynicism and the decline in humanitarianism from freshmen to senior students. The accumulative findings (as reviewed by Myser and Kerridge, 1995) suggested that the medical school environment fosters cynicism in medical students, and there is considerable evidence (Price et al., 1998) that undergraduate medical education can have a negative impact on attitudes. Wolf et al. (1989), who investigated attitude change during medical education across ten dimensions of an attitude profile, argued that the increased cynicism is adaptive in light of medical school and clinical practice demands, and may enhance functioning in certain areas. Other frequently researched attitudes have been general concepts, such as 'Dogmatism' and 'Authoritarianism' (Flaherty, 1985), as well as studies that have focused on specific issues, for example attitudes towards chemical dependence, the elderly, or towards AIDS patients (Price et al., 1998).

'Medical ethics' education

Another topic that has been very dominant in medical training research is the ethics curriculum and teaching in medical school. The present study is concerned with students' ethical encounters as well as with curriculum, but it does not focus on ethics teaching in medical school, since 'curriculum' as perceived and researched in the present study relates mainly to students experience – the 'received curriculum', and to the notion of 'total curriculum' (see: curriculum perspective). Hence, this section dealing with ethics teaching in medical school is reviewed hereby only as a background to the study of student experience in their ethical reality.

Much of the literature on teaching ethics to medical students has focused on what issues the 'core curriculum' should include – e.g., 'informed consent', do-not-resuscitate [DNR] orders, reproductive ethics (Hebert, 1996); on how the materials should be taught – e.g., with cases, surrogate patients, or role models (Miles et al., 1989); and on how it should be analyzed – e.g., using ethical principles, normative moral reasoning, or legal theory (Fox at al., 1995).
Since the 1970s, schools of medicine have been gradually introducing courses in medical ethics, usually as a single course, often in a lecture format, but occasionally taught in the ethical rounds format as pioneered by Pellegrino (1989). It can be said that medical ethics education “had come of age” (Miles et al., 1989). Every medical school in the United States teaches medical ethics as part of its required curriculum (Fox et al., 1995). In the UK a 'core curriculum' has been recommended in “Tomorrow’s Doctor” (General Medical Council, 1993), and a consensus group (Doyal and Gillion, 1998) outlined 12 agreed themes of a proposed 'core curriculum' for medical ethics and law. Summarizing the status of 'core curriculum' they have said: “A 'core curriculum' offers flexibility in how it is taught – but not that it is taught” (Doyal and Gillon 1998, p.1623).

The grounds for the development of medical ethics as a body of instruction in its own right is related to the technological, democratic, morally pluralistic nature of modern society (Pellegrino, 1989). More specifically, the fields’ growth is related to the questioning of professional autonomy, the exposure of unethical research practices, and the rapid development of technology in medical care and its associated potential for dehumanization (Parker et al., 1997). Another cluster of reasons to the rise of ethics education was summarized by Baylis and Downie (1991):

"Technological advances in medicine, decreasing health care resources, the recent developments of inter-professional teams medicine, the increasing multicultural nature of society, and the patients' rights movement present physicians with dilemmas not easily resolved by reflection on the traditional sources of ethical directives" (p.413).

A ‘traditional’ model (Fox et al., 1995), that is essentially analytic and emphasizes the process of moral deliberation, has dominated medical ethics teaching. The content of the ‘traditional model’ may include (Gillon, 1994) ethical theories (e.g., utilitarianism, deontology), moral principles (e.g., beneficence, nonmalficence, autonomy, justice), codes of medical ethics (e.g., the Hippocratic Oath, the Declaration of Geneva), and various clinical topics (e.g., euthanasia, confidentiality, abortion). However, a critique of this model
(O'Tool, 1995; Nicholas and Gillet, 1997) points out that details of context and specific relationships, that are an intrinsic part of ethical health care, are not included within a rather philosophical method that seeks some sort of universal approach. Hence, a number of alternatives have been proposed to the ‘traditional model’ (as reviewed by Fox et al., 1995; Nicholas and Gillet, 1997): (1) a revival of 'casuistry'; (2) an 'ethics of caring', proposed both from nursing and from feminist theory; (3) 'everyday ethics', the issues that routinely arise in daily medical practice, and 4) ‘narrative ethics’, recognizing, as does casuistry, the centrality of story or narrative in ethics, and coping with context and relationship (also a focus of 'ethics of caring'). Narrative ethics also relate to questions of interpretation and power as a necessary part of ethics.

Another incipient trend in ethics teaching has been the emphasis on ethical issues of immediate relevance for medical students. It is an approach which is respectful of the experience that participants bring with them, while their responses and contexts are a full part of conversation and exploration during the courses. The concept behind this trend is that “it is in making decisions and living with their consequences that ethics cease to be only a theoretical discipline and begins to become a professional code of conduct” (Christakis and Feudtner 1993, p.254). This approach has been exemplified by 'ward ethics' sessions (Christakis and Feudtner, 1993; Feudtner et al., 1994) in which students’ moral dilemmas, personal and situational, started to be articulated. The following part of the review deals with that reality, as accounted by medical students, the reality which is the major concern of the present study.

**Moral dilemmas of medical students**

**The road taken: Mapping the field**

One of the changes of emphasis that have occurred in the teaching of medical ethics has been the shift from teacher-centred courses to student-centred courses, in small groups of clinical students. These sessions have elicited a different kind of ethical dilemmas that originate from the students’ own reality (Fox, 1995). The tendency to deal with students’
dilemmas has been attempted in various medical schools (Southgate et al., 1987; Osborne and Martin, 1989; Bickel, 1991). The most striking evidence emerged from the University of Pennsylvania School of Medicine (Christakis and Feudtner, 1993; Feudtner and Christakis, 1994). As a component of the internal medicine clerkship, two senior medical students asked junior students to submit cases focusing on dilemmas they encountered in the wards. The taxonomy of dilemmas they developed, has become the leading articulation of the recurrent students' dilemmas as well as the most comprehensively cited study in this field of research.

The following five problem areas most frequently identified by Christakis and Feudtner's (1993) analysis of students' cases were:

1) **Performing procedures: Education vs. patient care:** Many of the ethical dilemmas that students face involve the tricky interplay of three often-conflicting aims: learning new procedures, working as part of medical team, and caring for (as oppose to inflicting pain on) patients. The requirements of 'informed consent' also come up, as well as authority and evaluation pressures, e.g., students being more concerned about their senior's impatience than about the patient's discomfort when they have trouble hitting a vein.

2) **Being a team player: Team vs. individual ethics:** Fitting into the team can easily become of paramount importance in the student's mind, but this goal leads students to do things they might otherwise question, e.g., writing progress notes on unexamined patients in compliance with a senior's request.

3) **Challenging medical routine: The effects of relative ignorance:** In the wards, knowledge is the coin of the realm. Students' relative lack of knowledge makes it hard for them to challenge any decision. The passive manner in which students are expected to accept their relatively ignorant status is ultimately defeating, as automatic capitulation to those who know more can become an over-worn habit.

4) **Knowing the patient as a person: Medical vs. social knowledge:** Because of the amount of time students spend with patients, they often become better acquainted with patients' feelings and circumstances than senior physicians. When this 'psychosocial' knowledge
leads the students to question the team's medical assessment or management, they must mediate between being a 'team player' and challenging medical routines.

5) Witnessing: To rock the boat or stay the course: Angry feelings and guilt arise when students witness, or even participate in unethical activities, while being powerless and unable to resist or protest.

In the decade since the publication of this core taxonomy, other studies have validated the 'mapping of the field' of medical students' moral dilemmas in various settings, using various methodologies and emphasizing various aspects:

(a) Quantitative validations: In contrast to the above-mentioned articulation of students' ethical dilemmas that was based on fairly qualitative data (the 'ward ethics' sessions), some validations of the diversity and scope of the phenomenon have been quantitative in nature (Bickel, 1993; Feudtner et al., 1994; Bissonnette et al., 1995; Baldwin et al., 1998; Satterwhite et al., 1998; Roberts et al., 2005). For example, the AAMC (Association of American Medical Colleges) survey (Bickel, 1993), a wide study that surveyed 35 American medical schools, has suggested rather similar categorization to the ethical issues reported (Christakis and Feudtner, 1993).

(b) Other settings validations: Bissonnette et al. (1995), identified and analyzed similar ethical issues to those reported in hospitals, that commonly occurred in ambulatory care, while Homenko et al. (1997) studied ethical issues in the primary care setting, identifying emerging ethical themes such as decision-making, professional standards, community responsibility, and confidentiality, that appear to be more pragmatic and less dramatic than those in the hospital setting. Satterwhite et al. (1998), who studied classes in a medical school offering 'clinical exposure' from year one, demonstrated that even early limited involvement in the clinical environment produces many of the same ethical dilemmas.

(c) Additional qualitative research methodologies' validations: A study by Hicks et al. (2001) combined two research strategies in an effort to probe more accurately students'
dilemmas: a survey that ascertained the existence of ethical encounters, and focus-
groups of students selected from the previously surveyed cohort. The content analysis 
of the focus-groups revealed three categories of ethically problematic situations: 
conflict between priorities of medical education and those of patient care, responsibility 
beyond a student's capacities, and involvement of patient care perceived to be 
substandard. Huijer et al. (2000) analyzed written case-reports concerning ethical 
events experienced by clinical students. Besides the most commonly known ethical 
dilemmas related to 'traditionally' categorized topics (disclosure of information, 
decisions at the end of life, and medical failures), students also reported a multitude of 
other dilemmas, linked to the students' unique position in the training process. Glick 
and Benshalom (2002), using open questionnaires, in a pilot study that related to the 
decision component involved with the students' ethical dilemmas, mainly analyzed the 
compatibility between what students decided to do and what they though ought to be 
done, according to their own accounts and values. Caldicott and Faber-Langendoen 
(2005) surveyed papers submitted for a required bioethics course, revealing ethical 
issues concerning deception, discrimination, and fear of reprisal.

It can be safely concluded that mapping the ethical dilemmas of medical students is rather 
substantial. The research of ethical dilemmas of medical students has reached the stage that 
the general topics of ethical dilemmas students encounter during their medical training are 
reviewed. However, mapping the dilemmas' topics is just the exposed 'tip of the iceberg', as 
other aspects of students' ethical dilemmas have only been initially and limitedly studied, as 
reviewed below.

The road not taken: The unknown field

The existing literature on ethical dilemmas of medical students has made several limited 
Attempts to go beyond the mapping of the dilemmas topics, although scarcely and as yet 
incompletely:

(1) Studies that partially analyzed the reasons and origins of the ethical dilemmas (Bickel, 
1993; Dwyer, 1994; Feudtner et al., 1994; Swenson and Rothstein, 1996) basically
inferred their conclusions about dilemmas' origins from the topics of the dilemmas they found. Although some interesting and reasonable assumptions were raised about the dilemmas' origins (for example: the relation between the dilemmas and student' status, raised by Swenson and Rothstein, 1996), the students themselves were not asked about the complex considerations and reasoning involved in their dilemmas. Thus, the above-mentioned studies have constructed merely the initial conceptual step in researching the reasons and origins of the dilemmas.

(2) Studies that partially analyzed the coping mechanisms of medical students with ethical dilemmas (Andre, 1992; Christakis and Feudtner, 1993; Dwyer, 1994; Feudtner and Christakis, 1994; St. Onge, 1997; Huijer et al., 2000; Musik, 2000) are hardly substantiated with students' data about their coping – their decisions and reactions. The 'ward ethics' sessions (Christakis and Feudtner, 1993; Feudtner and Christakis, 1994) revealed that while facing authority, some students adopt a strategy of 'postponement', waiting until they are empowered; Dwyer (1994) summarized five years of ethical deliberations with students, by maintaining that most of the dilemmas faced by students are situations where they must decide whether to speak up or be quiet, arguing that students find themselves quoting frequently the Hippocratic maxim: Primum non nocere (do not harm), while they should use more frequently the Socratic maxim: Primum non tacere (do not be silent) (Dwyer, 1994). Other studies (Andre, 1992; St. Onge, 1997; Musik, 2000) tend also to be programmatic and thought-provocative as Dwyer (1994), however hardly explorative. Thus, the above-mentioned studies, although eloquently pointing at directions for further research, have not actually substantiated them.

Evidently, the relatively new field of study concerning moral dilemmas of medical students needs a wide and innovative research endeavor to better understand the processes of coping and enduring, that are involved with students' unique ethical reality. What seems to be missing is a research that examines the ethical dilemmas of medical students in a context of the ethical reality they encounter — what are the origins of these conflicting situations, how do students react to or cope with them, what do the students think about this reality,
what are the personal and professional implications of the conflicts, what are the emotional and cognitive processes underlying the occurrences, and so forth. The potential of such a research is partially exemplified by the study of Huijer et al. (2000), that examined written narrative case-reports and elicited students' descriptions of their reactions and emotions. For example, in cases where the students disagreed with their superior's values or behaviours, they hesitated to speak up or pose critical questions: "Some of them were angry, shocked, or grieved, but they felt powerless to voice their thoughts or emotions" (Huijer et al. 2000, p.839). The richness of the materials presented by the case reports is evident. However, since information was obtained from written reports and the subjects could not be asked additional questions, less information was gained. It seems evident that a further study, in which students are being interviewed, being asked to elaborate in their own words about their response to the dilemmas, about their coping strategies and the support they get, could have supplied more insights into this area of research. The challenge of the present study is to examine the students ethical reality by allowing them to report and narrate about it openly and holistically – relating to various aspects of their ethical reality, not only to a representative single event.

It can be understood from the studies reviewed above, that the emerging incipient field of research concerning ethical reality in medical training is dynamic, developing and in a search for meaningful direction. As part of this search for conceptual interpretive frameworks that have not yet been established in this field of research, the next section presents some of the conceptual questions and assumptions that can be discussed in regard to students' moral dilemmas research agenda.
Theoretical/conceptual questions concerning medical students' moral dilemmas, emerging from the existing literature.

The reviewed field of students' moral dilemmas that reflect students ethical reality, is rather new, and the research has not yet reached 'maturity' – namely, a strong, solid body of empirically-based knowledge and theories. Therefore, conception-wise, in the recent literature there seems to be more fundamental questions than answers. Studies that have attempted to offer some conceptual/theoretical frameworks or explanations (e.g., Feudtner and Christakis, 1994; Dwyer, 1994; Feudtner at al., 1996; Swenson and Rothstein, 1996), are written basically as intellectual essays, not necessarily based on empirical studies substantiated with data. Thus, the following section of the literature review, which delineates several potential interpretive theoretical frameworks in regards to medical students ethical dilemmas, is presented as a series of conceptual questions and deliberations.

Questions/issues from a philosophical/social angle:

1) "Can virtue be taught?" (Shelton, 1999): Is it at all possible to study or to acquire moral behaviour? This question is phrased and discussed in several variations in the literature (e.g., Swenson and Rothstein, 1996). Discussions may be philosophical (Andre, 1992; Shelton, 1999), or descriptive (St. Onge, 1997), or prescriptive: Swenson and Rothstein (1996), for example, have suggested a series of means that, to their opinion, would help students to 'navigate with moral compasses'.

2) Do students come to medical school with formative moral character and values that can only be moderately shaped? (Bore et al., 2005). What kind of images of 'a good/moral person' and 'a good/moral physician' students bring with them? (Swenson and Rothstein, 1996).

3) Is a person autonomous in his moral choices? (Rest, 1986; Blasi, 1993; 1995; Rest et al., 1999). What are the boundaries of autonomy in contextual settings? (Carr and Steutel, 1999).
Questions/issues from an educational/curricular angle:

4) **Ethical education – a destination or a journey?** Which perception is more valid: the static conception of 'core values', 'core curriculum', and 'linear ethical growth', or models of dynamic value-systems and of development of 'ethical selves'? This distinction relates to the notion of 'Curriculum Perspective'– the perception of curriculum as a process and not as a product (Kelly, 1999).

5) **What are the implications of studying through 'modelling'?** How does the mechanism of negative 'reverse modelling' operate? What is the minimum obligation – "to take notice of bad practice and try to conduct in a better way when [the students] become full-fledged physicians?" (Dwyer 1994, p.15).

6) **How broad or how narrow should be the definition of ethical learning process?** Should it state specific rules of conduct for specific situations, or should it be a general education, concerned with principles and ideologies? Dwyer (1994) has defined two possible dangers in the learning process: if responsibilities are not clarified and delineated, students' moral concern might remain diffuse and may be ineffective. On the other hand, if responsibilities are defined too narrowly, technically and legalistically, moral concern, creativity and personal growth might be lost. This issue relates to a fundamental curricular debate “limiting the curriculum in terms of applying exclusive statements runs the danger of impoverishing it... adopting inclusive statements runs the risk of making the curriculum unachievable...” (Lofthouse et al. 1995, p.14).

Questions/issues from medical school’s culture and environment angle:

7) The medical education literature report about contradictions in medical students' world: contradiction between declared and observed norms (Shuval, 1980); contradiction between explicit and implicit messages ('hidden curriculum', see: pp.33-39); contradiction between students' status in patients’ and society’s view, and their actual status in the ward and team (Hass and Shaffir, 1987; Konner, 1987). Hence: Are ethical encounters and moral dilemmas inherent in Medicine and medical training? If so, is there anything medical educators can do to reduce moral conflicts?
8) **Is the ethical reality of medical students distinctive to their special stage in the training process?** or is it "an initiation into the central paradox of the physician human condition – being at once both powerful and powerless"? (Feudtner et al. 1996, p.10); Are the dilemmas students face similar in essence to dilemmas that residents encounter later, (Baldwin, 1998), or is there a qualitative difference?

9) The previous question is related to an old debate in the field of medical education: the polemic about the status of medical students. According to Merton and his Columbia associates (Merton et al., 1957), medical school is conceived as an institution within the medical profession, while the students are already accepted as colleagues – 'Students-Physicians', as the classic book by Merton et al. (1957) is titled. The Chicago group of Becker et al. (1961), on the other hand, views medical school as a more separate and distinct institution in its own right and relates to the students as 'Boys in White', in a subordinate position separated from the faculty by a high social barrier, and forced to undergo a difficult ordeal before being allowed entrance into the profession. Hence: **Is there a distinctive "student culture" in regards to their ethical reality?** What are the collective aspects of the ethical dilemmas and the coping strategies employed by students?

Those conceptual questions and possibly others may serve as potential interpretive frameworks for the present study, according to the data gathered and analyzed by it.

**Final comments: Students’ ethical dilemmas**

The multitude and magnitude of conceptual questions articulated in the previous section, point out that this field of study has produced mainly ideas and concepts for future research orientations. Nevertheless, some subjects concerning medical students’ dilemmas have already gained conceptual maturity. The accumulated knowledge and understandings revolve around two areas: (1) An awareness to medical students’ unique ethical reality; and (2) Implications of the information about medical students’ dilemmas to ethics education in medical school.
1) **Awareness to dilemmas:** A taxonomy of students' ethical dilemmas has already been provided (Christakis and Feudtner, 1993; Bickel, 1993, Bissonnett et al., 1995), emphasizing that the predicaments medical students confront differ from those that other member of the medical team face. The role of the student, lodged within the social structure of hospital-based medical education and specifically the medical team, shapes student dilemmas. As the students embark on their hospital wards, they bring with them professional and personal ideals of ethical behaviour from individual experiences. However, clinical training frequently erodes rather than reinforces these ideals. A phenomenon called 'ethical erosion' has been documented (Feudtner et al., 1994), pertaining to students' perception of erosion of their ethical principles, expressing dissatisfaction with their ethical development, and experiencing themselves as acting unethically. This sense of ethical erosion correlates with students' observations of unethical behaviours by other members of the medical team. Thus, students experience confusion about what constitutes ethical behaviour in the wards.

2) **Medical ethics education:** it seems evident that 'traditional' medical ethics education has not equipped students with the types of moral skills they need. Medical students typically have experienced ethical dilemmas differing significantly from those presented in medical ethics courses (Fox et al., 1995). Training medical students to behave more ethically entails teaching them how to respond to their ethical dilemmas.

By way of summary, it is important to point out issues that are not yet known or studied. How does the experience of serving as apprentices in clinical wards relate to ethical views and moral values of students? What aspects of this experience and its environs affect students' ethical development most? What are the fundamental processes that underlie the ethical conflicts that students encounter, and what do these conflicts reveal about the medical training process and the basic 'human condition' of young students? There is a need to explore how the ward environment affects students' evolving conceptions of what being an ethical medical doctor entails, and to evaluate fundamentally the types of values routinely transmitted to students during their clinical training.
Paradoxically, although the focus of the present study is not upon teaching medical ethics, most of the information obtained by now that concerns students’ dilemmas originates from various ethics courses settings, and aims at ethical teaching improvements. Apparently not much is known about the inner processes of coping with ethical problems. There is a lack of empirical interpretive information about the processes the students actually experience, as students should be asked about the broad context of their ethical reality during their clinical training. The students have been asked specifically in various studies what are the moral dilemmas they have encountered (e.g., Chistakis and Feudtner, 1993; Bissonnett et al., 1995; Huijer et al., 2000), but not as an exploration of the whole process they are involved in. It would be significant to know how students interpret their moral reality, how they interpret their coping strategies, their responses, their decisions, their doubts and their personal development. Studies about doctor stories (Hunter, 1991), physicians’ biographies that describe their medical school years (Konner, 1987; Conrad, 1988) have supplied narrative data about medical school processes, though from a time and role distance.

The objective of the present research is to conduct a study of medical students' narratives, to elicit their deep personal stories that describe and reflect upon their ethical life, their ethical self, as perceived by them. Such a study of the ethical reality of medical students in the context of their personal experience could aim at analyzing the meaning of medical ethical training process to their life and identity. In its representation of subjective experience, narrative gives access to perceptions and valuation of people, as stated by Nicholas and Gillett (1997):

“Narrative depicts events embedded in the lives and ongoing concerns of the protagonists, it represents moral choice not as a snapshot but as unfolding web of character and motivation, luck and circumstance – with all the apparent non-essentials that give human beings their sense of identity” (p.296.)
Summary

When summarizing the Literature Review, several topics seem to be parallel in the two main sections of the review, the two perspectives of the present study: (A) Curriculum perspective: a holistic framework of an education-training program; and (B) Ethics perspective: aspects relating to medical students' coping with ethical reality in medical education. These topics representing the connection between the ethical reality of medical students and curriculum studies are:

- 'Total curriculum' – a concept that encompasses the overt and the 'hidden curriculum', in various educational settings, relates to ethics acquisition.
- Student experience of the curriculum – a concept that is reflected both in the notion of students' ethical reality and in the concept of 'received curriculum'.
- Contextual approach within curriculum perspective – a concept that is parallel to situational-contextual ethics, in ethical perception.

Methodological considerations of the present study, that examines contextual-ethical students' experience, and perceived ethical reality, recommend qualitative interpretive paradigms (such as phenomenology and narrative inquiry) as the preferential research approaches. These qualitative approaches are compatible with studying the broad context of human experience, such as the ethical processes in a medical training program.

The present study aims at researching the actual ethical learning in medical school. Therefore, it evaluates the 'total curriculum', mainly the hidden and informal, by trying to understand what the students have been actually receiving or learning. The contribution of the present study is (1) that it aims at studying ethical reality in medical school through concepts from the field of education, as reflected in the curriculum domain; and (2) that it aims at studying ethical reality in medical school through concepts from ethics research domain. Both are new research endeavours. In an attempt to discern what are the deep ethical processes in a medical training program and what is the received ethical curriculum, the present study is designed to examine the students' world mainly through open
questionnaires and interviews with medical students and medical school faculty members, in attempt to understand the context through its participants. The methodology by which this study is conducted is addressed in the following chapter.
Chapter Three

Methodology

This chapter begins by restating the study's objectives and research questions. It then presents the theoretical paradigmatic context of the methodological framework and the research strategy, by outlining considerations in choice of research tools, and research design. Further on, it reviews population/sampling considerations and the process whereby the research instruments were refined. This is followed by a discussion of the concepts and methods of data analysis and of validity: trustworthiness, generalisability and limitations of the study. Finally, ethical considerations relevant to the study are analyzed.

I. Introduction

As the overview of the literature in the previous chapter highlights, although there is a growing interest in medical students' moral dilemmas and some research of 'hidden curriculum' in medical education, there is hardly any research that has thoroughly probed the ethical, personal and curricular processes medical students face. It is this ethical reality of medical students including their conflicts and coping mechanisms, their moral development and changes, and the ethical curricular aspects of medical education, that the present study addresses. Thus, the research questions are:

1. What are the perceived moral dilemmas and ethical conflicts in the medical students' reality?
2. How do medical students cope with their ethical reality? What strategies do students use for coping with ethical encounters?
3. How do medical students acquire and construct their ethical perceptions in the course of their medical training?
4. What are the perceived ethical-curricular processes in medical school?
5. What are the expectations of medical students and faculty members from the school curriculum and from themselves concerning ethical aspects of medical training?

This study's concern is the medical students' ethical reality, focusing on the students' experience in medical school and their interpretation of this reality. Defining the study in terms of students' experience of the curriculum, and in terms of the perceived moral reality from the point of view of its actors, frames it within a methodological paradigm of qualitative *Facere* phenomenological-interpretive research, as discussed later in this chapter.
II. Locating the Study

**Theoretical context: conceptual and empirical framework**

Two conceptual frameworks deriving from 'curriculum' and 'ethics' studies have been reviewed in Chapter two. The current curricular perceptions that have been discussed emphasize the centrality of students' experience of the curriculum, the presence and significance of the 'hidden curriculum' and the contextual approach to curriculum studies.

As for the ethics perspective, several theoretical frameworks have appeared to be relevant to this study: the concept of ongoing, meaningful moral development in adulthood, the situational-narrative approach to the study of moral encounters, and the incipient body of research concerning moral dilemmas of medical students.

The present study aims at linking these theoretical bodies of knowledge by studying the ethical reality in medical school using concepts from both educational and moral development fields. In particular, the theoretical context of the study is intended to fill a void in the body of knowledge that has so far been accumulated regarding moral dilemmas of medical students, and that can be briefly summarized as mappings and typologies of dilemmas, a growing awareness of the inherent ethical conflicts in medical training, and a growing curricular awareness of students' moral dilemmas. While previous studies asked students about their ethical dilemmas and conflicts, much of that research was conducted in questionnaire surveys, where complicated situations could not be elaborated upon.

Moreover, even when more narrative forms of research were used, whether in open questionnaires or written or oral case-reports, the focus was on separate, specific, isolated dilemmas that were analyzed and categorized, and not on long-term, deep processes.

Thus, conceptually, the overall ethical reality of medical students has not been systematically exposed. The holistic story of six years of ethical processes, conflicts, development and changes has not yet been told. Nor have there been empirical studies until now that interview students about their perceptions of the ethical aspects of their training.
and invite them to reflect on medical school experience from personal, contextual perspectives.

This study aims to enhance the understanding of the explicit and implicit moral processes and the personal ethical experience of young people in a long meaningful training period, as reflected through their own viewpoints. This objective led to the adoption of the methodological framework presented below. Both theoretical premises and applied aspects are discussed.

**Methodological mapping**

Qualitative research has been adopted widely by educational research because it enables exposure of processes, attitudes, values and norms, by collecting and analyzing authentic data (Sabar Ben-Yehoshua, 2001). More specifically, qualitative inquiry is applied in curriculum research: "The efforts to uncover the 'hidden curriculum', to trace the ways by which knowledge is socially constructed, and to expose the bias and power relations, have been the focus of qualitative-naturalistic paradigms" (Lincoln 1992, p.89). In the study of moral dilemmas, a narrative contextual approach (Gilligan, 1986; Brown et al., 1988; Brown et al., 1989; Gilligan et al., 1990; Tappan, 1990; Brown and Gilligan, 1991), aims at developing frameworks that can "describe the complex, frequently paradoxical and ironic, nature of moral actions" (Brown et al. 1989, p.164).

A methodological-paradigmatic mapping of the present research states that (I) it is located within the qualitative-naturalistic research paradigm, (II) it follows the phenomenological tradition, (III) it adopts an interpretive methodological approach that (IV) is based on narrative texts, (V) obtained through interviews and open questionnaires. The following section analyzes each component of this statement with regards to the research methodology literature and to the attributes of the present study.
Qualitative-naturalistic research paradigm

Bassey (1999) describes a paradigm as "a network of coherent ideas about the nature of the world and the function of research which, adhered to by group of researchers, conditions the patterns of their thinking and underpins their research actions" (p.42).

The choice of paradigm is related to the purpose of inquiry, the question being investigated, and the extent of control the researcher has on the occurrences (Yin, 1984; Creswell, 1998; Lincoln and Guba, 2000). A qualitative-naturalistic research paradigm is chosen to "study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meaning people bring to them" (Denzin and Lincoln 1998, p.3).

These values of qualitative research are integrated in the preset study that investigates the complex processes of ethical encounters in a learning/training situation of individuals and groups. Some characteristics of this study related to qualitative research attributes are:

1. The starting point of the research – the attempt to find unique and personal patterns, as well as collective ones.

2. Significance of the meaning of the occurrences in the eyes of the people that take part in them – findings are substantiated with narrative data reflecting the personal perspectives of the students and their teachers.

3. Context – medical school and medical training treated as a cultural environment.

4. Aims – exposing hidden or tacit ways by which certain values, attitudes and behaviours are transferred.

Phenomenological tradition

The phenomenological tradition is seen as central to the qualitative research paradigm (Holstein and Gubrium, 1998):

"Many of the qualitative research approaches are indebted to the phenomenological tradition... as they share a set of subjective assumptions about the nature of lived experience and social order, derived most directly form Alfred Schutz's attempt to"
develop a social phenomenology bridging sociology with Edmond Husserl's more philosophical phenomenology" (p.138).

Several of the phenomenological tradition's major attributes as articulated by Patton (1990) characterize the present study:

(a) "The phenomenologist is committed to understanding social phenomena from the actor's own perspective. He or she examines how the world is experienced" (p.57).

The present study focuses on medical students' perspectives of the ethical reality they encounter. Furthermore, when the medical school's faculty members were interviewed, they were also asked about the students' perspective.

(b) "Phenomenological inquiry focuses on the question: "what is the structure and the essence of experience of this phenomenon for these people"? The phenomenon being experienced may be an emotion – loneliness, jealousy, anger. The phenomenon may be a relationship – a marriage, or a job. The phenomenon may be a program, an organization, or a culture" (ibid, p.69).

The present study analyzes the meaning of students' ethical reality from various angles: emotions, attitudes, personal processes and values as well as relations with patients, peers and faculty members. In this context, the training program, group culture and norms are also considered as part of the studied phenomena reflected in the students' accounted experience.

(c) "A phenomenological perspective can mean either or both (1) a focus on what people experience and how they interpret the world (in which case one can use interviews without actually experiencing the phenomenon oneself), or (2) a methodological mandate to actually experience the phenomenon being investigated (in which case participants' observation would be necessary)" (ibid, p.70).
The choice of the researcher in the present study is to focus on the students' experience through their accounts and through their interpretation, using open questionnaires and semi-structured interviews, described in following sections.

(d) "There is one final dimension that differentiates a phenomenological approach: the assumption that there is an essence or essences to shared experience. The experiences of different people are bracketed, analyzed, and compared to identify the essences of the phenomenon" (ibid, p.70).

The assumption adapted in this study is that medical students' shared experience is meaningful beyond the experience of each individual. The analytical strategies, elaborated upon later in this chapter, reflect the two concepts of human experience – the idiosyncratic individual aspects of experience ("within-case analysis") and the shared collective aspects of experience ("cross-cases analysis").

**Interpretive methodological approach**

Tesch (1990) identifies different approaches to analysis: (I) Approaches based on language, in which the focus is on how language and discourse are used; (II) A 'descriptive' or 'interpretive' approach, which "seeks to establish a coherent and inclusive account of a culture from a point of view of those being researched" (Tesch 1990, p.9); and (III) 'Theory building' approaches, in which the generation of theory is the primary goal.

The present study is located within the second approach, which seeks to construct a comprehensive and authentic description of the process the research subjects are going through in their training program. Thus, the analysis is interpretive and descriptive in nature, rather than linguistic, or theory-generative.

Critics of interpretive approaches commonly point to the subjective nature of all interpretations. However, this study adopts the concept advocating that a presentation of coherent, well-documented, substantiated, meaningful interpretation is capable of reflecting
a phenomenon, even though other interpretations may be valid as well (Denzin, 1998; Lincoln and Guba, 2000; Sabar Ben-Yehoshua, 2001).

**Narrative texts**

Narrative research, according to Lieblich et al. (1998) definition, refers to any study that uses or analyzes narrative materials. The present study can be classified as a narrative one, as all its data obtained through open questionnaires and semi-structured interviews is narrative in nature, containing accounts of events, ideas, stories and thoughts of the subjects. This research's assumptions are that "people are story tellers by nature" (Clandinin and Connelly 1998, p. 152) and that "one of the clearest channels for learning about the inner world is through verbal accounts and stories presented by individual narrators about their lives and experienced reality" (Lieblich et al. 1998, p. 7). In other words, narratives provide the study with access to people's identity, personality and self-understanding.
III. Research Strategy

The research was conducted using two complementary methodologies: (a) open questionnaires and (b) semi-structured interviews, administrated to two research populations: sixth-year medical students (questionnaires and interviews-for-students), and medical school faculty members (interviews-for-teachers).

Open questionnaires as a research strategy

The two-page questionnaire includes four questions (1-4), each followed by a space of about ten lines for the answer (Appendix no.1). The first two questions of the questionnaire are designed to elicit data concerning the ethical reality of medical students: Questionnaire's question (1) that deals with moral dilemmas and conflicts the students encounter, corresponds with research question number one; questionnaire question (2) that asks about students' coping mechanisms with the dilemmas, corresponds with research question number two. The other questions of the questionnaire are designed to elicit data concerning perceived ethical curricular processes: Questionnaire question (3) that seeks for consultation patterns in regards to moral dilemmas, corresponds with research question number four; questionnaire question (4) that deals with students' expectations from medical school in regards with ethical encounters, corresponds with research question number five.

The open questionnaires provide several advantages of a quantitative research approach – uniformity, easy administration and minimal dependency between subject's response and researcher's behaviour or personality. At the same time, the information elicited by the questionnaires is qualitative since it is narrative in nature, embedded within contextual and situational data, and consequently complex for analysis and comparison. Thus, the questionnaires provide relatively abundant data about issues the researcher wishes to be quantitatively informed (such as consultation patterns, suggestions for curricular/organizational methods medical school might apply in ethics training), while they also enrich the research with narrative materials (moral dilemmas and coping
strategies) that in conjunction with the interviews' narratives, build the 'narrative corpus' (Lieblich et al., 1998) of the present research.

**Interviews as a research strategy**

Although this study applies more than one research tool, interview is regarded as the main research strategy, because, as Fontana and Frey (1998) point out: "Interviewing is one of the most common and most powerful ways used to try to understand our fellow human beings, because interviewing is interaction and social science is the study of interaction... The interview becomes both the tool and the object" (p.47).

Patton (1990) also attributes to interviews the strong qualities that are central to this study's research strategy: "Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit" (p.280).

The present study uses the semi-structured interview's strategy that involves outlining, before interviewing begins, a set of issues that are to be explored with each respondent, and insuring the interview remain conversational and situational. During the interview, the guidelines outlined in advance serve as a basic checklist to insure that all relevant topics are covered. However, a very important feature of the interview is its openness to variations and different lines of conversation according to the subjects' understanding of the questions and the reality they are describing. As this study deals with complex and long-term processes covering an abundance of occurrences and events, it was reasonable to assume that most subjects had not previously systematically articulated the nature of the ethical process of medical training. Thus, any suggestions of definitions or criteria by the interviewer might have influenced the way the interviewees narrated and analyzed their reality, and as such were carefully avoided. The study followed two of Cohen and Manion's (1994) criteria for productive interviews: (a) "Non-direction" or a minimal guidance by the interviewer and (b) "Depth and personal context" that is, that the interviewer should give much space in order to elicit personal context, idiosyncratic associations, beliefs and ideas. Two additional features, somewhat more specific to the present study's interviews can be
pointed out: (1) A "phenomenological strangeness" (Schutz, 1970) – as the researcher is not a physician, she could be considered an outsider or a stranger to the interviewees. (2) An "epistemological adventure" (Leiblich et al., 1998) – the interview may serve the interviewees with a unique opportunity to think, to analyze and to articulate issues and conflicts, in ways they have not previously encountered.

The semi-structured interview was advantageous for this study since on one hand it is open enough to enable personal understandings and emotions to be exposed, and on the other hand it is not totally open, so that the interviewer has some control of the interview time and the direction of questions. This allows for analysis on a rational basis. It should be emphasized that relative to semi-structured interviews, the present study interviews are rather open, because the questions lead to personal styles of narrations that do not resemble one another. The flexibility of the interview is based on the assumption that every interview is a unique encounter, a dialogue between the interviewer and the interviewee (Lieblich et al., 1998). While there are some solid "anchors" of similarities between all the interviews, namely questions that are repeated in all of them, there were significant differences in the dynamic of each interview – structure, style, analyses provided by the interviewees, and directions taken by the interviewees. The two analytical systems applied in this study (presented in a following section), reflect this dual nature of the interviews by giving a place to their similarities – via categorization, and to their uniqueness – via 'ethical profiles' readings (see: pp.88-89).

**Research course**

The research strategy involves several steps carried out in a purposeful sequence:
1. Open questionnaires, designed in line with the reviewed literature and the objectives of the present study were administrated to sixth-year medical students.
2. Preliminary analysis of data provided by the questionnaires was subsequently used in designing the interview schedule for medical students, according to the reviewed literature and the objectives of the present study.
3. Interviews with sixth-year medical students were conducted.
4. Preliminary analysis of data from the students' interviews was used in designing the interviews' schedule for medical school faculty members. One specific ethical dilemma that appears in a student questionnaire was chosen to be included in all faculty members' interviews. (Appendix no. 4).

5. Interviews with faculty members were carried out.
IV. Data Collection Methods

This section presents the research tools of the study: the context of research population and sampling considerations for each tool, the process of research tools' piloting and refining, and administrative procedures.

Open Questionnaires

Sampling and administering
The sixth year's curriculum in the medical school includes a mandatory two weeks intensive course titled "Physician and Society". The sixth-year cohort's students, who attended the introductory lecture of that course, were addressed, at the end of it, by the researcher and were asked to voluntarily participate in a study by answering an anonymous open questionnaire. They were also informed that in a later stage some of them would be addressed by telephone for their consent to be interviewed.

The sampling approach for this tool was "purposeful random sampling" (Patton 1990, p.179), since the class as a whole was a relatively small size sample (62 students), chosen for in-depth qualitative study. The return rate for the questionnaire was relatively high (60%), as 38 students answered it (n=38). Although the questionnaire was anonymous, gender could be identified because of Hebrew grammar in 35 out of 38 returning questionnaires, of which 19 respondents were male and 16 were female.

Instrument development
The open questionnaires were based on the previous literature and on the present study objectives. In choosing and articulating the questions, an effort was made that:
1. Questions would concentrate on topics the research was aimed at focusing on in a relatively quantitative manner.
2. The format would be 'friendly' – not too long, but leaving enough space for free and comfortable writing.
Accordingly, four questions were phrased:
The wording of the first question – "Describe a significant moral dilemma you personally had to cope with as a medical student during your six years of medical school" – was articulated in a way that specified that a personal dilemma was expected, not necessarily from clinical years, as the BGUMS has a unique 'early clinical exposure' training program (see: 'Introduction' chapter).
The second question – "In what manner did you cope with the dilemma?" – was phrased to elicit information about mechanisms used to cope with real ethical dilemmas, a topic that previous studies have neglected.
The third question – "Who, if any, have you addressed or consulted with concerning the dilemma?" – was aimed at identifying consultation patterns (Hicks et al., 2001).
The fourth question – "In what ways can medical school help students cope with similar dilemmas?" – was articulated to elicit suggestions for the medical school training program and expectations of it, without directing the answers to certain curricular or organizational solutions. As previous literature has not dealt with ethical aspects of the 'received curriculum' (Jackson, 1992), this question was intended to be so general and open that it would facilitate the greatest possible diversity of response.

The questionnaires were piloted on ten fifth-year students, from the same medical school, whom the researcher addressed in a clinic rotation. The assumption was that fifth-year students, after completing almost two years of clinical rotations in the wards, are rather similar in their experience to their sixth-year colleagues. The return rate of these questionnaires was very high (eight out of ten) and yielded meaningful results: the answers were elaborate and rich with narrative materials that seemed to satisfy the research objectives and provide valuable and illuminating data. As no alterations seemed necessary, the questionnaires were addressed to the sixth-year students as described above. The full format of the open questionnaire appears in Appendix no. 1.
Students Interviews

Sampling and administrating

In building the sample for students interviews there were two main considerations: (a) sample size, and (b) ways of choosing the interviewees.

