# 5 BIOETHICS AND PROFESSIONALISM AT THE IMU

*Sivalingam Nalliah, Winnie Chee, Nazimah Idris, Wong Chin Hoong, Muneer Gohar Babar, Verasingam Kumarasamy, Haider Abdulameer Al-Waeli, Vasudeva Challakere, Syed Imran Ahmad, Alexius Cheang and Sheba DMani*

## 5.1 Introduction

This chapter provides insights on the strengths and weaknesses on the teaching and assessment of professionalism and bioethics in the IMU. Strategies are suggested on how to enhance professionalism in all stakeholders in the organisation and to align with the core values which are enshrined within the acronym TRUST: trustworthy, responsive, unity, service, and tenacity. The core values are central to the IMU and linked to the vision and mission of the organisation.

### *5.1.1 A Glossary of Definitions*

For the purposes of this document, the following definitions need to be clarified:

**Ethics:** The field of ethics (or moral philosophy) involves systematising, defending, and recommending concepts of right and wrong behaviour (Anscombe, 1981).

**Medical ethics:** The term "ethical" is used to refer to matters involving (1) moral principles or practices and (2) matters of social policy involving issues of morality in the practice of medicine. The term "unethical" is used to refer to professional conduct which fails to conform to these moral standards or policies (American Medical Association, n.d.).

**Bioethics:** Bioethics is a relatively new word coined by the biochemist Van Rensselaer Potter in 1970 to draw attention to the fact that the rapid advances in science had proceeded without due attention being paid to values. The word bioethics, using two Greek words, *bíos* – meaning life – representing the facts of life and life sciences, and *éthos* - meaning morals – referring to values and duties (Potter, 1971). Bioethics should not be confused with medical ethics, which is only one of its branches.

The field of bioethics is as wide as the facts of life, and its study is divided into many branches, each one with its specificity: Ecological or environmental bioethics, Medical bioethics, Clinical bioethics.

The idea of Potter, and in general of bioethics, is that not all that is technically possible is morally right, and that some control of our intervention in nature and the environment, on animals and on human beings, is needed. Global bioethics is bioethics involving all actual human beings, future human beings and all living organisms and the environment.

**Professionalism:** Professionalism refers to the conduct, aims, or qualities that characterise or mark a profession or a professional person.

**Medical professionalism:** Refers to the conduct, aims, or qualities that characterise or mark the profession of medicine or a medical professional. The project 'Medical Professionalism in the New Millennium: A Physician Charter' defines professionalism as the basis of medicine's contract with society (Medical Professionalism Project: ABIM Foundation, 2002). 'It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession'. Professionalism is, therefore, directly related with ethics. Its ethical expression is called Professional Ethics.

### *5.1.2 Professionalism Defined*

The healthcare profession in its entirety has been called to address the challenge of how it defines itself. The

challenge of defining what constitutes its profession, i.e. professionalism, has seen intense debate for some time. The World Medical Association has issued several statements pertaining to bioethics over the last 35 years. The American Board of Internal Medicine (ABIM), Society of Academic Emergency Medicine, the Accreditation Council on Graduate Medical Education (ACGME), American College of Physicians and American Society of Internal Medicine (ACP-ASIM), the General Medical Council (GMC), the Royal College of Physicians (RCP) and the European Federation of Internal Medicine (EFIM) have tried defining professionalism (ABIM, 1994; 2002; Van Mook et al., 2009; GMC, 2013; RCP, 2005; Kirk, 2007).

Van Mook *et. al.* (2009) defined medical professionalism as "the ability to meet the relationship-centred expectations required to practice medicine competently." The RCP defined medical professionalism as a set of values, behaviours, and relationships that underpin the trust the public has in doctors – this definition, they assert, can apply to other healthcare professionals as well (RCP, 2005). The King's Fund (Rosen & Dewar, 2004) called for professionalism to put patient's interests back at the centre of care. They also assert that stakeholder parties should be facilitated to have open and responsive discussion regarding professional standards relevant to prevailing values and expectations. Meanwhile, the Picker Institute Europe looked at patient-centred professionalism, which they defined as "doctors fulfilling their changing (and in some cases unchanging) roles in ways which coincide with changing (or unchanging) patient roles, as well as working with patients and others to see whether areas of conflict can be eased" (Askham & Chisholm, 2006). The well-known Physician Charter (Medical Professionalism Project: ABIM Foundation, 2002) reiterates professionalism on three principles: primacy of patient welfare, patient autonomy, and social justice and ten responsibilities: professional competence, honesty, confidentiality, appropriate relationship with patients, improving quality of care, improving access, equity, integrity of scientific knowledge, maintaining trust and managing conflicts of interest, and professional responsibilities. Society and the community stand to gain from ethical and professional practice.