(a) Qualitative inquiry typically focuses in depth on relatively small samples, and its logic lies in selecting information-rich informants (Patton, 1990). There are no rules for sample size in qualitative studies (Sabar Ben-Yehoshua, 2001), and there is always a trade-off between the researches' breadth and depth. Lincoln and Guba, (1985) recommended sample selection "to the point of redundancy" (p.202) which is difficult to identify and define. In the present study the decision was to interview 14 students, about one quarter of the entire population, as the length of interviews and the richness of materials provided both abundant and manageable data.

(b) Students' names from the sixth year cohort were picked randomly by the researcher (every fourth name in the class alphabetical list) – a "random purposeful sampling" (Patton 1990, p.179), and the students were phoned and asked to be interviewed. If they agreed, an interview time was scheduled; if not, the next person on the class list was called. There were two exceptions to this rule of random selection: (1) the aim of the researcher was to have an equal number of male and female students – a strategy of "stratified purposeful sampling" (Patton 1990, p.182), that illustrates characteristics of particular subgroups; (2) when an interviewee recommended another class mate as a interesting prospect or as a willing interviewee, this person was called – a strategy of "opportunistic sampling" (Patton 1990, p.183) that follows new leads during field work.

The interviews were held in a medical school office, lent to the researcher by a colleague, a convenient location for the students that was equipped with taping facilities and provided a controlled quiet environment. Immediately following the interview, the researcher wrote down, in an "interview diary", any observations she had about the interview.

Instrument development

The interview was developed on a triple basis: (1) information gathered from the literature about students' ethical dilemmas; (2) preliminary findings emerging from the open
questionnaires data; (3) the objectives of the present study, aiming at revealing and understanding students' perspectives on the ethical processes they undergo during their training. Thus, correspondingly, some of the questions were planned to be related directly to "classical" students' moral dilemmas (topics derived from the literature): medical 'practicing' procedures (Bickel, 1993; Feudtner and Christakis, 1994; Bissonnet et al., 1995), 'silent' witnessing of ethical misconduct (Dwyer, 1994), and cynicism (Eron, 1955; Wolf et al., 1989; Feudtner et al., 1994), and some of the questions were planned to be related broadly to the students' conceptualization of ethical processes, to their evaluation of the medical training program and curriculum from an ethical point of view, and to personal perspectives.

The initial interview schedule was designed and two pilot interviews were carried out with a male and a female student from the sixth-year cohort. The pilot interviews' style, as a whole, proved very productive: (1) both pilot interviews were information-rich; (2) trust had been established; (3) taping procedure went smoothly and timing seemed reasonable to all concerned. However, some problems emerged, relating both to interviewing style and to unproductive questions:

1. It was noticed that the interviewer should avoid expressions of familiarity and comments as much as possible, as the atmosphere can become too friendly and supportive, and lose its scientific rigor.
2. An extra effort should be made not to ask leading questions.
3. A question phrased: "How do you define a moral dilemma?" proved to elicit textbook answers and clichés and was eliminated.
4. A question phrased: "Describe a moral dilemma you faced before you became a medical student" proved to reach back too far and related to the world of teenagers' in a way that seemed remote and irrelevant, and was also eliminated.

The final interview schedule was then developed, with each question written on a different card to allow for changes in order of questioning. Each card contained a number of variations of the same question, relating to different aspects of the topic being discussed, to
allow suitable phrasings of questions, according to subtle nuances in the process of the interview. A transcript of an interview schedule appears fully in Appendix no. 3.

Several distinctive stages and parts of interviews and several questions are fully elaborated below.

The opening part of the interview, whose purpose was to establish rapport, included:
(1) introducing the researcher, the study and the nature of qualitative-naturalistic research;
(2) getting informed consent for the interview; (3) discussing confidentiality issues;
(4) introducing the procedures of the interview – taping and transcribing. Each interview lasted about an hour and a half. All the interviews were taped, transcribed verbatim and typed.

The first question in all the interviews asked the students to describe a significant moral dilemma they had encountered in medical school. This question was meant to serve as a "warm-up", because of its relatively defined boundaries. It also marked the personal narrative-contextual nature of the interview. Comparability with the questionnaires was also aimed for. The last question in all the interviews asked the students to add anything that might enhance the researcher's understanding of the topic under investigation, and was not brought up during the interview (sometimes the aforementioned "phenomenological strangeness" was referred to at that point).

The remaining topics that were addressed in the interview presented below. It should be noted that with the exception of the first and last questions, the order was not strictly adhered to. In almost all interviews there were other "supplementary" questions that were proposed as part of elaborating on certain points, or as additional topics introduced by the interviewees.

- The interviewees were asked to relate to the ethical aspect of medical school as a process and to analyze what were the stages, the turning points etc. This question was deliberately phrased in terms that had been used by the subjects themselves previously in the interview, to create "a 'sharedness of meanings', in which both interviewer and
respondent understand the contextual nature of the interview" (Fontana and Frey 1998, p.68).

- The topic of acquiring experience through procedures performed on patients – 'practicing' – as a basic moral issue in medical school (as pointed out in the literature: e.g., Bickel, 1993; Feudtner and Christakis, 1994; Bissonnett et al., 1995) was raised and quested about directly, or, preferably, in response to the interviewee's narration.

- The factor of 'silence' (not reacting when witnessing un-ethical acts), that was also mentioned frequently in the literature (Dwyer, 1994; Swenson and Rothstein, 1996), was brought up by the interviewer, only if proved to be relevant to what had been said by the students.

- The students were asked to describe/analyze what steps had been undertaken by the medical school faculty members and physicians in relation to students' ethical reality and moral issues.

- The students were asked to evaluate what could or should have been done concerning ethical issues in medical school, in terms of curriculum, organizational managerial elements and so on.

- Although it is advisable (Seidman, 1991) to avoid speculative questions, the students were asked to assume that one day they would be senior physicians and would teach students in the wards, and were asked to analyze what they would do concerning their students' ethical reality and encounters. This question was deemed appropriate for sixth-year students in their final stage of studentship, who could probably visualize the next phases of their career and reflect on their student years from a relatively outside perspective.

- The students were asked to give a title of their own to the ethical process of medical students, or a headline that highlighted the topic researched. This question appeared to be not at all easy, and some interviewees tried to avoid it. However, after patient waiting, this question usually opened some interesting venues to personal reflections.
Faculty Members Interviews

Sampling and administrating

The choice of seven faculty members (two females and five males) to be interviewed followed two special criteria for purposeful sampling articulated by Patton (1990):

(1) "Intensity sampling – Information-rich cases that manifest the phenomenon intensely, but not extremely" (ibid, p. 182) – three of the interviewed faculty members were physicians who train students and are known for their interest in ethical issues, such as holding a monthly department ethics seminar;

(2) "Sampling politically important cases" (ibid, p. 182) – four of the interviewed faculty members were physicians holding significant roles in the medical school: current and former heads of the admissions committee and the head of the internal medicine internship program.

As faculty members were not the primary focus of the present study and their interviews were aimed at helping understand the students' ethical reality, it was important to interview people who were aware of ethical issues and of students' encounters. In short, people who had proved to be interested in the topic and were willing to relate to it and to contribute their perceptions. Interviews with faculty members were not carried out for verification purposes and as such were not needed to sample the variety of training styles among faculty members, but rather to shed light on students' accounts from the additional viewpoint of experienced people who are familiar with the medical school environment and issues.

The interviews were held in each faculty member's office, for their convenience, a location that could not be controlled for perfect taping conditions. Nevertheless, administrating the interviews went rather smoothly, with only a few interruptions by phone calls and pagers. Immediately following the interview, the researcher wrote down, in an "interview diary", any observation she had about the interview.

Instrument development

This interview was developed on the basis of preliminary findings from the open questionnaires and preliminary findings from the interviews with medical students, after the
14 interviews were initially analyzed. Practically no literature has been written so far about the way faculty members at medical schools perceive students' ethical reality and development. The interview was piloted with one faculty member who is a prominent figure in the medical school (head of residents training program), and who as a personal friend of the researcher, was willing to help. After the pilot interview the researcher and the interviewee discussed the interview, and on the basis of the interview and the discussion the final schedule was designed. Even though the questions (see below) may appear rather structured, the interviews with faculty members were even less structured than the semi-structured interviews with the students. Although several topics appeared in all interviews, faculty members, being so different in their background experience (unlike the students that shared the same status and stage of life), led the interviews in some idiosyncratic directions. A transcript of an interview schedule appears fully in Appendix no. 4.

The introductory part of the research was similar to the students' interview. The basic questions in the interview with faculty members concerned:

- Awareness of the ethical reality of medical students
- Mapping the training process from ethical viewpoint - stages, years, etc.
- The role of medical school in training for ethical coping mechanisms
- Their personal role as medical students' teachers, concerning ethical issues
- Their response to and reflections on a typical moral dilemma students confront - the dilemma was chosen from the questionnaires, and was presented on a typed card to secure anonymity and uniformity (see Appendix no. 4).
- What was done in medical school concerning the ethical reality of medical students?
- What should be done, or could be done?
- Personal conclusions and reflections as teachers in a training program, concerning ethical issues and curriculum.

All the above described instruments produced an abundance of contextually rich narrative data that posed a challenge to analysis and stimulated the data analysis considerations elaborated upon in the following section.
V. Analysis

Lieblich et al. (1998), following Bakhtin's (1981) "dialogical listening" suggest that working with narrative materials requires attention to three "voices": the voice of the narrator (the interviewee), the "voice" of the theoretical framework – that supplies the terms and tools for interpretation, and the reflective "voice" of the researcher – that monitors the process of reading and interpretation, with awareness of its nature. The awareness of these "voices", namely the analysis considerations of the present study, is the concern of the following section.

The analysis section focuses mainly on the approaches used for analyzing students' interviews, that were perceived as both challenging and central to the present study. The interviews with the students were complex and personal, concerning processes and events not simple or easy to tell about. The analysis of the open questionnaires and the interviews with faculty members are presented briefly at the end of this section.

The double-approach choice

The two main approaches for reading, interpreting, and analyzing narrative materials are "categorical" versus "holistic", or "contextual" approaches (Huberman and Miles, 1998). The categorical perspective, in which sections are collected from several texts belonging to a number of narrators, may be adopted when the study aims at understanding a problem or a phenomenon shared by a group of people. In contrast, the holistic approach, in which the story of a person is taken as a whole, may be adopted when the study is interested in the development of the person to the current position.

As this study aimed at understanding ethical processes of individuals that belong to a group, both approaches seemed relevant: viewing the medical students as a group – finding themes that collectively emerged, as well as deeply listening to each person's story, identifying inner motives and reflections. Limiting analysis to just one approach would have been problematic: with categorization and coding "the text that is cut out is taken out
of its natural context" (Bryman and Burgess 2000, p.218), while with holistic analysis, differences in narrations can make it difficult to draw patterns. Reading the interviews, abundant with contextual situational materials, it became clear that any limitation of the research approach would result in a loss of the richness of the materials or undermine the study's effectiveness. Consequently, it was decided to follow both approaches: (1) categorization of the interviews utilizing a content analysis technique; and (2) analysis of each interview as a separate entity, examining individual profiles of ethical coping and personal development.

**Cross-cases approach – content analysis**

The categorical-content approach is also familiarly known as "content analysis". Adopting this approach, categories of the studied topic are identified, and separate sections of the text are extracted, classified, and gathered into these categories or groups. In the present study where a "directive interview" (Lieblich et al. 1998, p.113) was used, namely, an interview that instructed the subject to focus on specific "relevant" material, all the obtained text can be taken as appropriate data for content analysis (Wiesman and Leiblich, 1992).

In an effort to be inclusive and encompassing, the study used: (1) both pre-defined categories and text-emerging ones; (2) no pre-set decision about breadth of categories; and (3) a dynamic process of categorization. In practice, this appeared to be a rather circular procedure that involved careful reading, suggesting categories, sorting the subtext into the suggested categories, generating ideas for additional categories or for refinement of the existing ones, and so on.

The categorization process treated the interview texts "horizontally" (Patton, 1990), relating to all the text equally, section by section, according to its content, with no attention to what question was referred to or in what stage of the interview it was narrated.

The first step was to pre-define several content categories expected to be relevant, according to the theoretical framework – categories such as 'practicing medical procedures'
(Bickel, 1993; Feudtner and Christakis, 1994; Bissonnett et al., 1995), 'silent witnessing of unethical behaviour (Dwyer, 1994), 'growing cynicism' (Eron, 1955; Wolf et al., 1989; Feudtner et al., 1994), 'identifying with the patients vs. identifying with the staff' (Conrad, 1988; St. Onge, 1997), 'students' status' (Becker et al., 1961; Haas and Shaffir, 1987; Peyton, 1998) and so on. Each pre-defined category was allocated a separate file. Then the reading of the text began, and any new, emerging content – theme, topic, attitude, statement or utterance – that seemed likely to form a new category, was also allocated a file. Whilst reading the first two interviews, more than a dozen new categories emerged, such as: 'modelling', 'interpretations of the term responsibility', 'paradoxes and contradictions', 'peer influence' and so on. As the reading proceeded, fewer new categories emerged, but more modifications had to be made, such as better definition of categories, combining two categories, or dividing a single broad category into more illuminating or better defined elements. With any new category emerging, or any change in the categories' combination, an additional reading of the previously read materials had to be done for re-sorting the data. Any classification or re-classification step (opening a new category, building a new combination, a division to sub-categories) was recorded in a "content analysis diary" that documented the whole categorization process.

In the next stage of analysis, every broad category that appeared to be significant and data-rich, was treated separately as a new "raw" text – with content analysis of its own. For example: many sections of data were gathered in the category-file relating to students' increasing or decreasing cynicism/sensitivity. This "new text" was analyzed again for patterns, contradictions, and sometimes, if relevant, even for enumerative counting of certain statements or utterances.

**Within-case approach – holistic multiple readings**

The holistic-content analysis in this study related to the complete interview of an individual, using a method of several repeated readings of it, each time with an alternating focus. This process of constructing the interpretive tool with its different readings was
Brown et al. (1989) elaborately articulated their methodology:

"The interpreter reads the story a total of four different times. Each reading serves as a lens to identify a different aspect of the narrative deemed relevant in locating self and ascertaining moral voice, each reading amplifies different voices" (p.148-149).

In the present study the process of interpretive analysis of the interviews took place in four different "circles of reading", each focusing on a different theme:

(1) The "self" reading – the extent of coherence vs. confusion; self-boundaries; contradictions vs. integrity; personal presentation vs. collectivity ("I" talking vs. "We" talking); uniqueness of the interview (special features of it).

(2) The "student" reading – viewing oneself as student vs. physician; existence of typical coping pattern; focusing on student status issues.

(3) The "ethical training" reading – analysis of processes in medical school; awareness of special issues in training and education; learning processes.

(4) The "moral credo" reading – existence and components of a set of values; personal, contextual morality vs. fixed, solid moral principles.

After four separate readings of each interview, major themes were analyzed and profiles of coping with moral reality could be offered.
Analysis of data obtained by other research tools

A. Open questionnaires – A relatively clear-cut analysis methodology was applied: the narrative answers to each question were filed together, thus forming a text that was analyzed by content-analysis approach, searching for categories and typologies. The categories were then combined with the categories identified in the interview texts.

B. Interviews with faculty members – Fairly holistic reading of the interviews was used, with marking and grouping major themes. In first reading of all the corpus of faculty members interviews the following themes appeared to be both salient and meaningful: (a) how the interviewee mainly perceived medical students – as "Boys in White" (Becker et al., 1961) or as "Student-Physicians" (Merton et al., 1957); (b) what the medical school had already done, could have done, or should have done concerning students' ethical reality; (c) how the faculty members perceived their role as student trainers from the ethical perspective; (d) are ethical dilemmas inherent to medical training; (e) what developmental effect, if at all, can a training program have on young adults.

The following table summarizes the ways by which this study coped with major problems and challenges of qualitative analysis:
Table no. 1:
Coping with major problems and challenges of qualitative analysis

<table>
<thead>
<tr>
<th>Problems/Challenges of Qualitative Analysis</th>
<th>The Present Study's Coping Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;The difficulty of attaining a higher order of abstraction without compromising authenticity&quot; (Bryman and Burgess 2000, p.219)</td>
<td>• Cross-case categorization – for attaining abstraction</td>
</tr>
<tr>
<td></td>
<td>• Within-case holistic readings – for retaining authenticity</td>
</tr>
<tr>
<td>&quot;How far concepts in qualitative analysis are defined a-priori, or emerge out of the research's data&quot; (Bryman and Burgess 2000, p.219)</td>
<td>• Allowing both pre-defined categories and text-emerging ones</td>
</tr>
<tr>
<td></td>
<td>• Performing a circular dynamic categorization process</td>
</tr>
<tr>
<td>&quot;The tension of reconciling the particular and the universal, between uniqueness and generic process&quot; (Huberman and Miles 1998, p.194)</td>
<td>• Repeating several &quot;circles of readings&quot; that amplify the uniqueness of the individual &quot;self&quot;</td>
</tr>
<tr>
<td></td>
<td>• Searching for patterns, categorizations and typologies that reflect the generic, the typical</td>
</tr>
</tbody>
</table>
VI. Validity of the Study

Establishing validity in qualitative research poses a challenge, as criteria for validity are bound to be different than those in positivistic research. An alternative concept to validity, that of trustworthiness, has been advocated, in an effort to grasp the unique nature of qualitative study (e.g., Creswell, 1998; Bassey, 1999). The term most often used in connection with trustworthiness and confirmation issues is triangulation, a means of cross-checking data to establish validity: "Triangular techniques in the social sciences attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint" (Cohen and Manion 1994, p.233).

A 'various standpoints approach' was adopted by the present study that used three of the four basic types of triangulation identified by Denzin (1978):

1. 'Methodological triangulation' – the use of multiple methods to study a single problem or program. This study relied on open questionnaires and interviews.
2. 'Data triangulation' ('population triangulation') – the use of a variety of data sources in the study. This study interviewed both medical students and faculty members of the medical school, that have a direct role in the students' training.
3. 'Theory triangulation' – the use of multiple perspectives to interpret a single set of data. In this study, the students' interviews were analyzed through two different research perspectives: (a) holistic (within-case) perspective and (b) content analysis (cross-cases) perspective, approaches representing two separate conceptual-theoretical frameworks.

A methodological limitation of the present research is that it studied one cohort of students in one medical school. However, as a phenomenological study, aimed at understanding the ethical reality of medical students and the meaning they give to their ethical experience, it addressed the challenge of 'single-case research' (Cohen and Manion, 1994) with the following attributes:
1. The interviews that were relatively long were deep and elaborate in nature, since they were focused on one specific (though vast) topic, the ethical aspect of medical training.
2. A relatively large proportion of the students' population was interviewed (25%).
3. The faculty members' perspective, reflected in their interviews, added a longitudinal dimension since they are involved in training other cohorts than the researched one.

The present study faces the challenge of generalisation ability commonly faced by every qualitative-interpretive study (Creswell, 1998; Denzin and Lincoln, 1998). The study addresses generalisation criteria on several levels:

1. The questionnaires and interviews were based on previous research literature, that provided a solid starting point and conceptual framework.
2. Several topics that appear in both open questionnaires and student interviews (e.g., the moral dilemmas students are exposed to, coping mechanisms, and suggestions for the medical school's future handling of ethical issues) provided the study with a relatively large number of answers that established a certain level of generalisation.
3. The 'narrative corpus' (Leiblich et al., 1998) that included all the narrative materials elicited by the three research instruments, created a very large body of data, containing numerous units of content that quantitatively enriched the analyzed categories of the 'Findings' chapter.

Finally, it is important to emphasize that in the paradigmatic framework of the present study which is mainly phenomenological and interpretive, generalisation ability and trustworthiness are closely related to a rigorous and reliable analysis of the materials elicited by all research instruments.
VII. Ethics

Ethical aspects of research have become central within the research community (e.g., Howe and Moses, 1999; Cohen et al., 2000; Busher, 2002). Many studies in the fields of education and social science evidence this growing awareness of moral issues and of the need for researchers to address ethical considerations concerning their subjects (Cohen et al. 2000). This growing awareness of research ethics is most probably related to the growing application of interpretive research paradigms, as much of the discussion of ethics is focused, though not exclusively, on qualitative research, (Busher, 2002). This has resulted in various articulations of codes for ethics in research, among which is the British Educational Research Association (1992), with general concepts such as respect for subjects and for democratic values, and with specific practical requirements of ethical procedures.

In spite of the universal nature of ethical codes, each study has its own features and nature that obligate the researcher to construct a relevant ethical code for her research, based on the general principles and concepts as adopted for the specific study's setting and needs. The following section presents the ethical considerations of the present study.

Two aspects of this study required a cautious ethical approach: (1) The "topic sensitivity" (Lee, 1993), that is, the involvement of students and faculty members in the evaluation and analysis of ethical processes in a training program in which they participate; (2) The main research tool, namely the semi-structured, in-depth interviews. Because the objects of inquiry in these interviews are human beings, extreme care must be taken to avoid any harm to them (Fontana and Frey, 1998). Patton (1990) phrases it in strong words: "Interviews are interventions. They affect people... Reflecting on an experience, a program, or one's life can be change-inducing" (p.353).

With awareness of these two aspects, the present study puts particular emphasis on the following ethical principles:
1. **Informed consent:** Consent received from the subject after he or she had been carefully and truthfully informed about the research objectives and procedures (Fontana and Frey, 1998; Howe and Moses, 1999). This major concept of research ethics derives from the subject's right to freedom of choice and self-determination (e.g., Cohen and Manion, 1994).

The present study followed the conditions that Cohen and Manion (1994) define as essential for a proper informed consent: the subjects (students and faculty members) were **competent**, they **volunteered** to participate, were **fully informed** about the study and could **comprehend** the explanation. Voluntarism – the questionnaires were distributed right after the end of a lecture, attended by all the students, and nobody was pressed to return them; the requests to be interviewed were made through phone calls and there was no pressure whatsoever to agree, as anybody could refuse on principle grounds as well as because of technical reasons like time schedules; Information – at the beginning of each interview there was a rather long introductory part, whereby many facts about the study were explained: its purposes; its nature; the credentials of the researcher as an interviewer; the procedure of taping, transcribing and sending the transcriptions for comments; the issues of privacy, anonymity and confidentiality that are addressed later on. The student interviewees were also informed about the further steps of the research, namely the interviews with faculty members that would be based on the findings from their questionnaires and interviews.

2. **Privacy:** Protecting the rights of the subjects to remain private (Fontana and Frey, 1998; Howe and Moses, 1999), especially when the research, like the present one, intends to probe into personal aspects of individuals' affairs (Cohen and Manion, 1994).

The present study regarded privacy as a primary value of human rights and attempted to secure it through the two mechanisms of "anonymity" and "confidentiality".

3. **Anonymity:** Protecting the identity of the subjects (Fontana and Frey, 1998; Howe and Moses, 1999) avoiding any link between data items and individuals.
In the present study no personal names were mentioned at any stage, and an effort was made to minimize the identifying details of events, people and places so that they could not be recognized. There was however some limit to the degree of anonymity, as, for example, some stories included details about different stages in the training process, mentioning "internal rounds" or "surgical rounds", though without relating to any specific department, or to identifiable staff members.

4. **Confidentiality**: Refers to the ways data is protected and used, especially regarding dissemination to third parties (Burgess 1994). The concept relates to data access and ownership (Patton, 1990).

In this study the data information was not transferred or conveyed to anyone, unless previously agreed. For example, students were informed that collective findings from their data, however not on any individual base, would be presented to faculty members during their interview. In cases where several students spoke in the interview about the same event, or in cases of students referring in the interview to faculty members who took part in the research or vice versa, the parties involved did not know anything about it.

5. **Protection from harm**: The ethical principle of "Non Mal-Facere" (Beauchamp and Childress, 2001), means that risk assessment is undertaken to avoid any physical, emotional, legal or educational harm (Patton, 1990).

The present study estimated that no harm of any kind could be inflicted to the subjects: (a) all the privacy measures that were taken should avoid any embarrassment with the schools program or authorities; (b) the interview atmosphere was very supportive and non-judgmental, to avoid any pressures or emotional discomforts or harm; (c) the researcher was not involved with the training program and the research process could have no bearings on the position of the participants.

To summarize, there are two main areas of research ethics that can be identified: (a) respect for the rights of the subjects, and (b) the pursuit of truth (Pring, 2000, quoted in Busher
2002, p.73). Nevertheless the area that is often translated into common practice, through
codes of conduct, is mostly the first one, dealing with issues of respect, dignity and privacy
(Busher, 2002). The present study followed carefully the codes of conduct concerning the
rights of the subjects. As for the second aspect, the "pursuit of truth", the present study,
located in the phenomenological-interpretive paradigm, did not claim to supply "true
answers", but rather to constantly attempt to pursue meaningful answers through truthful
and trustworthy ways.
Chapter Four

Findings

Introduction

The purposes of the present study are to identify and analyze the ethical reality of medical students, including their conflicts, coping mechanisms, moral development and attitude change, and the implications of their daily ethical experience, and to explore ethical curricular aspects of medical school, such as learning processes, students' experience of the curriculum and suggestions for ethics training in medical school.

Accordingly, the research questions are the following:

1. What are the perceived moral dilemmas and ethical conflicts in the medical students' reality?
2. How do medical students cope with their ethical reality? What strategies do students use for coping with ethical encounters?
3. How do medical students acquire and construct their ethical perceptions in the course of their medical training?
4. What are the perceived ethical-curricular processes in medical school?
5. What are the expectations of medical students and faculty members from the school curriculum and from themselves concerning ethical aspects of medical training?

For achieving these objectives, the study gathers data by two complementary methodological instruments: open questionnaires addressed to a cohort of sixth-year medical students, and semi-structured interviews with 14 sixth-year medical students and with seven faculty members who have taught them in medical school. Thus, the Finding chapter presents the data obtained from two research tools and from two researched populations.
The structure of the 'Finding' chapter

The findings are presented according to nine categories – seven thematical categories presenting data obtained from students, and two inclusive categories presenting data obtained from faculty members. The categories are the product of a 'content-analysis' of the entire 'narrative corpus' obtained from the 38 open questionnaires and the 21 interviews (see: Methodology, pp.89-90). The relation between the research questions, the research tools and the categories is presented in the following tables:

Table no. 2:
The relation between students' thematic categories, data sources and research questions

<table>
<thead>
<tr>
<th>Thematic Category</th>
<th>Data Source</th>
<th>Relevant Research Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students' Dilemmas</td>
<td>• Questionnaire Question no. 1*</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>• Student Interview Question no. 1**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student 'Narrative Corpus'**</td>
<td></td>
</tr>
<tr>
<td>Coping Mechanisms</td>
<td>• Questionnaire Question no. 2</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>• Questionnaire Question no. 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student Interview Question no. 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student 'Narrative Corpus'</td>
<td></td>
</tr>
<tr>
<td>Silence</td>
<td>• Student Interview Question no. 3</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>• Student 'Narrative Corpus'</td>
<td></td>
</tr>
<tr>
<td>Cynicism vs. Sensitivity</td>
<td>• Student 'Narrative Corpus'</td>
<td>(2)</td>
</tr>
<tr>
<td>Ethical-Learning Processes</td>
<td>• Student 'Narrative Corpus'</td>
<td>(3)</td>
</tr>
<tr>
<td>A Six Year Processes</td>
<td>• Student Interview Question no. 4</td>
<td>(4)</td>
</tr>
<tr>
<td></td>
<td>• Student Interview Question no. 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student 'Narrative Corpus'</td>
<td></td>
</tr>
<tr>
<td>Expectations for Ethical Training</td>
<td>• Questionnaire Question no. 4</td>
<td>(5)</td>
</tr>
<tr>
<td></td>
<td>• Student Interview Question no. 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student Interview Question no. 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Student 'Narrative Corpus'</td>
<td></td>
</tr>
</tbody>
</table>

* Appendix no. 1
** Appendix no. 3
*** Appendix no. 3
**** Libbiech et al., 1998
Table no. 3:
The relation between faculty members' inclusive categories, data sources and research questions

<table>
<thead>
<tr>
<th>Inclusive Category</th>
<th>Data Source</th>
<th>Relevant Research Question</th>
</tr>
</thead>
</table>
| Ethical Reality of Medical Students – Faculty Members' Interpretation | • Faculty Members Interview Question no. 1  
• Faculty Members Interview Question no. 3  
• Faculty Members 'Narrative Corpus'' | (1,2)                      |
| Ethical Curricular Training Process – Faculty Members' Interpretation | • Faculty Members Interview Question no. 2  
• Faculty Members Interview Question no. 4  
• Faculty Members Interview Question no. 5  
• Faculty Members 'Narrative Corpus' | (3,4,5)                   |

Appendix no. 4  
Libliech et al., 1998

It is important to note that the data-analysis process of the present study included a 'within-case' analysis (see: 'Methodology', pp.89-90), that yielded 'ethical profiles' of the interviewed students. The 'ethical profiles' are incorporated in the 'Discussion' chapter as part of several interpretive frameworks. As the 'ethical profiles' are idiosyncratic in nature, their presentation as raw data in the 'Findings' chapter would have necessitated a 'cross-cases' processing that is inappropriate for such holistic materials (Brown and Gilligan, 1991; Denzin, 1998; Leiblich et al., 1998). Consequently, it was decided to integrate the 'ethical profiles' as constructive elements of the Discussion.


**Conceptual comments**

- The circular dynamic categorization process of the 'content analysis' produced both pre-defined categories and text-emerging ones (see: Methodology, pp.88-89). Thus, out of the seven thematic categories presenting students' data, four categories are pre-defined - "Students' moral dilemmas", "Coping mechanisms", "A six years process" and "Expectations for ethical training", while three categories are text-emerging - "Ethical learning processes", "Silence" and "Cynicism vs. sensitivity". The two categories that present data elicited from faculty members' interviews are more inclusive in nature. The first one, "Ethical reality of medical students – faculty members' interpretation", includes all the data related to ethical reality of medical students, while the second one, "Ethical curricular training processes – staff members' interpretation", includes all the data related to ethical training processes in medical school.

- The data obtained from the two research instruments (open questionnaires and students' interviews) are all integrated in the seven students' thematic categories, since, as became apparent when the materials were analyzed, they yield the same kind of materials and they involve the same narrative analysis (see translated samples of students' questionnaires, Appendix no. 2). Thus, the depth of the present study presenting understandings of the researched phenomena stems from the interviews that penetrate deep into the students' world, while the breadth of the present study understandings stems from the questionnaires that broaden the number of dilemmas, of coping strategies, and suggestions for the ethical training program. The integration of both data sources in the 'Findings' chapter enables the study to present the researched phenomena as wide-scoped and personally-deep, simultaneously.

- In contrast, the findings on students and faculty members are presented in totally different categories, thus enabling a valuable comparison, that is presented in the 'Discussion'.

102
• As is common with findings of a phenomenological-interpretive nature, there are few quantitative remarks regarding how many students expressed each idea or observation. Since emphasis was on relevant processes, reactions and ideas expressed by students or faculty members, the exact numbers of the individuals who exposed the data is less relevant. The study does, however, refer to the frequency or volume of certain phenomena, notions or expressions indicating if it is only one person that says it, if it is unique or usual and so on. Accordingly, descriptive quantitative terms, such as many, few, frequent, most, hardly any, sometimes, almost never, rather rare, and so on, have been used. Exact numbers of references are mentioned (in tables) when it is relevant, and where quantitative information is both available and significant – in the categories: "Students' moral dilemmas" (typology of the dilemmas), "Coping mechanisms" (consultation patterns), and "Expectations for ethical training".

**Technical comments:**

• The findings presented in the nine categories are articulated as texts, including observations, ideas, classifications, accounts, and descriptions, all supported with direct citations from the subjects' accounts. Some of the citations are short, even in headline format and some, that are more personal and elaborate, are delivered in detail as long format narratives.

• Citations from the open questionnaires are titled "Anonymous", while citations from students' and faculty members' interviews are identified with fictitious first names.

• The researcher's remarks are added in the following format: [.... E.B.]
Students' moral dilemmas

This section presents: I. An introductory part that explains how the body of dilemmas was methodologically and conceptually constructed; II. The nature of the dilemmas; III. Typology of the dilemmas according to criteria of decision-making and personal responsibility.

I. Construction of the body of dilemmas

The dilemmas presented are gathered from two research tools: questionnaires and interviews. The first question in the questionnaire: "describe a moral dilemma you personally had to cope with during the six year of medical school", was answered by all the students that returned the questionnaires (n=38). The same question was addressed to all interviewed students (n=14), at the beginning of the interview. Additionally, most students frequently describe during the course of the interviews more moral dilemmas they had encountered. The total number of distinguishable moral dilemmas narrated by the students in open questionnaires and interviews is 74. These dilemmas are specific events which the students identified as moral dilemmas they had coped with. Examples:

"An aggressive physician examined a patient and undressed him brutally" (Yotam);
"A patient of mine asked about his treatment and I did not know whether to tell him to go for a second opinion" (Anonymous); "I did not tell the first patient I drew blood from that I am a student. He would never have let me do it" (Hila)

Interestingly, reading the interviews, it was found out that the students refer also to yet other kind of ethical situations – not dilemmas specifically relating to certain events, but ongoing ones, relating to recurring events. Many (51) times along the interviews the students described routine or usual situations which they consider ethically problematic. Thus, besides the "specific-events" kind of moral dilemmas exemplified above, the students relate also to an "ongoing-recurrent" kind of moral dilemmas they encounter. Examples:
Many times when you see physicians examining patients, the question arises whether they behave as they should. Questions about behaviour toward patients, towards us, towards patients’ families" (Yotam); "I’ve witnessed many times that patients do not get the information they should get and their needs are ignored in a patronizing manner" (Omer); "There are situations when I do not introduce myself as a student" (Ido)

As the two sets of the above cited examples show, the topics of the “specific-events” dilemmas and the “ongoing-recurrent” ones seem to mutually correspond. The validity of the “specific-events” dilemmas reported by the students in the questionnaires and the interviews is confirmed and empowered by the descriptions of the repetitive nature of ethical situations encountered in medical school. The similarity of both kinds of ethical events (specific dilemmas and routine, general dilemmatic situations), motivated the decision to include in the category, "Students’ moral dilemmas", all students' references to their ethical encounters (n=125).

II. Nature of the dilemmas

An overview of the moral dilemmas reported by the students reveals that most dilemmas are related to the routine reality of the clinical wards, and generally do not involve dramatic occurrences. These situations are characterized as “miniature”:

"The situations are miniature: you have to report on more information than what you actually examined, you debate whether to go back to the hospital because you forgot to do something, you do not know whether to admit a mistake you’ve made" (Alon)
The dilemmas are mundane and ordinary:

"Most of the cases are the ordinary daily situations: taking blood and causing pain to someone, examining people when you are in a bad mood and do not feel like being nice, not performing a rectal examination even when needed, not examining a patient thoroughly because you are in a hurry as someone is waiting for you" (Gilad)

The dilemmas are "ethically simple":

"Most of the situations we encounter are not complicated ethical dilemmas but improper behaviours that form simple daily ethical dilemmas" (Oren)

Nevertheless, the "uncomplicated" ethical nature of the dilemmas does not make them simple to solve or to cope with – it seems that it is easier to solve the "big moral dilemmas" (that are discussed in ethics courses), than to cope with the daily real actual personal dilemmas:

"The big decisions – like parents who refuse to give permission for their child’s operation – are simple to solve. The small dilemmas are difficult to solve or to decide upon" (Gilad)

The moral dilemmas students report, that are actual, contextual and situational in nature are categorized within that typological frameworks given below.
III. Typologies of the dilemmas

Typologies of the dilemmas as presented by the students

Presentation of vast data of dilemmas (125 dilemmas) requires some kind of categorization according to typological criteria. During the interviews several students suggested possible classifications of students' moral dilemmas in medical school. These are illuminating as they point out major areas of ethical concern. One student classifies the dilemmas in a minimal way – by merely two central topics that are too limited and do not cover the whole range of topics reported:

"The dilemmas, composed of many small-scale situations, can be grouped into two general issues: (1) While working in a team you see somebody who functions improperly, in my opinion; (2) What you can and cannot say to a patient, as a student" (Shoshana)

Another student provides a wider scope by defining two typological criteria:

"There are dilemmas between me and the patient: how much I harm him and how much am I allowed to harm him. There are dilemmas between me and the system, i.e.: delaying a patient in an 'emergency' because students, for their practice, examine him thoroughly, which causes nurses in the ward to work extra hours" (Yaara)

A third student defines a gross division between universal dilemmas and medical students' dilemmas, and then defines several areas within the framework of students' dilemmas that mostly relate to students' status and role:

"There are universal dilemmas and there are medical students' dilemmas:
   - concerning students' personal status
   - concerning criticizing the system"
- concerning loyalty to the system
- concerning students' responsibility to study and practice" (Tami)

Yet another student distinguishes between dilemmas one copes with:

"Typical dilemmas: how much to tell a patient – you are usually asked before the patients asks the staff; how many procedures I should perform and so on" (Rami), and "dilemmas of "life and death' – you are exposed to them but do not cope with them" (Rami)

This later criterion, the degree of active coping with the dilemma, proves to be an illuminating one. It came to serve as an inclusive comprehensive criterion, encompassing all the reported dilemmas, and is the core criterion in the typology constructed by this study, presented below.

**Typology of the dilemmas: the "responsibility continuum"**

When medical students report their moral dilemmas a major issue is raised, relating to the degree of responsibility they have concerning the ethical situations they encounter. One extreme view denies any responsibility: "As a student I did not have any responsibility for any decisions" (Ayala); another view claims a by-stander position: "Students are in an ethical observational stance, not in any position for decision-making" (Irit). On the other hand, there is also a claim for active moral responsibility of students in medical school:

"Our main dilemmas concern what we are allowed and not allowed to do – when is it within the framework of what we are allowed and when our morality is to be judged" (Yaara)

It seems that students' ethic dilemmas form a responsibility continuum line that ranges from ethical situations where students do not have any personal responsibility to situations where they can either react or not, to situations where they have to decide whether to actually do something or not. Accordingly, the typology places the 125 dilemmas on a " responsibility
continuum": (1) ethical issues and situations students are exposed to, which raise ethical reflection and thoughts – "reflection dilemmas"; (2) ethical issues and situations students witness in the wards, that raise the need to decide if and then how to react – "witnessing – optional reaction dilemmas"; (3) ethical issues and situations students directly encounter as part of their medical role in the wards, that force them to decide how to act – "action dilemmas". At the end of the following descriptive presentation of the typology, a chart summarizing data is presented (p.119).

"Reflection dilemmas” (n=11)
Most of the "reflection dilemmas" concern matters of 'life and death': "Most of the dilemmas in the ward relate to 'life and death' and the ending of life" (Alon). Almost all the students mention this topic and relate to it as a central ethical issue. They are bothered by the conceptual ethical aspects of the dilemmas: "A typical ethical issue – we can prolong a patient's life medically, but from a 'quality of life' perspective maybe it is better not to" (Ido), as well as by the behavioural aspect of the physicians' role: "There are many significant ethical and emotional dilemmas in the process of accompanying dying patients" (Gilad). Another aspect that students specify relates to the contrast between the declared statements about 'life and death' issues and the daily reality in the wards:

"In one second they decided in the ward to stop a patient's artificial breathing. The ease surprised me. On the one hand, it is an issue of ethical debates in symposia, and on the other hand, it occurs so 'simply' in reality" (Oren)

"We witnessed euthanasia of patients in coma; in symposia panels the claim is that it should be granted to patients after conscious consent. There is a gap between what you see and the laws" (Rami)

One student describes a very powerful story that represents for him the dilemma of life and death and patients' will, with its complexities:

"There was an 80 year old lady with progressive heart failure that came from an old peoples' home at night and asked specifically not to be resuscitated. She was
asked about her family and she claimed she had no close family. The physician found her to be clear and sane and her wish was honored and she died with no resuscitation. In the next morning her two daughters came and enquired about their mother who had been brought to the hospital at night. This situation is strong and dramatic and touches something deep: life and death and loneliness and autonomy” (Alon)

Students understand and reflect on the gravity and significance of such ethical issues, but they do not regard those 'reflection dilemmas' as part of their personal ethical agenda:

There are dilemmas that I, luckily, don't have to decide upon, like dying dilemmas. However, I think about them, gradually more and more as I progress in the clinics” (Tami)

The next sub-category deals with situations where students have to think not about theoretical conceptual questions but about their reactions to what they observe and encounter.

"Witnessing – optional reaction dilemmas" (n=53)
These dilemmas concern situations in which students observe or witness an act, an event or a conduct that they consider ethically improper. There is a decision to be made whether to react and how. In most of the dilemmas included, the students report that they did not react. The non-reaction phenomenon is elaborated in the 'Silence' category (pp.130-136). The 53 dilemmas of "witnessing – optional reaction" can be divided according to their origin:

(a) Witnessing ethically-problematic human relations (n=24) – The most common topic in this sub-category concerns the human relations in the wards, especially physicians' behaviour toward patients: "We witnessed harsh and degrading behaviour to patients in the physicians' rounds" (Anonymous), but also among physicians: "Doctors in surgery rudely criticized each other" (Yotam), and toward students: "They treated us like mules" (Yotam). Students find physicians' improper conduct toward patients very disturbing from an ethical
point of view, and describe their feelings when encountering such behaviours: "It is so difficult for me to watch the lack of in consideration for patients' pain or discomfort" (Oren). The students' problem is how they should react to harsh behaviour whether in their presence or directed toward them.