### *5.1.3 Factors That Influence or Hinder the Evolution of Professionalism*

#### *5.1.3.1 The Changing Global Landscape*

The varied opinions on professionalism are probably a reflection of the changing global landscape. Events of recent years have seen widespread political instability, wars, and economic downturn. Healthcare provision is challenged with limited resources, rising costs, and an ageing population. Communicable diseases like HIV and AIDS, malaria, tuberculosis, influenza, and polio remain serious global concerns [World Health Organisation (WHO), 2009 & United Nations (UN), 2012]. There is an increasing emphasis on non-communicable diseases, e.g. cancers, cardiovascular diseases, chronic respiratory diseases, and diabetes (WHO, 2009; UN, 2012). Globalisation of mass media, urbanisation, industrialisation, increasing access to information, consumerism, and increased migration have contributed further to widespread changes in traditional cultural norms and expectations and changes in family dynamics (Sawyer *et. al*., 2012). Controversially, Epstein and Hundert (2002) highlighted greed as an underlying value contributing to this change.

Additionally, patient safety is increasingly important and well recognised publications from the Institute of Medicine have highlighted the scale of healthcare-related adverse events and their related consequences (Institute of Medicine, 1999). The World Alliance for Patient Safety (WHO, 2008b) showed the significant burden on mortality and morbidity from healthcare. Rising litigation is a

concern for many healthcare professionals, fuelled further by publicity of high-profile cases. Tighter regulation has been seen as a fitting response but some assert that self-regulation through professional bodies may give way for independent regulation (RCP, 2005).

Universal health coverage has been seen as essential to addressing the concerns above and allowing sustainable human and economic development (UN, 2012; WHO, 2009; Geoghegan, 2013; Ban, 2012). The WHO has called for an increasing focus on the adolescence stage of life as a pivotal period and a determinant of future health (Sawyer et al., 2012). At the same time, the United Nations put in place the Millennium Development Goals (MDG) that aim to eradicate poverty, improve maternal and child health, improve primary education, and reduce gender inequality. Such pressures have increased the desire for accountability and measurability, as well as evidenced-based output and pay-for-performance schemes in both developed and developing countries (Eichler & Levine, 2009). To this end, WHO has published a series of Health Reports looking at improving health systems financing (WHO, 2010), primary healthcare (WHO, 2008a), global public health security (WHO, 2007), the training of healthcare workers (WHO, 2006), maternal and child health (WHO, 2005), and global health risk reduction (WHO, 2002).

Healthcare research will also face many of the above challenges, initially to acquire new treatments and technologies, but also in the equitable and safe distribution of such treatments and technologies (Cash, Wikler, Saxena, & Capron, 2009). To this end, WHO will be publishing its World Health Report in August 2013 titled "Research for Universal Health Coverage?"

#### *5.1.3.2 The Changing Doctor-Patient Relationship*

Worryingly, the RCP in its 2005 report "Doctors in Society" highlighted the historically poor response the medical profession has been in adapting to societal expectations. Further, they asserted that many skills unique to individual professions are being redistributed or reassigned and healthcare has not been spared in this (RCP, 2005). Healthcare professionals have to redefine their roles within increasingly complex health systems and in interprofessional teams and can no longer function as individuals.

The traditional paternalistic doctor-patient relationship is making way for a relationship of equal standing that involves the patient in decision making based on evidenced based recommendations (Van Mook *et. al*., 2009). Cultural competence, empathy, good communication skills, aided by continuous professional development on the part of the professional have become essential elements in this relationship. Such a relationship builds patient satisfaction and trust. Further, it contributes to treatment adherence, and also minimises litigation and complaints (Hall *et al*., 2002; Rowley, Baldwin, Bay & Cannula, 2000). The relationship also facilitates the professional development of healthcare providers (Swick, 2000 & Van De Camp, Vernooij-Dassen, Grol, & Bottema, 2004).

In medical education, professionalism is now considered a competency and no longer part of the "hidden" curriculum, but formally and explicitly learnt as an integral part of the curriculum (Wear & Kuczewski, 2004). Most advocates agree that personal characteristics such as altruism, empathy, accountability, excellence, duty, honour, integrity and respect for others need to be taught as they are vital in professional practice. Such soft skills are no longer considered part of the "hidden" curriculum (American Board of Internal Medicine, 2002, Wear & Kuczewski, 2004).

#### *5.1.3.3 Formal Standards of Professionalism*

Codes of conduct established by international organisations and local regulatory authorities like the Malaysian Medical

Council become measures of the standards of care. Such standards are normally visible to the public.

## 5.2 Role of Humanities in Medicine and Patient Care

Since antiquity, the doctor's basic toolkit comprised "the herb, the knife and the word" (Benjamin, 1984). With the advancement of technology, doctors have favoured medication and treatment procedures over the art of communication. The 'word' by the doctor, which is sorely needed by patients, is often not uttered or even carelessly spoken. The 'word' by patients, which requires listening, is often brushed aside by overwhelmed or sometimes uncaring doctors. The humanities are a study of human thoughts and experiences and involve inquiry into consciousness, values, ideas, and ideals that shape our understanding of the world. Its role is to develop and support the fulfilment of the goals of medicine (Evans, 2002).

Gordon and Evans (2010) have suggested several outcomes for the humanities:

- Help learners to develop skills in interpreting experiences
- Opportunities for students to encounter and appreciate human diversity
- Nourish a wonder of embodied human nature and embodied consciousness, leading to medical care that is, in its essence, reverential
- Help students to develop personal values
- Encourage students to take experience and subjectivity seriously
- Enable medical education to move from technical training to a genuine university education
- Help students to draw from and appreciate the reflections of others
- Help students to develop communication skills

The inclusion of medical humanities within the medical curriculum has flourished in the USA, UK, Australia, and New Zealand over the past 20 years (Goulston, 2001). Recent reforms incorporate argument-based reasoning in medical ethics, narrative-based reasoning in literature, creative reasoning in the fine arts, and historical reasoning in learning from the past to uncover hidden assumptions and biases (Doukas, McCullough & Wear, 2010). Within the Asian region, there is no evidence of a formal programme for medical humanities in the medical curriculum.

### *5.2.1 Is IMU Ready for the Integration of Humanities?*

The IMU faculty participated in a survey to gauge the level of acceptance in integrating humanities modules in the curriculum. All programmes were represented but only 89 responses were received. Full details of the survey can be obtained on request. Overall, the majority felt integration would benefit their programme, improve students' effectiveness in caring for patients or clients, would value learning from the humanities, and accepted humanities as an important aspect of broader education.

From the 23 open responses, 46.42% had major concerns about the capability of the curriculum to include interdisciplinary studies due to credit overload. A small number also questioned the availability of trained faculty to teach the Humanities modules. The survey also collected information from first-year medical students on their orientation towards Humanities modules and received 79 responses.

### *5.2.2 The Way Forward*

The development of modern medicine and healthcare that has been dominated by science, technology and economics has been associated with the erosion of medical ethics in the traditional sense. This has in turn led to the rise and emphasis on biomedical ethics. The following are further challenges that will be faced in moving forward:

- To encourage leadership from various levels and expertise that will be accountable for promoting the humanities, convene a working group comprised of experts to plan and strategise the integration of humanities into the learning environment and develop modules that will be able to achieve the learning outcomes of health education.
- To ensure that all staff understand the vision and mission of the university, training on medical humanities should be provided.
- To ensure continuity and depth by developing a structured programme requiring students to complete assignments in humanities with a specific focus on topics related to ethics and professionalism over a 5-year period, and to compile a list of recommended books and films to be used in the learning of Ethics and Professionalism modules.
- Establish a narrative medicine programme
- To meet the vision of educating students to appreciate the value of caring, to meet the education philosophy of learning by doing and, to learn by serving the community.
- Engage in interprofessional learning research to identify ways students' learning can be facilitated and enhanced to enable confident transition to workplace.

### 5.3 Implementation of the Teaching of Professionalism and Bioethics in the IMU

The implementation of Professionalism and Bioethics (P&B) has occurred in the following ways:

- It is embedded in the curricula across the IMU. It is one of the eight domains in the IMU spiral curriculum.
- Workshops and an International Conference on Bioethics in 2013 has sensitised the learning of P&B in the IMU.
- Events like the White Coat Ceremony, involvement in Community and Family Case Studies (CFCS) and the IMU Cares projects have provided opportunities for students to improve their skills in this area.
- The adoption of the UNESCO Core Curriculum for Medicine has been accepted for delivery through incorporation into the existing curriculum
- The teaching has been formalised into the curriculum where the content, delivery and assessment methods are made explicit.
- The curriculum for P&B across the IMU is designed to align with the multiple roles that future healthcare professionals are expected to perform.
- The learning is stage and content specific. Junior students learn the fundamentals of P&B where the delivery methods are mostly via lectures, small group sessions and simulated clinical experiences. Senior students, learn advanced skills in authentic clinical situations. Different schools identify the specific competencies for the respective profession and design their curriculum accordingly. Across the IMU, interprofessional learning is being utilised to provide authentic professional experiences.
- As the IMU has outcome based curricula, P&B teaching cannot be a stand alone subject but needs to be threaded through contextual learning with incorporation of patient safety issues and medical law being integral to professional practice.
- Assessment is also stage specific, with higher orders of learning according to Miller's pyramid as student's progress. Where applicable, the 360 degree assessment is performed. The assessment is both formative and summative. Direct observation of behaviours and multisource feedbacks from faculty, nurse educators, peers and patients are among the methods used.