A rather frequent example of misconduct relates to patients being humiliated by being undressed in an improper manner:

"The patients' clothes were brutally taken off" (Anonymous)

"An aggressive physician examined a patient and took off his clothes violently. Should I report to anybody about it?" (Yotam)

(b) Witnessing ethically-problematic clinical procedures (n=15) – Students spend three years in the clinics, practicing next to medical teams, and they witness quite a few problematic clinical procedures which they regard as concerning ethical aspects. They report on cases of medical mistakes as a result of negligence, such as "an uncalculated decision to do a mastectomy" (Anonymous) and "fatal diagnostic misjudgment" (Anonymous), as well as more ongoing behaviours that seem clinically improper: "a physician that performs non-consensual treatments" (Gilad). Their main ethical problem is what they should do with the information they encounter:

"There was a patient with rectal bleeding that happened to be a tumor that had not been diagnosed, and was not treated as such. What should I do with that information? Should I inform anybody?" (Ido)

Students also report on situations where the witnessed clinical unethical behaviour is perhaps less damaging than the above-mentioned examples, but the personal ethical behaviour is troublesome. They describe events of personal dishonesty when physicians "often write on patients' charts examinations they did not perform" (Irit). The ethical
question again relates to witnessing and reacting: "what should I do when I witness a physician that routinely reports rectal examinations he did not do?" (Anonymous)

Another aspect of witnessing problematic procedures is related to doubts students have about their status: when they are confident on the one hand that they have some kind of medical knowledge that can help the patients, and on the other hand they are not sure if they can actually say it without jeopardizing their status as neophytes: "Should I intervene and tell the physician that I happen to have more up-to-date data about that syndrome?" (Anonymous)

(c) Witnessing ethically-problematic behaviours/approaches (n=11) – Being in the wards, students are also exposed to ethical dilemmas of a general nature that can occur in any human setting. A dominant issue students are bothered with is an unjust or even racist approach towards certain segments and ethnic groups in Israeli society: "There is a certain amount of racist misconduct" (Anonymous); "Physicians sometimes express racist attitudes" (Irit). One student elaborates and explains that those attitudes are built-in within the system, which makes them even harder to react against:

"The way patients are treated bothers me a lot. The system does not give a fair treatment to patients and it depends on status and ethnic group. It bothers me a lot"
(Alon)

(d) Witnessing ethically-problematic behaviour of students (n=3) – Students are exposed to ethical dilemmas by being members of a class, a cohort of students that spend six years together. Students describe conflicts when facing peers who seem unsuitable to be doctors, and not knowing what their role should be, if any. The dilemmas relate to "trustworthiness – like fictive signing of presence" (Anonymous), to cheating in tests, to improper behaviour of colleagues, and to doubts about colleagues who will become physicians:
"My friend and I were very worried about one of our colleagues who seemed so unfit for medicine. We wondered if we should do anything about it" (Anonymous)

Whereas the dilemmas cited above are classified as witnessing/reaction kind of dilemmas, as the students have the choice whether to react to what they witness or not, the following sub-category relates to medical students' coping with ethical decision they cannot avoid.

"Action dilemmas" (n=61)
These are the dilemmas that students encounter as a direct outcome of being students. Most of the dilemmas in the previous subcategories could have been encountered also by people with a different role in the ward who witnessed ethically doubtful behaviours or reflected upon ethically disturbing issues. In contrast, the "action dilemmas" relate (a) to the special status of students – the issue of providing information to patients, and (b) to students' main function in the wards – the issue of acquiring practical experience.

(a) Dilemmas relating to providing information to patients (n=18) – The centrality of "patients' right to information" as an ethical value in the modern medical world is reflected in students' moral dilemmas regarding their role in providing information to "their" patients. Students in clinical practice spend much more time with patients than the physicians, a situation that often leads to close relations and trust between students and patients that, in turn, leads to the ethical dilemmas, that can be sub-classified as follows:

The first type of dilemmas concerns the conflict between what students know about their patients' medical situation, and what they are allowed to tell. Most of the dilemmas of this kind describe pressures from patients and families for information about procedures: "A surgical patients' parents demanded to know if the operation was justified" (Anonymous); about examination' results: "I was present in a Gastroscopy resulting in a malignant finding. The family waited outside and asked me for the results" (Anonymous); and about clinical problems: "The treatment of a patient of mine had unexpected complications and she consequently died. I did not know whether to tell her family" (Anonymous).
The second type of dilemmas concerns personal ethical decisions students have to make regarding "their" patients. One kind of decision is whether to inform a patient about an alternative treatment: "Should I share with my patient my personal knowledge about a better treatment elsewhere?" (Anonymous), or "Should I recommend other options in other medical settings?" (Anonymous). Another kind of decision relates to informing patients about dubious procedures – for example: whether to tell parents that certain blood tests taken from their kids is for research only, or whether to tell a patient that he is being tested for aids just because a student was injured by a syringe needle and she is very anxious.

In the third type of dilemmas students hesitate whether to rectify situations where there is a conflict between what they have been taught about patients' rights and what they see: "A physician that gives a five-word explanation to a patient" (Yotam); "In a ward where I was practicing, a patient had not been told about a malignant diagnosis for an entire week" (Tami).

(b) 'practicing': dilemmas relating to students' practicing medical procedures (n=43) – Many of the ethical conflicts students describe concern students' need to experience medical procedures with 'real' patients (hereafter: 'practicing'). It is evident that there is an overall agreement with the principal need to practice procedures on patients, as many students express explicitly their general consent to that kind of training:

"The understanding of 'the potential future benefit' enables the practicing. I accept the fact that there is a 'learning curve'. There is no other solution" (Tami); "I do not have problem with practicing. The students that are eager to practice seem like 'vampires' to outsiders, but we were persuaded that we have to learn that way" (Oren); "It is a university hospital and the patients know it. We have to practice on somebody" (Ido)

There is also a developmental diminution factor in the ethical conflicts caused by 'practicing': "In year 4 you feel awful that you hurt patients just for your sake. They do not
gain anything. Today I don't feel that way. It seems legitimate to me" (Yotam). However, in spite of the overall acceptance of practicing, and the diminishing factor of inexperience, sixth-year students, the present study subjects, describe frequent ethical issues and dilemmas related to 'practicing', and raise the issue of moral limits to the general consented right to gain practice as medical students. The 43 dilemmas concerning 'practicing' are presented under the following sub-division: (1) The general ethical issue of 'practicing'; (2) Pressures on students to practice; (3) Limits of 'practicing' – patients' rights and well-being.

(b.1.) General ethical problems of 'practicing' (n=11) – The ethical problems of 'practicing' relate mainly to the basic asymmetry between the students' obvious learning benefits and the obvious disadvantages of the patients. The students refer to the question of reasonableness: even though one accepts practicing as a learning method, there are different aspects to it and variations within the framework of practicing:

"In certain procedures, like gynecological and rectal examinations, you "gain" much more than the patient" (Anonymous)

"The question is how many and what sort of procedures I will perform – it's my gain against the patient's" (Rami)

Another aspect of concern is the ethical question of performing procedures on anesthetized patients. Since "it is common to practice procedures, like intubations on anesthetized patients" (Ido), it seems as a consented issue, though sometimes ethically debatable: "Is it ethical to perform procedures on patients in comma? In my opinion it is not" (Hila)

(b.2.) Pressure on students to practice (n=6) – A rather prevailing issue in 'practicing' relates to a situation in which many students examine one patient in order to practice. One of those dilemmas was introduced to faculty members in their interviews (see: Appendix no. 4), and is addressed later. Several students describe specific ethically challenging situations, where patients (mainly women in gynecological examination) express their stress, while physicians press the students to go on with the examination:
"My dilemma was whether to go on examining a gynecological patient that resisted, because of the physician pressure to do so" (Anonymous)

(b.3.) Limits of 'practicing' – patients' rights and well-being (n=26)

(b.3.1.) Personal embarrassment of patients and students (n=6) – The students show sensitivity to patients' embarrassment during practicing and to their own. Some dilemmas relate to conflicting feelings about performing medical procedures: on the one hand they act like physicians, and on the other hand they still have feelings as laymen would have:

"I felt very embarrassed to examine the testicles of an adolescent boy" (Yaara)
"I had to ethically cope with the treatment of patients that disgust me. To cope with not being able to feel that every person is equal" (Gilad)

Besides having laymen emotions, the boundaries of practicing are not clear and even troublesome:

"How far should I interfere with the treatment of a relative?" (Anonymous)
"One student wanted to attend a gynecological examination of a woman we all knew, and we practically had to drag him out of the examination room" (Hila)

(b.3.2.) Patients' consent – introduction of oneself as a student (n=9) – Another dominant issue concerning 'practicing' relates to students' doubts about whether and how to present themselves as students while performing procedures on patients. Students know that they should introduce themselves as such and ask patients' permission for any procedure, but they express their doubts: "Should you say you are a student when you insert an intravenous"? (Anonymous). The doubts originate from the fear that they will not be allowed to have their try: "I did not tell the patient "this is only the second time I have taken blood". I wanted him to agree so I did not tell the whole truth" (Tami). Another student admits, "Many times I did not introduce myself as a student" (Yaara). An extreme example
of consent dilemma is presented in the 'Discussion' (p.207), as part of a student 'ethical profile'.

(b.3.3.) Causing pain to patients (n=5) – Students are bothered by the pain causing factor of 'practicing', especially during the first year in the clinics, especially to children or elderly weak people, and in specific situations like labor "where one performs painful check-ups just for the sake of learning" (Tami). On the other hand, students are anxious about the fact they are not concerned enough with patients' pain, and instead are preoccupied with their own performance and their personal success or failure:

"You cause pain to people, especially those that are difficult to take blood from, but it is perceived by you also as your failure – you find yourself thinking about your failure more than about their pain" (Rami)

(b.3.4.) Causing harm to patients (n=6) – The general consensus that students express is that 'practicing' should not harm the patient physically: "I would not perform difficult or dangerous procedures that could be harmful" (Shoshana). However, there is an awareness that physical damage is not the only criterion for judging students' practicing on patients. Another criterion might be the mental harm and embarrassment of patients:

"In practicing certain procedures (rectal or gynecological examination and taking arterial blood) you 'gain' a lot but the patient 'loses' a lot" (Anonymous)

Another criterion concerns the degree of potential damage, relating mainly to practicing surgical stitching. There seems to be a conflict between the will to try stitching and the damage that can be caused because of less experienced hands: "I performed a surgical stitching that needed more experience and I regret it" (Anonymous). The following example of practicing stitching demonstrates the complicated nature of the issue:
"A musician (guitar player and teacher) came to the emergency room with a cut in his palm, and a student decided to stitch his cut, even though he was not experienced. This was arrogant and cruel move" (Mili)

A highly debatable issue among the students relates to the stitching procedure after labor (episiotomy), that is considered very delicate and can be potentially harmful. A general statement hints at the scope of the problem: "There are students that push themselves to perform episiotomies and it is awful in my opinion" (Mili), and then the student becomes more personal:

"I did not push myself. If a physician would have offered to sit by me and watch, I would have done it perhaps. I am glad though I was not offered to" (Mili).

More specifically, two students relate at length in their interviews to that issue, representing the depth of the ethical debate. One of them (Hila) was asked, and hence consented to perform the episiotomy and had to defend herself in front of her student friends. Her testimony is presented later in the 'Discussion' (p.208). The other student, Yaara, who rejected the offer, nevertheless reveals what are the forces of temptation to break the ethical limits of no-harm practicing:

"The temptation to practice is immense – you say to yourself, sometime I will have to do it so I will take any chance. There was the big argument about the episiotomy and I was so argumentative and angry. My friend said that residents in gynecology also do it for the first time but before that as clerks they stitch fingers and hands and bellies and only then they do episiotomy... The patient is a human being!! It could have been me that gave birth and was being sewed by inexperienced student!!"(Yaara)
The data summarized in the above chart present the major significant findings:

1. 49% of the dilemmas are "action dilemmas" – situations in which students have to decide, usually immediately, on the spot decisions, whether or not to perform some kind of action (to tell their patient the truth, to perform a complicated procedure, to introduce themselves as students and expose themselves to the patient's refusal and so on).

2. 42 % of the dilemmas are "witnessing – optional reaction dilemmas" – situations in which students have to decide, but not necessarily immediate decisions, whether to react or not (whether to protest, to complain, to report about unethical conduct).
3. When taken together, the two sub-categories that involve students' own decisions about their own actions (in the form of immediate activity or delayed reaction), are overwhelmingly dominant – 91% of the dilemmas.

4. Only 9% of the dilemmas students report as their significant ethical dilemmas during training are the classical medical-ethics dilemmas concerning life and death issues.

5. The sub-category "'practicing' medical procedures" is clearly the largest among the subcategories, with 34% of the total number of dilemmas (70% of the dilemmas in the "action dilemmas" category). This implies that a major ethical issue students have to actively decide upon in their daily ward routine concerns procedures they have to perform as part of their practicing.

6. The sub-category "Witnessing ethically-problematic relations" is the second major one, with 19% of the total number of dilemmas (45% of the dilemmas in "witnessing – optional reaction dilemmas" category). This implies that relations and behaviour in the ward are ethically troublesome to students.

The picture revealed relating to ethical dilemmas medical students encounter shows that the dilemmas are daily, contextual dilemmas, heavily related to the wards' reality and atmosphere, and mainly to students' functioning in the clinics as part of their training. The dilemmas relate mostly to students' decisions about their immediate actions or delayed reaction. The ethical situations relate closely to the training process and to the educational-learning program of the students.
Coping mechanisms

This category examines the various strategies and coping responses of students to ethical problems they encounter, namely the ways they deal with unethical situations they are exposed to. In the interviews there was no specific direct question about "coping with the dilemmas" but students spontaneously described their responses and reactions to dilemmas throughout the interview. In the questionnaires however, question no. 2 - "how did you cope with the dilemma you described" - directly addressed the issue. Answers to yet another question in the questionnaire - question no. 3: "with whom have you consulted about your dilemma" - are also included in the present category because consultation with other people about disturbing ethical issues is considered one of the coping mechanisms.

The most common response to ethical dilemmas students described appears to be the pattern of not responding - not doing anything about it, not saying anything, not reporting or protesting, just keeping silent. As this action (or rather inaction) is so dominant in students' narration and since their failure to act seems so disturbing to them, the data concerning the 'silence' response is excluded from 'Coping mechanisms' and is analyzed separately. Hence, the concern of the present category is rather with active responses of students to dilemmas they face, namely actions they take in their daily routine in the wards: I. Direct responses; II. Indirect responses; III. Alternative performance (acting instead of physicians); IV. Resistance and protest; V. Consulting with others.

I. Direct responses

One pattern of responses that does not frequently appear relates to directly approaching physicians - remarking about a problem noticed by the students or asking for any alteration of the situation. The direct responses or requests seem very minor and humble, and are not articulated in any confrontational way:

"I addressed a physician whom I know to be humane and asked her to deliver the bad news to the patient's daughter before anybody less sensitive did it" (Rami)
In one response where the student sounds insistent, she herself admits that it might not have originated from ethical integrity, but rather from a self-preservation measure:

"I insisted that a physician check after me in 'white admittances' [where students are solely responsible for admittances to the ward E.B.], even though most physicians tend to accept them. However, this can be also interpreted as me covering and protecting myself" (Hila)

II. Indirect responses

Another pattern of responses that seems rather frequent and very complex, relates to indirect requests and questions that in various ways influence what happens in the wards. The students elaborated on that mechanism and reveal both the techniques they use and the reason for this equivocal pattern. As they don't want to raise antagonism by direct confrontations, they find ways of subtle manipulation to make their impact on the reality. Citations in this sub-category are relatively long as they describe sophisticated processes and reflections [the underlining is added, E.B.]:

"We’ve developed the skill of asking gently and indirectly. We ask intelligent questions that are difficult to ignore, like: 'do you usually not tell the patient about... or is it just in this specific case?' I will not ask a direct question because it is out of place and it will not gain anything; a direct remark will raise antagonism" (Oren)

"With a little bit of "brains" one can activate the system...Our coping pattern has to be very clever...You have to be cautious and choose your battles. For example, in emergency, when there is a sensitive case, like a battered woman, I tell the surgeon: 'let me handle it' (if I know him as a person that responds brutally). I can do it because he highly estimates me professionally and appreciates the help I offer him...So we are not helpless... There was not even one case when I said: 'that's it,
there is nothing I can do, I won't do a thing'. You should act indirectly: 'I am sorry doctor but I don't understand, or maybe I misunderstood the textbook?', or: 'what do you think?', or: 'Is there any specific reason that this patient can't have a different pain killer?'. You do not come with a direct attack: 'why doesn't she get valium?', you should do it wisely. There is no situation of complete helplessness" (Rami)

III. Alternative performance – acting instead of physicians

This sub-category presents a pattern that combines direct actions with subtle indirect influence – performing sometimes instead of physicians in an attempt to rectify unethical situations or misbehaviours. Student reports to that effect are rather pessimistic, because of the narrow spectrum of cases one can rectify by this 'doing instead' mechanism:

"When the staff does not do things, you can do some things in their stead, in many small ways. It is much more problematic when the staff does things you don't approve of. Then we don't know how to respond..."(Tami)

Sometimes I don't do anything...My comfort is that I can say something here and there and maybe rectify some evil...most of the time you cannot do anything; it is not your responsibility and you cannot do other peoples' jobs instead of them"

(Yaara)

Apparently, students behave in two different ways that can be related to this mechanism: (a) delivering information to patients, which they are not entitled to by their legal status as students, and (b) performing various kinds of 'corrective behaviours' that can make a difference to the well-being of patients.

(a) Information to patients

It seems that a very problematic situation for students originates from the reality that, whereas they are very close and intimate with patients they 'receive' and accompany, they
are not allowed to inform the patients about their diagnosis and treatment. Only one student that reflects about this legal status claims that she stopped following her prior instincts: "I understood at some point that legally I am not allowed to say or do some things. So I learned not to express my opinion" (Shoshana). All others describe how they consciously acted according to their understanding, usually 'behind the scenes' and 'after formal hours':

"I stayed after the round for few more minutes and talked with 'my' patient" (Anonymous)
"Gradually I advanced in my studies I tried to be more involved, as much as I could. Without criticizing the physician, I simply tried to better explain to the patient what it is all about, or to come after the round and explain things to the patient" (Omer)

(b) 'Corrective behaviour'
'Corrective behaviour' is another mechanism that directly affects patients' emotional and physical being, and is performed in an indirect, implicit or even 'hidden' silent way, when students attempt to rectify unethical situations or improper behaviours they encounter [the underlinings are added, E.B.]:

"There are always daily minor incidents - like not pulling the curtain when examining a patient. The students are usually the ones that bring a mobile curtain when needed, not the physicians. Or, we are the ones that hold the patients' hands, or explain to the patient after the rounds what the physicians omit. Students have more time and more sensitivity" (Hila)
"I try very much to listen. Many times patients have said to me: 'this is the first time I have told it to anybody" (Mili)
"Many times I've found myself apologizing to the patient for the physician that treated him, trying to do some repair. It could be during the morning round when you stay for two minutes by the patients' bed and explain what it was about and what has been done to him and why he was seen naked and humiliated...I don't always do it, and I regret it when I don't. I know that it is difficult for me to take responsibility for other people's deeds" (Shoshana)
"I supported the patient's family after they brutally received a difficult diagnosis in the corridor" (Anonymous)

"To stay by the patient's bed and try to rectify the brutal behaviour of the senior physician" (Anonymous)

IV. Resistance and protest

Two patterns of resistant responses can be traced. Both patterns relate almost always to a collective decision and are infrequent phenomena.

(a) Refusal to perform

A few students reported they actually refused to carry on a gynecological examination of distressed women. One female student describes in detail how she and her friends attended a clinic in a Bedouin village where the gynecologist acted harshly to the women and insisted that many students would examine each woman. The student refused, left the clinics with her two friends, and reported the incident to the program coordinator. Her full testimony is presented in the 'Discussion', as part of an 'ethical profile' (p.227). Two male students describe a similar situation in fewer words:

"I refused to examine a distressed woman when it was my turn" (Anonymous)

"We utterly refused to check gynecological patients that showed resistance to the examination. We were three students" (Ido)

It should be noted that all the cases reported involved very distressed and tense patients who clearly showed their 'non-consent' and that in most cases the refusal was collective, by a group of students, a fact which probably helped in making the decision.

(b) Complaints or formal protests

The few cases of explicit or formal complaint or protest about unethical behaviour represent a different kind of action. The first two testimonies describe events in the early
exposure pre-clinical years, when the students observe the clinical wards but do not participate in their routine. Both complaints are collective ones:

"Students from our cohort complained, in one of the preclinical years, about misbehaviour toward Bedouin patients. Whenever there is a complaint, it is always about misbehaviour of physicians and not about medical considerations" (Alon)

"In year one, we complained about a patient waiting two hours naked in emergency. We even wrote about it to 'Dabeshet' [the medical school students' journal, E.B.]

(Yaara)

Another collective protest process relates to the overall function of a surgical round, without specific reference to ethical issues. The student telling about it is conscious of the futility of their protest and acknowledges that in order to have an impact they should have acted more strongly, which they did not:

"The protest we expressed in surgery round was in the debriefing, where we arrived as a group to protest systematically and strongly. A better way could have been to publish it in 'Dabeshet', but we did not" (Yotam)

Throughout the 'narrative corpus', there is only one 'dramatic' account of a personal, emotional protest, that took place in a 'grand round' in a ward when the physician abruptly undressed an Ethiopian patient in front of 20 students:

"It was so appalling to me that I took some steps backwards and stood aside, not to be part of that scene. But the physician noticed my move and asked me to approach and then I told her I felt uncomfortable with the situation. She started shouting at me: 'what's the problem? In our ward we have to examine patients all over...put your gloves on and examine the patient'. She really embarrassed me by shouting at me for two long minutes. However, after I stepped aside she gave the patient his pajamas to cover himself and I felt that I had achieved something for him. And
finally, I think she appreciated me and I got an A from her, though I was in panic before the exam" (Yaara)

The student that tells about that incident also admits that it was a unique, specific case of expressing her emotions: "I just could not restrain myself because I had met this patient before and I knew how shy and timid he was" (Yaara). 'Rebellion' and 'protest' are not frequent occurrences.

It seems from the data that there is no one mechanism that is typical or exclusive to one student. Interestingly, students claim basically that their pattern of behaviour is not unified and coherent and describe it rather as a mixture of strategies depending on situational circumstances and personal motives:

"I sometimes make criticizing remarks, sometimes I ignore the situation, sometimes I 'make a face', and maybe somebody notices it, or maybe not" (Alon)

"There are situations that you let wrong things pass and think about it later, and you realize that the whole day you've been moody and nasty... there are situations that you do not even pay attention that you are misbehaving...there are situations that on the spot you know that you are wrong, you know it" (Gilad)

V. Consulting with others

The issue of consultation with others about a dilemma was addressed directly in question no. 3 of the questionnaires. Thirty three students related to it. The answers given are mostly very short, just naming the figures with whom the students have consulted, with no additional information about the nature of that consultation and its results. In the interviews, four students relate to that issue, one of them with significant elaboration, an account to be presented later (p.129). Table 4 presents the various figures and persons students have consulted with about the ethical dilemmas they present.
Table no. 4:
Persons with whom medical students consult about ethical dilemmas

<table>
<thead>
<tr>
<th>With whom the students consult</th>
<th>No. of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other students</td>
<td>16</td>
</tr>
<tr>
<td>Spouses and other family members</td>
<td>5</td>
</tr>
<tr>
<td>Junior physicians</td>
<td>4</td>
</tr>
<tr>
<td>Senior physicians</td>
<td>2</td>
</tr>
<tr>
<td>Non medical school friends out of medical school</td>
<td>2</td>
</tr>
<tr>
<td>Lecturers in medical school</td>
<td>1</td>
</tr>
<tr>
<td>Nobody</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>

There are several issues raised by the data:

- The role of fellow students as consulting figures is prominent. It appears that when a student is bothered by a dilemma he/she quite frequently consults with classmates, preferably from the same clinical rounds, who usually form a group of friends within the entire cohort. It is not a random consultation with other students, but rather a selective and exclusive one:

  "I discussed it with friends doing the rounds with me" (Anonymous)

  "We discussed it together – the group of students-tutors of the same course" (Anonymous)

  "The discussions among us strengthen us a lot" (Yaara)

- The number of students not discussing or consulting with anybody calls for attention.
• It is also apparent that the number of physicians consulted with is low, and especially low when relating to senior physicians (head of wards or deputies), who are basically responsible for the students' training.

An interesting elaborated account relates to a consultation with a lecturer (of bio-ethics) in medical school. The student, in the early clinical exposure of year one, attended an "abortion committee" presided over by an extremely harsh gynecologist who humiliated the young women summoned to his committee. The student wrote about her shocking experience in a paper submitted to a lecturer of ethics, analyzing models of paternalism. The lecturer told the student in a personal conversation that:

"Of course he leaves the question for me to decide about but he would recommend that I not complain or report, because it could harm me as I will be perceived as a 'trouble-maker'. And I did not do anything, not a protest and not a report, besides writing about it in that paper and thinking about it a lot" (Tami).

It is interesting to realize what role this lecturer may have played in this early phase socialization process of not "rocking the boat", and of being or becoming "silent".

The coping mechanisms that students report present, quite convincingly, the complexity of dealing with ethical situations that are contextual or actual in nature. It appears that there is not any single coping mechanism which seems as suitable or is preferred, certainly not for a group of people, and not even for one person for a long duration. The reactions depend on the situation, the persons involved and the context. The various coping mechanisms, most of them subtle and indirect, relate to a combination of contextual common sense on the one hand and moral integrity on the other hand. It is important to note the type of "students' culture" that is revealed in the patterns of consultation that they commonly activate, mainly among themselves.
Medical students refer in their testimonies to the reasons why often they do not do anything or say anything when they witness an unethical unjust or insensitive behaviour. It should be emphasized that it is not the researchers' judgment about the nature of the unethical conduct. All these references are made by the students – they describe situations that are by their own judgment wrong, and concomitantly explain, sometimes apologetically, why they have not done anything about it, in spite of their ethical convictions. The references to 'silence' are gathered from the questionnaires' data – question no. 2: "How did you cope with the ethical dilemma you described?", as well as from the rather elaborated explanations of situations in the students' interviews. The most salient features of this 'silence' phenomenon are its high frequency and the variety of reasons provided to account for it. There were 30 references to 'silence' issue in the 38 questionnaires, and out of the 14 interviewees, 11 students, related to that topic, though none was directly asked about it.

The data is presented in three sub-groups of reasons explaining 'silence': (I) Reasons related to students' status; (II) Reasons related to medical school structure; (III) Reasons related to values and attitudes.

I. Reasons related to students' status

- The most common reason for 'silence' relate to self-interest and personal fears. Three types of reasoning that relate to preserving the self interest of the students and to their apprehensions can be traced:

One very frequent explanation of the "silence effect" is the fear of retaliation by the faculty member (the senior physician) that is involved in the event the student has considered protesting against or complaining about:

"Our future is in his hands so we were forced to be silent" (Anonymous)
"You do not make any remark because of your status as a student. You do not want to get in trouble because you are being graded, so you do not get into futile conflicts. And you know why you do not say anything or react. It is obvious to you" (Gilad)

"When I tried to make some remarks I was pushed aside in such a manner that I did not have any energy left to go on and to do anything about the incident. I was too busy calculating my grade and I was worried about my own interests" (Shoshana)

The second type of self-preservation is not specific but relates to students' consciousness of how they are regarded by the staff and about their image in the ward: "I was worried about my personal well-being: I didn't want to be hated" (Alon).

The third type of personal apprehensions is an irrational, general fear and helplessness acquired in an authoritarian environment, that is described by a student with strong words:

"There is something that I don't know where it comes from, but there is this kind of fear that I can be hurt, can be wrongly treated if I complain or protest. I was sure that the ward head would find out which ward I was heading for and would call them and recommend that I won't be accepted. My thoughts went that far. It stays in your mind. Physicians have much power, they are powerful. I also thought that other wards wouldn't be thrilled to accept the "one that complains", as if everybody knows that I am the trouble maker that wrote this protest. It might be completely untrue but it is located somewhere in your mind, in my opinion" (Yotam)

- Students sometimes do not protest or react when confronted with certain unethical behaviours because they are not sure whether what they think or feel is legitimate. These self-doubts reflect their inexperience and neophyte position. There are expressions of doubt about one's knowledge – whether one knows enough to criticize and evaluate other people's behaviour and decisions: "you find it difficult to be critical because you do not know a lot and you are inexperienced. There is that inner feeling that maybe truly you do not know" (Tami). There are also expressions of doubt about
one's emotions – whether what one feels is the result of being a sensitive young student and not a mature physician: "maybe I am truly too sensitive and do not judge the circumstances rightly" (Mili)

• The students are aware of the limited, temporary and external nature of their position in the wards – the outsider observer stance. That stance is defined by the students both in technical terms of time shortage, and in more substantial terms of an observant, bystander position.

"We only spent a week in that ward. [where they witnessed the unethical behaviour, E.B.] And the whole issue repressed" (Ayala)

"I stay there in the ward for a while and I leave after some time. The physicians there will have to live with their decisions. I am just observing them, as I am not accountable for the results" (Ido)

• Having a medical student's status, implies also seeing yourself as a future physician. Thus, students express also an identification with the future profession they are being trained for, and this identification leads to (1) understanding the physicians they work with and being more forgiving to unethical or improper behaviour, and (2) feeling that they themselves might behave improperly some time in the future:

"How can you judge from your comfortable and protected position, without the commitment, the years of experience, the erosion, the responsibility" (Tami)

"People that are outsiders to the system can interpret these events differently than people within" (Gilad)

"I did not tell anybody about a fault that caused death because the lesson from it was studied by the staff and the physicians made the mistake out of tiredness and not out of wickedness. The students are in a panic – they start to understand that some day they will also make a mistake. Medicine is a complex profession and there is always this risk of making a mistake. People are really afraid about themselves and they are emotionally identifying with the doctors" (Alon)
II. Reasons related to medical school system and structure

- A basic explanation that is given to being silent and non-actively critical relates to the hierarchical authoritative nature of medical school. The students express their feeling that they are in the lowest level of the hierarchically-structured system:

"The system gives the impression of a hierarchical structure and you feel like the last link in the food chain" (Tami)
"They are doctors and they teach us and we are under their authority and we are silent" (Mili)
"You are so small in the system... In five more years I will be able to say my words" (Gilad)

In that hierarchical structure students feel that nobody will listen to them:

"You feel so small and you ask yourself – who will listen to you anyhow?" (Tami)
"I did not feel I could go and tell somebody or do anything about it [the unethical behaviour, E.B.] because the physician that was involved was very senior and had a high status in ward and I did not feel that I would really be listened to" (Shoshana)

- Another attribute of the system, in students' eyes, that prevents them from reporting unethical behaviour is the absence of any direct and clear institutional authority one can complain to or address regarding issues involving ethics:

"I did not know what to do and with whom to consult" (Anonymous)
"The factor that prevented me from doing anything was the absence of a direct authority to deal with such problems" (Anonymous)
"I am sorry to disappoint myself [for not protesting, E.B.], but who would I tell? There isn't any 'head of committee for students' ethical complaints'..." (Yotam)
• The students make it clear that they operate in a system that has prevailing norms of performance and behaviour. It seems difficult for them to react and protest when other people in the same environment accept these behaviours. It is problematic to respond in an unusual way in a normative system with customary routines and conventions: "It is not considered appropriate to speak openly about such issues" (Anonymous)

• Understanding and describing the system as they do, students express deep doubts about their ability to change it. One student summarized his position: "I did not do anything because I do not have any ability to make a change or to influence" (Anonymous). Others described the events they encountered in more detail:

"I was not sure that even if I complained and encouraged the patients' family to complain they would succeed in their struggle and gain anything" (Alon)

"When we did complain, in the 'debriefing's at the end of a ward rotation, how much did it help? The physician that represented the ward in the 'debriefing' did not agree with anything we said. Something could happen only if you went to the press or to the hospital head office, but that would be problematic because we are students" (Gilad)

• The students work in the wards and for the duration of the time they spend in the ward they are part of it. They spend days and nights with the staff and they develop a natural hesitation to provoke an unpleasant atmosphere in the ward. They don't want to be responsible for creating annoying situations for people they team with:

"How can I point to the doctors' mistake without hurting him and causing a confrontation?" (Anonymous)

"You put the physician [that you want to complain about, E.B.] into a complicated situation – the press, a big blow-up" (Alon)
III. Reasoning related to values and attitudes

There are somewhat more abstract reasons attributed by students to the 'silence' phenomenon, reasons that relate to general attitudes, values, and ethical viewpoints: collegiality, moral relativism, moral judgment and moral transmission.

• There are students who emphasize collegiality as an ethical value — not merely the worry about unpleasant relations but a perception of collegiality, respect and loyalty as basic values that student should adhere to:

"The head of the ward is very experienced, so I have to listen and study and not criticize" (Anonymous)

"I was debating with myself whether to complain or to be loyal to the medical team I belong to during my training" (Anonymous)

"I also prefer to be silent as part of the collegial relations among the physicians in the ward" (Ido)

• An interesting moral view expressed by students is relativistic perception, the claim that it is just to protest, complain or criticize, but only in extreme cases that involve life and death situations, or extreme negligence. Accordingly, the obligation to "speak your opinion" or to react does not apply to daily mundane events of improper behaviour or other dilemmas the students recount and are disturbed by. Even though the situations may seem to them unethical, by their own standards, students do not see them as important or irritating enough to oblige or even encourage a moral reaction.

"I have not encounter a situation that was so extreme... I don't have any means of judging if I have developed a "thick skin" but I did not encounter anything that obligated a complaint or a report. There is a wide spectrum of styles. Not every impolite behaviour of a physician should be reported or protested against" (Irit)

"In cases of improper behaviour I witnessed, it seemed to me petty to remark anything. They were not matters of life and death" (Ayala)
"In most cases you witness you don't do anything. Most of the time you just shut your eyes and say to yourself: it is not so bad, there are worse things" (Yaara)

- Another essential ethical issue raised by the students relates to the right to morally judge other people: Do individuals have the right to decide what is right and wrong ethically and to judge others by these norms?:

"A moral issue is a private issue. Moral stance is not something that you can force on other people. My morality is very private and personal, and sometimes one has to accept the fact that other people do not see the world the way you see it" (Mili)

- Finally, there is the value-laden argument that questions the ability to influence people, to educate them or to change them. The students express a deep doubt about the success of any effort to influence or change adults' nature:

"Is it possible to change people?" (Tami)
"What for? What benefit will result from my saying anything, as I will not educate anybody?" (Mili)
"I can see today a senior physician that speaks horrendously rudely to patients and I know that there is no point in saying anything to him because it is irrelevant. He is a mature adult and it is very difficult for him to change" (Omer)

It can be seen that a phenomenon as powerful as 'silence' – inaction in the face of ethical misdoings – owes its strength and existence to a rather large number of reasons, rationalizations and explanations. The various reasonings build up a continuum, ranging from simple fears of vindictively-biased grades and ward evaluations, to philosophical contemplation about the right to judge others. Several issues are expressed in regard to the 'silence' phenomenon – pragmatic issues that relate to hierarchy and authority, medical school structure and students' status on the one hand, and fundamental questions of values and ethics, such as relativism and moral judgment, on the other hand.
Cynicism vs. Sensitivity

The category "cynicism vs. sensitivity" name is derived from students' accounts that appear to relate intensively to the two terms as normatively considered to be mutually exclusive and dichotomous. Students are well aware of the popular, as well as academic consensual opinion that medical students become more cynical and less sensitive along the course of their training (e.g., Eron, 1955; Feudtner et al., 1994). All the interviewed students seem to cope somehow with that assumption, or rather that conventional belief. The question whether or not they become more cynical during medical training seems to occupy the students throughout the interviews and they try to analyze it and clarify it to the interviewer, and maybe also to themselves. It should be noted that the students view the "cynicism vs. sensitivity" issue as an ethical issue that relates to their ethical development, and as such they discuss it in the interviews.

This category presents two aspects of students' testimonies: (I) The complexity and development of students' attitudes during training, as interpreted by them; (II) Implications for the future: students discussing the question of whether they will become cynic physicians.

I. Students' attitudes during training

In the students' interviews there are a few statements that claim simply and clearly that students become more cynical:

"The sensitivity that typifies students vanishes and is forgotten, as if it is waning" (Hila)

"Spending time in "cynical wards" influences the students.... It is easy to get drawn to it...The situations in the ward have to be more and more extreme in order to shock us" (Ayala)
There are two especially strong expressions of this process, which both use a common terminology – 'rhinocerosation', a verb that describes a gradual growing of a thick skin (rhinoceros-like), which is derived from Unesco's famous play's "The Rhinoceroses":

"I think that there is a certain level of 'rhinocerosation', as a loss of sensitivity. This is something that happens and you cannot function without it. You cannot function when you fall apart because of the patient's misery as it happens sometimes in the beginning. 'Rhinocerosation', having a thicker skin, helps you and helps the patient as well.... The process of immunization, of desensitization that we all experience is not necessarily bad, but one should beware not to become completely heartless" (Rami)

"I think there is some kind of 'rhiocerosation', or more precisely some kind of radicalization of attitudes" (Irit)

Students generally agree that there is a growing cynicism ("defense mechanisms", as defined by Gilad and Oren), and a diminishing level of sensitivity. They do not seem to be a naive group of people. However, most of the students claim that it is not a simple and clear cut issue, but rather complex and that it has several aspects to it. The function and the attraction of desensitization are explicitly described:

"It is not a defense mechanism. You belong to a group that gives legitimacy to unloading emotions, to black humor and so on" (Oren).

"I personally did not change, I am the same. I am still moved by people's condition and aware of their rights and dignity...But I do put things in perspective. You don't have a choice, you simply don't...I don't know if it is desensitization but you put things in perspective, some of them maybe in a better perspective, as time passes. You cannot function without this sense of proportion. You cannot scold people all day long. You cannot go around all day gazing at the ground mumbling: 'it is not right, it is not right'..." (Yaara)
Moreover, those students supply very emotional descriptions of how the threshold level of their sensitivity has changed: how they are not attentive anymore to patients' non-medical needs in the ward, or how they would never 'collapse' again as they did at the beginning of their training:

"I know how much we need these 'defense mechanisms'. I once went through an event with no defenses and I know how difficult it was for me. It was half a year after my grandmother died and in the ward there was an old woman that looked and talked like her. We were in a ward round and I just couldn't bear it and I had to go out and I fell apart. That showed me how vulnerable one can be...I do not think it could happen to me again today" (Gilad)

However, in spite of their awareness of those transformations, many students claimed that alongside the 'desensitization' process, they have become even more sensitive, in certain other ways, as the training process has progressed. Some present it analytically (e.g., Oren) and some more personally and emotionally (e.g., Gilad, Yotam):

"On one hand students are still the group of people that appreciate human considerations, and are still shocked by certain wards' attitudes to patients. On the other hand, it is obvious that most of the physicians were once sensitive medical students. There is desensitization to patients' sufferings and you are less agitated by what happens, but there is no less sensitivity to ethical issues" (Oren)

"We come here with values that seem clear to us, as if we know what is right and what is wrong. It is easy to say in the admission interview: 'all the patients are equal to me and I'll treat all of them equally'. But rather quickly you notice that some patients annoy you... it is easy to say 'everybody is equal' but it is difficult not to be revolted when a patient stinks...It is a dual situation: you get used to situations and there is desensitization but ethically you handle things better because you get used to difficult things" (Gilad)

"My aunt is now hospitalized and my mother tells me about her pains and how physicians are insensitive, and I say to her: 'I do it all the time, I cause pain to
people... I try my best to do good things but in the process I do many bad things...but at least I am aware of it and see it" (Yotam)

Illuminating explanations for the growing sensitivity and several analyses of the new kind of emerging sensitivity are also suggested by the students:

- As the students advance in their training, they are less apprehensive, less under stress and less in a survival process, and consequently they are freer and more open to human sensitivity issues in medical treatment: "When you gain more confidence you allow yourself to get to the humanistic aspects and relate to ethical considerations" (Mili). It seems that confidence breeds more ethical awareness and sensitivity – when one is less occupied with personal survival issues one is more conscious of other issues:

  "In ethical aspects you become more sensitive with the passing years, because you are freer to think about them; being more confident and less apprehensive enables you to become more conscious and more attentive. If we do not consider ethical aspects then there is apparently a process of becoming less sensitive, but from an ethical perspective, awareness and consciousness are rising, not declining" (Tami)

- Being more professional means seeing things in their complexity and depth, and that in turn means being more sensitive to subtleties, and more understanding – professionalism leads to deeper ethical sensitivity. Students explain that they are no longer "excited and agitated" (Alon), as they were in the beginning and not loudly and superficially argumentative:

  "At this time (year six) we view ethics from a much more mature stance than the argumentative one we had before...Back then, the ethical discussions were baseless and meaningless" (Omer)
Students acquire, instead, more elaborate considerations, less simplistic opinions, and consequently, they believe, they can be more sensitive, in the true sense of the concept:

"It is not about being cynical or not. On the one hand you identify more and more with physicians and you understand their mistakes and tend to forgive certain behaviours, but on the other hand you become more sensitive morally. I can say that my moral sensitivity even sharpened as I see reality in more complex ways and I can think in complex terms" (Alon)

- An interesting point is raised by a student (Gilad) comparing medical students' sensitivity not with their own starting level but with the sensitivity level of other young people at their age who are not in medical school. He argues that medical students are much more sensitive to human sufferings and to human conditions than other people their age because of the intensive exposure to a variety of other peoples' lives, unlike their peers who do not get so close to human lives. This exposure causes students to be more sensitive in a wider meaning of the word. An example for the 'growing' or rather 'acquired' sensitivity:

"The routines we encounter in medical school are harsh. We meet people that are both sick and poor and we know so many things about the human condition that no other people outside the medical world know. I have friends that work in high-tech and they are surprised to hear about a mother that doesn't have 4 pounds to buy her child his medicine... we are exposed to misery and suffering and we take part in treating these situations. We are exposed to people's lives, to people's life stories. We cope with people in their worst and most embarrassing situations and we are there, we see it, we act within this environment, we are part of it" (Gilad)

- It seems from students' accounts that the influence of the medical school's overt and declared emphasis on human aspects of medicine has its impact on students and 'shields' them from becoming too insensitive:
"You are conscious of cases of unethical behaviour or violations of a patient's rights. Your awareness does not become blunt, it stays sharp and clear. You are being trained to see the moral violations again and again and not to let it be forgotten. I do not get insensitive, as it is sometimes described in the literature about medical students, because I was trained to pay attention to cases when they happen, to watch for ethics all the time" (Shoshana)

• The position of the students when interviewed, being senior students in the last year of clinical studies, is considered by them as 'good for sensitivity'. Firstly because they are more involved:

"You are even more sensitive in that sense that you get more and more involved so you become 'friendly' with the dilemmas, you become part of them" (Yaara)

Secondly, because they have much more time than physicians to dedicate to each patient, while they have greater skill and experience than fourth-year students. They benefit from being both students and 'almost physicians' simultaneously:

"As adult students, almost physicians, we enjoy both worlds – we don't have commitments yet and we can dedicate a lot of time to each patient while, at the same time, we already possess many medical professional tools that we have acquired (interviewing, examining, treating)" (Gilad)

This last account reflects positively on the student's position in the last part of training but it also reflects concern about the issue of their sensitivity when they become 'real doctors', when they'll all have heavy commitments, an issue that bothers them and is presented below.
II. Implications for the future

An issue that appears repeatedly in students' interviews is their concern about the future — whether they will stay sensitive in the future, when they are physicians. The students are concerned about the future prospective and about whether the ethical sensitivity they describe as even growing while they are students will be maintained. They express their worry with the language they use in their accounts about the future — words like 'pray', 'hope', 'guess', 'maybe' (Yotam, Shoshana, Mili, Oren, Ido), a use of 'doubting terminology'. The students seem to shift between pessimism and optimism for their future as ethical, humanistic, sensitive physicians.

A pessimistic view can be derived from Gilad's description of the advantages of year six when students have time and medical abilities (cited above), as it sounds like a temporary advantage that will vanish when they are physicians. Pessimism or maybe realism is explicitly expressed by students when they think about the physicians they meet, knowing that they also started their professional life as good people with good intentions:

"We are still naïve and believe that we will be alright. But the physicians they all probably started like us, full of good intentions, but most of them did not stay like that. There are departments where the behaviour to the patients is awful and we cannot think of ourselves as behaving in such way, but those people are not less good than we are. It is part of the risk in this profession — not everyone stays sensitive with time" (Oren).
On the other hand, there are some reasons for optimism that can be found in students' accounts:

1. Today's students are more mature and consciously balanced:

   "Some of us, maybe most of us will become indifferently tired or tiredly indifferent. However, I am more optimistic because today young people are more conscious about their quality of life, and are more conscious about the right balance between life and career and have more legitimacy to complain and to demand. We are more mature and balanced" (Alon)

2. The advantages of humanistic medicine are clear:

   "As a student I had the time needed to dedicate to patients, and I realized how beneficial it is from a medical perspective. So, I believe I will retain it afterwards, because I see the advantages of sensitivity as a medical tool" (Mili)

3. School emphasis on ethics will slow the erosion process:

   "It can happen that I will become less sensitive, but the pace of this process is and will be much slower than what I see happening with friends of mine that study elsewhere. Because in our school the emphasis on ethics is a constant message. I will know how to keep my sensitivity in the future, perhaps" (Shoshana)

4. Present functioning shows that there are ways to preserve humanistic values:

   "There are physicians that I will never be like; I hope I will never become like them. Maybe I will not become like them because I still get shocked by certain behaviours, even now, and I am not getting used to anything. I also have more confidence to answer back, to demand, to express my opinions" (Yotam).
These examples of thoughtful reasoning seem very mature and analytical – the students do not say 'we will stay sensitive just because we are good people'. That way of reasoning is not enough for them. They express their doubts and try to analyze what are the mechanisms, within the system, that can keep a person loyal to his beliefs and ideas.

Reading students' accounts deeply, it seems that the first impression of a dichotomous conceptualization that is implied by this category's title can be replaced by a continuum conceptualization that is more complex and reflects multi-faceted reality. The processes of cynicism and sensitivity bother the students to a large extent. This is evidenced by the number of references to the topic. All the interviewed students related to it although there was no direct question about it, by offering a variety of explanations for the growing sensitivity and definitions of new kinds of acquired 'ethical sensitivity', and by contemplating about present and future prospective. It seems that the issue has been given much thought by the students before as well as during the interview.
Ethical learning processes - how do medical students perceive the acquisition of 'ethics education'

There are rather many references in the students' narratives to ways of learning and acquiring ethical knowledge and attitudes (with no specific direct question about these topics). The data is presented in two sub-categories: firstly 'modelling' (role-modelling) as a learning/teaching process; secondly perceived means of ethical learning/teaching in medical school. The presentation frequently uses the combination of learning/teaching or uses them alternately as in students wording the terms are not always distinguishable.

I. 'Modelling' as an ethical learning/teaching mean

One of the dominant topics that is referred to in the students' accounts in an impressive abundance (about 20 notable references) is the issue of 'modelling' (role-modelling) – how ethics is studied by the students through role-modelling of teachers/physicians. The term 'modelling' is used by students and faculty members, so the study follows their rather popular terminology, even though it is not always in accordance with the academic term of role-modelling. Most of student references to 'modelling' relate to the existence of negative and positive role-models in the medical school's training program.

Negative models

A significant number of student references related to encounters with negative models, or to exposure to unethical behaviour of physicians are presented in other categories ('Students' ethical dilemmas'; 'Coping mechanisms'; 'Silence' and 'Cynicism vs. sensitivity'). The present category, concerned with learning processes, reflects students' accounts about the multitude of negative models and the difficulty of responding to the more extreme ones:
"There are many more negative models. Only a few physicians are models for imitation for me" (Mili)

"One sees many physicians that are completely insensitive to their patients and one hopes not to get to that position" (Ido)

The students relate to the negative models' influence and supply two opposing analyses of their impact that are not mutually exclusive, as the processes described can exist simultaneously. A rather common claim among the students is that negative models they observe have an opposite effect, causing them to understand how not to behave and to decide what they should not become:

"There are things that you see and you say to yourself: I will not become like that "
(Rami)

"I've established my red lines by watching what not to do" (Gilad)

On the other hand, students describe two ways by which negative models can have an impact on them. (1) The first one relates to the fact that as time passes, students understand the system better and identify with the difficulties of the physician's workload, and thus are more tolerant to harsh or insensitive behaviours of physicians. According to this explanation, it is not the negative models that directly influence students' behaviour, but the context in which they are performed:

"My responses seem to change. Things that I have not been forgiving for before, I am more forgiving now. I understand why these things happen, I understand why patients are being examined in the corridor where people are passing by, or why the doctor says only five words as an explanation to the patient" (Shoshana)

"It changes. You go through a process of identification with the system and you understand also the 'not-nice' physician, you understand that he has already checked 20 people today and the 21st patient does not interest him at all" (Yotam)
(2) The second way negative models might influence is voiced clearly by a student who expresses his fear that massive exposure to negative 'modelling' will make it more likely that later he will behave in a way he clearly dislikes now:

"There are physicians that I know I will not be like them, but it is possible that I find myself in a situation when I am impatient with a patient, the fact that I was exposed to such models during my medical training will eventually give me the legitimatization for such behaviour" (Ido)

Positive models

One kind of account concerning positive models refers merely to the fact that there are some good positive models, not only the negative models that are notorious:

"There are also good physicians, those that close the curtain when examining a patient, concerned about his privacy" (Hila)

"During the studies one encounters some models that are impressive" (Ayala)

There are also strong and explicit expressions about learning from the good models directly, being inspired by them and being thankful for their modelling. Students acknowledged the contribution of good models to their training and education. A salient feature of learning from models whose contribution is acknowledged, is that the process is not accidental or 'hidden', but rather intentional and conscious learning:

"I try to learn from good people how to talk to patients" (Alon)
"I listen to people that I highly esteem and I am inclined to hear their considerations" (Shoshana)
"In every department I stayed in, there was one physician that I truly loved and identified with, and I measured myself in comparison with him – how would I like to be and behave" (Yotam)
A quite impressive voice in students' interviews reflected that certain people in the medical school staff are very influential and very much identified with ethics education. The following examples show that it is the personality of the people involved that makes them exemplary figures, as well as their personal willingness to serve as active conscious and intentional models:

"Prof. X simulated for us in a communication course, year one, two interviews with patients. One was very clinical and the other was very open and seemed unfocused, but by it he received from the patient so much more social and environmental information, with not much more time" (Mili)

"All the sessions with Prof. X were part of the program. It is a combination of the content he delivered and his personality. It has an accumulative effect" (Ayala)

"We had a class with Prof. Y, where he showed us how he tells bad news to a patient and it enriched me so much more than any simulation I would have done by myself. He did something that was so surprising, so amazing to me that it was imprinted in my memory and I do hope that when I am in such situation his example will return to me" (Mili)

Besides the accounts of good modelling, there are several students that elaborate more by explaining what are the mechanisms that have enabled the teacher to become good models for their students. The students' descriptions point out ways of teaching, explicitly and implicitly. The mechanisms by which positive models are activated:

- The first obvious one is behavioural modelling – simply behaving nicely as a routine conduct:

"When you see somebody that behaves nicely as a way of life, it gives you the energy to do things" (Ayala)

The rest of the teaching mechanisms that students analyze are not related directly to "classical" modelling, but are regarded by the students as meaningful for them:
Talking to the students, explaining things and discussing with them what they go through:

"The doctors that behave properly are the same ones that talk with you and discuss it with you. There is a correlation" (Ayala)

Doing things together with the students:

"I was privileged to have a good modelling in the internal ward — they talked with us and did things together with us" (Alon)

Being sensitive to the students' agonies and problems and caring about them:

"There was a physician in the internal ward that was protective to me — he understood what I was coping with and cared about me and tried to help me with my difficulties" (Mili)

Personal exposure of physicians, telling students about their conflicts and dilemmas:

"Models of senior physicians that are deliberating about their moral dilemmas are the most impressive ones" (Yaara)

It is evident that students distinguish, identify and appreciate positive models immensely.

II. Ways of ethical learning/teaching in medical school: Students' insights

Several topics concerning ethical learning in medical school emerge from the students' narratives. Although some issues are mentioned also in other categories, they are collectively presented here to reflect the students' interpretation of their learning experience.
In a variety of articulations and in many contexts, students express quite strongly their preference that physicians teach medical ethics in courses and in the wards alike. The emphasis is on the important function of ethics in the wards as being taught and modeled by physicians and not by other teachers, lecturers and ethicists:

"Teaching of ethics not by physicians causes resistance" (Alon)

"Ethical learning must occur in the ward and not in the lecture hall. For example: a team discussion about a patient that poses a moral dilemma" (Alon)

"Only physicians can relate to us and have a true bond with us" (Yaara)

Students' accounts also provide convincing evidence that exposure, and emphasis of all sorts, formal, informal and especially experiential, are the key factors in ethical training. Their accounts reflect the basic notion that when issues and topics get attention in volume and time dimensions, they are bound to make an educational impact:

"The school should force people to experience everything – like interviewing in first year – and not let anybody, like me, escape...

Any exposure is beneficial: a course, group discussion, anything" (Mili)

"It is important that ethical issues be in the syllabus because it transmits centrality. I do not remember in what courses exactly ethics were discussed, but I have this feeling that it was discussed a lot and it was central to the school program" (Ayala)

"The process was powerful and repetitive. We spend six years here and it is a long time. It is like the education of children – we were educated and molded. An emphasis has been put on ethics and humanities and it penetrated" (Shoshana)

"Learning/teaching is done not by talking about things, but naturally by experiencing things" (Irit)

A very important aspect of the present study is the way students perceive and interpret their moral development during their training, how they explain the ethical learning
process in medical school. The data supply three conceptualizations of the ethical learning process in students' own words:

(1) The first conceptualization describes a way of learning that uses simulation as a tool of identification and clarification:

"I have put myself at times in the place where the staff is standing and imagined what I would have done. I used to listen, watch and criticize" (Shoshana).

(2) The second conceptualization describes a means of concretization and application, a dynamics of construction and deconstruction of rules according to changing realities and rethought principles.

"I have learnt to apply moral dilemmas in a less abstract way. When you think about actual situations and experience them, it enriches your cognition... I did the thinking and developing process within myself and by myself... The theory becomes practice. As times passes, theoretical aspects become actual and you not only observe more things and experience more, but you become more and more responsible... You try to create for yourself simple rules and they keep breaking all the time. Everything is so complicated, because you change and patients change and there are so many factors and each time the decision is different. And not always are you able to know what is right... An example for those changing rules - there are naïve sayings of youngsters, around the age of fifteen, such as: 'I want to die at seventy when I am still healthy. And when I deteriorate I'll go to a cliff, drink red wine and jump'. And then you see old people that cling to life and you say to yourself: "reality is much more complex', because those old people were also once fifteen years old" (Alon)

(3) The third conceptualization describes an adult learning process which is implicit and unconscious, but involves verbalization and discussion: "It is a learning process of an adult. It is an inner process. There are processes that are hidden, even hidden from
The three aspects of ethical learning portray a process of achieving conceptual ethical maturity, of collecting isolated particles that are integrated to a higher stage of understanding and articulation. It is a description of the personal nature of processing ethical reality to become rules or principles. The learning process is analyzed and discussed in detail during the Discussion.

• Finally, an interesting aspect of ethical learning relates to students' perception of year-six as a culmination of the ethical learning process. The students supply an analysis of their perception of the state of mind they achieved toward the end of their training. The unique characteristics of year-six in students' eyes can be pointed out [underlinings are added, E.B.]:

1. Students view themselves as more professional mature and subtle:

   "You are more subtle and you have more data for your decisions as a result of your contact with people and your knowledge and your emotions and inclinations that are in my opinion more sophisticated" (Omer)

2. Students view themselves more responsible accountable and involved in decision-making:

   "In year six you are already doing 'white admittances' so nobody checks you and it is up to your conscience whether to report if you did not succeed to see something... In that stage you have to decide. It does not mean that you do not see different shades and angles but you have to decide and do actual things... you can no longer continue with the fruitless discussions that are suitable for year one. You learn to save, to categorize, to be more systematic in your thinking in order to save time and space for decisions-making" (Irit)
"The theory gradually and slowly becomes more concrete and tangible...As time progresses it is not only that you see more things or experience more, but you become more and more responsible. In the beginning you just observed others and now you admit patient all by yourself and you know that in less than a year you will be there all alone in the middle of the night with all these dilemmas. The whole issue becomes more actual and realistic" (Alon)

3. Students understand the complexities and the endless alternatives of solutions:

"When you are deep in the clinics you understand that there are no simple solutions. You identify yourself more with the system on one hand, and on the other hand you understand more about illnesses and death, about recovery and family and about medical concepts...Professionally you become more and more similar to a physician, and from gathering all the experience you see more and more things and you can more and more think about the complexities. There are infinite possibilities in these kinds of dilemmas" (Alon)

4. Students gain a general view and confidence

"In year six I feel that we get some kind of general vision. If in year five we developed defenses, in year six we gain confidence" (Gilad)
In year six you can talk with the physicians more freely and you feel more confident. In year four you do not know anything and you feel timid. Now I can ask the physician – why did you do it like that, or I can discuss problems with the senior doctor or even with the head of the ward" (Yotam)

In this category presenting ethical learning processes in medical school as perceived by the students, with regard to ethical training, the students deal mainly with two basic issues: what means are applied in the learning process and how the ethical development occurs. A salient part of their accounts relates to 'modelling' processes as it seems to be central in a training environment that is heavily based on apprenticeship. 'Modelling' appears to be
multi-faceted in nature – positive and negative, direct and indirect, explicit and implicit, and is activated through various channels – talking, acting, exposure and consciousness. The overwhelming influence of 'modelling' of which the students are aware, leads to their expressed wish to have as many as possible strong and right ethical models. Other elements of ethical learning the students point to are their clear preference of physicians as ethical guides (vs. non-physician teachers), and the importance they attribute to a variety of accumulated learning experiences. When the students relate to their ethical development process as adults in medical school – "ethical coming of age" – they supply data concerning a complex process that is examined in the discussion.
A six years process: What was done in medical school on the subject of ethics

This category is based on two questions that were addressed to all students in the interview: (1) "Describe, or map, the process of ethical training in medical school (stages, turning points etc.)."; and (2) "What steps had been undertaken by the medical school faculty members in relation to students' ethical reality and moral issues?". This category gathers students' perceptions and interpretations of their curricular ethical training and presents the following findings: (I) Most of the students seem quite confident that the school has put an emphasis on ethics education and has invested much time and effort teaching and talking about ethics; (II) When mapping ethics education chronologically, the students emphasize the difference between preclinical and clinical years; (III) Students raise several critical issues concerning ethics courses; (IV) Conspicuously, a year 4-5 workshop course titled "emotional processing" (that is basically a small group discussion type of course, led jointly by physicians and psychologists), is related to by all interviewed students, and is therefore presented with attention to detail.

I. The medical school's emphasis on ethics

There is strong evidence from students' accounts that, in their view, the school has dedicated courses, time and effort to ethics education. Though most of the information given by the students is impressionistic in nature, not detailed or systematic, their perception of the ethics curriculum in medical school that it was the product of a massive investment. One student only supplies a list of elements he remembers: "Seminars, weekly-conferences, lectures" (Alon), another emphasizes that ethics education started very early: "Lectures of ethics starting already in the summer course, before the first year" (Oren), while others refer to the total effort to relate to ethics in many formats and in various frameworks.
"There is a spotlight on ethics. Starting from the summer course – lessons relating to patients-physicians relationships, ethics...we did a lot of talking. It helped to open your eyes that could have been theoretically shut up. It is a topic massively discussed; it receives a lot of weight and volume" (Tami)

"The practice to be conscious to human aspects is done from the beginning in year one in the communication course. It continues in the clinical studies with lots of posts along the route. The clinical weeks in the pre-clinical years, contact with physicians that are outstanding in their attitudes and so on. There are many meetings and conferences concerning ethics and a humanistic approach, all these special weeks that we have every year, even a week that was dedicated to 'human sexuality' that put an emphasis on viewing the patient as a person" (Shoshana)

An interesting element that appears in students' perception of their ethical training is the 'esprit de corps' element, namely, the comparison they make with other medical schools that do not put ethics and community as their major 'motto' as the school in Beer-Sheva does:

"They have done more about ethics in this school than other medical schools: two weeks of 'The physician and society' in year six and more opportunities where we talked about ethics" (Hila)

"I see a great difference between us and friends of mine that have studied medicine in other schools" (Shoshana)

Although students' accounts about the schools activities are partial (they do not list many courses and activities), it is nevertheless evident that they feel their school is aware of ethics and ethics education. The most comprehensive voicing of that feeling is by a student that analyses both the totality of Beer-Sheva training and its nationwide influence:

"First of all the selection of the students, people with a humanistic set of values, and then events and meetings and conferences about ethics...I think that when you educate a cohort of 70 people, that afterwards spread to various places, it is
meaningful and powerful. I think that we receive a lot about ethics. We had now this two-week course about society... They even prolong our academic year because of that additional non-formal aspect. Maybe they are formal but certainly non-conventional. Since ethics is put on the agenda, since it is introduced in the syllabus, it influences you. You understand it is something important and valuable. That it is part of your being a physician, not something to neglect, it is part of the studies. Ethics is considered one of the central topics. It also creates some kind of group pressure because even if it does not interest someone, one cannot avoid it" (Ayala)

II. Chronological aspect: the division line – preclinical vs. clinical years

When analyzing their ethical education process, the most salient characteristic of students' mapping is the dividing line between the preclinical years (years 1-3) and the clinical years (years 4-6). Most argue very clearly that from an ethical perspective the main turning point is the introduction to clinical years, to clinical training in the wards in year four. This is quite surprising or at least unexpected since the Beer-Sheva medical school is different from other medical schools in Israel in that the students are exposed to clinical aspects during the preclinical years (mainly in years 1 and 2), as part of the school rationale of humanistic-centered medicine ('clinical exposure', see: Introduction, p.9). The fact that Beer-Sheva students nevertheless place the dividing line between the preclinical years and clinical years, which is the classic division line in 'traditional' medical schools, is therefore rather significant.

Students refer to the shock they experienced at the start of the clinical years and its bearing on ethical stance: "The dividing line is the entrance to the wards" (Oren). The dominant voice reflects the existential nature of this transitional period of time in the training process, describing it mainly as a survival phase:
"In the wards everything is stronger and more intensive. In year four the encounters were difficult. I remember them. I remember the sensation of going out of the ward at the end of the day, it was as if you are being shot from a cannon... we used to burst out the door as if we were running away from something" (Ayala)

In the midst of this existential-survival period, there is also a sudden abundance of ethical encounters:

"It is a shock, the clinics in year 4...There are many confrontations in this year and it is the year that you encounter many ethical situations, because you deal with internal and pediatric wards and because of the primary nature of your clinical experience" (Gilad)

Thus, year four is described in students' words in double contexts: in the shock effect context, and in the context of the sudden, abundant exposure to real, actual ethical dilemmas.

III. Students' perception of ethics courses: points of critique

In spite of students' appreciation of medical school's emphasis on ethics, they criticize several aspects of their ethical training. The main point of criticism relates to the nature of ethics courses and deliberations and to their irrelevance to students' ethical reality. This irrelevancy is attributed both to the timing factor (courses and discussions occurring in pre-clinical years), and to content factor (courses concerned with 'big dilemmas').

The notion that ethics in the preclinical years is theoretical in nature seems to be shared by many students, though their attitudes relating to this fact seem to vary. Some report it quite neutrally, as a fact to be noted:
"In the first years you do not cope ethically because you study in a classroom, you are a regular student studying his materials" (Alon)

"In the first years there are no ethical dilemmas...everything is completely theoretical...if I had dilemmas they were not ethical ones, but rather emotional dilemmas with patients" (Yaara)

Several others relate to it critically – criticizing the amount of talking in the first years (the quantity) or the nature of ethical talk conducted by ethicists vs. physicians (the quality):

"In years one and two there is a lot of talking about ethics, and it is very much stressed by the school and felt by the students" (Ido)

"There is a difference between a theoretical talk of people that dedicate most of their time to ethics, in preclinical years, and those people that deal most of their time with medicine and not ethics, in the clinics" (Oren)

Yet others are even more critical, faulting ethical discussion in the first years for being naive and non-productive:

"Ethical deliberations that are philosophical and non-decisive are suitable to year one, not for later years" (Irit)

Students clearly relate to the conflict between what they are being taught and what they observe in the wards. In relation to ethics teaching it appears that they criticize ethics courses' concern with the "classical" "big" ethical medical dilemmas that are far from their daily reality as students:

"There were courses and discussion panels but they always deal with the big ethical issues like euthanasia. In the wards I witnessed euthanasia performed on unconscious patients while in all the ethics panels it is always agreed that it should be performed with consent of conscious patients. There is a gap between the
discussions and what you actually see...The discussions are not on the actual ethical problems" (Oren)

"Ethics courses and discussions like 'physician and society' did not help me. They 'hang in the air', they supply 'textbook answers' and academic articles and do not relate to the daily reality." (Rami)

A similar line of criticism can be found in students' accounts when they relate to ethical teaching and deliberations in the ward, that according to their perception seem necessary and right, but occur only very rarely and arbitrarily:

"It depends on the wards whether you get ethics education. I was lucky to have a good ethical educational example in the internal ward. They talked with us and did procedures together with us. Ethics should really be taught in wards and not in theoretical lectures" (Alon)

"There are no frontal conversations in which somebody comes and says: 'let us talk about what happened today in the ward, what are your difficulties'. I never encountered such a situation and never heard about somebody else experiencing it either" (Omer)

IV. Students' perception of the 'emotional processing' course

The students, while describing their interpretation and perception of their six years ethical education in medical school, specifically and elaborately singled out one course, "emotional processing". It is a weekly workshop in year four (mandatory) and year five (voluntary), where two faculty members (one physician and one psychologist/psychiatrist) lead discussions with small groups of students about their emotions and conflicts during clinical training. This course was mentioned as a central issue in the students' account of their training program, as they all related to it, with no direct question addressing it. All the students emphasized that the course success depended on the teachers' facilitating capabilities, with extreme fluctuations from group to group. In their elaborate references to
the 'emotional processing' course, students actually exhibited a course evaluation process, based on their experience, that yielded several interesting curricular aspects and insights. As this study is interested in students' views and interpretation of their 'received curriculum', their testimonies are presented in some detail:

**Students' insights about the course – personal level**

- The dominant (and obvious) contribution of the course is an emotional one – the opportunity to discuss personal problems, in an accepting atmosphere, in the midst of a critically pressing time for the students, the first year of clinical training (year four):

  "The problems that were discussed were mainly personal difficulties in coping – for example, what we do when someone senior speaks rudely to us and we, that feel so inexperienced, silence ourselves in his presence" (Oren)

- The emphasis of the course, according to some students, is on venting emotions, and not necessarily on reaching any conceptual conclusions or formulating any preferable or recommended routes of action:

  "There was emotions' ventilation and the legitimacy to talk about mistakes. People did speak about themselves...No conclusions were drawn but I think that it is the way with educational processes" (Ayala)

- Some students try to analyze the course's function within the context of the whole training program, as a course that is helpful in building their professional personality, in constructing coping mechanisms and a set of rules of conduct:

  "My group was a good one and we got tools for coping in the future not only with medical situations but with all the essence of being a physician, in all aspects, personal and professional" (Omer)
• In contrast to most students, there are a few students for whom the course did not work out well:

"I liked this course less than any other part of the program. I am not a person that talks in public. I had to attend that mandatory course, but I did not participate. It is difficult not to, but it is possible. I did not gain anything from it, not only because I did not participate. People talked about banal issues, like their difficulties entering the clinics, but they did not talk about strong issues, like what to do when you witness a malpractice..." (Ido)

Students' insights about the course – program level

• The course is considered to be consistent with the school's program's goals, to promote the education of humanistic caring physicians:

"I don't know how much I gained personally from the course but it is a wonderful idea. It proved to me that for the faculty this process is important" (Mili)

"The idea behind this course is so closely related to the total educational program of the school. It is inseparable" (Shoshana)

• There are some problems addressed (voluntarism and exposure problems) and some improvements suggested:

"I think that students should be forced to come only to 4-5 sessions to get acquainted with the tools of group discussion and the way it is carried away in 'emotional processing', and afterwards it should be on a voluntary basis, not a mandatory course" (Yaara)

"The 'emotional processing' is somewhat missing the point. It includes many discussions about group dynamics and it is important, but because there are faculty members present there, you do not want to expose everything. It is too big a request
to expose yourself in front of the class. There is also the problem of timing: you can have weeks with no personal problems and then you do have a pressing problem, but you have to wait for next week’s session” (Gilad)

- An issue that is debatable among the students relates to the extent of relevancy of "emotional processing" course to ethics education and to ethical aspects of their training. Some students view it as an ethics course:

"There is no separation in the course between ethical and emotional issues. It does not supply any answers. You see how others are coping, students and physicians alike, and it thus adds to your behavioural options. There is no categorization – all issues are raised: coping with death of patients, with entering a room in the ward that you feel uncomfortable to be in, with taking blood, with faculty members' improper behaviour toward patients and students and other faculty members" (Rami)

"Students as early as year four have ethical and emotional dilemmas. Slowly and gradually dilemmas come up: what to do with information, what to do with patients, what to say to them. In the beginning more emotional problems come up and later the ethical dilemmas emerge” (Yaara)

"I think that a workshop like 'emotional processing' is the best place especially for handling ethical problems, as you have the opportunity to realize that everybody share the same concerns” (Yotam)

Some others view the course as an arena for emotions exposure and even vehemently oppose the combination of ethics and emotions:

"This course is concerned mainly with personal emotions and rarely with ethics” (Tami)

"I apologize that I am cynic about this "emotions" course. There is a problem with ethical discussions among adults. I feel that it is like a discussion in the youth movement where the facilitators try to stimulate my cognition. You understand the
dilemma quickly and the rest of the discussion stays in the air, with no substance....I do not want an 'emotional processing forum to be mixed with ethical issues. An emotional forum has a goal to unload personal worries. In an emotional forum I do not want to hear what Kant said. There I want 'emotion for emotion'. If we go for the emotions we should not mix emotional and ethical issues. For philosophy I would rather have a separate philosophical course, analytical and deep" (Irit)

It is clear that the students raise, deeply and elaborately, a philosophical-educational-curricular issue concerning the relation between emotions, cognition and ethics.

Findings of the present category show that students are very much aware of the wide emphasis the medical school in Beer-Sheva puts on ethics, and are even proud of it. Nevertheless, in spite of their respect for the medical school tendency, the students criticize the nature of ethics courses and the lack of "ward ethics" curriculum. In an analysis of their six years medical-ethical education as a process, students clearly distinguish between the three pre-clinical and the three clinical years. The distinction relates to the existential aspect of coping with a pressing reality and to the emergence of real ethical dilemmas in the clinical years. The ethical dimension of pre-clinical years is characterized by the plentitude of ethical discussions that are theoretical in nature and are criticized as immature and non-productive. When asked about their perception of the ethical education in medical school, the students provided meaningful insights relating to ethics curriculum as a total process as well as to several specific aspects of it. A detailed evaluation/interpretation of one curriculum element (a workshop-type course) exemplifies the process of students' curriculum assessment through their experience. The most evident and salient attribute of students' perception of their ethical curricular/training process, is the holistic, complex, reflective nature of it.
**Expectations for ethical training**

The present category is comprised of two sections:

The first section relates to data gathered from two questions: (1) question no. 4 of the questionnaire: "In what ways can medical school help students cope with similar dilemmas?", on which 34 (out of 38) students answered; (2) a question from students' interviews: "What could or should have been done in medical school concerning ethical issues?", on which all 14 interviewees answered. The large number of the answers made feasible the relatively quantitative treatment of this section.

The second section relates to data gathered from the students' interview question: "Imagine yourself fifteen years from now, as a senior physician, what would you do concerning your student’s ethical reality?", on which all 14 interviewees answered. The personal answers account for the narrative nature of this section.

**Section I: Recommendations and suggestions for improving ethical training**

Students answers are partly presented in tables, however only as indication of dominant trends of students' suggestions and not as statistical empirical data, as some of the students interviewed may have also answered the questionnaires anonymously. The data provided, suggesting future courses of action that the school should adopt, proves to be similar in the two sources – hence in each table there are suggestions deriving from both.

Table no. 5 presents the distribution of the varied suggestions of students that are satisfied with the existing ethics education and wish to enrich it within the ongoing framework.
Table no. 5:
Students' suggestions and recommendations to continue existing ethics education in medical school

<table>
<thead>
<tr>
<th>Suggestions and recommendations to continue existing ethics education</th>
<th>No. of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>More workshops like 'Emotional Processing'</td>
<td>5</td>
</tr>
<tr>
<td>More courses like 'Communication', 'Physician and Society'</td>
<td>4</td>
</tr>
<tr>
<td>More personal simulations and physicians' demonstrations</td>
<td>2</td>
</tr>
<tr>
<td>The school is on the right track in ethics education</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Some of the students who rate efforts in ethics education as satisfactory, elaborate on why they think so:

"Every exposure leaves its imprints. I think that they should include in the program hours for thinking – it could be an ethics course or 'emotional processing' workshop or others. Even if I do not get anything from what they originally meant me to, the mere fact that I had this hour when I was forced to sit and listen and think, contributes to me. Because it is easy to run away, and one needs those hours when one is forced to stop and think" (Mili)

"I think that we are very conscious of ethics issues. I think that we've been spoken to about it a lot, maybe not always in the right timing. It might be a good idea to transfer some discussions to years four and five but on the other hand the discussions in pre-clinical years left their impression on us. I am a living proof of that, I remember" (Yaara).

Table no. 6 presents the distribution of the varied suggestions of students that wish to include new topics in the curriculum of ethics education.
Table no. 6:
Students' suggestions and recommendations for new topics to be added to the future curriculum of medical school

<table>
<thead>
<tr>
<th>Suggestions and recommendations for topics to be taught</th>
<th>No. of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to support your colleagues</td>
<td>1</td>
</tr>
<tr>
<td>The &quot;patient's rights law&quot;</td>
<td>2</td>
</tr>
<tr>
<td>Inter-relation communication course for physicians</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Awareness of ethics&quot; course for heads of wards and physicians</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
</tbody>
</table>

It is interesting to note that no less than six students think that a necessary part of ethics education should involve teaching their teachers – either a communication course or some lessons to enhance their awareness of ethical issues.

Table no. 7 presents the distribution of the varied suggestions of students that wish the school to establish new bodies to deal with ethical issues ad ethics education.

Table no. 7:
Students' suggestions and recommendations for future establishment of new ethics-related bodies in medical school

<table>
<thead>
<tr>
<th>Suggestions and recommendations for new bodies to be established</th>
<th>No. of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular meetings of physicians and students in clinical years</td>
<td>2</td>
</tr>
<tr>
<td>Medical staff's sessions with psychologists' guidance</td>
<td>1</td>
</tr>
<tr>
<td>Powerful and meaningful 'year committees' (mutual staff and students committees) in clinical years</td>
<td>1</td>
</tr>
<tr>
<td>Pairing of a senior physician to a student in clinical years</td>
<td>2</td>
</tr>
<tr>
<td>A permanent Ombudsman-like ethics institution</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>
Noticeably, the idea of establishing some kind of permanent institution to deal with students' ethical problems is common to seven students, though it seems not to be very developed in details and technicalities. One student relates vaguely to a group that meets, on a regular basis:

"Not a formal curriculum is needed. It is not efficient, not personal… Maybe what is needed is a body that convenes for ethical consultations. Some kind of a permanent group that one can consult with" (Tami)

Another student expresses a 'dream-like' wish to have an officially nominated 'figure' to address, as part of their students' rights, not as a personal favor to the students, based on personal relations:

"There should be a 'figure'; someone that can be addressed if needed while securing privacy. An adviser, who is also a physician, who will help students that face ethical problems. He will be confidential and will give you a practical solution, not some 'rounded theoretical' one. It is important that there will be someone formal to address to. I could always address Prof. X informally but it is not always comfortable" (Hila)

The most actual and developed idea is expressed by a student that suggests a permanent function, with explicit role-definition that will serve as an official consultant for ethical issues, some kind of ethical "hot-line":

"I think we should have a body with the function of 'emotional processing' but on a personal basis, and not with a psychologist or social worker but with a senior physician that would have this specific role-title. Then you would know that there is a place for you to come...I know that there are physicians that say: 'my door is always open for you to come and consult on any matter', but this is bullocks, and you do not really do it, nobody does. But if there was a role-definition like that, and you could meet with a senior physician who would be in charge of all the students
in, let's say, internal ward rounds, and you'll be able to tell him: 'today I witnessed something, with no names if you prefer, and he'd supply you with his viewpoint, that I hope would be helpful. It would be enough even if he told you that it had happened to him once...And it would be immediate. You would not have to wait for a formal class or session" (Gilad)

Ethics in the ward

Eleven students claim that ethics education should be taught and managed within the clinical wards during clinical training (years 4-6). The basic argument is that most of the ethical dilemmas concerning the students occur in the wards. No table is presented as this is a one-track suggestion, but various attributes of this desirable educational change are discernable, and different elements are emphasized [the underlinings are added, E.B.]:

"The physicians and students should present a variety of topics and discuss them" (Anonymous) "Heads of wards should be aware of ethics. They should see to it that there would be a discussion in real time around an issue which concerned everybody in the ward" (Oren)

"There should be small groups of students from the wards that sit with young physicians and discuss. The leaders of the discussions should be people that are very close to the field. Only people that are very remote from the ward can say: 'the students should demand gently but firmly from head of the ward to stop smoking by the patient's bed' [irony, E.B.]..." (Rami)

"Ethics education should be in the wards. It should be an integral part of the clinics, with a specific time allocated for it. One hour a week that would be dedicated to a patient who represented a moral dilemma – to discuss the case, including a conversation with the patient...Another idea – an interview of a patient by a physician or a student and a following discussion accompanied by a short theoretical background...The problem is that most of the ethicists are disconnected from practice and this provokes strong resistance from the students... It might be
intellectually interesting to study Locke or Kant in a lecture about ethical principles, but you cannot bring Lock to the dying patient's bed" (Alon)

Apparently, students have in mind a clear perception of ethics education in the ward. They would like it to be an integral part of a program planned very seriously by ward heads and performed regularly in small groups. Students wish the course to deal with real dilemmas from the real field, with the genuine help of the ward's physicians. The dynamics of such an educational program could involve both planning and improvisation.

Summarized quantitative data
Table no. 8 summarizes the distribution of the above data that presents the recommendations and suggestions of students for improving ethics education in medical school.

Table no. 8:
A summary of the students' suggestions and recommendations for future improvement of ethics education in medical school

<table>
<thead>
<tr>
<th>Suggestions and recommendations sub-categories</th>
<th>No. of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. To continue and enhance the existing ethics education</td>
<td>15</td>
</tr>
<tr>
<td>II. To include new topics in the program</td>
<td>9</td>
</tr>
<tr>
<td>III. To establish new forums to deal with ethical issues</td>
<td>13</td>
</tr>
<tr>
<td>IV. To teach ethics education in the wards</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
</tr>
</tbody>
</table>

There seems to be an obvious division between the first sub-category that represents satisfaction with the existing program for ethical training and the other three sub-categories that seek minor or major changes in ethics education. Thus it can be said that a vast majority of students (about 70%) recommend change. Even if only the last two sub-categories are regarded as concerning major and significant change – involving new ways
of teaching and new institutional bodies to be established, half of the students (24 out of 48) express their wish to experience meaningfully different ethics education in medical school.

Section II: Students' perception of themselves as seniors

In the present section suggestions for ethical training are raised as an answer to the imaginary "senior physician" future role. The question elicited contemplative and personal answers, wherein students reveal themselves both as future physicians and as students.

It should be noted that when asked about the future, several students expressed their concern and doubts whether they will still remember how they feel now and what they think now. It appears that even when talking hypothetically about the future, students do not want to sound naïve or dishonest:

"I hope that I'll have the ability to regard ethics in the same degree of importance as all the other responsibilities I'll have. It is difficult; it is too utopian to do everything. In fact many good and impressive people do not. I hope to remember but I am also realistic. It would have been easier to say that I will remember to prioritize ethics if I saw half the physicians around me still doing it" (Oren)

In spite of the doubts, students supply some suggestions for ethical training approaches and means:

- Two broad approaches can be discerned in year six students' accounts about their future as senior physicians tutoring students in their turn.

(a) The emphasis on informal ways of teaching ethics they would prefer to apply – not with an 'ethics title' and not in a 'special ethics hour'.
"I will encourage students to discuss ethics, like an experience we had last year in one of the wards, where we participated in discussions.....It is important though not to label it: 'now we deal with ethics', but to relate to it as something that is embedded and always exists, as an integral part of ward rounds, one aspect of the current students teaching. When you 'discuss' a patient, you relate to the ethical and humanistic aspects that his sickness or his treatment raises" (Tami)

"I will involve ethics in a more structured way, but as part of a regular conversation, a ward meeting, not as a separate hour" (Ayala)

(b) An emphasis on a non-pressing and non-threatening atmosphere in their future teaching environments. Though this aspect may not relate directly to ethics, the students seem to attribute teaching atmosphere to ethical education:

"I think I'll be good to my students - in understanding them, understanding their constraints, their limitations. I will provide them with good teaching, maintaining a good atmosphere. I don't think I'll ever be threatening, I hope I will not. I do not want to be, I do not think I can get anything by threats" (Yotam)

• Several teaching means are suggested by the students to be applied when they are senior physicians:

Student involvement –

"I would try to involve them in my dilemmas because it is the best way. Not case-studies on the board but actual cases in the field. I would try to let them solve the problems, to be involved" (Hila)
Discussing real life ward events –

"I will dedicate time to ethical considerations. For example [Alon relates to an ethical dilemma, quoted in 'Findings', p.110 E.B.]. If I were the head of the ward I would have discussed it thoroughly with the students" (Alon)

Observing students and intimately discussing clinical and ethical aspects with them –

"I will want to observe my students more than I have been observed as a student. We are sent to perform things without anyone observing us...Nobody has ever observed me interviewing a patient in a full, real interview. I hope I will be able to sit with students after observing them and discuss their experience with them. In an ideal world I would sit with the students after every procedure they perform or any admittance and discuss the clinical aspects as well as the delicate emotional, ethical issues" (Mili)

Initiation of conversations –

"I myself would initiate talks about problematic issues. Today, physicians are defensive and view an open discussion as a personal attack on their judgment, so the initiation should come from them" (Ido)

Sensitivity to students with difficulties –

"It is rather problematic to assume that students will come to you with a problem when you are their evaluator. However, I would try to pay attention to a student that seemed to experience difficulty or to face a problem. To be sensitive to specific situations" (Gilad)
Personal demonstration of physician's role in difficult moments –

"I'm thinking about something good that was done in surgery ward, of all places. The head of the ward did something I'll take with me anywhere I go. He took students, one at a time, to accompany him when he delivered bad news to families or patients" (Rami)

Sharing personal experience with students without pushing your own ethical solutions or value system –

"I will follow a model that deserves to be imitated. There is much antagonism that accumulates when you create a structured situation: 'let us talk about...' It does not work. But with the right people and the right 'chemistry' it will work. And when a subject comes up, you as a tutor have to be sensitive to it and to lead it onwards. And there are no right answers; you only need to share your experience with the student that will in turn take what is proper for them. You are not talking here of eight-year-old children for whom you have to prepare a hierarchy of cultural normative social values. Here the students are in the same intellectual standard as their teachers, with less years of experience. So the corners are sharper and black and white are more separable, but it is very interesting to listen to somebody that started like you and is now 20 years ahead of you, to listen to what he has to say from his experience" (Irit)

Truthful self-exposure of personal ethical dilemmas and the complex considerations involved –

"In surgery we had night shifts in Ashkelon [a periphery hospital, E.B.], in a very difficult ward. There were some sensitive and aware physicians, to our surprise. We had fascinating conversations with them as they face enormous ethical dilemmas, such as to what extent to expose details to patients and families, collegial issues and other dilemmas. There was one I really bonded with and he told me and another
student about his inner conflicts and we were fascinated, by the high standard of his analysis and the complexity of the dilemmas and their insolubility. He said: 'I have to live with what I decide to do'..." (Yaara)

From students' answers to the direct question "Imagine yourself fifteen years from now, as a senior physician, what would you do concerning your student's ethical reality?" it appears that they are neither naïve in assuring they will remember all the vows made as students, nor avowedly righteous. They are aware it may be difficult to preserve all the sentiments and values they express now. Nevertheless, it is clear to the students what trends of action they would like to adopt when they are senior physicians in regard to their future students' ethics education: informal ways of teaching, personal involvement, conversations and discussions. They express clearly which type of model-teaching they would try to follow: truthful sharing of inner professional and attitudinal conflicts, and sensitivity to students' conflicts, emotions and values.
Ethical reality of medical students - faculty members' interpretation

This category presents data from interviews with faculty members, concerning two main issues:

1. What are the moral dilemmas medical students cope with, according to faculty members' understandings? This issue corresponds with research question no. 1 (p.15).
2. How do faculty members interpret the ethical processes (coping mechanisms and developmental aspects) of medical students? This issue corresponds with research question no. 2 (p.15).

1. What are the moral dilemmas medical students cope with according to faculty members' understandings?

In the beginning of the interview with faculty members, they were all addressed with the same direct question asking them to specify what moral dilemmas medical students cope with in medical school. The main finding is that with the exception of two faculty members that mention four and five issues each, most faculty members name only one or two kinds of dilemmas students encounter. Taken individually, it seems that each of the faculty members views only a narrow aspects of students' moral dilemmas. For example, one is aware only of problems with witnessing problematic behaviours (Hadar), another one raises only action dilemmas (Reuben) and so on. However, taken collectively, the list of dilemmas faculty members provide (n=19) can be presented according to the same categorization of self-reported student' dilemmas:

I. Reflection dilemmas

1. Treatment of terminal patients (David)
2. Dilemmas concerning death and dying (Eran)
3. How aggressive to be with treating demented patients (Orna)
4. Issues of resuscitation (Orna)

II. Witnessing: optional reaction dilemmas

1. Watching the ways of ward decision-making (Hadar)
2. Coping with mistakes and failures (Hadar)
3. Discrimination of certain population groups (David)
4. Witnessing conflicts of staff members (Orna)
5. Witnessing arrogance of staff members (Orna)

III. Action dilemmas

Concerning the system:
1. Confronting staff members, physicians and nurses (Carmel)
2. How much responsibility to take when relating to a patient (Reuben)
3. How to respond to directions – when to obey and when not (Reuben)
4. How to relate to the paramedical staff (Reuben)

Concerning the patients:
5. The "other side" of the clinics: patients and their families (Carmel)
6. Delivering information to the patient (Eran)
7. How to present yourself to a patient (Reuben)
8. Information to patients' families: students as patients' advocates (Orna)
9. The trainee students represent the system to the patients (Eli)

Concerning the students personally:
10. Joining the "medical system" life vs. "normal people's" lives (Eli)

Besides the dilemmas that are reported as a direct answer to a direct question, faculty members relate also to the issue of whether 'practicing' is to be considered as a moral issue.
in medical school. No less than five faculty members out of the seven interviewed, appear quite certain that 'practicing' does not constitute a moral problem for medical students training in the clinics:

"'Practicing' is obligatory. The students understand that there is no other way of learning. We follow them in the beginning and direct them and the patients give us much credit" (Carmel)

"'Practicing' is not problematic at all. You can set up some rules and help students in finding people that agree to be practiced upon and in coping with unsuccessful experiences without interpreting them as failures" (Orna)

"People accept the principle that in a university hospital they are being practiced upon by students. One can explain and ask the patients for their consent. The majority of patients agree, if it is done delicately. With some common sense, not with ten students examining one patient" (Reuben)

It can be concluded that faculty members regard the 'practicing' issue as a non-issue from an ethical point of view. They reason that it is the only way to study, patients and students alike are aware of it and as long as it is done without exaggeration, with consideration of patients' feelings and will, there is no ethical issue involved. It seems that concerning the issue of 'practicing', faculty members do not interpret 'practicing' as students do, and this finding certainly calls for analysis and discussion.

In addition to naming the ethical issues students encounter (the dilemmas), some faculty members also express general understandings of the ethical situations students cope with, providing valuable information about their interpretation of students' dilemmas. Each insight or understanding is presented separately as each adds a different angle on students' moral dilemmas:

- "Students deal with the problem, not with its causes" (Hadar) – students are exposed to the problematic issues in the ward and are very agitated about them, but they cannot yet
evaluate all the factors that cause or lead to the creation of these problems – systems' problems, budgets and priorities.

- "The students 'suffer' most from the problematic behaviours of physicians" (Carmel) – all the moral dilemmas of medical students are around this issue, even when given different names and articulations.

- "The distinction between students and physicians is only in the topics they are exposed to" (Eran) – initially, the students are exposed to death so they are preoccupied with it. Later on when they specialized as physicians they will deal with the dilemmas in their field – like dilemmas of fertility and so on.

- "The overall issue behind the moral dilemmas is the question of authority and the students' approach to it" (Reuben) – all the dilemmas originate from the question whether or not to obey authority figures.

- "The dilemmas relate to students' special relations with the patients as they have a 'special ear' for them" (Orna) – the core reason behind all the dilemmas is the special bias students have toward patients.

It appears that faculty members raise certain core reasons for students' dilemmas, and they all relate to the students' status as trainees: their disposition toward authority (Reuben) and authority figures (Carmel), their special relations with patients (Orna), the position that allows them not to be fully responsible to all aspects of the problematic issues (Hadar) and the limited range or their ethical issues exposure (Eran). Students' ethical dilemmas are thus described as closely related to a unique phase of clinical training and practice.
2. How do faculty members interpret the ethical processes of medical students?

In the interviews, faculty members described the ethical processes that students go through, according to their interpretations. The descriptions deal with the common, 'classic' issue of 'loss of sensitivity' (an issue students cope with also), as well as with other aspects of ethical processes. Some of the descriptions form a certain continuum of pessimism versus optimism about the process. On one end of the continuum there is an extreme pessimistic view that claims that students become significantly less humanistic:

"I see a negative ethical process, that we are responsible for. There is much more chance that a first years students will raise ethical issues than a fourth or fifth year student, that experiences more ethical encounters" (Eran)

At the other end of the continuum there is an extreme optimistic view that sees students as a group that stays very sensitive, in spite of the harsh reality:

"Students go through regression to reality without losing their sensitivity. They aspire throughout the six years training toward the maximal ethical threshold, and they should do it. They are not to be educated to compromise at that stage. The compromises should be made later, during the rest of their lives" (Hadar)

Somewhere in the middle one finds descriptions that analyze the ethical process somewhat realistically – there is an understanding that a loss of sensitivity does occur but not as a dramatic change or loss, and not as a direct responsibility of faculty members and physicians:

"The students enter medical school full of dreams... Our life here in the hospital is full of routines that are not compatible with the dreams. It is not easy for many students and they ask themselves whether that's what they wanted to learn and to become" (Carmel)
"The students are exposed to everything and see everything. They become more cynical. It is a necessary, even mandatory defense mechanism. They learn how to live with their silence. There is not any order in the process, it evolves gradually. It happens all the time and we all change" (David)

One faculty member (Eli) elaborates more on the ethical process of medical students and describes a chronological development:

"In the first years, the pre-clinical years, the nature of students' moral dilemmas is of 'sitting on the fence', being between the layman and the professional. As the students do not belong yet to the medical profession they observe the system through laymen's eyes. But, as they study about the system from professionals they receive their teachers' messages, though they still have the laymen perception. Their conflict is one of adopting the professional identity – whether to adopt it totally or to stay loyal to their judgment of the system as outsiders, as customers. At this stage the students' ethical problems relate to the ambiguous way they view themselves; In later years most of the students cross the line to the other side and view the system as professionals, and by then to a large extent they lose their criticism of the system. Thus they solve their previous dilemma. In those years, namely the clinical ones, other kinds of dilemmas emerge that relate to the cases the students are exposed to in their professional practice. On one hand they are viewed by the system as learners, and on the other hand for the patients and their families they represent the system. They are viewed as professionals but they know their imitations. At this stage, the medical students' ethical problems relate to the ambiguous way other people view them" (Eli)

This analysis raises an issue that appears in all faculty members' interviews, the question of whether the students are basically "Boys in White" (Becker et al., 1961) or "Student-Physicians" (Merton et al., 1957). This "classic" question in medical training is addressed by faculty members in relation to ethical process and decision-making in morally conflicting situations. Most of the faculty members view the students somehow as "boys" –
as young people at the beginning of a process, in a developmental process, not yet as professionals or grown ups. The dominant voice in faculty members' descriptions is that students are still "kids", in a special moratorium period. This concept was mentioned before where one faculty member said that students do not compromise and should not compromise in facing ethical dilemmas (Hadar), and where another said that students are basically sensitive and that physicians are the ones responsible for their problematic development (Eran). Another faculty member emphasizes on the special learning position of the students, that puts them in a specific ethical stance:

"Physicians and students alike 'use' the patients for their learning – but I 'learn' on a patient in order to make a practical decision and they 'learn' on a patient in order to impress me... Physicians' decisions affect patients immensely but do not affect themselves; on the contrary, students' decisions do not affect the patients but affect them immensely" (David)

Only one faculty member regards students as adults with no concessions, even though she acknowledges the ethical process they go through:

"It is difficult for them to realize how harsh the world they are entering is, but they are already physicians in a nutshell... They are adults who have chosen to study a profession. Maybe they have forgotten it during the preclinical years that resemble high-school. When they come to the clinics I expect the students to stand up for themselves and for their opinions because they are not kids anymore" (Carmel)

The ethical aspect of standing up for one's opinions and values was directly addressed in faculty members' interviews. At one point in the interview all faculty members were presented with a dilemma, taken from a student interview that concerns a situation in 'practicing' where a student is pressed aggressively by a physician to go on with a gynecological examination of a woman, even though she is very stressed after having been examined by several previous students. The interviewed faculty members, all expressing their shocking anger toward the situation one of their colleagues caused, relate the dilemma
to students' coping mechanisms with such situations and to the ways of ethical learning in adulthood. Some suggestions and examples of coping mechanisms students can and should activate in such situations, according to faculty members:

"There are ways to deal with such situations, besides confronting the teacher: to comfort the woman, to address her and ask for her permission" (Hadar)

"The stress and the anxiety caused the student to think that he had no choice. But there are ways to apologize to the patient and to talk with the physician later" (Orna)

"I teach them to give comfort to the patient, so that the patient will gain something from the student's 'practicing' on him" (Eli)

Some insights about ethical learning in adulthood that can be inferred from faculty members' reactions to the dilemma presented to them:

"The student did not react actively but he remembered the encounter. Even if most of us keep silent in the face of evil doings, the students learn from their silences" (David)

"When I was a medical student I refused to go on with a similar situation. The student here learned something from his dilemma. That was his true lesson, not the gynecological examination he unwillingly performed" (Reuben)

One faculty member recommends a different approach to ethical learning that might have produced a different reaction from the student:

"If the student could have discussed the case with his tutor right after the encounter, to be relieved from authority and hierarchy consideration, maybe then the vicious cycle of obedience could be broken. Perhaps he would have done it differently next time. He could stop between checking the women, take a deep breath and say to his tutor that he did not like the way things were done, that he felt very stressed and that he would have liked to do things differently" (Eli)
The above citation relates to a hypothetical dialogic-learning situation where a discussion or a conversation is being held. The next category deals with actual ethical learning in medical school as perceived by faculty members, and its curricular implications.
Ethical curricular training processes - faculty members' interpretation

The present category deals with the way faculty members describe and interpret the ethical curricular training process of their students in medical school. They relate both to their individual role as educators and to the training process of medical school as a system. The data is presented in three sub-categories, articulated as three basic consecutive questions: What do faculty members think about the ethical education they provide and should provide? ("Gaps"); How do faculty members explain any gap between the desired and the actual training? ("Difficulties"); What are the possible ways to overcome the difficulties that prevent providing the desired ethical training? ("Suggestions")

What do faculty members think about the ethical education they provide and should provide?

When faculty members relate to the elements of ethical education they are involved with, they interpret it basically as a question of whether they personally discuss ethics in the ward with the students they train, in their role as teachers-physicians. The dominant voice in faculty members' interviews describes the absence of regular initiated ethical discussions and deliberations with their students. One faculty member admits that when he is discussing ethical issues it is done mainly with his residents, not with his students and another laments that there are no ethical discussions on a regular basis. The wards routines seem not to include ethical discussions:

"We teach them illnesses and medications, but not about the unpleasant part of medicine, like the demented patients with 'pressure sores'. They see the harsh reality without ethical instruction about it. We do not stop the ward rhythm in order to discuss the unpleasant problems with the students, instead of the brilliant diagnoses..."
and the brilliant procedures. As for myself as physicians' educator, I teach them ethics only by having them watch my actions and decision" (Carmel)

Ethical discussions do occur, even according to faculty members that complain about the absence of them, not as a routine process but as a sporadic initiation of the teacher:

"There is no structured ethical discussion in the ward. Sometimes ethical issues emerge when students' admissions are discussed or when I ask a student 'does it bother you?' about certain problem. It is rare but it occurs. A year ago we discussed the issue of resuscitation and elderly people. It was a 'one session' discussion and not an ongoing process" (Orna)

Two exceptional descriptions are supplied by two faculty members that describe their extensive intentional ethical discussions with the students training on their wards. They are both aware that their attitude is rare and 'boast' about it with detailed wordings. The first one explains that he deliberately shocks the students and confronts them with ethical issues, as he considers it his duty and as the ward is the real arena for ethical conflicts discussions:

"Our duty is to talk with the students and discuss problems with them. The course 'emotional processing' does it also but it works only partially. It is not sufficient to say [sarcastically, E.B.] 'bring your problems to the group, expose your problems'. In natural conversational settings the problems come out, in seminar rooms, in the ward they come out and I discuss the problems with the student there and then. I discuss ethics a lot with my students. It is important to me because values and ethical issues bother me. I think that we should talk constantly with the students. Even if you do not talk, the educational action is done, so you should talk and talk" (David)

In his interview David supplied many examples of his special way of ethical intriguing and even manipulations – when he and his residents and students stand by a terminal patient and discuss whether or not to perform dramatic life-saving procedures, the students usually
do not say anything because it is such a painful and problematic issue. Then he, the teacher, raises the issue by himself and does not let them go without discussing it thoroughly and candidly. Another topic he reports that he explicitly and bluntly discusses with his students relates to ethnic discrimination that is typical of the medical system. He, the teacher, tries to 'correct' it by letting patients from discriminated groups stay longer in his ward in order to give them more medical attention than they would get back at their local clinics. David admits to being very personal about the attitudes he wishes to convey and he describes the relation between his experience in medicine and the education of his students:

"It is very difficult to be nice to 'not-nice' patients, like drug addicts, convicts and so on. I myself make an effort not to know what the charges are against a convict that is admitted to my ward. It is easier for me to be empathic to an old lady that resembles my grandmother than to an addicted woman that injects into every available vein...I had a student, a delicate girl that comes from a religious protected upbringing, and I deliberately asked her to admit an addict prostitute because I wanted her to experience what she feels and how she deals with the 'not-nice' cases. I watched her and instructed her and discussed with her the moral implications of the case as well as her conflicts of emotions. I believe that the first step of overcoming the difficulty of treating such patients is to talk about it aloud"

(David)

The other faculty member that dedicates a lot of time and energy to ethical issues relates it to his inclination to remain critical of the medical system as if he where still a layman an not a professional that works within the system (Eli). He discussed ethical issues in various situations where he is the initiator of the conversation:

"One of the issues that bother me relates to delivery rooms where sometimes one encounters lack of privacy or problems of communication – self presenting of staff members and informed consent. I point out these misdeeds to the students and we
Eli then describes an unusual mentor-student relationship that he succeeded in developing with one student from year one in medical school until he became a physician. Their acquaintance was accidental in year one and became regular but informal for the duration of medical school training, consisting of personal meetings that included many conversations and ethical discussions as well as personal consultations. Some of the characteristics of their informal and individual mentorship are the basis of Eli's suggestions for medical school options of coping with ethical training and education (detailed in pp. 199-201).

When returning to the dominant voices in faculty members' testimonies, after reviewing these two exceptional examples, it can be seen that most of them not only describe the absence of ethical discussions in their teaching environment, but also express their explicit opinion that such discussions should have been an integral part of the training process. It is very clear from faculty members' interviews that ethical discussions should be part of the daily routine in the wards, "like the discussions and considerations of medical cases" (Eran), dealing with the "difficult and even ugly issues that are exposed in the wards" (Carmel). There are ethical issues involved in so many cases and they should be discussed just as medical considerations are discussed: "every problem should be discussed and not ignored, and if problems are exposed, more dilemmas would be raised and seen" (Eran). The emphasis here is on the integrated nature of ethical discussion, "not in separate special sessions, but in the ward rounds, in a holistic approach" (David). It is clear that faculty members think that any separation between ethical discussions and hands-on cases in the ward is less beneficial, and they give examples:

"From the standpoint of integrity we should be honest with the students and discuss all our considerations with them. They are watching us and we should expose the ethical-based decisions, to say: here I took a decision, here we have an ethical cross-road that we should not deny. It should be part of the processing of the
medical case, even if it is banal sometimes, like the case of a 61 year-old man that had a heart attack and you consider whether his heart is so weak that it is better to suggest an early retirement or whether it is better for him to get back to his normal working life. It is not a heroic moral issue but it has its ethical implication for our impact on individual patients' lives" (Hadar)

Another aspect that faculty members emphasize is that it is their role and duty as educators to "initiate and lead these discussion" (Orna), though it is clear that such discussions can be initiated in the wards only if "there is the suitable personnel for doing so" (Eli), and that perhaps "physicians should be directed and instructed how to initiate such discussions and how to handle them" (David). The clear and salient gap between what should be done by physicians with regard to ethical issues and what is actually done in the wards leads to the central question of the next sub-section.

How do faculty members interpret the gap between desired and actual ethical training they provide?

It is clear that faculty members are aware of the gap between the way they would like to perform their role as medical students' teachers in regard to ethical training, and what they actually do. Faculty members provide in their interviews several reasons for this gap, reasons that are presented in two main groups of explanations: (a) Structural reasoning, concerning medical school as a system; (b) Human resources reasoning, concerning medical school personnel.

The structural systemic reasons supplied by faculty members shed light on several aspects of medical school and especially on physicians' role as students' teachers. The physicians' role as educators is performed simultaneously to their role as physicians, usually in high positions as head or sub-heads of busy and demanding clinical wards, and their rationale for neglecting the ethical aspect in students' training relates to the framework they function within. As a rule, when people are busy and stressed, "it is easier not to deal with more
bothersome aspects [like ethics, E.B.] than to deal with them, even though it should be part of our job, it is usually ignored" (Orna). There is also "the ever-used pretext of lack of time. Nowadays we are measured by output and ethical discussions are time consuming" (Eran).

Two more elaborate descriptions of the working environment and the constraints on physicians in the medical wards further explain the aforementioned gaps:

"It is difficult to do what we should do because we, the physicians, are examined and measured by criteria that are not medicine-related, by the number of papers and publications and by dubious loyalty to certain people... Additionally, the system strengthens the technical field - what is the patients' temperature and how many leukocytes in his urine - these are the questions you are asked and not: have you talked to the patient, how does he feel or have you related to his stress and anxiety" (Hadar)

"The ward is like a factory with many simultaneous problems that need to be solved. Most of the things happening are urgent, some are purely medical while others are administrative. And we, the physicians, are perhaps less conscious of what seems to us as obvious. We should stop the race and explain to the student why things are done in a certain way or why we think in a certain way. Simple, regular decisions like what pain relief medications should be given to a terminal patient, in what doses and how. We do not stop to explain and the students should nag us. It is not that we neglect the ethical field but we put an emphasis on the medical aspects because we are worried about their professional medical training and we are preoccupied with it" (Carmel)

The last cited testimony leads to the issue that is referred to faculty members as a core problem of ethical teaching in the wards, namely the issue of human resources, personnel, and more specifically the 'modelling' process. While a minor personnel problem that is mentioned relates to the ethical formal abilities of physicians, "physicians do not have any understanding and knowledge in ethics" (Eran), and "we do not have ethicists at our
"service in the wards" (Eran), the major personnel issue that faculty members raise relates to the role-model that they provide:

"I think that even if we do not talk to the student the educational process occurs, for better or for worse. We serve as role models constantly and the students despise us or respect us. They know us and they know exactly who we are and we cannot hide anything from them. They are our most bitter critics" (David)

The 'modelling issue', particularly the negative 'modelling', appears in faculty members' interviews as no less salient than in students' interviews as each of the interviewees relates to the issue somehow. It seems that the entire range of attitudes toward the problematic issue of negative 'modelling' in practical learning can be found in faculty members' words:

(a) One 'approach' of faculty members toward modelling is to concentrate on their own positive modelling, ignoring the other models. They put much emphasis on the crucial effect of significant positive modelling, supporting their point by reminiscences of their own ethical training as medical students and the fact that they still remember the role models who influenced them.

"Our role is to be role models. We have a central role as internists in students' education, because we and the pediatricians are the physicians that students meet first in their clinical rounds and we teach them the basics of medicine like 'admission' of patients. 'Admission' symbolize the whole profession for me...there is no doubt that we transmit something somehow...it is obvious to me that something is transmitted because I remember my teachers and their influence on me. Things we do are imprinted in the students somehow. My body language, the ways I check patients. I can give an example from my clerkship in Indiana where my boss used not to take extra payments from medical personnel or the clergy, and it impressed me and I remember that" (David)
Another faculty member also gives an example of his days as a student to prove how significant a personal positive ethical model can be:

"When we were in year one or two, a neurologist from England came to present some treatment to us and he took off a sock from a patient's foot and was very keen on putting the sock back himself even though the patient said 'I will do it' and a nurse hastened to do it also. It was impressing: a senior professor that treats the patient personally all the way" (Hadar)

(b) Another 'approach' regards negative role-models that the students encounter in the wards as part of the reality and finds ways to cope with them:

- One can learn many things from negative role-models: "I am not bothered because this is also a way to study. The same way as we teach about papers - this is a good one and that is a bad one" (Carmel);

- One learns from negative models by doing the opposite: "The students watch many bad behaviours and one should hope that they will learn from them also. There are many things I do opposite to what other people have done because they vexed me" (David);

- If not covered or hidden, and if things and behaviours are discussed, things can be corrected: "we should not deny the problematic models and discuss them according to our integrity" (Hadar);

- The students are grown up people, adults, so we can hope that they will choose for themselves the right models: "We should trust them to do so" (Carmel).

(c) There are however faculty members who regard the concentration and the large number of negative role-models as very problematic. Eli talks about himself as an ideal mentor and even suggests a completely different ethical training concept than the existing one, because
of the negative role-models (see in later section, pp.199-201). Orna, an internal ward head, represents the most worried side of the continuum and ask herself how to cope with the large proportion of negative models students are exposed to:

"I have a big problem with the present role models in our medical school. We used to be more homogeneous in that respect but now, with all the physicians we admitted, physicians that were educated in different medical approaches than ours and come from different cultures, there are many clashes, real ones, that do not lead to discussions but to conflicts. The magnitude of that modelling makes it too negative. I am not sure I know the way to overcome the problem. The physician that behaves wrongly in my opinion is senior to the students and the wrong behaviour is not discussed frequently enough...I am very frustrated at the bluntness of some of our 'house-doctors' which I have not been able to abolish. There are conflicts every day. Not necessarily big ethical issues but daily routine behaviours like the way a sentence is said, or a negative gesture to a patient who asks a question in the corridor. The students see everything and it confuses them. Imagine that I have to tell a nurse to go and see what a patient wants because the bell has been ringing for ten minutes. The students watch it all and absorb everything. The double messages are very disturbing and confusing" (Orna)

Discussing the ways to deal with this kind of problematic modelling, Orna also relates to her double role as ward head with responsibility for her staff, and as students' educator:

"I sometimes try to balance the wrong behaviours by asking the physicians: did you speak with the patient? have you explained things to him? However, I do it in a forum where all the staff and the students are present and then it becomes negative and critical and a-educational to my opinion. I cannot tell the students to leave the staff meeting because I want to 'educate' my staff. I send the physician to correct behaviours that upset me immensely, but it is difficult for me to do so, to put a senior physician in a difficult position in front of the students" (Orna)
This structural reasoning that faculty members give to explain the difficulties that prevent initiating directed ethical education reappears when discussing the 'modelling' issue. The double or multiple roles of senior physicians and students' educators put them in conflict situations when they need to consider their students educational needs. In the next section faculty members discuss the possible ways to overcome this ambivalent position and offer some suggestions for improvement or even total systematic change.

What are the possible ways to overcome the difficulties that prevent providing the desired ethical training?

Faculty members' ideas about ethical education of their students can be divided into two distinct parts: (a) Suggestions for improving ethical education – how to make it better within the existing framework of medical school and medical training; (b) Suggestions for changing ethical education – how to make it totally different, as an alternative to the existing system of medical school and medical education.

(a) Improvements of the existing ethical education

• One suggestion relates to opinions presented in previous sections, emphasizing the faculty members' own responsibility for ethical training of their students in the wards, during the daily routines, when they cope with contextual dilemmas. Accordingly, they suggest to empower their own ethical educational capability by basically improving their ethical-discussion skills and their ethical educational tools:

"Physicians that educate students should pass some kind of training to teach ethical issues in the wards. It is not 'home — made' knowledge. You bring with you your natural humanity and your basic mode of relationships with people, but you need help in acquiring tools that facilitate ethical decisions and lead to their discussion. Such tools will make ethical deliberations in the ward easier and consequently more frequent" (Hadar)
However, some doubts are expressed about any central direction and orientation for physicians because this could turn into some bureaucratic artificial guidelines that would be the opposite of the nature of ethical deliberation. Nevertheless, the idea of some kind of training and guidance for teachers seems plausible:

"Maybe the school should plan ethical interventions and discussions with the physicians that train the students, but I am afraid that this kind of planning will result in a 'let's talk about ethics today' routine [ironically, E.B.]. I do not think it is a suitable framework for the wards where all interventions and discussions should be holistic and natural. However, it might be beneficial if teachers were directed to involve ethics as an integral part of their general discussions with their students. It is relevant to have workshops for faculty members that will raise their consciousness to their ethical role as teachers. We should study some ethics and ethics-discussions techniques just as we got lessons about medicine and the law" (David)

- Another improvement that is suggested relates to faculty members' consciousness of students' moral dilemmas, and their awareness of the ethical position of students in the wards, especially its implicit aspects:

"It is very important for physicians that train students to be conscious of the ethical dilemmas students have to cope with. They should also be conscious of the fact that they confuse the students with their conflicting behaviours and the hidden messages" (Orna)

Put in even stronger words, teachers should be aware not only of their students dilemmas and ethical conflicts but also of the mode of teaching that actually occurs in medical school, beyond the 'declared curriculum':

"We teach the students about sensitivity and ethics and human communication on special days in year one and later they come to the wards and observe catastrophic
behaviours. The real curriculum is not what you teach in 'clinical day'. Even if we could teach beautiful courses with very detailed and planned units, the real teaching is in the 'hidden curriculum' [Eran's choice of term, E.B.], with its unwritten aspects. Thus, there is no other way than to interview students and teachers alike, finding out from the teachers what they planned to teach and from the students what they actually received from that teaching. Examples of the dilemmas the students described in the questionnaires and interviews should be publicized. This mode of sincere and honest apprenticeship is the best mode of teaching for our profession" (Eran)

From the two suggestions of faculty members presented above (training physicians as ethics facilitators and raising their awareness of students' dilemmas) it is clear that faculty members are aware of the importance of ethical issues and of difficulties of addressing them in clinical ward life. The suggestions to raise physicians' awareness of ethical issues and to train physicians how to deal with such issues seem conceptually clear but lack any structural means to perform them. In the following section two suggestions for change in the system provide for another kind of ethical education.

(b) Changes of the existing ethical education

The two suggested structural changes are completely different in nature – one relates to the whole curriculum and teaching and considers medical school as a system, while the other relates only to one aspect of ethical training, the mentoring factor, and puts this element in focus.

- One alternative, described by Eran, relates basically to a combination of declared ethical goals, declared ethics curriculum and planned teachers' training. Eran begins by describing the present problematic situation where ethics education is not high priority in physicians' agenda:
"Ethics is a field we are not experts in and it is neglected and will continue to be neglected. For example, we had a visitor from the US, an expert in medical ethics who came here for a Sabbatical. He offered to teach us how to deal with ethics teaching in the wards. So we planned to gather all the heads of clinical units but I was abroad and other heads did not show up even though they received an interesting article written by him prior to the planned meeting. When I say we, I mean people with significant positions in school, with a say about students' and residents' curriculum. If we had regarded this challenge seriously it would have prevailed" (Eran)

Eran strengthens his claim by describing an opposite example where a certain topic seemed important enough in his department to stimulate a curricular priority:

"Take for example the issue of communication: we decided to make it a school's requirement, so we made a communication workshop mandatory for our residents. Now we are going to continue with a psychologist's follow-up of communication processes. We decided to put it in focus and not to let any resident pass his exam without that workshop. This is a form of strategic decision. If one decides that ethics is an important field that cannot be ignored, one finds ways to include it" (Eran)

The first step in any change is a person (or a small group) that are dedicated to the idea they promote and believe in it:

"It always depends on one zealot or a group of fanatics for the cause. When you have such a zealot he finds money and he finds other followers to raise the goal. This is the secret – to mobilize other people for the idea and for its fulfillment. First of all conceptual and ideological mobilization and than looking for the operational steps that can be applied effectively" (Eran)

Once the initiative starts, the goal should be to create an overall focused planned infrastructure to deal with the desired change – a different, better ethics education:
"My idea is that the zealot and his team should build an infrastructure. Initially I would have decided that every year of their studies medical students should cope with ethical issues. We talk here about a multi-annual plan. We do not talk about a course in year six – the physician and the community. It is bullshit – year six? It should start in year one. If you say that you want the students to meet the community in year one, then you start there. There could be one course or more as an introduction but eventually the issue should be coped with on a daily basis. It is not possible in a course to say: 'let's talk now about ethical problems'. They should be discussed while you work: 'we have seen ten cases today. Let's choose one and discuss its ethical implication'. Sure enough from ten cases one will produce fruitful discussion. The problems exist constantly. We don't have to say: 'let's look for the complex ethical issue'; it is there and it will be raised, by the student or the resident or the expert. Each of them by the way he feels and copes, and thus the circle of people dealing with the issue will be enlarged. We will open their eyes then. This goal necessitates the teacher's deep and serious training, as part of infrastructure building. I do not want to put an ethicist as an outsider in the wards. I would have rather taken one senior physician from each department and created a group that works with an ethicist on cases from their departments. That group would study together how to cope with ethical issues. Then we could bring this knowledge to the wards and then we should even ask about ethical conflicts in exams, for students and residents. Thus we could create an alive process. There is no point in teaching students something that is not alive" (Eran)

- The second alternative, described by Eli relates to the personal aspect of teaching ethics, namely mentoring and modelling. Eli is bothered by the absence of exemplary role models:

"We created an educational system that has theoretical role models, but with fewer real role models that are there, on the spot. It would have been ideal if we had such a system" (Eli)
The idea Eli raises is a system that works on a "one on one" basis:

"Unfortunately we do not have "one on one" tutorship or mentorship relationships. I had this kind of relationship with one medical student, from year one to year six and even later... he shared with me his personal, ethical, professional decisions... I would have liked something similar to that to operate for the whole system" (Eli)

Eli is aware of the problems involved with such an idea:

"Obviously it is a very costly system, personnel-wise and time-wise, but it is a very significant system. And there is also the problem of choosing the people that are involved in this system. I am not sure everyone can be a mentor, even though many people think they are worthy to be... Everyone probably wants to transmit his/her model, so the school's problem is who will be the person or the committee that will decide who are the desired models and to whom shall we match a student... Another option can be that we will tell the students to find mentors for themselves on a personal level, but this is not so efficient as students, when they need their mentors mostly, do not know the faculty members well enough... in the beginning of the clinics they are exposed to few physicians and the supply of worthy mentors is not so vast" (Eli)

Later in the interview Eli comes back to the mentoring concept because he is bothered by the fact that the study groups in the clinics have grown too big in his opinion and intimate instruction is becoming difficult, so he advocates mentorship, in spite of the obstacles involved with it:

"Nowadays, in larger study groups, the ratio of students-instructors is wrong. If we could have gone back to more intimate instruction maybe the students could have felt better about their personal development... a mentorship system can be an answer to that need. In our profession, that relies so much on life experience,
mentorship can contribute a great deal. The wonderful aspect of personal mentorship is that it enables the student to retain and develop his sense of critique, because he has nothing to fear, as he can be open with his mentor (unlike in a big group). With the mentor the students can discuss issues that are lost in a group due to group pressures, group atmosphere and so on. It is a much better process of self-development and self-expression fostered by real consultation with an experienced sensitive teacher. It could be a big contribution." (Eli)

Findings gathered in this category show that faculty members (who clearly regard ethical training as part of their role), are much aware of the gap between the desired ethical training in medical school and the actual one. After elaborating upon the structural causes of that gap, faculty members suggest several improvements in the ethical training process in medical school, some within the system and some in changing the ethical education's infrastructure. It can be claimed that faculty members reflect their role as students' ethical educators by analyzing the deep and underling processes that are part of ethical education in medical school, and by offering their insights about innovative approaches to improve it.
Chapter Five

Discussion

This chapter begins with preliminary comments on the study's purpose and methodology. Then it discusses the meaning and implications of the findings, providing interpretive-conceptual frameworks to the analysis. The discussion dedicates one section to each of the topics of the present study research questions: I. The perceived moral dilemmas in medical students' reality; II. Coping with moral dilemmas; III. Learning processes of medical students, in regard to their ethical experience; IV. The perceived ethical curricular processes in medical school; V. Students' and faculty members' expectations and proposals concerning ethics education. The structure of the Discussion chapter is presented in table no. 9 (p.204).

Preliminary Comments

The overview of the literature highlighted the absence of research that thoroughly probes the ethical processes medical students undergo. Therefore, the present study has attempted to chart the ethical reality of medical students, including their conflicts and coping mechanisms, their moral development and changes, and the ethical curricular aspects of medical education.

This study's concern is the medical students' ethical reality, focusing on the way sixth-year students at Ben-Gurion medical school describe their experience and interpret this reality, in an effort to understand the context through its participants. Accordingly, qualitative interpretive paradigms – such as phenomenology and narrative inquiry – are the preferred research approaches. These qualitative approaches are compatible with studying a broad context of human experience, such as the ethical processes in a medical training program.
No empirical study to date has interviewed medical students and medical school faculty members about their perception of the ethical aspects of medical training, with the ability to reflect on medical school experience from a personal, contextual perspective. This study aims at better understanding the explicit and implicit moral processes, the personal ethical experience of young people in a long training period, as reflected mainly through their own viewpoint, and assessed also by their teachers. The study further aims at reviewing ethical reality in medical school through concepts from the field of education, as reflected in the curriculum domain, in an attempt to discern 'ethics education' processes in a medical training program, and to analyze the 'received' ethics curriculum.

The study is based on students' open questionnaires, students interviews and faculty members interviews. Analyzing the elicited narratives, the study follows two approaches: (1) Cross-case approach: categorization of the narratives utilizing content analysis technique; and (2) Within-case approach: analyzing each student's interview as a separate entity, examining students' profiles of ethical coping and personal ethical development ("ethical profiles"). The products of the first approach comprise the main body of the 'Findings' chapter (Findings' categories). The products of the second approach, the students' 'ethical profiles', are incorporated in the 'Discussion' chapter. Four such profiles are presented integrally in the discussions, in sections I-III. Each profile represents one of the four different "circles of reading", each focusing on a different theme (see: 'Methodology' p. 90). Thus the 'Discussion' chapter, that is inherently interpretive in nature, is also partially narrative in form.
Table no. 9:
The relation between 'Discussion' sections, research questions and 'Findings' categories

<table>
<thead>
<tr>
<th>'Discussion' Section</th>
<th>Relevant Research Question</th>
<th>Relevant Students' Categories in 'Findings'</th>
<th>Relevant Faculty Members' Categories in 'Findings'</th>
</tr>
</thead>
<tbody>
<tr>
<td>The perceived moral dilemmas in medical students' reality</td>
<td>1</td>
<td>• Students' Dilemmas</td>
<td>• Ethical Reality of Medical Students – Faculty Members' Interpretation</td>
</tr>
<tr>
<td>Coping with moral dilemmas</td>
<td>2</td>
<td>• Coping Mechanisms • Silence • Cynicism vs. Sensitivity</td>
<td>• Ethical Reality of Medical Students – Faculty Members' Interpretation</td>
</tr>
<tr>
<td>Learning processes of medical students, in regard to their ethical experience</td>
<td>3</td>
<td>• Ethical-Learning Processes</td>
<td>• Ethical Reality of Medical Students – Faculty Members' Interpretation • Ethical Curricular Training Process – Faculty Members' Interpretation</td>
</tr>
<tr>
<td>'The perceived ethical curricular processes in medical School</td>
<td>4</td>
<td>• A Six Year Processes</td>
<td>• Ethical Curricular Training Process – Faculty Members' Interpretation</td>
</tr>
<tr>
<td>Students' and faculty members expectations concerning 'ethics education'</td>
<td>5</td>
<td>• Expectations for Ethical Training</td>
<td>• Ethical Curricular Training Process – Faculty Members' Interpretation</td>
</tr>
</tbody>
</table>
The perceived moral dilemmas in medical students' reality

The present research starts where most research on medical students' ethical dilemmas ends. The previous literature concerning students' dilemmas (Bickel, 1993; Christakis and Feudtner, 1993; Bissonnette et al., 1995; Homenko et al., 1997; Huijer et al., 2000; Hicks et al., 2001), deals mainly with exposing and mapping the topics of the dilemmas, and generally neglects the ways students cope with them. Only Huijer and colleagues (2000) discuss students' patterns of consultation about ethical dilemmas, as do Shreves and Moss (1996) about residents' desire for a formal process for resolving ethical conflicts. Dwyer (1994), partially deals with students' coping mechanisms when describing and criticizing the 'silence' phenomenon, that is, not reacting to unethical encounters. In the present study, the starting point is the ethical dilemmas that students encounter, but the research goes beyond this to explore their ways of coping with the dilemmas and the ethical learning in medical school.

This section of the discussion is concerned with the first research question ("What are the perceived moral dilemmas and ethical conflicts in the medical students' reality?"), and includes three parts:

(I) Validation attributes of the present study findings, in regard to mapping students' moral dilemmas.

(II) Conceptual attributes of the offered typology of students' moral dilemmas (see: Findings, p.119).

(III) The centrality of the 'practicing' issue: two interpretive frameworks (accompanied by 'ethical profile').

(I) Validation attributes of the findings, in regard to mapping students' moral dilemmas

The first validation attribute relates to the extent of compatibility between the present study and previous ones. The findings about students' dilemmas discussed in this section are in
accordance with those of previous studies and are, thus, mutually validated. Much like in
the previous studies (Bickel, 1993; Christakis and Feudtner, 1993; Bissonnett et al., 1995;
Homenko et al., 1997; Huijer et al., 2000; Hicks et al., 2001) the dilemmas reviewed in the
present study dominantly occur in the daily routines of clinical reality. The classification of
dilemmas (Bickel, 1993; Christakis and Feudtner, 1993) corresponds with issues found to
be relevant in the present study including witnessing conduct of faculty members and
collegiality (Christakis and Feudtner, 1993), special communication of students with
patients (Bickel, 1993), and 'practicing' issues (informed consent, self-introduction and
causing pain to patients) (Bickel, 1993).

The second validation attribute relates to the methodological strengths of the data about the
moral dilemmas. (I) accounts of dilemmas were gathered from both questionnaires and
interviews, and (II) the combination of 'specific' and 'ongoing' dilemmas (see: 'Findings',
pp.104-105), both increases the number of the reviewed dilemmas and supplies a time-span
dimension to them ('ongoing', recurrent dilemmas).

The third validation attribute relates to the study's approach, namely to interview faculty
members about their perception of students' moral dilemmas. These findings constitute
considerable support to the validation of students' moral dilemmas. They also fill a gap in
the literature concerning faculty member perception of students' moral dilemmas. The
present study's findings show that faculty members as a professionally related group
collectively identify and understand the basic topics and origins of students' dilemmas.
Students' accounts of their dilemmas and faculty members' accounts of student's dilemmas,
appear to be widely compatible. There is a resemblance in the topics, and in faculty
members' perspectives on students' reality. For example, two articulations of faculty
members – "The students 'suffer' most from the problematic behaviours of physicians"
(Carmel), and "The dilemmas relate to students' special relations with the patients as they
have a 'special ear' for them" (Orna), correspond accurately to two major subcategories
("Witnessing ethically-problematic relations" and "Providing information to patients") in
students' dilemmas' typology. One significant gap between student and faculty member
interpretation, namely the 'practicing' issue, is discussed in detail later in this section.
(II) Conceptual attributes of the offered typology of students' moral dilemmas

The present study offers a classification framework of the students' dilemmas according to their decision-making component. It identifies the significant components of responsibility and decision-making, through a conceptual framework that puts all the dilemmas along an "responsibility continuum" (see: 'Findings', pp. 108-120): (1) "reflection dilemmas" – ethical issues and situations students are exposed to, that raise ethical reflection and thought (9%); (2) "witnessing – optional reaction dilemmas" – ethical issues and situations students witness in the wards, that raise the need to decide if and then how to react (42%); and (3) "action dilemmas" – ethical issues and situations students directly encounter as part of their medical role in the wards, that force them to decide how to act (49%).

This is an important finding of the present study, since it shows that most of the dilemmas are ones in which students have to decide upon their action: either a decision about if, how and when to react to an event they witness, or a decision of whether or not to perform an action that is expected of them, in an event they are personally involved with. This finding grounds the world of students' dilemmas in a very practical-contextual-actual perspective of "decision-dilemmas", which call for an action and not for a theoretical deliberation. It is interesting to note that a significant part of the "decision dilemmas", are "action dilemmas" (49% of the total dilemmas) that not only call for a decision, but actually require immediate, on the spot decision-making. Unlike the situation in "witnessing – optional reaction dilemmas" where students have time to think if and how they want to react to unethical conduct they encounter, in "action dilemmas" the students must decide, without any delay, whether to tell the patients that they are students and face a refusal to perform a procedure, whether to try again to draw blood and cause more pain to a patient, whether to grab the opportunity to practice a major but dubious procedure, how to answer a patient's direct question, and more. The reality that is delineated by the students is laden with ethical decisions that must be solved instantaneously, and almost automatically. This highlights the important dimension of the dynamics and rhythm of students' ethical reality in the wards.
(III) The 'practicing' issue – an ethical challenge in medical school

An analysis of students' dilemmas in comparison to faculty members' perception of students' dilemmas, points to a gap that calls for discussion. An illuminating resemblance is found between students' and faculty members' statements about 'practicing' (performing procedures on patients) as a learning mechanism in medical school. Both groups are certain that (I) there is no alternative for learning medical procedures, (II) patients are willing to take part in it because they realize it is a university hospital, (III) there is a necessary 'learning curve', and (IV) there are appropriate ways to exercise practicing, with dignity and consideration. However, the dominance of this subcategory of dilemmas is striking. It is the biggest subcategory, double the size of the next largest (see: 'Findings', p.119). Namely, 34% of the dilemmas relate to performing procedures on patients, including personal embarrassments, informed consent, pressures to practice, causing pain to patients and causing harm to patients. All of these are "action dilemmas" that are followed by an immediate decision the student has to take about his/her course of action. There is a noticeable gap between the apparent agreement of both students and faculty members that 'practicing' does not pose a serious ethical problem, and the students' reports of an abundance of ethical dilemmas that occur during 'practicing'. It seems that this gap relates to two issues that are central to the medical students' world: (I) "Students' culture" regarding 'practicing', and (II) "Laymen vs. professionals" aspect. These two issues are offered as interpretation frameworks to account for the frequent occurrence of 'practicing' in students' perceived and narrated moral dilemmas.

(a) The perspective of practicing in "students' culture"

One of the first and classic studies of medical school from the students' perspective (Becker et al., 1961) identified specifically that 'practicing' is an existential issue in students' clinical perspective, being their main apprenticeship goal, while the organization in which the students practice "suggests that they seek opportunities to get clinical experience and exercise medical responsibility" (Becker et al. 1961, p.241). In the present study it
becomes clear that ethical concerns are in conflict with that basic challenging need to practice which both students and the medical school environment value so much.

An elaborate description of one student (Hila) telling about her practicing encounters, remarkably exemplifies the ethical conflicts students have when trying to fulfill their vital goal of getting experience. Hila's 'ethical profile' is rich with practicing dilemmas and is presented with its various conflicting contradictory components:

"The problems started in year four. I did not tell the first patient I drew blood from that it was my first time [laughingly, E.B.], he would have never agreed. However, I introduced myself as a student. I always do that. I just did not say it was the first time or the second. There is a problem with practicing even though the goal is positive. Nobody is a sadist that wants to harm and cause pain. But one should not forget that the patient has the right to refuse, and one should get an informed consent for any procedure.

You will always find someone to practice on, but if you tell the truth [that it is your first time, E.B.], it can become more and more difficult to find patients. It is problematic because there are twenty students that want to get experience and I am not the only one in the world. Additionally, there are patients that "harm" students... there are things that they will not refuse to physicians but will refuse to students, and you face a problem – you have to take the blood, you simply have to, but the patient does not agree. He would not have refused a physician" (Hila)

The above paragraph is studded with contradictions: "You will always find someone to practice on" on one hand, but "there are twenty students in the group" and "if you tell the truth (that it is your first time), it can become more and more difficult to find patients", on the other hand; and, the gap between the cliché: "the patient has the right to refuse", and the anger toward patients that refuse. This conflict between the idea of patient's autonomy and the ambition to get medical experience is exemplified in the next practicing story, extracted from Hila's 'ethical profile', that focuses on an extreme case of consent issue:
"There is the problem of LP. [Lumbar spinal Puncture, E.B.]. I did it, kind of. I cannot say that I did it completely because...Perhaps I did an LP, maybe somebody held my hand. I never did it alone so I do not remember. It is not significant to me so I do not remember. There is also another story related to LP. It was a very unethical story, that LP incident. In neurosurgery, a resident offered me to perform LP, as some sort of a bonus. The patient, a young woman asked specifically that it should not be done by a student (me). The resident winked at me and I was ready to take the needle and perform it behind her back (literally). At the last moment he decided to perform it himself because the anatomy was not so clear and he himself failed four times in doing it. Behind her back he planned that I'd do it and I agreed to. It is not that I did not have a problem with it, but I thought to myself: here I am a sixth year student and I have not perform it yet, and there is going to be the first time sometime anyhow... And tell me, is it more ethical to perform a procedure on comatose patients? I am not sure because that is what we usually do, we prefer to do the first things like arterial gases on someone that is artificially respirated. It is more ethical because it does not hurt the patient, but on the other hand I don't know if it does not hurt him. But, the patient shouts less and cannot refuse, so maybe, on a third thought, it is even less ethical" (Hila)

It is rather logical that after describing such a dubious ethical position, the student opens a discussion with the interviewer (with herself, actually) about the ethical aspects of practicing on anesthetized patients. She feels bad about her willingness to act against the patient's will, and she puts the whole idea of practicing and patient's rights in a philosophical perspective of "free will" and its limits. The climatic 'practicing' incident concerns episiotomy [i.e. after labor stitching of the perineum and lower vaginal walls, E.B.]:

"I delivered a baby in labor. The resident physician asked me if I wanted to do episiotomy. I have never sewed before, not even a simple belly stitch or leg sewing. Episiotomy is more significant because it has implications for the future sex life of the patient. It concerned the issue of "if not now when?", and I sewed her.
Completely. Me, by myself. From beginning to end. And it is not that simple technically. Later I regretted that I had done it. And we did not tell her that I was a student. We did not tell her and she was a little bit dizzy from the petidin she received. I could have sewed a belly or a leg before I sewed a human being. And maybe I did harm her future sex life. The resident that offered it to me was near me the entire time. And he watched what I did, but I was the one that performed it. I talked about it with my friends. Only with them. They were a little bit shocked because nobody thought to do it. But when they thought about it, if someone had given them a chance to do it, they did not say they would not have done it definitely... You tend to agree if someone offers you and you don't have to beg and... to push for getting a chance to practice. It is an opportunity and if he (the physician) is sitting next to you, and if he offers it means that he is willing to help you, so he will be patient with you, which is so important when you do procedures for the first time, so you grab the opportunity. It is usually a resident that offers. A senior physician will not offer you such things. It is the residents usually because they are closer to the students. They are more pro-students. As they are closer to the student they think about what the student wants or not, what he knows and does not know. Seniors are somehow remote already. They forget sometimes...Anyhow, I am not sure that I would have done it again...I am not sure about my friends' reaction. I am not sure if they would have done it. They simply did not know. In the beginning they were in shock. I was also shocked when I realized that I was offered the opportunity and agreed. Others said that they did not know what they would have done. It means that they did not say no for sure" (Hila)

All the conflicting elements are encapsulated in the narrative: 1. the great desire to get experience; 2. the temptation to perform progressive procedures and the pressure to do it (if a resident offers, it is difficult to refuse); 3. the students' peer norms that are discussed by them, the doubts that these discussions raise, the justification one gets from the indecisiveness of one's peers; 4. the feeling of remorse after an ethically doubtful action. The episiotomy story reveals how strong and powerful 'practicing' issues are in medical students' reality, and how strong and painful are the ethical dilemmas concerning it. The
ethical dilemmas are strongly related to the actual specific reality of students in their very unique situation and status.

In addition to the students' self-pressures to practice, exemplified by Hila's 'ethical profile', there are also pressures to practice that come directly from physicians, especially in situations of several students examining one stressed patient. Student's reactions to such pressures stretch from resistance to perform (rare) and protest (post-factum), to acceptance (against one's will) and performance. A typical reaction is expressed by Alon, who describes other students' performance and then accounts for his own:

"I witnessed a physician that put a huge pressure on a patient to agree that students would gynecologically examine her, and she yielded to the pressure; the two students that were there with me examined her even though it was clear that it was against her will and against their will. I did not examine her. Maybe, in another situation I did examine a patient and somebody else did not. I don't think I am a saint concerning that matter. However, in an overall perspective of this story, I feel it is for the best interest of society and it makes it easier for me" (Alon)

Here again, the confusion and embarrassment can be seen. Alon, a student who is generally very accurate in his words, says: "maybe I examined", like Hila, who seems to exhibit a good memory, but says in the previous citation: "maybe I performed LP, I don't remember". Alon's words: "I am not a saint" relate to the ethical problematic nature of 'practicing', while his words: "it is for the best interest of society and it makes it easier" relates more to the ethical solution that students try to construct for themselves. It seems that the pressures to practice – the external pressure by physicians, and mainly the inner self-pressure of the students themselves, seeking opportunities to gain experience, create ethical situations abundant with moral dilemmas.

212
(b) "Laymen vs. professionals" aspect

One salient dichotomy in the literature about medical school is whether students are "Boys in White" (Becker et al., 1961) or "Student-Physicians" (Merton et al., 1957). This early debate is reflected in most of the literature since (e.g., Shuval, 1980; Haas and Shaffir, 1987; Pellegrino, 1989; Andre, 1992; Dwyer, 1994; Feudtner and Christakis 1994; Baldwin et al., 1998; Hicks et al., 2001), as many studies of students' attitudes, conduct, conflicts and dilemmas are bound to relate to the sociological-cultural hierarchical status of the students in the wards. In the present study, most faculty members regard medical students as "kids" (not "boys" since there are "girls" also), as neophytes that are in a special "moratorium" period, and not as adults that are equal to them in all respects. A related aspect that is relevant to the abundance of 'practicing' moral dilemmas in contrast to declarations that 'practicing' is ethically non-problematic, is the dichotomy between being a layman and being a professional. One faculty member, Eli, when analyzing the ethical process students go through, emphasizes this dichotomy and argues that students have ethical dilemmas in the first stages of medical school because at that time they still view the medical system through the patients' – the customers', the layman population's – eyes. This interpretation is validated and strengthened by students accounts:

Firstly, students tell how concentrated they are on their needs and tasks: "What we do seems to us the greatest thing, even if it is only an IV" (Oren), and how frightened and anxious they are, like any layman would be in performing new procedures: "We stumble and stutter and shake and shiver, we do not know much, we do not even know what we feel" (Mili)

Secondly, students exhibit embarrassments that are typical to laymen (see: 'Findings', p.116), like examining someone who is familiar to them, or examining the testicles of an adolescent boy etc.

Thirdly, students directly and specifically testify about their layman position and emotions, about their empathy with the patients, which leads them sometimes to act as "conspirators", breaking the professional rules:
"In the beginning we looked at patients more as people, and with time the patients become more patients and less people, and you are aware only of their illness" (Ido)

"Sometimes I broke the rules; if anyone had known 'what the student Tami told the patients'...I adopted an approach concerning what we are "supposed to do" that I feel better with. I did not agree to act like 'a silent fish' with patients I was responsible for" (Tami)

The data shows clearly that the students view patients from a layman perspective, at least at the beginning of 'practicing' (year four) and this is exactly the time when they have the least professional ability. There is an inherent paradox: at the point when the students are least experienced, they have to perform on fellow layman procedures that embarrass both sides and can cause pain, stress, discomfort or even harm to patients. Later on, in year six, when students feel more confident, more professional and sure about themselves as almost physicians to be, they view practicing as a solved issue, more like their fellow physicians. However, when they reflect on their anxieties in the three clinical years, they still remember and raise the daily ethical conflicts they had with themselves (about causing pains, getting consent and so on) and with their supervisors (pressing to practice, tempting to practice), and narrate these episodes elaborately. It would seem, then, that the summarizing words: "there is no ethical problem with practicing" are physicians' professionals' wordings of sixth-year mature students, while the abundance of strong emotional ethical dilemmas concerning 'practicing', which are self-reported by the students, is a reflection of the years of practical training as insecure neophytes, that start from a layman position, and view themselves as layman would.

The 'practicing' ethical issues, reveal how deeply the students are immersed in their existence and reality, preoccupied with their embarrassments and anxieties, their ambitions to practice and the pressures to perform, bothered by their professional doubts and layman's perspective. They are adults age-wise. They are not "kids" anymore. Yet, they take part in a learning process of a profession, a process in which they are initially laymen. This
'practicing' framework is certainly the powerful source of a vast number of potential moral dilemmas. As cited already in 'Findings' chapter, one of the interviewed faculty members describes this ethical stance of students, 'laymen apprentices' in comparison to the ethical stance of professionalized physicians:

"Physicians and students alike 'use' the patients for their learning – but I 'learn' on a patient for making a practical decision and they 'learn' on a patient for impressing me... Physicians' decisions effect patients immensely but do not effect themselves; on the contrary, students' decisions do not effect the patients but do effect themselves immensely" (David)

It thus appears quite obvious that the situation of 'practicing', when one is not professionally skilled, when one only gains from 'practicing' and is not assured of contributing anything to the patient, creates a position which is ethically problematic by its nature. These situations are an actual and inherent part of the students' life, not theoretical and general.

The moral dilemmas students face during their training are daily and mundane and reflect their routine. Medical students need and want to practice and they act within the clinical wards, where the situations pose ethical issues. **Reality sets up the ethical agenda:** Students' moral dilemmas are triggered by students' experience and objectives. During the training period, when "students' culture" is immersed in practicing encounters, with efforts to gain experience in order to become professionals, students view issues that inherently relate to this reality as their ethical dilemmas.

Another important aspect of students' dilemmas that is reflected in their accounts relates to their relations with physicians and specifically to the students' reactions toward situations they witness. That aspect of the dilemmas is discussed in the following section that deals with students' coping mechanisms – how students react to ethically problematic situations which in great part are concerned with physicians' conduct in the wards.
Coping with moral dilemmas

This section deals with the question: how do medical students cope with the moral dilemmas they encounter? Although analyzing the students' coping mechanisms is of considerable significance, it has not been thoroughly researched yet, as medical students' moral dilemmas have only recently been exposed, acknowledged and classified (e.g., Bickel, 1993; Christakis and Feudtner, 1993; Huijer et al., 2000; Hicks et al., 2001). The present research aims at examining and understanding how the students reacted to the abundance of ethical situations they encountered: what they actually did, what they thought and felt about their choice of reaction, how their decisions were made, and how their attitudes correspond with the decision-making process. In the findings chapter there are two categories that relate directly with the ways students act within their ethical reality: (1) 'Coping mechanisms' category, that gathers students' narrations concerning their decisions, reactions and actions, and (2) 'Silence' category, that gathers data concerning the most frequent pattern of reaction, namely inaction or non-reaction, that is, being 'silent'. In addition, the category 'Cynicism vs. sensitivity' seems relevant for the present section of the discussion, as it gathers students' testimonies about their developing and changing attitudes toward their training and profession.

This chapter begins with a short analysis of the accumulated data – the implications and understandings gained from the research findings about coping mechanisms. This is followed by two conceptual perspectives that provide the analysis with interpretive frameworks: (a) the relation between coping mechanisms and students' status and (b) the moral context aspects of actual, practical moral decision-making. Two 'ethical profiles' of students, focused around the interpretive analyses, are also presented.

Coping mechanisms with moral dilemmas: analysis and implications

From the data supplied by the students concerning their mechanisms for coping with ethical encounters, several significant conclusions can be drawn regarding patterns of ethical
coping in complex situations during professional training. While so far in the literature there was merely initial documentation about the ethical dilemmas medical students have to cope with (e.g., Bickel, 1993; Christakis and Feudtner, 1993; Huijer et al., 2000; Hicks et al., 2001), the present data shed light on the ways the students actually cope with these dilemmas. Five important aspects seem to arise:

1. **Direct coping mechanisms**: There is only a limited repertoire of direct coping mechanisms: direct remarks, resistance to perform, or clear and loud protest/complaint. Students testify that they rarely "talk back" or criticize physicians directly.

2. **Indirect coping mechanisms**: There is, however, a vast and impressive variety of indirect ways to cope with problematic ethical situations: questions, subtle suggestions, substitute performance and various kinds of corrective behaviour. Students' descriptions open a whole world of ethical reactions and actions that do not appear as protest-like or dramatic performance, but rather reveal different choices within a complex environment. Faculty members also mention several ways students can choose to react in situations when they witness ethically-wrong behaviour. The coping mechanisms faculty members suggest are significantly similar to students' indirect reactions: comforting behaviours, corrective behaviours, and subtle ways to discuss ethical problems with physicians. Faculty members' description of possible indirect refined coping mechanisms confirms and validates the students' accounts.

3. **Students' consultation patterns**: The data concerning students' consultation patterns when faced with ethical dilemmas, which shows that students consult mainly among themselves and hardly with their teachers, points to a 'students' culture' (discussed in the previous section) and to the students' special status in medical school (to be discussed in the present section).

4. **Reasons for saliency of 'silence'**: Dwyer (1994), in a rather dramatic essay named "primum non tacere" ['first do not be silent', E.B.] raises the argument that most of the moral dilemmas faced by medical students are in situations where they must decide
whether to either speak up and react, or avoid any reaction and keep silent, and that they often opt to keep silent. The data of the present research corresponds with and validates Dwyer's observation, as along the interviews and the questionnaires students report very frequently that they did nothing about ethically problematic situations they encounter, especially in witnessing/reaction type dilemmas. The interviewing methodology of this study whereby students openly described their reasoning, decisions and motivations, made it possible to examine the reasons students chose so often to remain silent. The frequent and persistent phenomenon of 'silence' appears not to be based or reasoned on one or even a few explanations or motivations. It has a vast base of rationalizations and argumentations. The students, analyzing their reactions, provide an array of personal and structural explanations that include: (I) reasonings first revealed in the present study, relating to ethical-philosophical considerations, such as relativism, moral judgment and educationally debatable issues, and (II) other reasonings that have been mentioned briefly in previous literature, such as self-preservation, doubts and inexperience, hierarchical structure, existing norms, collegiality, and identification with the future profession (Konner, 1987; Haas and Shaffir, 1987; Dwyer, 1994; Feudtner et al., 1996; Huijer et al., 2000). The reasons for silence as a coping mechanisms can be thematically classified in 3 sub-groups: (1) reasons relating to students' status (self-doubts/inexperience, self-interest/personal concerns, by-stander stance, identification with desired future profession); (2) reasons relating to medical school structure (hierarchy and authority, the prevailing norms, non-existence of relevant institutions, fears of provoking the system, doubts about the ability to change the system); (3) reasons relating to attitudes (collegiality and respect, relativism and proportions, the right to judge others, the ability to change or educate adults). The first two sub-groups are embedded in the first interpretive framework of this section (pp. 221-225), while the third sub-group is treated in the second interpretive framework (pp. 226-233).

5. Growing ethical sensitivity: There is a popular and scholarly convention that medical student go through an attitude change in medical school and become gradually more cynical and less sensitive (Eron, 1955; Flaherty, 1985; Myser and Kerridge, 1995; Price et al., 1998). A phenomenon called 'ethical erosion' has been documented (Feudtner et
al., 1994), pertaining to students' perceived erosion of their own ethical principles, expressed dissatisfaction with their ethical development, and evaluation of themselves as acting unethically. The students interviewed were very much aware of that consensus, and bothered by it, so that each one of them, with no exception, related to this common attitude during the interview, without facing a direct question about it. The most surprising finding is that the students, even though honestly admitting the growing cynicism process, claimed also that in certain ways they were becoming simultaneously even more sensitive. The students not only declared they were becoming more sensitive but also analyzed that "other kind" of sensitivity: first, the students distinguished between "emotional sensitivity" and "ethical sensitivity" – while the former might decline, the latter one concomitantly increased; secondly, they related to a different kind of awareness of the reality surrounding them. These explanations of the increasing sensitivity phenomenon are illuminating explanations that have not been expressed before in related studies. The literature (e.g., Eron, 1955; Flaherty, 1985; Haas and Shaffir, 1987; Feudtner et al., 1994; Price et al., 1998) has regarded the issue as a bipolar, dichotomous issue – cynicism increases and sensitivity decreases. The students' accounts reveal that the mechanisms involved in such emotional and ethical processes are more subtle and elaborated. Their gradually gained confidence, their increasing professionalism, their exposure to human lives' decisions, the special status of medical students, the emphasis of the medical school on ethics – all are factors that are involved in ethical processes and are reflected in a developing, growing 'ethical sensitivity'.

219
Mechanisms for coping with moral dilemmas: conceptual interpretive frameworks

(a) Students' status in medical school: The relation between coping mechanisms and students' status

The classic approach of medical sociology (Olmsted and Paget, 1969; Shuval, 1980) suggests that the sources of the powerful socialization process in medical school are its strong normative emphasis and the school's power structure, expressed clearly in the low status of the students during their training, and in their high dependency. In line with this classic assumption, the findings of the present study do show the centrality of students' status and their dependency on physicians. The high motivation of students to perform their part in the training process is related to the need to obey the systems' rules, and attributes a lot of power to the senior socialization agents that train the students. The findings place the hierarchy and dependence components as central to the behavioural solutions students find for their dilemmas and conflicts.

However, the findings also show other angles to the socialization process and norms-acquisition by illuminating the relation between mechanisms for coping with ethical dilemmas and students' status in medical school:

(a) Students describe a complex status, rather than a simple one: it has many disadvantages of dependency on others, concerns for self-interest, fears and anxieties that accompany inexperience; it has the advantages of a by-stander, with almost no responsibility; there is a growing identification with the future profession that has an impact on students' involvement and reactions.

(b) The findings shed light upon the many ways students find to integrate within the system, by assisting patients through correcting wrong-doings and by all other indirect ways of influencing the reality they are involved with. The findings do not reflect processes of blind obedience – the pattern of being silent is indeed prevalent but there
are dozens of examples of ways by which students do express their values by choosing creative behavioural alternatives.

(c) The findings do show on one hand that reasons for 'silence' are fears, anxieties, existing norms, concern about self-interest and the feeling that student are not listened to, but on the other hand, the findings also show that there are many other reasons for 'silence', reasons relating to perceptions about the future profession, collegiality as a value, doubts about the validity of criticism, and philosophical ethical reasons concerning the nature of moral judgment (see next interpretive framework).

(d) The findings obtained from faculty members' interviews show also that students' ethical dilemmas relate to students' status as trainees – to their disposition toward authority or authority figures, but also to their special relations with patients and their limited accountability (see: 'Findings', p.180).

An "ethical profile" of Irit, one of the sixth-year students interviewed, exemplifies some of the points made above as it shows students' status not only as one of subordination and dependency, but as a composite of 'status' elements that are personally and structurally interwoven:

"We do not have any authority in our hands. Not medical authority or any other. We are blocked from the patients, we cannot express any opinion, and it should be like that. Even if I disagree with the staff's doings, there is a great value to collegiality, and I, from my status as a student, I cannot suggest anything, I will not come and tell the (patients') family what I think" (Irit)

From a humble acceptance of students' status as inexperienced, authority-absent neophyte, Irit goes on to the various ways a student can have an influential role in the ward, or choose consciously not to:
"One can do things quietly and gently, and achieve the same goals. Physicians accept this kind of involvement and it is better than getting into arguments... I try in most cases to express my opinion gently. An example: I was involved in taking anamnesis from a patient when I realized that the patient did not understand what she was asked. I repeated the question in other words. Physicians accept it. Nobody ever shouted at me after such interferences.

Physicians sometimes complain about the population they treat and express racist remarks about different segments of the society. If those remarks are said in front of me, I express my opinion of it. However, I am not sure it is suitable to have an open argument – what for? Just in order to be heard and to "exchange" sentences? I am not going to change the rude physician's mind. In most cases I try to express my views gently. This is what happens when you are working with people – the headline for our relationships and conflicts is 'working relations'" (Irit)

And then, Irit leads the narration to yet another aspect of students' status – an almost egalitarian status, a mutual responsibility to the main purpose of the training period, to be actually trained:

"The headline I used, 'working relations' is really comprised of two elements: you are not part of the network of working relations you are thrown into. It is very important to remember that fact. And it puts you in a certain position of weakness, but it also grants you a position of power. As without any regard to what happens in the ward, you, the student, come to fulfill certain assignments that should be defined and clear to you. Your objectives should be clear to both you and to your teaching staff. The responsibility is yours, not less than it is your teachers' responsibility. So, on one hand you are part of that working network, and on the other hand, you have demands from it. You expect to get certain products. Teaching is also the teachers' interest (academic faculty status) and nobody is doing you a favor. The responsibility to study something from being in a ward round is yours and you can stand for your rights, for example, talking with staff about night shifts where you did not learn anything and so on. I am willing to help in the ward if needed and
asked, but not to bend myself totally just for pleasing someone that is hierarchically above me" (Irit)

And finally, Irit sounds very confident that she is there to study a profession, and to acquire professionally sound working rules, and she does it by making a clear distinction between training years in the wards as physician to be and the early years of being a medical student in pre-clinical years. There is a certain "noblesse oblige" nature in clinical years' medical students' status:

"I hear students that start to philosophize about doing this and not doing that and it seems to me like some camouflage for your own indecisiveness. You allow yourself to over-talk because you are a student so you are allowed to criticize the whole world. But actually, you need to learn to think algorithmically. You have to decide upon one way and to do something regarding the certain patient. Even if you decide not to do anything it is a decision. All the discussions that go around and around seem to me suitable for year one" (Irit)

In the last paragraph, which is an individual, though quite representative student's interpretation of her own status, Irit raises another aspect of students' status – their common status as a collective group. The students status as a group is revealed by the patterns of consultation about ethical conflicts, patterns that show that students consult or discuss their dilemmas mainly with fellow students and rarely with physicians (Table no. 4, p.128). The recurring pattern of 'students' inner discussion', presented mainly in the students' questionnaires, seem to serve various functional purposes:

1. Immediate behavioural backing function – in situations that call for reaction of a group of people, like pressure to examine one patient by several students, situations where it is easier not to obey when in groups, and where it is easier to obey when others do it too.
2. **Consultation** function – for example, in a situation where a physician brutally undressed a patient, the student that writes about it using plural pronouns says: "we talked among ourselves and decided not to react...actually we discussed such dilemmas quite often" (Yaara)

3. Pressures/frustrations **ventilation** function – telling others helps the student to unload a burden off his/her shoulders "I did not say anything to the physician [who made a racist remark, E.B.], but I took care that all my friends in class would know about him" (Anonymous)

4. **Norms building** function – a group helps building patterns of behaviours, norms and attitudes: "according to my experience and mainly based on other students' experience, I know that physicians do not like to be criticized" (Anonymous).

These functions exemplify the approach that relates to medical students as a collective group organized in situations of pressure, and convey a perception of medical training as a 'survival period' (Konner, 1987; Haas & Shaffir, 1987). However, the findings show other sides of students' collective status – namely a status with opportunities and advantages "There are advantages to our status – we have a little more time and a little more patience" (Mili), a status with strength and power, not only weaknesses and defensive needs:

"Our status as students is seesaw-like: on one hand there is a special status in the ward because of our ability to present and activate processes, and to talk directly to the head of the ward, while the physicians around us will refrain from doing so. With little brains one can activate the system. On the other hand, we are somewhere in the lowest stage of the "food chain", and our mode of coping should be very smart" (Rami)

The strength in students' status derives from: (1) their temporary by-stander observer position, (2) their self-enhancing training orientation and clear goal-seeking objectives, (3)
their 'ex-ward' position and (4) their 'omni-presence' in the wards, as one faculty member describes it:

"I think that even if we do not talk to the student the educational process takes place, for better or for worse. We serve as role models constantly and the students despise us or respect us. They know us and they know exactly who we are and we cannot hide anything from them. They are our most bitter critics" (David)

The students' status as reflected in their choice of mechanisms for coping with their moral dilemmas seems to be dialectical in nature. It is comprised of structural hierarchical elements, combined with anxieties and obedience and collective defensive group norms. However, at the same time it is clear that students are aware of their powers and rights, aware of their emotions and of the ways they can express their opinions and values. The students' status as revealed in the present study is not a one-dimensional dependent status but a multi-dimensional status of a conscious group of active young people that finds itself in a reality abundant with situations that should be coped with wisely and realistically.

In summarizing this issue it can be said that the previous literature about medical students traditionally centered on the notion of growing cynicism in regard to attitudes (Eron, 1955; Flaherty, 1985; Myser and Kerridge, 1995; Price et al., 1998), and on the dependency status in a hierarchical organization in regard to status (Olmsted and Paget, 1969; Shuval, 1980; Dwyer, 1994; Bissonnett et al., 1995). By giving students an opportunity to narrate elaborately about their personal/educational experiences, the present study has demonstrated that these traditional patterns are not necessarily valid in students' ethical world: (a) cynicism does not stand alone as an attitudinal change, but is accompanied by a developing stage of ethical sensitivity; and (b) hierarchical dependency is not the sole status factor, as students' status entails a variety of potential actions, positions and choices.
(b) Morality in context: The moral context aspects of actual, practical moral decision-making

The data about the many indirect ways of coping with moral dilemmas narrated by medical students and validated by medical school's faculty members is very significant as it illuminates ethical development in adulthood, not only as a cognitive-ethical stage, but also as a real functional ethical stance, expressed in actual aspects of ethical behaviour.

The findings raise a crucial issue of moral thinking – is it worthwhile or necessary or reasonable to protest against wrong-doings? The arguments expressed in the findings relate to an array of fundamental moral issues: collegiality vs. other values; the relativity of values; principles vs. actions in real life; the right to judge others; the potential capacity to change or educate others. The very fact that the students raise these fundamental moral questions in regard to their own daily behaviour exemplifies their moral standard and demonstrates the cognitive and ethical deliberations that relate to moral dilemmas in adulthood in general, and during professional training in particular.

The most notable finding concerning the students' ethical development is their identification of a new kind of sensitivity that arises and grows while they are trained – the 'ethical sensitivity'. While emotionally students do become less sensitive and can distance themselves from patients' suffering, ethically they become more aware, more sensitive, more conscious of ethical issues and more capable of taking complex elements and multi-faceted aspects into account. Another noteworthy finding is the mixture of pessimism and optimism that students express about their ethical future – will they be able to preserve their present level of sensitivity? Their analysis of future processes appears balanced and mature – the erosion process is bound to occur, but they are confident that counter mechanisms have been acquired during and through their educational and personal development in medical school.
These study's findings can be interpreted within three cognitive-ethical conceptual contexts:

1. *Moral balance* model – The findings add a special angle to the understanding of the "moral balance" model (Nisan, 1985, 1993, 1995). The theoretical model has suggested that people calculate a sort of moral balance for themselves on the basis of all their morally significant actions within a given time span. This moral balance is compared to a personal standard of 'minimal morality', which the individual assigns to himself as personally obligatory, and from which he is not willing to allow himself to descend. When faced with a moral conflict, one not only evaluates the planned action but also evaluates one's moral balance, in accordance with one's acceptable level of morality that is part of identity and self-concept (Nisan, 1985, 1995). Medical students indirectly strengthen the model by their descriptions. They do not argue that they were always just, and they do not argue that their standards and values for deciding what ought to be done have altered. Basically they claim that there are situations where one cannot act according to one's total values, especially when one's fulfillment of a valuable self-interest is at stake. Nevertheless, by not forgetting the values that are in conflict with their self-interest, the students emphasize that the behavioural choice is a temporal choice, a choice that is true for a certain situation, and it does not impinge on their integrity, values, or their future choice. The contribution of the findings to the understanding of the model is that subjects were not asked about simulated dilemmas or situations in a framework designed to validate the 'moral balance' theory. Their coping mechanisms and cognitive-ethical thinking that express the concept of 'moral balance' emerge from the narrative descriptions. It seems that when people raise real contextual dilemmas (Gilligan, 1986; Tappan, 1990; Brown and Gilligan, 1991), from their own reality – actual personal practical dilemmas – very complex and multi-faceted situations are revealed, situations that bear inner conflicts between what ought to be done and the behavioural choice. According to the findings of the present study, the 'moral balance' model accurately reflects the reality where both principles and personal ethical considerations are jointly involved in the decision making and the behavioural choice.
2. **Dialectic understanding** – A central component of adult ethical-cognitive thinking is the dialectic component: a recognition of the relativist nature of the world of knowledge, acceptance of contradictions as part of the reality, an ability to contain conflicts and contradictions, pragmatism and contextual perception (Commons et al., 1984; Alexander et al., 1990; Nisan and Applebaum, 1995). In the dilemmas students expose, the dialectic component is salient, both in the conflict description, and in the explanations for the significant number of cases where students choose to behave not according to their own ethical perceptions. It can be safely argued that in the students' narrations, a dialectic cognitive-ethical thinking is present, a kind of thinking that is typical of adult-stage thinking.

3. **Adult cognitive-ethical stage** – Perry (Perry 1970, 1990) who constructed a direct relation between cognitive and intellectual development and the development of ethical reasoning, articulated a scale of four meta-stages: 'Dualism' (polar view of the world), 'Multiplicity' (recognition of diversity), 'Relativism' (diversity of opinions) and 'Commitment' (decisions made with the awareness of relativism). Most students' choices in ethical encounters prove to relate to the 'Commitment' type of thinking, as in many of their narrations they tell about choices and decision they have had to take while being aware of their own values, of the norms prevailing in the ward, of the relativist nature of human opinions and of the contextual personal nature of the ethical decision at stake. Although there are relativistic remarks like: "everyone is entitled to think as he wants" (anonymous), and "morality is a private business" (Mili), the students do not evidence a simplistic atomist relativist thinking. Students' accounts (as exemplified in the following 'ethical profile'), reflect complex approaches that assume that there are no ideal sets of values where one can activate every value perfectly. Gilligan et al. (1990), distinguished between two kinds of adult moral reasoning, one that is logical – the relativism issue is solved by a logical system, while the second is contextual – the criterion of adjustment of moral principles is based on 'most suitable' rather than objective truth. In many students' accounts the inner deliberations, conflicts and doubts reflect a choice or a decision made with awareness of relativism, with awareness of the need to choose between complex priorities and various 'moral
navigation' routes. When asked about dilemmas of actual real life, students tell about their ways of activating adults' contextual moral reasoning.

The above elaborative conceptual contexts can be exemplified by Mili's 'ethical profile', that reveals how a student, a physician to be, tries to find integrity between her personal values, reality in the wards, and professional demands. The narration delineates subtle processes, composed of contextual situations and decisions. It describes a process of considerations how to form an ethical stance – it is not a one-time decision and it is not an immediate one. It changes and it includes many factors:

"In gynecological round we go to a gynecological clinic in a Bedouin village. It is different in my opinion from the hospital because at a university hospital people know that there are students learning there. The teacher wanted each of us to examine every woman. In the beginning I did what he wanted. Later I understood what was happening and I said to myself that I would examine in my turn one woman each time and not after my friends had already examined. When the teacher realized I was not examining he was very angry and said: I am the one that directs the procedures here. He was persistent but I, and later my friends, did not examine. After we went on resisting I spoke with my friends and we decided that we would simply go home. I told him that I was not willing to do it and that was the end of it. He argued something else – that I should not project my feelings on Bedouin women. I did not know them and their mentality – they were already used being told what to do, and if I was so introverted and uncooperative, it did not mean that they were like me. I did not agree with him. I think that a woman is a woman, and no ethnic background makes it any different" (Mili)

The description emphasizes how important the context is. Even to Mili it might have seemed different if the setting was a hospital, where patients assume and expect to be examined by students, and not a village clinic. It shows also the slow, gradual understanding of the ethical context and the power of the group. And then Mili puts the
situational dilemma, after the behavioural choice has been made, in a general ethical and professional framework, loaded with doubts:

"My dilemma is that I am a person that generally accepts directives and authority and I believe that physicians that teach us know what they are doing. They are people that know their profession, know the population they treat and if the physician demands anything maybe he knows what he is talking about, and maybe it is me that is exposing my over-sensitivity. That is why it took some time to pass, or rather some women, until I could formulate an opinion and decide that it was awful to ask so many students to examine one woman, and I refused, with my friends together, and reported it to the person in charge of that clinic practicing. It was not easy to decide to report it ... he is a senior physician... it took some courage to do it and it is not something I usually do. I am a person that does not rebel generally, I am accepting authority, I come from an English upbringing where children do what grown-ups tell them to, and that's it. I think this was different because it was a woman's situation, in a vulnerable position. It touched me immensely, it was painful to me. I would never have agreed to three students examining me after the physician did, so I could not allow myself to go on with that procedure. It was so immoral" (Mili)

However, the same person that articulates clearly: "it was so immoral", gives also quite many reasons why not to react when encountering ethically wrong behaviour of physicians:

"Why not to react? What for? What benefit will result from my saying anything, as I will not educate anybody? The gynecologist from the dilemma – I will not educate him. He's been working like that for years. I will not change anything in him and I will just cause an unpleasant atmosphere, people will be angry at me. I will come out as sanctimonious, and so on. Another reason why not to react is that other people behave like that and so many people saw this atrocious behaviour and nobody protested, so maybe I am truly too sensitive and do not judge the circumstances correctly. Maybe I am not suitable for the profession. Maybe it is
true that in the Bedouin culture every man can tell the women what to do and it is right for them. And besides, a moral issue is a private issue. Moral stance is not something that you can force on other people. My morality is very private and personal, and sometimes one has to accept the fact that other people do not see the world the way you see it. It is difficult for me to think that people are really bad. I think that they have justifications for what they do and that the physician thought that he would teach us like that. That it is the best way and the biggest exposure and I do not think he is a bad person. He simply sees things very differently from the way I see them” (Mili)

The process she is going through, both at the time of the decision-making and in the long period since the dilemma occurred is composed of (1) ethical-cognitive philosophical thinking; (2) professional collegiality and appreciation; (3) doubts originating from inexperience; (4) general statements about human nature; (5) exposure of values and attitude; (6) exposure of emotions and persona characteristics; and (7) considerations concerning the training process of medical students. Not relating to this one dilemma, Mili expresses also some other aspects of the ethical process she goes through. She does not go easy with herself:

“In year one, we hurried to serve every patient that asked for water. Now in the ward I don’t have time. So, I have to quit listening to these kinds of patients’ requests, because it is painful that you cannot help. So you stop hearing, you do not hear those cries anymore… maybe it is even legitimate because it is not a physician’s job to serve water to patients, I have other things to do. I hope and pray that I will not become so insensitive as some people I see here. It can happen. Those human ‘monsters’ were not like that when they started. They were also nice people and something happened to them along the way. It is frightening. Some students already regard themselves as physicians; they build distance from ordinary people. That’s how you lose sensitivity, by taking a role. However, as a student I had the time needed to dedicate to patients, and I realized how beneficial it is from a
medical perspective. So, I believe I will retain it afterwards, because I see the advantages of sensitivity as a medical tool" (Mili)

It seems that the loss of sensitivity is disturbing, and doubts about the future exist. Interestingly even Mili, when she wants to be sure she will stay sensitive tries to mobilize the instrumentality of sensitivity – "it has advantages as a medical tool". Finally, when Mili goes back to her present as a student she sees the advantages of her stance, and vows not to forget her values, not to forget herself:

"I try very much to listen. Many times patients said to me: 'this is the first time I've told it to somebody. And I feel it helps them and it helps me as it turns the medical profession to a beautiful one, not a technocratic one...As a student I can still allow myself to dedicate a lot of time to listening. We hold much power in our hands concerning the patients. They remember us much better than we remember them. I walk in the streets of Beer-Sheva and people say hello to me and I try to remember where I know them from and to them it is clear where they know me from. I was there at a very critical point in their lives, so I leave a great impression on them. Those points in life are so sensitive that one should be aware of them. And physicians, instead of being aware of those special points in life, take advantage of them, and enjoy an 'ego trip' toward their patients: 'because I said so', or 'you would not understand' or 'I don't have time now' and so on. We should not forget who we really are" (Mili).

One aspect that is salient in Mili's powerful profile is that she definitely puts much thinking into the dilemmas in her training process. All interviews (and even the questionnaires that were open) revealed the same phenomenon – the students seem to reflect a lot about the dilemmas they encounter, they are aware of them, not forgetting and not hiding or suppressing them. Thus, it can be said that students show another angle of morality and moral identity – the awareness, the memory, the willingness to expose conflicts and the reflection. The present study's findings illuminate the high standards of cognitive-ethical thinking of these medical students as reflected in their ethical memory. Even though the moral dilemmas are contextual, the memory of the ethical conflicts and the
ongoing inner deliberations live much longer than the actual events. The students' ethical attitudes are constructed in a complex serious process that is not ephemeral.

An additional testimony to what students provided so elaborately in their accounts is expressed in faculty members' accounts. When asked in their interviews about a painful students' dilemma of obedience and silence, two faculty members related not to the dilemma itself, but to its role in students' memory and students' ethical integrity:

"The student did not react actively but he has remembered the encounter. Even if most of us keep silent in front of evil doings, the students learn from their own silences" (David)

"When I was a medical student I refused to go on with a similar situation [too many students examining one woman, E.B.]. The student here has learnt something from his dilemma. That was his true lesson, not the gynecological examination he unwillingly performed" (Reuben)

Some insights about ethical learning in adulthood and about what one really learns from a learning situation can be inferred from those words. The next section of the discussion deals with ethical learning processes in medical school.
Learning processes of medical students, in regard to their ethical experience

The ethical reality medical students faced during their training, that called for their decisions and coping, occurred in the educational/learning setting of a medical school program, with medical curriculum in general and ethics curriculum in particular. How do medical students study ethics? How do they acquire or build their attitudes and values during their years of training? These elusive questions, related to ethics education in medical school, have basically led to two research frameworks:

1) Research that studies ethics courses and curriculum in medical school and their contribution to students' attitudes (e.g., Pelegrino, 1989; Miles et al., 1989; Fox et al., 1995; Self and Olivarez, 1996). Such research typically relies upon attitudes questionnaires (e.g., Baylis and Downie, 1991; Self and Baldwin, 1994), and written virtual dilemmas and vignettes (e.g., Savulescu et al., 1999).

2) Research that assumes that ethics are acquired not necessarily through the formal, overt, declared curriculum, but rather through the informal (Hundert et al., 1994, 1996), 'hidden curriculum' (Hafferty and Franks, 1994; Marinker, 1997; Hafferty, 1998). Such studies look for ways to study aspects in medical school that relate to those concepts. The present study belongs conceptually to the latter framework.

The concepts of both the informal and the 'hidden curriculum' stand in contrast to that of the formal curriculum and it is generally assumed that there is a fundamental distinction between what is formally taught and what is actually learnt. Hence, the term 'hidden curriculum' is used in the medical school ethics literature as a generic term for the curriculum that is not the formal one (Hafferty and Franks, 1994; Hundert et al., 1994, 1996; Marinker, 1997; Hafferty, 1998). A major methodological problem that research of 'hidden curriculum' faces concerns the difficulty of tracing the informal/'hidden curriculum' and discerning its modes of influence. Nevertheless, perhaps the most important contribution of the concept of the 'hidden curriculum' resides in its challenging invitation to researchers to look at education and teaching in an interpretive fashion. A study of a 'hidden curriculum' requires a broad view and acknowledges that researchers are not quite
certain what the variables are. Such a perspective corresponds with tendencies in curriculum research toward qualitative, ethnographic or interpretive studies (Jenkins 1992).

The interview of the present study, a phenomenological and interpretive research in nature, did not design any direct question about ways and processes of ethical learning in medical school. The basic research decision was to listen to what students and faculty members express independently about ways of learning ethics, so that their accounts could serve as a basis for as open and broad an analysis as possible. The significantly elaborated data supplied by the interviewed students and faculty members concerning ethical learning modes is analyzed in two tracks: (1) external sources – modelling processes in ethics learning; (2) internal processes of ethics learning. Along these two frameworks, the present section of the discussion demonstrates that students and faculty members alike show awareness and consciousness of processes that are regarded in the literature as hidden and implicit – structural and organizational processes (Hafferty, 1998), informal learning processes (Hundert et al., 1966), and norms acquiring processes (Shuval, 1980). The students and faculty members explain, explicitly and eloquently, how ethics are acquired and how informal and hidden processes of ethical learning occur, thus giving "new" meaning to "old" concepts of hidden, informal and implicit curriculum.

'Modelling' – a resource of ethical learning process

The concept of 'modelling' is mentioned rather frequently in students' and faculty members' accounts. It is used by most interviewees, in a combination of Hebrew and English, as the term is articulated in English in midst of Hebrew sentences. The interviewees refer to the term 'modelling', seldom using the potential Hebrew translations – words expressing meanings like 'imitation', 'role-modelling', 'personal examples' and so on. It seems that the term 'modelling' exists as a token of speech in medical school, amongst students and faculty members alike, and serves them as a generic term for a certain learning process that occurs during clinical training, a process described in detail by the subjects, and labelled as they do here – 'modelling'. The centrality of 'modelling' in ethics education in the medical school is
revealed by the frequency of independent reference to it in the data and by its parallel occurrence in students' and faculty members' interviews.

From faculty members' accounts it is clear that they are very much aware of the gap between what they know should be an integral and ongoing part of ethics education – planned ethical deliberations conducted routinely in the wards (the "desired ethical education"), and what they know to be the prevailing existing reality – the absence of such ethics education. Hafferty and Franks (1994) claim that the 'hidden curriculum' operates along various dimensions: pedagogical, personal and organizational. When faculty members explain the aforementioned gap between what they know they should do and what they actually do regarding ethics education, they supply explanations that operate along these dimensions: (1) **Organizational level** – physicians are busy with senior roles in the departments, they do not have the time to handle ward-ethics discussions, they are rewarded on publications, the system strengthens technical elements (such as lab results) rather than other elements (such as long discussions), the system operates like a factory, or like a race track, with time limits and hectic pace and rhythm; (2) **Pedagogical level** – physicians are not trained in ethics and there is no pedagogical organ to implement ethics in the wards; (3) **Personal level** – faculty members relate to their personal modelling as teachers and physicians, expressing their worries about the potential bad modelling and addressing the strength of their modelling role.

Faculty members, elaborating in all dimensions related to 'hidden curriculum', appear to be very much aware of it. They know what messages they transmit and they know why. The messages are not hidden in any way – faculty members are aware of the kinds of pressures the system places on them. They are aware that even though ethics appears to be rhetorically central, and the "desired ethics education" dimensions are eloquently declared, other pressing elements of the physician's reality gain priority. The 'hidden' dimensions of the system, the pressure for publications and technicalities rather than for teaching humanistic attitudes (Bloom, 1988; Jolly and Rees, 1998; Regan-Smith, 1998) are very clear and explicit to the interviewed faculty members:
"We teach the students about sensitivity and ethics and human communication on special days in year one and later they come to the wards and observe catastrophic behaviours. The real curriculum is not what you teach in 'clinical day'. Even if we could teach beautiful courses with very detailed and planned units, the real teaching is in the 'hidden curriculum' [Eran's choice of term, E.B.], with its unwritten aspects" (Eran)

From students' account it is also clear that they are conscious of what influences them in 'modelling'. They are aware of the process of learning from other people's behaviour, a process which is not a simple imitation or repetition of behaviour they observe, but rather a conscious and analyzed process which the students describe. They name the elements that make a good 'modelling' process: the leading one is the obvious – sensitive, ethically worthy behaviour of physicians toward patients. The other elements relate to ways of teaching that are impressive and influential and help the 'modelling' learning to occur: physicians that talk to students and discuss issues with them, physicians that perform things together with students, physicians that are sensitive to students' problems, and are willing to expose their own conflicts and dilemmas. It is important to note that according to students' perception, 'modelling' of physicians is not only a process achieved by watching physicians' behaviour toward patients. It is also a process achieved by being exposed to certain teaching behaviours physicians activate toward the students. It is interesting that the 'modelling' occurs not necessarily by what physicians do in the wards in regard to patients, but by what they do in the wards in regard to students. Ethics is not studied just by watching how professionals behave ethically, but also by how professionals behave professionally as both physicians and teachers.

Learning from models, 'modelling' in interviewees' wording, appears to be influential in students' and faculty members' accounts, thus validating the data powerfully. The compatible elements between students and faculty members are:

1) The presentation of 'modelling' as a vital ethical learning process.
2) The memory of personal 'modelling' – names of powerful models students repeatedly mention and stories faculty members tell about teachers they remember from their student days that influence their attitudes and ethical behaviour.

3) Similar proposals to allocate ethically exemplary influential people in crucial points – positions where they are more likely to serve as models for students – in medical school.

4) The major finding that the interviewees are aware of the learning process they participate in – it is apparently not a latent process but a rather conscious and analyzed one.

Teachers are aware of their role as ethics educators, even if not satisfied with the way it is performed, and students are aware of the ways 'modelling', the process of ethical learning from external sources, is activated and occurs. The 'hidden' elements of the process are exposed and analyzed and are explicit and overt.

**Internal processes of ethics learning**

Student accounts concerning internal ethical learning describe complex processes: (1) integration (induction from cases and contextual situations); (2) simulations (imaginary replacing the person in a decision situation as a tool of identification and clarification); (3) concretization and application (dynamics of construction and deconstruction of rules according to changing realities). The students collectively portray a process of achieving ethical maturity by gathering and accumulating contextual experiences that are constructed and integrated as ethical insights, understandings, and articulated personal codes.

One student's *ethical profile* (Omer's – a student who dedicated most of his interview to the learning process), sheds light on the learning process – a process of maturation and ethical evolution. Descriptions of learning processes appear in parts in all students' interviews. The *ethical profile* provides the opportunity to view the ethical learning process encapsulated. The analysis of the accumulated data from students' accounts and the
'ethical profile' exhibit how ethical learning occurs from inner perspectives. It shows how deep the process is and also how deep students' understanding of the process is. The students' informative self-analysis is a testimony against the notion that ethical learning is a hidden process, unconscious and blind (e.g., Hundert et al., 1996; Hafferty, 1998; Papadakis, 1998). It is true that parts of the ethical learning processes are implicit, and that there are periods of latency (presented in the profile), but the elements of the process, at least reflectively, in year six, are familiar to the students and analyzed by them. It appears that when students are asked about their learning process reflectively, they can supply insights about what works for them and about the major factors of their inner ethics' acquisition process. It is valuable, open, mature information that is provided by adult participants of an educational training program – not hidden or latent but rather explicit and illuminative.

The initiation point of ethical learning in the 'ethical profile' is at the beginning of the clinical years. At this turning point, students have very strong emotions about their identity as medical students, loaded with issues of existential doubts, survival struggles and confidence problems. Thus, in the very beginning of actual, 'real' ethical learning, students' main preoccupation is not with it:

"When a student enters the system for the first time, I know it sounds bad, the patient does not interest him very much. The student is interested in what influences him. The beginning of the time in the wards (year four) raises many emotions of a lack of confidence and questions like: am I suitable for that profession. Because during years one to year four you do not practice medicine, you sit in a classroom and study. You build up fantasies about yourself and then the first day in the wards comes and you do not know anything. Everything you studied until then seems irrelevant, as there is a huge gap between theoretical knowledge and its implementation. And you find yourself powerless in the situation. It does not matter how good you were as a students in the previous three years. Quite the opposite, nobody knows that you were a good student because it is not the same teachers that taught you. So you stand by the patient's bed and you are being interrogated, and
sometimes you do not have the right answer, and the physicians do not always help you feel better, since part of the educational setting is to embarrass you" (Omer)

And thus, in that state of mind, students start to face ethical issues in ward life, issues that involve 'practicing', procedures and patients. According to the testimony presented, the encounters between students' survival efforts, namely their clinical learning, and wards' reality with its ethical dilemmas are not easy:

"The situation that the student is facing is that he enters the wards and he is under immense emotional stress... You react like any other person that finds himself in an emotionally stressing situation, putting more emphasis on existential aspects than on cognitive/philosophical aspects. You are so busy with the professional aspects – to study, to observe, to practice. A patient can shout in the ward and you say to yourself: "I do not have time now, I have to do my errands". Any other lay person would have reacted differently. Even you yourself, if someone stopped you on the street and needed your help, you would have more patience for him than in the wards. Or when ten students examine a patient and you know it is ethically wrong, but you find yourself saying: "I will examine because I have to learn and I need to know more in order to be able to help other people, and it is the learning process, and it should be accepted as such". You are inclined more to the professional side and less to the ethical or human side. When you enter the clinics you are quite lost professionally. You allow yourself to stretch your moral boundaries. There are things that you see and you are silent and you do not react and you are willing to perform in order to learn. You do not always ask the patient's consent, because if you do maybe he won't let you do the procedure and other moral issues of that sort. And it seems to you then that ethics is a luxury in the medical environment. This is my feeling, maybe I am exaggerating a little... Anyhow you are busy with the routine of learning and practicing" (Omer)
Omer says clearly that in the beginning of the clinical track he allowed himself to stretch his "moral boundaries". However, it is not a static state, and built into it is the dynamic of change. A routine of ethical learning starts then and by the end of the process (end of year six) the students feel they know how to cope with ethical considerations – coping that is different both from the baseless "black and white" ethical discussions of year one, and from the beginning of clinical training when ethical considerations give way to surviving learning considerations:

"Toward the end, as time passes and you become more confident in your knowledge or in your ability to cope professionally, you start to open your eyes more, to watch and see models of behaviour that partially you like and partially you do not like. I mean watching what other doctors do and what other students do. But this time, it is from a different stance, a more mature one than what you were in the beginning. Because then, in year one, it was only baseless discussions and talking. Today when you find yourself in front of a situation that is professionally or humanly problematic, you, with the years and experience, see concretely its complexity and the moral considerations are an integral part of your professional evaluation. When you decide whether and what to tell a patient about his illness, you consider the person's age and family conditions, you consider the patient's abilities to cope with the information. You do it from a much less argumentative position than the position you held in year one, when you said either: "yes, you always have to tell the patient", or: "no, you should not tell him" (Omer)

According to students' accounts in year six, they are more mature and professional, they view themselves as responsible and accountable, they have developed mechanisms for decision-making (such as systematical categorizations), and they confidently achieve general perception of the alternative ethical considerations.

A question to be asked is: what happens along those six years? What is the process that enables the change from year one ("baseless discussions"), and from year four ("stretching of moral boundaries") to the end of year six ("complexity of moral considerations")?
The answer is comprised of three elements: a gathering of a variety of experiences, through which a personal code of ethics is constructed, in a gradual inner integration maturation process.

An influential element in this gradual transformation process is the multi-environmental ethical exposure the medical students go through while passing from one department to the other, exposed to a variety of experiences and attitudes:

"You mature here and you move from one department to another and from one approach to another. When you are in the internal side of medicine you hear awful things about the surgical side of it and vice versa. However, you are an adult, you do not enter medical school as a kid, so you know that not everything that anyone says is true and not every remark is proper or wise. As time passes you collect, you gather more and more models. Part of the things you adopt and parts you don't. There is also your side that you bring into this narrative, this puzzle. And eventually, even if it is not a conscious process, you build for yourself an integration of elements that construct your ethical code, your professional code, what are the things you are willing or unwilling to do" (Omer)

Omer is aware of a long learning process, a process of acclimatization and enculturation and labels it "emotional evolution":

"The process of ethical education in medical school is some kind of emotional evolution as well as a professional one. Every person that arrives at a work place has his acclimatization period when he checks the power balance and what needs to be learned. In medical school it simply takes much more time. You change your working environment frequently, you come each time to a new place with a different discipline and you actually see things from different points of view. When does it start to be balanced? When you do not change your approach anymore. In year four you are involved more in the internal side of medicine. In year five, mainly in surgery, you alternate all the view points. Later on, you go back in year six to all
wards but then you are less stressed by the changes. It is a long process of evolution because you are in a system that demands a lot of learning. The learning curve is a long one and you change environments all the time. So it takes time until you globally absorb the profession, it simply takes more time" (Omer)

In that gathering process, the students' ethical code is constructed. Omer describes the basic code he created and it appears that at the end of year six (interviews' timing), he talks already about an ethical code of a physician, not necessarily a student anymore. It is a very impressive metamorphosis from the self-portrait of a student ignoring ethical considerations at the beginning 'survival' period in the clinics, to an ethically and professionally confident student three years later, expressed in ethically-articulated statements:

"When I talked about building my ethical code, I want to stress that it is important for a physician to have boundaries and he has to think about the professional and human implications of his decisions. But I also think that the primary aspect is that you need to have professional knowledge. You should be the professional authority, so that the patient will perceive you as an authority, so that you will project to your colleagues sincerity and professionalism. And on that basis you should build your ethical moral layer. Mastering what you need to know professionally is also ethics. To philosophize all day long over euthanasia is interesting intellectually, but when you come to a patient and you don't know what to do because you are not updated, in my opinion it is a moral wrong-doing, an ethically improper behaviour, not less than not having the discussion over euthanasia. The discussions are very heroic usually but eventually decisions like that should also be made with much less pathos than reflected in the dramatic discussions and panels. I think that primarily you should know what you are doing, and be confident that you are doing the maximum you can for your patient. And if you hang around for the better part of your professional life with reasonable guilt feelings it is healthy for you because nobody can be perfectly updated all the time. If you are moral enough and have guilt feelings for not being able enough, it is a good process. A person that is always
satisfied with what he is doing and feels he can solve anything seems to me as ethically wrong" (Omer)

The learning in those training years occurs in a process that is described by students as a slow process of change, non-linear and not always explicit. Nevertheless, the very existence of such a process is evident, and so are some of its components – (1) time factors; (2) factors that accelerate and encourage the process (verbalization, observation from different angles, discussions, dissonance); (3) integration and maturation:

"It is a learning process of an adult. It is an inner process. There are processes that are hidden, even hidden from you. You find yourself at one point and after few months you suddenly realize that your viewpoint has been changed. You are not always aware of the processes... Situations that are in dissonance with your ideas irritate you and cause you to think, to verbalize it with colleagues and friends, and it works somehow. Next time you think about it you are on a different level. I have an analogy for that from my saxophone playing. In pressing times I practiced less. There were periods of weeks I did not practice at all, but when I came back to playing I was on a different level, and I could not explain this elevation. I thought about it a lot and I realized that it does not relate to practice alone, it relates to other aspects too. It is analogous to studying for a test, when the materials are embedded for several days in your head and suddenly certain integrations are created, integration that did not exist before. I think that ethics-wise or cognitive-wise things are not different. We make integrations we are not aware of. When you discuss it with somebody else it accelerates the processing. You need not come to a conclusion every time. It is sufficient to raise the issues, to verbalize them, to look at them from different angles, and the next time you will talk about those issues with someone else, you express an elaborated idea you have not articulated before. It happens on a time continuum. I do not think it is a separated, isolated process. Sometimes you feel that things change and you cannot define why. It happens with many things, like your maturity to get married, or to have children. When you start
your studies you are not mature for certain ethical processes and understandings, and when time passes things change" (Omer)

One can argue that there is a paradox here, on one hand Omer specifically says that the process is hidden, hidden from the participants themselves. On the other hand, along the whole 'ethical profile', Omer describes a process, being very aware of its existence and elements, and he analyzes the 'hidden' aspects very convincingly. However, the awareness seems to be prevailing. In fact, at one part of the interview Omer actually talks about all the elements of the present section of the discussion: the reality of daily ethical decisions making, the problematic issue of ethical learning, ethics curriculum and 'unwritten curriculum', normative conflicts, modelling and informal ways of learning:

"One of the problems of medical ethics, and that is why physicians relate to it as some kind of luxury, is the preoccupation with the eccentric aspect of it: euthanasia, human genome, human cloning etc. This is not your bread and butter. You are faced every day with dozens of situations that need consideration, and I think that common sense combined with a simple human kindness, can solve most encounters. And those are things that cannot be taught. Nobody can teach you that. If you are a person that has the predisposition for that you will see modelling of other people and you will aspire for that, but if you do not have the fundamentals I think it will be very difficult to get them. It is like teaching a person not to steal when it does not morally bother him. I do not agree with Prof. X, the head of "medical education" unit, that we can prepare an ethics training program for students in medical school, an "ethics curriculum". We should pay attention and be on guard that people who are there, at critical points in the students' education process, will be people with high ethical standards. However, the notion of having a structured program, that assumes that you are ethically elevated with every course and you come to year four as a perfect moral person that enters the wards, is baseless and impossible. The most important thing is to have people in key positions that will be models for the students. Prof. X has spoken about one term which is right: the 'unwritten curriculum' [underlining added, E.B.]. You can have discussions, you can show
films about physicians and moral dilemmas for three long years and then you come to the wards and you meet a physician that says to you: "we deal here with the real thing, so let go of what Prof. X has told you". He does not even have to say it... However, if you have during your training people around you that can do 'modelling' for you, you can discuss ethical issues with them informally...” (Omer)

It appears that faculty members and students both talk about 'hidden curriculum' or 'unwritten curriculum'. Students and faculty members alike are aware of such learning processes in the training program, and they comment on them when analyzing the ways ethics is learned in medical school. It seems that in long open interviews with adults, the implicit learning processes are brought to the surface and deep learning processes are clarified. The participants in ethical learning/teaching processes appear to be conscious and aware of their learning environment, influences and subtleties. Many layers of the latent, implicit 'hidden curriculum' are exposed by the study's subjects that shed light on ethical learning in medical school.

The next two sections of the discussion analyze the perceived existing ethical curricular processes in medical school as well as the aspired ones.
The perceived ethical curricular processes in medical school

Students in the present study were asked in the interview to analyze the ethical training process that medical school provided for them (see: 'Findings', pp. 156-165). The request for the students' interpretation was rather open, as they were not asked to relate to any specific element in their training or curriculum, thus allowing them to present their perception entirely independently, in terms of choice of words and conceptualization. The theoretical framework leading to this approach is based on two theoretical premises:

(1) The notion of 'total curriculum' (Schremer, 1996; Ariav, 1997; Marsh, 1997; Kelly, 1999), which (a) views curriculum as a broad flexible interactive concept (Posner, 1988; Ariav, 1997), (b) emphasizes the heterogeneity and relativism of educational reality (Dole, 1993; Schremer, 1996), (c) acknowledges the importance of many stakeholders that take part in curricular processes (Lofthouse et al., 1995), and (d) accordingly calls for phenomenological, interpretive forms of inquiry (Connely and Clandinin, 1987; Schremer, 1996).

(2) The notion of evaluation of the curriculum by students - the evaluation of the 'received curriculum' (Jackson, 1992), which regards students' experience of the curriculum as a valid and valuable source of perception and interpretation of curricular processes (Kelly, 1999; Preedy, 2001). When curriculum is conceived as students' experience, evaluation relates to the ability of the evaluator to apprehend the overall situation adequately and fully (Preedy, 2001). The present study adopts the approach of students' interpretation as an evaluation composite, even thought the concept of curriculum as experience, and the reliance on curriculum perception as student experience have never emerged as dominant in practice (Marsh, 1997).

When asked to describe their perception of the ethics curriculum, students basically supplied several insights that shed light on both the nature of ethics education and of students' experience as a means of curricular evaluation.
The 'total curriculum' – the curriculum is holistically assessed by the students as "ethics laden"

The students have a very strong impression that the school has invested a massive curricular effort in ethics education during their training. It is notable that they do not mention and/or remember the sequence or names of most courses or activities relevant to ethics, but the holistic picture they describe very strongly is of major curricular effort provided by the school: "there is a spotlight on ethics" (Tami). The impression of totality of ethics curriculum is intensified by the students' impression that ethics was taught every year (even before school started, in an orientation summer course), and in many formats (courses, panels, symposia, week-conferences, special guest lectures). In their accounts the students themselves analyze the feeling of totality, realizing that it comes from a certain abundance and emphasis of the school: "I do not remember where ethics was in the syllabus but I have this certain feeling that we talked about ethics a lot in medical school" (Ayala). The atmosphere of "ethics laden" curriculum and ethics emphasis by the school is described by the students as a very significant factor students cannot ignore, and they even mention the influence of the symbolic well-known reputation of Beer-Sheva medical school with an emphasis on ethics (Ben-Gurion University of the Negev, 2000), that creates group pride and processes of comparison with other medical schools. It is interesting to note that even students that admit that a certain course or element in the curriculum is not significant for them, can concomitantly recognize the importance of including that course in the curriculum because it transmits a message that ethics has status in medical school priorities. Even when students criticize ethics courses, they still remember the main impression of ethics as a major topic in medical school.

It appears that students clearly perceive the curriculum as a total system, as a holistic entity, and as an impressionistic complex notion. It is noticeable that when students are asked to reflect upon their ethics curriculum they relate to it first of all as a total process of learning, of experience they were exposed to in medical school, and as such they perceive it, interpret it and evaluate it. **According to the students, their 'received ethics curriculum' is perceived as 'total curriculum'.**
Mapping and assessing ethics curriculum – students' experience as the measuring stick

The students view a clear and distinguishable separation between pre-clinical years and clinical years with regard to the dimension of ethics education. The shock of entering the clinics is powerful, significant and overwhelming, and involves existential and survival aspects. Even though there is a certain clinical exposure in years one to three (the pre-clinical years), those years remain theoretical from the point of view of ethics and do not involve the students personally with moral dilemmas. Students are aware of the emphasis the medical school puts on ethics and moral dilemmas and they remember the discussions from the first years courses, but they are doubtful about the significance and the implication of those premature, "big words" and theoretical discussions to the students' world and reality.

Students' accounts are compatible with the literature of medical education that puts a clear dividing line between the pre-clinical and clinical years (Lowry, 1993; Towle, 1998; Jolly and Rees, 1998). However, in the Beer-Sheva medical school context this is quite surprising since the school is widely known for its 'early clinical exposure' program that gives students opportunities to experience clinical encounters with patients in years 1-2 (Ben-Gurion University of the Negev, 2000). The students' perception of their ethical education explains how they actually experience their reality: even though there are many courses, demonstrations, simulations and experiences offered by the school concerning 'early clinical exposure' (clinical elements in pre-clinical years), from students' perspective, the division line is still the 'traditional' one – between the pre-clinical and clinical years, at the point where the real major change occurs in reality, when the 'neophytes' actually join the clinical routines as medical students in the ward rounds.

The students' accounts reveal clearly that the reality of their experience is stronger than any curricular elements that are offered. Relevancy to students' existential stance is the most meaningful aspect in their educational/curricular interpretation and evaluation. These are the terms in which they view their ethical curriculum and by which they evaluate and
criticize it. Their criticism of their ethics courses, which is consistent with some previous studies (Osborne and Martin, 1989; Fox et al., 1995; Nicholas and Gillet, 1997; Parker et al., 1997; Musik, 2000) relates to its relevance to students' ethical-clinical reality and is basically two fold in its nature: (1) the students criticize the philosophical, theoretical preoccupation of pre-clinical ethics courses for being pre-mature and for labelling things 'black and white', and (2) the students criticize the absence of ethical deliberations during clinical years, in the form of 'ward ethics'. The validity of that critique in the present study is strengthened as faculty members, like students, also claim that there are no ethical discussions in their wards, even though they should be conducted there, and even if some of the faculty members describe efforts to conduct such discussions personally in their role as clinical teachers. This point is further elaborated later in this discussion, in connection with students' and physicians' expectations.

The students basically raise a paradoxical element in ethics curriculum: ethics is discussed in the early years of training, in courses that deal with 'big' dilemmas, when the students are not ready for them and deal with them without seeing the relevance and without self involvement. Thus, when ethics is not relevant it is discussed. On the other hand, in clinical years when ethics becomes very relevant and there is an abundance of ethical, personal dilemmas that call for decisions and discussions, there are no regular, planned channels for the kind of deliberations students need:

"In the wards it depends whether you get ethics education. I was lucky to have a good ethical educational example in internal ward. They talked with us and did procedures together with us. I did not get this kind of training in any other department. Ethics should be really taught in wards and not in theoretical lectures" (Alon)

"There are no frontal conversations in which somebody comes and says: 'let us talk about what happened today in the ward, what are your difficulties'. I never encountered such a situation and never heard about anybody else experiencing it either" (Omer)
Students present very clearly in their ethics curriculum interpretations that students' experience, students' existential stance and relevancy to students' reality are the major measuring-stick for their perception and evaluation process. According to students, their experience of the curriculum is the most relevant element of it.

One course assessment – the complexity and significance of students' evaluation

Two major points of discussion emerge when considering the presentation of students' informative and elaborated assessment of one course, singled out from their whole curriculum, namely: 'emotional processing' – a small-group workshop jointly-led by physician and psychologist, aimed at discussing conflicts arising during the first years of clinical training in the wards: (1) the very fact that this course was chosen by the students as a target of their analysis; (2) The amount and nature of information supplied by the students – its complexity, its variety and the methodological implications of such a process.

(1) It appears significant that the students chose to discuss the 'emotional processing' course (workshop) as part of their evaluation/interpretation of the ethics curriculum. By doing so very impressively (all the interviewed students related to that course one way or another along the interview as a relevant element to ethics education/curriculum), the students defined the 'ethics curriculum' very widely. Moreover, a deep question that appears in students' accounts relating to this course is whether there is a relation between emotional and ethical issues, or can there be a clear cut separation between emotions and cognition. By putting this course forward as part of their 'ethics curriculum' students raise a deep educational philosophical question about the relation of ethics and emotions and by that stretch even more the boarders of 'ethics curriculum' and pose them in a very wide circle, far beyond the traditional 'one ethics course in a medical program' (Fox et al., 1995). The students, by being so inclusive in their approach and by regarding ethics and curriculum conceptually widely, present their perception of curriculum as a totality, and present their perception of ethics as a
conflict-laden concept that involves both an attitudes/values realm and a decision/character-building realm. By relating to 'emotional processing' as part of their 'ethics curriculum', students demonstrates that adult students' perception is inclusive, wide and total, and can relate to conflicts, contradictions and relativist alternatives (Perry, 1970, 1990; Alexander et al., 1990; Rest et al., 1999). The views students express shed light upon moral cognition and consciousness in adulthood, delineating the complexity of moral ways of thinking and decision-making for young adults in a professional training process. By their own choice they put ethics in a wide frame of both cognitive and personal attributes and view their ethics training in a total curricular framework.

(2) The analysis of students' evaluation/interpretation of that one specific course in the curriculum ('emotional processing' workshop) reveals that students' experience of the curriculum is totally varied, a fact that makes the effective evaluation of the curriculum a complicated issue. The students are able to reflect and analyze the course on many levels: on a personal level (how much and in what ways it contributed to them or not), on a program level (whether the course was meaningful or not as part of a the training program), on a pedagogical/didactic level (timing, frequency, ways of teaching, quality of teaching), and on an educational/philosophical level (voluntary vs. mandatory participation, emotions and ethics). Additionally, students offer many suggestions for improvements and changes. All that rather impressive information reflects methodological implications on the use of students' experience as a curriculum evaluation tool: it appears to be a very difficult tool to use as it is so elaborated, complex, and produces complicated data. When one asks students openly about their experience of the curriculum, one does not get simple answers. However, one does get interesting answers that raise many educational questions and deliberations.
The effect of retrospective evaluation/interpretation of the curriculum

As the interviews were conducted in year six, the whole setting is retrospective. The students were aware of their perspective and related to it. An example for this retrospective relativist nature of students' evaluation is a course given in the beginning of year six, which did not appeal to the students, busy with clinical chores. However, the students seem to perform the retrospective processing within a short span of time:

"Now, this year we have this course about 'what the patient really wants to know'. It is important and those things are embedded in you, even though the course gets on my nerves because the meetings are at impossible hours and it involves simulations I find irritating" (Mili)

"There was a course in year six and I was very negative to it and rebellious, because I was so busy. And it took me some time to realize it was important and rewarding because it was about what the patient really wants to know and it kind of breaks the myth of 'telling everything to the patient because it is his right'...

(Yaara)

A longer time-span retrospective process seems to generate a somewhat more total aspect - how time and experience affect ones evaluation of previously unappreciated parts of the program:

"In the first years we had all these sessions and 'clinical weeks' and at that time maybe ethical dilemmas were not so relevant to us, but we do remember. We do remember that we were talking about euthanasia, about abortions and so on, so it had its impact" (Yaara)

"In the beginning I thought that all those communication courses and community and integrity focuses were only words with no meaning, school's clichés... Today I do not think that way. I do think that it is meaningful and necessary and special...I was also skeptical about the 'emotional processing' workshop and I was sure I didn't need it and that it was irrelevant for me but today I think differently. And they
told us that later we would think differently but you never believe that you actually will think differently" (Yotam)

The students words about both short-span and long-span retrospective views of the curriculum are very informative for curriculum and training program planners. The students themselves understand that while in school their judgment of curriculum quite often relates to their actual needs and not necessarily to the overall benefit it has. They explicitly say that a wider exposure to ethics is important and that they should be forced to join discussions, simulations and activities the school arranges for them, even though they are sometimes reluctant to participate. The retrospective and open stance, that enabled students to freely evaluate their 'ethics curriculum' revealed valuable information. It sustains the conclusion that a methodology of retrospective interviewing of adult students can supply curriculum planners with important insight about the relative importance of curricular elements, with holistic considerations as well as with the difficulties that the program structure presents to the students.

This study presents the advantages and potential contribution of students' experience as an evaluation/interpretation tool of ethics curriculum. It produces an abundance of relevant and elaborated perceptions, and interpretive, illuminating information about curriculum elements and processes, thus proving to be a mature source of valuable information. The literature concerning students' experience as a source of curriculum evaluation/perception poses a question: why is student experience so rarely used in evaluating curriculum? (Erickson and Shultz, 1992; Kelly, 1999). The answers in the literature include 3 kinds of reasons:

(1) From a theoretical orientation, student experience has not been a central construct in educational assumptions (Erickson and Shultz, 1992; Kelly, 1999);
(2) There are technical difficulties and methodological problems of research on student experience related to the time and memory gap between the experience in school years and the accounts later in adulthood;
(3) There has been a systematic silencing of students' voice (Posner, 1988; Dole, 1993), and even powerlessness of learners in discussions and involvement in curricular processes (Lumby, 2001).

The present study, in regarding students experience as a resource, answers by its own right the question posed by the literature, adds new angles and supplies additional reasons that encourage the challenge of using students' experience as a curricular resource:

(1) **Theoretical orientation** – the present study emphasizes the centrality of students' experience;

(2) **Technical difficulties** – the data in the present study supports the value of using the experience of adult learners as a source. Nevertheless, as the present study shows, the technical difficulties lie in the complex methodological implications of data analysis of the deep narrative information students supply;

(3) **Systematic silencing of students' voice and powerlessness** – the present study shows how powerlessness can be reduced by giving students an opportunity to present their views about elements of their curriculum as well as the totality of it. During the interviews students reflected about curricular and training issues they had not thought about before and used phrases that expressed their feeling of empowerment, through the interview and by their contribution to it.

It seems that the present study shows how fruitfully to enhance "that self-concept transformation which turns learners into fulfilled individuals" (Silcock and Brundrett, 2001, p.41), by regarding students' experience of the curriculum as a productive source of evaluation/interpretation of the curriculum.
Students' and faculty members expectations concerning 'ethics education'

The present section of the discussion focuses on faculty members – namely comparing their accounts with those of the students. The novelty of this section is that very connection between what students and faculty members propose for a desirable ethical education in medical school, a connection that has been generally neglected in the literature (Parker et al., 1997).

Curricular/pedagogical level: Ethics should be studied in the wards

From the previous literature, it seems evident that traditional medical ethics education has not equipped students with the types of moral skills they need, as medical students typically have experienced ethical dilemmas that differ significantly from those presented in medical ethics courses (Osborne and Martin, 1989; Fox et al., 1995; Nicholas and Gillet, 1997; Parker et al., 1997; Musik, 2000). The term used in the literature as an alternative for that problem is 'Ward ethics' (Feudtner and Christakis, 1994; Swenson and Rothstein, 1996; St. Onge, 1997), although there is not much information on what it should include. The only other recommendations are for creative techniques to be used in ethics courses in order to make them closer to students' world (Fox et al., 1995).

The data collected and analyzed in the present study strongly supports the general understanding that 'ethics education' must focus on students' experience (Feudtner and Christakis, 1994). Moreover, in both students' and faculty members' accounts, the authentic call for dealing with 'ethics education' within the wards by physicians discussing ethics directly and routinely with students is very explicit. Originating independently from the students' and from the faculty members' interviews, the findings concerning the desirability for 'ward ethics' as an integral element of students' ethical reality and context, are significant and valuable, as they supply detailed suggestions on how ethics should be
handled in the wards and in accord with which educational approaches ethics should be conducted. A central finding of the present study is that students' ethical reality is experienced routinely and contextually in the clinical wards, and is involved with daily decision-making. The demand to conduct the ethical education processes within the wards is an important addition, compatible with the study's main findings and analysis.

When students describe the kind of 'ethics education' they would have liked to see in medical school (as students of sixth year summarizing their training, or contemplating themselves as future senior physicians), they portray ethics discussions in the wards, led by physicians (not by 'professional ethicists'). They view senior physicians or young physicians initiating and leading conversations with small groups of students, discussions in real time, as an integral part of the wards rounds. A specific time should be allocated in rounds for ethical issues, either about a case that represents a moral dilemma, or about ward and students' ethical issues. A variety of topics should be presented in a variety of ways. The responsibility for that ethical education should be part of the ward clinical education program, not a separate curriculum of ethics courses. The heads of wards and physicians should be aware of ethics, and should be aware of students' own ethical dilemmas and ethical encounters. The students suggest also that physicians be prepared for their role as ethical facilitators in the wards by way of 'awareness of ethics' and 'inter-relation' communication courses for physicians.

When faculty members relate to ward ethics, they address the same issues:

1. Awareness of their double and conflicting role as physicians and teachers: "Physicians should also be conscious of the fact that they confuse the students with their conflicting behaviours and the hidden messages" (Orna)

2. The need for better awareness of students' ethical situations and dilemmas: "Examples of the dilemmas the students described in the questionnaires and interviews should be publicized" (Eran) [i.e., the present study data, E.B.]

3. The discussion of ethics in the wards, "discussed daily and routinely, when dilemmas occur" (Eran).
(4) Training physicians with discussion leading skills: "Physicians that educate students should pass some kind of training to teach ethical issues in the wards" (Hadar)

What seems very clear is the similarity between students' and faculty members' view of the right, desired 'ethics education'. There is a close relationship between the type of dilemmas students cope with (daily, situational, calling for personal decision dilemmas), their ways of coping with the dilemmas (indirect, subtle, complex ways), and the type of 'ethics education' students and faculty members seek (ethics in the wards, dealing with contextual ethical issues). When "You are faced every day with dozens of situations that need consideration" (Omer), and when the students need to take actual ethical decisions that involve them personally, they express the logical, basic need and desire to deal with their decisions in the relevant environment with a willing, aware, experienced professional.

Organizational-structural level: bodies that relate to ethics education

The analysis of section III of the discussion (Learning processes of medical students, in regard to their ethical experience), dealing with the hidden messages of medical school's 'ethics curriculum', shows that 'ethics education' is conducted not only at pedagogical/curricular levels but at personal and organizational levels as well (Hafferty and Franks, 1994). In section I of the discussion (The perceived moral dilemmas in medical students' reality), the analysis shows the relationship between coping with ethical issues, students' status in medical school and students' culture. Thus, the present study has established the relationship between ethical dilemmas, structure, organization and culture of medical school. Accordingly, students' and faculty member' proposals for change in 'ethics education', logically entail structural and organizational changes including the establishment of new institutions.

The students propose instituting a body that will regularly and systematically deal with ethical issues that arise during students' training. There is a relation between this proposal
and the fact that the moral dilemmas the students narrated concern student-physician encounters, facing unethical behaviour, pressures of problematic practices, un-clarified issues of students' status regarding "their" patients (information, informed consent) and so on. Students suggest several options of institutional arbitration: (1) regular base informal meetings of students and physicians to discuss ethical issues, (2) empowered "year-committees" (existing committees in medical school, with faculty members and student representatives), mandated to deal with ethical conflicts, and (3) a permanent "ombudsman" institution for ethical disputes. Interestingly, those students who reported dilemmas that put them in conflict with physicians, where they feared for their status or grades, and where they had no one to consult with, said they would prefer to have regular, external bodies where disputes and conflicts could be discussed, and consultation can take place. Noticeably, faculty members do not raise the issue of establishing such regular base dispute-solving institutions. This might be related to faculty members' seemingly limited concern regarding students' relational ethical encounters: they seem to be more concerned about students' moral dilemmas with patients, with professional-ethical decisions and with attitudes and norms construction, and less with students' moral dilemmas regarding physicians' own ethical behaviour, that is, dilemmas that concern students' reaction to ethical conflicts and encounters with physicians themselves.

Another kind of institutional change also deals with the relations between students and physicians but from a different perspective – that of sharing the professional experience with a neophyte in an ongoing, intimate mentoring process. Mentoring is proposed by students and faculty members as an option, with a permanent pairing of a student and a teacher, regardless of the rotation that typifies the clinical years. The idea of mentorship arises as a remedy for the inherent situation of the long training in medical school, where students move from one department to another, and rely on their teachers for grades and evaluation. The faculty member that describes this option at length (admitting the difficulties of its implementation and the cost) describes the advantage of a threat-free consultation (see: 'Findings', pp.199-201). When exposed in the interview to students' moral dilemma of pressure to examine a patient who is under stress, the faculty member, Eli,
describes mentorship as an option that would have made it possible for the student to clarify and construct his attitudes and values:

"If the student could have discussed the case with his mentor right after the encounter, to be relieved from authority and hierarchy considerations, maybe then the vicious cycle of obedience could have been broken. Perhaps he would have done it differently next time. He could stop between the checking of the women, to take a deep breath and say to his teacher that he did not like the way things were done, that he felt very stressed and that he would have liked to do things differently" (Eli)

One of the students that called for mentorship defined the characteristics needed for that position – combined (probably rare) modelling of professional (clinical) and ethical merits:

"Most of the physicians expect you to learn from their behaviour, and that is almost their only educational contribution, without any talking and conversations...I think that in medical school there is generally less learning than what should have been, not only in the ethical aspect but in the medical-professional one too. There are too few people willing to instruct, to be tutors in the full sense of the word. The profession has become very technical and physicians' nature is to run quickly out of the hospital to their own private business, and that does not leave much time for teaching. If we isolate the ethical aspect, I think that models are very important. It is even more important that a person that is professionally good will also be an ethical model. Some sort of a mentor. Because it is easier for a student to receive instruction from a person he appreciates professionally, as this is the aspect you evaluate the most. So, if it is entangled with ethical modelling it is embedded better in our memory" (Omer)

It seems clear that students' and faculty members' proposals regarding institutions to be established are closely related to the organizational, cultural, structural, hierarchical reality of medical school, and to the problems inherent in teaching in the wards, students relations with physicians and training constraints.
Analyzing the two basic expectations of students and faculty members concerning 'ethics education' in medical schools (ethics training in the wards and establishment of new institutions, mainly for conflict-resolution) they might seem contradictory as they reflect both trust in the system (the clinical training rotations), and mistrust of the system (the need to establish external, additional bodies). Nevertheless, when viewed from the prism of the present study, from the view of students' moral dilemmas that are the core of this research, the two basic suggestions seem compatible and reasonable and not contradictory at all. They supply answers to two different ethical needs of students, which are expressed in the typology of moral dilemmas ('Findings', p.119). The study has categorized the dilemmas according to a "responsibility continuum": (1) 'Reflection dilemmas' – that is, ethical issues and situations students are exposed to, that raise ethical reflection and thoughts; (2) 'Witnessing – optional reaction dilemmas' – which are ethical issues and situations students witness in the wards, that raise the need to decide if, and then how to react; (3) 'action dilemmas' – defined as ethical issues and situations students directly encounter as part of their medical role in the wards, that force them to decide how to act. It seems that the first basic suggestion, 'ethics in the wards', will serve as an arena for discussions of 'reflection dilemmas' (not purely theoretical ones, but rather those that arise around actual cases in the wards), as well as 'action dilemmas' where students have to make instantaneous decisions in the ward on what kind of information to deliver, how far to practice, how to introduce themselves and so on. The second basic suggestion, namely new bodies of conflict-resolution and of intimate confidential consultation, will serve as an arena for solving 'witnessing dilemmas' (ethical problems students have with the system and its representatives, the physicians), and as a forum for engaging moral dilemmas students witness and have to decide whether to react or not, not necessarily immediately, personally or directly. In light of the different sorts of students' moral dilemmas, it seems from both students' and faculty members' accounts that there is a need for both inner wards' ethical deliberation processes, where students can benefit from the individualized instruction of their experienced teachers, and external bodies where students can benefit from out-of-wards confidential ethical consultation.
Analysis of students' and faculty members' expectations and suggestions about a better ethical education illuminates the similarity between the two groups in regard to ethics teaching. Both students and faculty members realize that ethics issues should be discussed and dealt with in the wards, directly between students and physicians who share the same professional environment which is so relevant to the training process. It appears that the centrality of clinical training in medical school, the traditional apprenticeship model of medical education (Downie and Charlton, 1992; Irby, 1994; Dacre, 1998; Jolly and Rees, 1998; Peyton, 1998) is reinforced by this study's findings in an original supplementary aspect that concerns ethical education: ethics' ways of learning and teaching are perceived by the two groups that participate in the educational process in a similar, complementary way. The two groups perceive ethics training as a process they share and undergo together, as a contextual developmental experience. 'Ethics curriculum', taught and discussed in the wards, related to students' needs as trainees and to physicians' accumulated experience as professionals, puts the traditional clinical educational setting in a new context of postmodern educational thinking of viewing curriculum as a process (Kelly, 1999; Marsh, 1997; Dole, 1993) based on students' experience of it (Cuban, 1992; Dole, 1993; Eisner, 1994; Lumby, 2001; Silcock and Brundrett, 2001).

When students described themselves as senior physicians to be, instructing students of their own, they emphasized several approaches they would try not to forget to apply – informal ways of teaching and a non-threatening atmosphere. They listed a number of educational means that seem to be helpful to them: active involvement of students, real-time discussions, observing students and giving them feedback, initiation of discussions, sensitivity to students' difficulties, personal sharing of ethical conflicts. The students expressed clearly what they know about ethical ways of teaching: truthful sharing of inner professional ethical conflicts, combined with sensitivity to students' conflicts, emotions and values, performed in an informal non-pressing environment, with a sense of personal responsibility of teachers to the ethical educational process of their students. Students' insights about their learning process lead them to teach themselves (and the present study) about teaching.
Chapter Six

Conclusions

This study examined the moral dilemmas of medical students – their ethical reality, experience and learning, and the ethical-curricular aspects of medical education.

The study focused on the students' perception of their ethical experience throughout their medical school years, and their interpretation of it. The understanding of the ethical reality of medical students entailed researching the meaning and influence of their daily ethical experiences: their actual moral dilemmas, their decision-making and coping mechanisms, as well as their moral development, norms and values. Moreover, by interviewing students about their ethical learning processes and ethical encounters, the study examined ethical and cognitive development in adulthood, and illuminated the issue of 'morality in context' – moral dilemmas in the daily life of their participants.

Another dimension of the study was the examination of ethical learning/educational aspects of medical training. The study investigated the centrality of students' experience of the curriculum, the presence and significance of the 'hidden curriculum', and the notion of 'total curriculum'. The study examined how students evaluate their ethical curriculum: what their accounts indicate they learned from the medical school's program – the 'received curriculum' – throughout the training years. Furthermore, the study examined how faculty members perceive students' ethical training and ethical processes, as well as their own role as medical students' clinical teachers. Finally, both students' and faculty members' expectations of the medical school's ethical training were scrutinized.

Defining the study in terms of students' experience of the curriculum, and in terms of the perceived moral reality, framed it within a methodological paradigm of qualitative-phenomenological-interpretive research. The qualitative approach is compatible with studying a broad context of human experience, such as the ethical processes in a medical training program. The objective of the present research was to study medical students'
narratives — to elicit personal stories where they describe and reflect upon the way they perceived their ethical life, their ethical selves. Since the research paradigm gave access to the students' world, it provides novel data concerning ethical aspects of their training. The elaborate narratives of ethical reality, authentically accumulated in the present study, made it possible to delineate the researched issues, to analyse the implications of the students' and faculty members' subjective experience, and to reach new and extended conclusions, presented here in three realms: (I) Moral dilemmas of medical students; (II) Issues of morality; (III) Issues of ethics curriculum/education in medical school.

I. Moral dilemmas of medical students:

- The study significantly validated previous research findings concerning the daily, contextual, decision-type nature of students' moral dilemmas, emphasizing the abundance of 'reaction' and 'action' dilemmas (e.g., Christakis and Feudtner, 1993; Bissonnnett et al., 1995; Satterwhite et al., 1998; Hicks et al., 2001). Furthermore, the study illuminated the complex nature of students' ethical decisions and typologically presented the variety of ethical encounters within various clinical experiences. The relation between students' moral dilemmas, student culture and student status in medical school is exhibited and interpreted by the study.

- The overall elaborated picture of students' subjective experience that emerges, and particularly the centrality of 'practicing' dilemmas in students' reality as found in this study, lead to the conclusion that moral dilemmas of medical students relate strongly to their actual training reality, to their daily assignments and activities, and to their pressing personal decisions. Existential situational aspects appear to be the main sources of medical students' moral agenda.

- Student coping mechanisms and reactions to the dilemmas were not a 'black and white' type of conduct. The wide picture described in students' narratives revealed a world of small scale, indirect and complex strategies. The students described strategies that can
change and influence the situations in dozens of innovative, creative, personal, idiosyncratic ways. Decisions and actions exhibited a great variety – different people behaved differently in various situations, various clinical settings and various years of the training program. Moreover, the common phenomenon of non-reaction ('silence') behaviour was shown to originate not only in the traditional self-interest preservation and hierarchical inferiority (Bickel, 1993; Dwyer, 1994), but also in much wider reasoning entailing considerations such as collegiality, norms adherence and moral judgment issues. Hence, students mechanisms for coping with moral dilemmas are not composed of heroic-dramatic lines of action, as reflected in theoretical discussions of moral dilemmas in ethics classes (Fox et al., 1995), but of subtle, elaborately calculated reactions and decisions, reflected in subjective, recurring, practical situations, and motivated by the complexity of personal and attitudinal considerations.

- The incipient theoretical framework that analyses medical students' moral dilemmas (Christakis and Feudtner, 1993; Bissonnet et al., 1995; Homenko et al., 1997; Satterwhite et al., 1998; Huijer et al., 2000; Hicks et al., 2001) has claimed that the abundance of reported dilemmas demonstrates the problematic nature of the training period, as well as the moral weakness of the students who, according to their own testimonies, do not react to those ethical encounters as they should (Bickel, 1993; Dwyer, 1994; Swenson and Rothstein, 1996; St. Onge, 1997). By eliciting the students' complex descriptions of their dilemmas and reactions, of their doubts and considerations, of their emotions while facing the situations and afterwards, the present study brings to light the significant role of ethical memory, providing new insight on ethical dilemmas. The study argues that the abundance of dilemmas students reported in their rich narrative is a clear indication of their great awareness of ethical issues, which they have remembered for a long period of time (sometimes years). These dilemmas were situational and contextual, but their memory, and the memory of the deliberations and doubts concerning them, are ongoing. Thus, it can be concluded that students present a novel facet of morality and moral identity – 'ethical memory' that entails 'moral awareness', reflective abilities and honesty. It appears
that this 'ethical memory' is significant to the students and reflects their values. The present study's findings are evidence of the high standards of cognitive-ethical thinking of medical students as reflected in their 'ethical memory'.

- A common claim concerning medical students relates to their growing cynicism during medical training (e.g., Eron, 1955; Wolf et al., 1989; Feudtner et al., 1994; Myser and Kerridge, 1995; Price et al., 1998). This study found that in terms of ethics, the process is just the opposite - ethical sensitivity grows and develops throughout the training period. While in the first three pre-clinical years the students exhibited simplistic ethical thinking, the years of clinical training that expose students to real complex ethical conflicts, led to a culmination of ethical sensitivity around year six. This ethical sensitivity entails the ability to view ethical issues within the prism of conflicting reality, while looking for adaptable, suitable alternative solutions to dynamic, complex and relativistic ethical situations. The revealed ethical sensitivity is accumulated and learned through exposure to many conflicts, through doubts and frustrations, through deliberations and discussions, through actions and in actions. This novel concept of constructed ethical sensitivity could be revealed, traced and understood in the context of this study, because the study included the holistic students' descriptions of their ethical reality.

II. Issues of morality

This study is an educational-empirical study that examined medical students' interpretation of their moral reality, their moral decisions and conduct. Conceptually, the study relied on several theories and models of morality, moral behaviour and moral decision-making (e.g., Rest, 1986; Blasi, 1995; Nisan, 1995), as well as on theories of epistemological-ethical thinking (e.g., Perry, 1970, 1990; Kohlberg, 1981; Gilligan et al., 1990). Those theories of morality suggested conceptual assumptions (Rest, 1986; Blasi, 1995), some inferred from hypothetical dilemmas research (Kohlberg, 1981; Nisan, 1995), and some from contextual
dilemmas' research (Perry, 1970, 1990; Gilligan et al., 1990). The present study offers a novel perspective in this field of morality research, as it examined issues of morality and moral conduct through the actual coping of the study's subjects along a significant time period in their lives, not through exposure to hypothetical dilemmas, or by analyzing only one-time life events. As such, this study provides important insights concerning morality that are reflected in the students' world:

- In line with the assumptions of most models (Rest, 1986; Blasi, 1995; Nisan, 1995), this study showed non-linear connections between reason and behaviour components, thus suggesting the interactive nature of moral decisions and personal 'moral identity'.

- This study showed that a single moral action (what a person chooses to do or not to do) is not necessarily, according to his/her interpretation, the ultimate and indisputable criterion of an adequate moral functioning.

- This study showed that in situations of actual moral choice, the students do not only pursue moral motives, but also specific ego interests that appear to them legitimate, and are weighted against moral obligation, in an attempt to calculate for themselves a sort of 'moral balance' (Nisan, 1995), on the basis of all their morally significant actions within a given time frame.

- The students exhibited a high standard of epistemological-dialectic thinking, characterized by understanding relativism, accepting contradictions, perceiving integration of variables as a process, and pragmatic focusing on context (Commons et al., 1984; Alexander et al., 1990; Hofer and Pitrich, 1997). The young adults' cognitive processes were shown to exist in students' accounts in daily, ordinary, practical decision-making, where pragmatic considerations require a move from abstract solution to a choice of action.
• This study provides 'thick descriptions' (Geertz, 1973), significant accounts of the highest stage on Perry's (1970, 1990) model of intellectual and ethical development, that constructed a relation between cognitive and intellectual development and the development of ethical reasoning. These descriptions of this ethical-cognitive adult stage of 'commitment' are invaluable source of insight, as the students' choices were made while confronted with the paradox of establishing values and perceptions in an epistemological context of relativism and doubtfulness. Typical conflicts that student recounted were certainty vs. doubts, idealism vs. realism, inner choices vs. external influences, action vs. contemplation, powerfulness vs. powerlessness.

• This study points up the strong contextualism of ethical decision-making (Gilligan, 1986; Gilligan et al., 1990). Students' decisions were not formal and were not expressed in objective concepts of 'social covenant' and 'natural justice' (Kohlberg, 1981), but rather in the actual real context of their lives, in an attempt to find mechanisms that are "most suitable" (Gilligan, 1986; Gilligan et al., 1990).

• In addition to these significant insights and implications, the present study adds also another important layer to the existing concepts concerning morality. The authentic materials elicited emphasizes for the first time the significance of students' 'moral awareness' – awareness of the ethical dilemmas, their problematic nature and complexities, awareness that reflects students' moral standard and values. Students' 'moral awareness' is two dimensional: it existed at the time of the actual ethical encounters, when the students deliberated, discussed, consulted contemplated and acted, and it retrospectively reappeared during the interviews, a long time after the actual occurrences of those ethically troubling events, expressed in the way the students remembered and analyzed the conflicts as part of their training experience in medical school.

Hence, briefly summarized, the present assessment of medical students reveals that students viewed their ethical conduct as an integral part of their 'moral identity' (Blasi, 1995), tried to maintain their 'moral balance' (Nisan, 1995), and reached the
high and complex stage of 'commitment' (Perry, 1970, 1990), while internalizing dialectic contradictions (Alexander et al., 1990), through contextual examination and deliberation (Gilligan et al., 1990). Furthermore, based on its findings and on 'ethical memory' exhibited by the students in particular, this study suggests an additional interesting aspect of morality – 'moral awareness' – that can be regarded as a novel component to the existing ethical conceptualizations.

III. Issues of ethics curriculum/education in medical school

- The students in this study perceived their ethics' 'received curriculum' as 'total curriculum', and they related to it as a holistic concept. The two dimensions that characterize contemporary curricular perceptions – the inclusiveness of multiple aspects of education in the term curriculum, and the contextual view of curriculum (Clandinin and Connelly, 1992; Jackson, 1992; Ariav, 1997; Marsh, 1997; Kelly, 1999), are evident in the medical students' interpretation of their ethics learning and curriculum. Medical students related to their ethics learning as a multi-dimensional longitudinal developmental experience, perceiving the curriculum as a process and not as a product. Even if students' ethical reality was burdened with ethical problems and conflicts, and even though they criticized elements of ethical education (irrelevant courses in unsuitable settings and timing), they conceptually regarded ethics 'received curriculum' in its totality and described it as 'ethics laden', appreciating the school's ethics efforts and the emphasis on a humanistic approach. Medical students' impressions of their training program and the 'ethics curriculum' share a basic view of curriculum as an open-ended system, as a broad flexible interactive concept.

- This study sheds light on a complicated field in curriculum research – curriculum evaluation through students' experience (Mann, 1968; Willis, 1991), a field that has receive little attention, in both conceptual work, and in empirical research (Erickson and Shultz, 1992; Marsh, 1997; Kelly, 1999). The present research attempted to assess
the ethical experience of medical students, an experience which is an integral part of the training program's curriculum in the broad sense of the term. The findings delineate the extent of relevancy of students' evaluation/interpretation of their ethics curriculum, its importance and its inherent difficulties. Relevancy is shown by the ways students assessed their learning processes, the teaching methods and the program according to their experience, their practical training and the ethical encounters of their reality. They were conscious of the centrality of practice, basically of the notion of 'curriculum practice' (Ariav, 1997, Flinders and Thornton, 1997). 'Practicing' was the central measuring stick for their ethical learning, both the existing and the desired or expected one. The importance of students' interpretation can be gauged by the significant amount of elaborated data provided, approved by the faculty members' testimonies that endorsed the need to hear the students in order to identify the most suitable ethical teaching/learning processes. The arguments for promotion of students' involvement in curriculum evaluation (Preedy, 2001), proved valid in the present study as the students strongly expressed their rights and desire to influence their own world, while the potential benefits to the system were confirmed by their teachers. The difficulties paradoxically are the abundance of narrative evaluations that are bound to be elicited in any 'narrative inquiry' (Connelly and Clandinin, 1987), that pose a methodological challenge. These difficulties notwithstanding, the present study advocates the potential value of viewing curriculum as student experience: the students' constructivist interpretations (Von Glasersfeld, 1991) were actively built up by them as cognizable subjects, who act upon a given experiential base, exhibiting a humanistic 'self-actualization' (Rogers, 1983). The strength of medical students' evaluation/interpretation of the curriculum through their experience lies within its ideas and concepts, its authenticity, awareness and reflection. Much can be inferred from it about processes of curriculum shaping according to students' evaluation, and on processes of students' empowerment and student voicing.

- This study adds a new dimension to current concepts of ethical learning in medical school. The conceptualization of the gap between declared and observed norms in medical school (e.g., Shuval, 1980; Haas and Schaffir, 1987; Jolly and Rees, 1998), and
especially the adoption of 'hidden curriculum' transmitted not through the formal curriculum, but via a more latent one, have been central explanatory concept to the process through which medical students internalize values, attitudes, beliefs, and related behaviours in the last decade of medical school ethics education research (e.g., Hafferty and Franks, 1994; Hundert et al., 1996; Marinker, 1997; Papadakis, 1998). The present study reveals the 'hidden' components as part of the exposed overt level that students are well aware of. It demonstrates to what extent medical students and medical school faculty members are both conscious of the process they personally participate in. They are aware of the modelling aspects of ethical teaching/learning within clinical training and of its organizational, pedagogical and personal problems. Faculty members are aware of their teaching role and of the obstacles to fulfilling it within the system that has different parameters for promotion and success (Hundert et al., 1996; Hafferty, 1998), while the students are also aware of these influential processes. Students described and analyzed very realistically the factors involved with their ethical learning, delineating the latent processes of experience gathering and ethical code construction through conflicts, contradictions and paradoxes. They expressed awareness of the factors that encourage ethical learning (ways of teaching/learning they recommended), as opposed to factors that hinder ethical learning. Students and faculty members related to terms like 'hidden curriculum', 'informal learning', and 'unwritten curriculum', and exhibited impressive awareness of those 'hidden' elements of their program and environment. Students' narratives described the contradictions between declared and observed norms, between formal and informal demands, and between ideologies and reality. Thus, this study shows that in a thorough analysis of medical students' and faculty members' accounts, it is possible to go beyond the traditional terminology of 'hidden curriculum', to decipher its hidden constructs, and to reach insights about the learning/teaching processes involved in the construction of ethical perception during the extended course of an educational training program.

- It is noteworthy that a close relationship was found between the type of dilemmas students coped with (daily, situational, calling-for-personal decision dilemmas), their
ways of coping with the dilemmas (indirect, subtle, complex ways), and the type of ethics education students and faculty members sought to promote (ethics in the wards, dealing with contextual ethical issues). Even more specifically, the study found a connection between the typology of student moral dilemmas – the 'responsibility continuum' – and the two basic suggestions for the desired ethical education: the first, ethics in the wards, is to function as an arena for discussion of personal dilemmas that require an ethical immediate decision – 'action dilemmas', while the second, new institution for conflict-resolution and of intimate confidential consultation, is to function as an arena for solving ethical problems students have with the system and its representatives (faculty members) – 'witnessing dilemmas'. The study thus shows a mutual inter-relation between the various parts of the analysis: the typology of students' dilemmas, the analysis of ethical coping mechanisms and the curricular/learning aspects of actual and desired ethics education.

- A further novel dimension of the study, was the examination of faculty members' views about students' ethical dilemmas and ethical processes. Faculty members' accounts validate students' descriptions of the ethical dilemmas, of the difficulties and problems they pose, and of ways of coping with the daily encounters. The different presentation of 'practicing' issues between students and faculty members contributed to the study's basic analysis of students' culture and students' layman stance. The attention to faculty members' views exposes a common understanding of students and faculty members concerning ethical curricular educational processes in medical school. Exhibited independently, these views reveal a similar analysis of 'modelling' and of 'hidden curriculum' issues, as well as similar expectations concerning the desired ethical education in medical school. The study shows that faculty members are aware of their students' unique ethical stance and of their own problematic and conflicting roles as ethics educators. The study illuminates a special mutual understanding of two groups, entangled together in an ethical educational process.
The study's contribution

From a theoretical perspective:

- This study adds an important layer of theory and knowledge to the research concerning moral dilemmas of medical students, as it researched and conceptualized novel aspects of the field: ways of coping with moral dilemmas, students' interpretation of their ethical reality, and processes of learning and ethical development of young adults.

- The study contributes significant understandings concerning 'morality in context', that is, the study of people actually coping with moral dilemmas. Most studies and models in that field have dealt with hypothetical dilemmas and models, or empirically with limited, individual contextual dilemmas (e.g., Blasi, 1995; Nisan, 1995; Rest et al., 1999). This study, based on testimonies about ethical encounters over a relatively long period of time, provides a wider conceptual and developmental viewpoint. This long-range view revealed a new concept – 'moral awareness' – that should be included in the theoretical framework of any further analysis of ethical coping situations in context. The research contributes also new dimension to studies of the adult stage of ethical-cognitive development.

- The study contributes to curriculum research and theory by analyzing curriculum concepts – 'total curriculum', and 'curriculum evaluation as students' experience' – in an educational/curricular environment of a complex training program of a medical school.

- The study contributed to ethics curriculum research and theory by examining, for the first time, the medical school faculty members' perception of ethics education and ethical processes of their students.

- A significant and important contribution of this study lies in the conceptual combination of two bodies of knowledge: students' ethical dilemmas and curriculum.
The study dealt with ethical reality of students in a learning-training period, and thus combined two factors: students' perspective (ethical processes and interpretations of young adults), and ethics curriculum perspective (in a training program). The present study's choice to combine these two independent, yet potentially inter-related fields of research and knowledge, is a significant theoretical contribution, as it enabled new elaborated insights and analyses.

From a methodological perspective:

The present study (a) was located within the qualitative-naturalistic research paradigm, (b) followed the phenomenological tradition, (c) adopted an interpretive methodological approach that (d) was based on narrative texts, (e) obtained through the research tools of interviews and open questionnaires. The methodological contribution of the study lies in the ways it used these methodologies, ways that can be regarded as future tools to be applied and refined:

- The study shows a way to fully adhere to the interpretive approach by encouraging the elicitation of ethical dilemmas, with no limitation, as the sole definition for a dilemma was its elicitation. The study, by taking students' interpretations into account, contributes methodologically to the concept of people's ownership of their subjective experience and its interpretation.

- In order to study actual ethical reality during a training period, the study examined awareness and reflection of encounters that occurred over a relatively long period (six years of the program). This methodological decision, new to a research field that so far has studied only individual representative dilemmas in a limited perspective, yielded rich materials and may, therefore, be used as a model in future studies.

- The study's analysis strategies reflected the two concepts of human experience – the shared collective aspects of experience ("cross-cases analysis") that yielded the
findings' categories, and the idiosyncratic individual aspects of experience ("within-case analysis"), that yielded the 'ethical profiles'. Using the 'ethical profiles' as an integral part of analyses and conceptual frameworks, demonstrates how powerful such elaborated and deep profiles can be. The 'ethical profiles' can be further developed as a subtle corner-stone research tool in ethical, attitudinal studies.

- The study's decision was to interview faculty members, the students' role-set partners in the training program that are mentioned in many students' moral dilemmas, through a focused prism. Faculty members were asked to respond to the students' ethical reality, thus avoiding digressions into faculty members' own world and concepts. This appeared to be a valuable research tool, not used before in dilemmas research, but it is a tool that should nevertheless be used carefully to avoid losing the focus on the research objectives.

- The study's combined use of open questionnaires and interviews gave a significant methodological advantage, because the complementary use of these tools elicited contextually rich narratives that provided access to people's identity, attitudes and interpretation. Thus, the study benefited in two ways: the questionnaires enabled it to get acquainted with the students' dilemmas, while the interviews enabled it to get acquainted with the students. Together, they appeared to form a powerful, interesting, significantly productive research instrument.

**Recommendations for future research:**

Future studies building on the present research:

A study that probes ethical encounters in the clinics more specifically in order to explore how the various ward environments affect students and to evaluate fundamentally the types of values routinely transmitted to students during their clinical training.
Studies of 'received ethics curriculum', evaluated and interpreted in terms of 'students' experience', with other populations of students in professional training programs (pre-service teachers' training, law interns and so on).

Studies of life narratives and 'ethical profiles' that research ethical choices and decision-making processes of people, during significant periods/stages in their lives.

Investigations ('ethical profiles') of the role of 'ethical memory' and the development of 'ethical awareness'.

**Final comment – Epilogue**

According to Schutz (1970) there are two levels of interpretation. First, that of the subject, constructing the reality of his life and explaining it to himself and to the researcher. Second, that of the researcher, creating an interpretive description of his own as an observer of phenomena, relating his findings to additional knowledge, and wanting to be able to say something more general about human nature. As the researcher that interpreted students' interpretations, I was aware of the sensitive issues students were requested to address and I, therefore, wish to conclude with some words of an interviewed student, that were expressed at the end of a reflective, self-exposing interview:

"I have a request. As part of our gradual admittance to the group of professional physicians we also adopt a very defensive position. It happens to all of us, and not always proportionally to the arguments against us... Nevertheless I think that you [i.e. the researcher, E.B.] should consider carefully how you analyze the situation of medical students and physicians. I address you with this request, not antagonistically though, because most of the researchers that perform studies like yours are not physicians. When you are a physician you can neutralize elements that as an outsider you are not aware of. Two physicians can think very differently but they can still see the legitimacy of the other opinion... there are so many factors
that "contaminate" the so-called ethical discussions...it is so easy to come and say about somebody that he or she is getting a thick skin like a rhinoceros, or that a student loses his sensitivity and becomes cynical like a physician and so on. But it is not fair to do so, it is so unfair. It is not fair not only because you are not facing my reality of not sleeping 32 hours when judging if I was polite or not to a patient. It is not fair because you are not aware of all the considerations of the system and profession, within which we operate. It is difficult for me to hear criticism from an outsider. You have to be realistic in the way you judge the issues... I do not say that the way I live with myself is the right model of ethics, but one should be careful when analyzing our narratives, because they are so complicated and they involve so many inseparable elements" (Irit)

I do sincerely hope that I have fulfilled Irit's request and interpreted students' honest and open accounts carefully, respectfully and sensitively.
References


General Medical Council (1993) Tomorrow’s Doctors: Recommendations on Undergraduate Medical Education. London: GMC.


Glick, S. (2005a) ‘Time have changed, the vision and the mission have not. The “Beer-Sheva Experiment” after thirty years’. In: D.E. Benor (Ed.) *Sustaining Changes in Medical Education*. Beer-Sheva: Ben-Gurion University of the Negev Press, pp.89-101.


Martin, J. (1976) 'What should we do with a hidden curriculum when we find one?'. Curriculum Inquiry, vol. 6, no.2. pp.135-151.


Towle, A. (1992) *Outpatient Teaching at St Bartholomew’s Hospital Medical College Mimeo*. London: SBHMC.


Appendices

Appendix no. 1 – Questionnaire

Appendix no. 2 – Samples of Students' Questionnaires

Appendix no. 3 – Students Interview Schedule

Appendix no. 4 – Faculty Members Interview Schedule

Appendix no. 5 – Charts and Tables
Appendix no. 1 – Questionnaire

**Questionnaire**

1) Describe a significant moral dilemma you personally had to cope with, as a medical student, during your six years of medical school.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2) In what manner did you cope with the dilemma?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
3) Who, if any, have you addressed or consulted with concerning the dilemma?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4) In what ways can medical school help students cope with similar dilemmas?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

ii
Appendix no. 2 – Samples of Students' Questionnaires

Questionnaire no. 1

1) Describe a significant moral dilemma you personally had to cope with, as a medical student, during your six years of medical school.

_During my fifth year, while I was doing my rounds at the Obstetrics and Gynecology Department, I was present at a delivery. In a minute, or rather a second, of lack of attention I cut the umbilical cord on the wrong side of the clamp, and the baby started bleeding, which caused a slight "hysteria" amongst the midwives and the neonatologist that were there, until they have managed to stop the bleeding. I felt awful, of course, I can't even begin to describe how much. Rationally I have told myself that it has happened since I was very tired after working a shift the night before, but emotionally I couldn't, and up until today haven't been able to understand how this happened to me. It was the first time I realized, in the most powerful sense, the meaning of having responsibility over human life._

The midwives and nurses "ordered" me not to say anything and to let the issue pass, assuming that everything will be OK and therefore there is no need to tell the parents, so they won't come up with a law suit. I, on the other hand, felt bad about it and wanted to disclose what I have done, and talk about it.

2) In what manner did you cope with the dilemma?

_I don't think that I have ever really dealt with my dilemma. I really wanted to come forward about it. I think mainly because I wanted to "clear my conscience". I do realize, however, why the "system" – in this case the midwives, out of their experience and encounter with the issue of law suits, have claimed that it is better to hope that nothing will be wrong with the baby, and that the whole incident will pass without any complaint on the family's side._

3) Who, if any, have you addressed or consulted with concerning the dilemma?

_I have only consulted my mother, and a few close class mates._

4) In what ways can medical school help students cope with similar dilemmas?

_I remember that in our first year every group of students had a tutor. These tutors were seniors physicians and the meetings with them were informal. Now we have a tutor, but only an academic one. I think his role should also be to help resolve ethical problems._
Questionnaire no. 2

1) Describe a significant moral dilemma you personally had to cope with, as a medical student, during your six years of medical school.

*I have helped in the admittance of a surgical patient, and I have connected with him and his family. During the operation the surgeon "screwed up" and as a result the patient has suffered from sepsis [severe infection, E.B.]. The patient's family has asked me whether I thought the surgeon has done a mistake, or was it an accident that was unavoidable. My conflict was the result of my lack of confidence regarding my position in the hospital's "food chain" – should I be loyal to the system, or can I still be loyal to myself and my belief in truth telling.*

2) In what manner did you cope with the dilemma?

*I haven't told the family the truth, but I have encouraged them to demand an explanation from the head of the department, hoping that he will give them a more elaborated answer.*

3) Who, if any, have you addressed or consulted with concerning the dilemma?

*I have not addressed anyone about my dilemma.*

4) In what ways can medical school help students cope with similar dilemmas?

- The "emotional processing" sessions we had, with fellow students and instructors from the staff.
- Teaching students how to back up colleagues – an issue that is not taught today, we only see how not to back up someone, especially in the surgical department.
Questionnaire no. 3

1) Describe a significant moral dilemma you personally had to cope with, as a medical student, during your six years of medical school.

*During my rounds in the surgical department, a patient that has been admitted for a simple laparoscopic procedure (cholecystectomy – gallbladder removal) has passed away in the post-operative period. This was a patient with whom I have done an admittance interview, as part of my practice in the ward, and I have done a full and thorough interview and examination, not like those usually done in the surgical ward, and as part of that I have checked the previous file of this patient and the indications listed in it for the surgery. To my opinion at the time, it was questionable whether or not she should be a candidate for such an operation. I have raised this question in front of a senior doctor, who has concluded that she is. Two days later I was called to help in a resuscitation and a only few minutes after I have started helping doing chest massages I have looked up at the patient and realized it was the same patient I interviewed a few days before. This patient died after a surgical procedure in which the complication rate is usually very low.*

2) In what manner did you cope with the dilemma?

*I have attempted to raise the question about the indication for the operation in this case, but it was a faint attempt. I haven’t really insisted upon understanding and arguing about the need to perform the operation.*

3) Who, if any, have you addressed or consulted with concerning the dilemma?

*I have talked with friends that were with me in the same ward.*

4) In what ways can medical school help students cope with similar dilemmas?

- Raising similar situations to student’s consciousness and reflecting the dilemma, debating about it.
- Inviting the students to attend medical ethical discussions that are taking place in the hospitals, as part of the routine in different wards (for example – mortality and morbidity meetings).
Appendix no. 3 – Students Interview Schedule

Introduction:
(a) Introducing the researcher, the study and the nature of qualitative-naturalistic research; (b) getting informed consent for the interview; (c) discussing confidentiality issues; (d) introducing the procedures of the interview – taping and transcribing.

The interview:
1) Describe a significant moral dilemma you had encountered in medical school.
2) How do you regard 'practicing' [acquiring experience through procedures performed on patients – E.B.] from an ethical prospective?
3) How do you regard 'silence' [not reacting when witnessing un-ethical acts – E.B.] from an ethical prospective?
4) Describe, or map, the process of ethical training in medical school (stages, turning points etc.).
5) What steps had been undertaken by the medical school faculty members in relation to students' ethical reality and moral issues?
6) What could or should have been done in medical school concerning ethical issues?
7) Imagine yourself fifteen years from now, as a senior physician, what would you do concerning your students' ethical reality?
8) Can you think of a title that highlights the ethical process of medical students?
9) Is there perhaps another aspect this interview did not cover and can help my understanding of the subject? Is there anything else you would like to add?
Appendix no. 4 – Faculty Members Interview Schedule

Introduction:
(a) Introducing the researcher, the study and the nature of qualitative-naturalistic research; (b) getting informed consent for the interview; (c) discussing confidentiality issues; (d) introducing the procedures of the interview – taping and transcribing.

The interview:
1) What are, to your opinion, the moral dilemmas the students reported in their interviews?
2) What steps are undertaken by medical school staff members in relation to students’ ethical reality and moral issues?
3) I have with me an example of a moral dilemma taken from an open questionnaire presented to a student. Please take a moment to read this dilemma, and share your thoughts with me.

"During my rounds at the Obstetrics and Gynecology department I was visiting a peripheral clinic, accompanying a physician. After the physician examined one of the patient's at our presence (two male students), he asked me to examine her. Since the woman (who didn't have any specific findings, and came to the clinic for the insertion of an IUD), started to show signs of emotional distress, I have examined her quickly. That was my understanding of the appropriate examination at the point. The physician did not approve of my examination, and he scolded me and instructed me to continue the examination, keeping my fingers inside her pelvis, while he lectured me about the importance of a thorough examination and stating that "it is really not so awful for the patient" (Anonymous)
4) How do you regard 'modelling' [teaching through role-models – E.B.] as part of ethical education?

5) What could or should be done in medical school concerning ethical issues?

6) Is there perhaps another aspect this interview did not cover and can help my understanding of the subject? Is there anything else you would like to add?
Appendix no. 5 – Charts and Tables

List of Charts:

Chart no. 1:  The conceptual framework of the present study................................. p.13
Chart no. 2:  The ‘responsibility continuum’ typology of medical students’ moral
dilemmas....................................................................................................... p.119

List of Tables:

Table no. 1:  Copping with major problems and challenges of qualitative analysis..... p.92
Table no. 2:  The relation between students' thematic categories, data sources and
research questions......................................................................................... p.100
Table no. 3:  The relation between faculty members' inclusive categories, data
sources and research questions................................................................... p.101
Table no. 4:  Persons with whom medical students consult about ethical dilemmas... p.128
Table no. 5:  Students' suggestions and recommendations to continue existing
ethics education in medical school.............................................................. p.167
Table no. 6:  Students' suggestions and recommendations for new topics to be
added to the future curriculum of medical school................................. p.168
Table no. 7:  Students' suggestions and recommendations for future establishment
of new ethics-related bodies in medical school................................. p.168
Table no. 8:  A summary of the students' suggestions and recommendations for
future improvement of ethics education in medical school........................ p.171
Table no. 9:  The relation between 'Discussion' sections, research questions and
'Findings'' categories.................................................................................. p.204