### 5.3.1 School of Medicine

During the first 5 semesters of the Medical Programme, aspects of professionalism and ethics are taught in the form of plenaries, case discussions and debates. Students are assessed through a written exam at the end of the semester. The curriculum content for Phase 1 has been criticised for focusing too much on the theoretical aspects of the subject. Students may not have the maturity to appreciate the significance of subjects discussed considering their limited exposure at this stage.

During Semesters 6 through 10, students follow the UNESCO Bioethics Module. Students are assessed through observation on their attitude and team working abilities, how they deal with criticism, communication skills, lifelong learning skills, humanistic values, empathy, and professional approach to patients. Log books, Objective Structured Clinical Examinations (OSCEs), student medical research, community service (IMU Cares), CFCS, and portfolio discussions are areas of further learning.

The contents of P&B from Semesters 6 to 10 are adequate and appropriate for this stage of their training. However, faculty members have to play a bigger role in the teaching and learning activities to guide and facilitate learning. Faculty must be competent in formative assessment and giving effective feedback. The following are the recommendations for the School of Medicine:

- Focus on more generic principles of P&B practice in Semesters 1 to 5 and learn specific/discipline-based issues in the clinical phase.
- To invite experts in medical ethics and law to deliver plenaries
- To have more case-based discussions (instead of plenaries) to promote students' participation. Clinical School faculty would facilitate the discussions.
- Faculty training to facilitate student's learning, give effective feedback, and be effective role models
- To incorporate humanities, medical law and patient safety issues appropriately.



### 5.3.2 School of Dentistry

The Dentistry P&B curriculum is an organised curriculum with learning outcomes and competencies spread throughout the curriculum. The School of Dentistry P&B curriculum is based on the American Association of Dentistry and Malaysian Dental Association principles of ethics and code of professional conducts. The curriculum is spread over 9 semesters. The Professional Practice Assessment is used as a tool to assess the students and helps them reflect on their strengths and weaknesses.

There are four qualities that have been covered in the P&B dentistry curriculum: (1) respect for human beings; (2) competency; (3) integrity; and (4) primary concern for service. The following are the recommendations for the School of Dentistry:

- P&B should be treated as a reasoned discipline in its own right and not simply as either abstract good heartedness or unquestioning devotion to code of conduct.
- The dentistry P&B curriculum should not be strictly theoretical, but based on the analysis of cases oriented to the delivery of healthcare and to the practice of dentistry.
- The enhancement of ethical decision-making skills should take place within the classroom and clinics. Discussion of specific cases encountered by students is beneficial in preparing students to reflect critically on their own practice.
- The IMU School of Dentistry learning curriculum should lead to graduates having a greater understanding and expanded experience in P&B, interpersonal

communication, respect and empathy as these relate to professional dental practice.

- Incorporating humanities into the undergraduate curriculum should lead to higher levels of postgraduate professionalism, increased patient trust, and stronger partnerships with our alumni.

### *5.3.3 School of Pharmacy*

P&B is implemented in the School of Pharmacy in the following ways:

- Symbolic Oath of Professionalism
- The Curriculum:
  - Specific Topics and Delivery Methods: Professionalism and ethics are introduced in B Pharm (Hons) programme from Semesters 1 through 5.
  - P&B is a core part of skill based teaching and learning activities e.g. Pharmacy Skill Development (PSD) sessions, OSCEs, practicals, extemporaneous dispensing, hospital and community placements etc.
  - Feedback on ethical and professional aspects is taken from preceptors during students' hospital and community placements. Similarly these aspects are assessed during various individual as well as group presentations.

### *5.3.4 School of Health Sciences*

The School of Health Sciences consist of programmes that are laboratory based (Medical Biotechnology & Biomedical Science), healthcare-related (Psychology, Nursing, Nutrition and Nutrition & Dietetics), and Complementary Healthcare (Chinese Medicine, and Chiropractic).

All the programmes teach a module of P&B delivered as plenaries with case discussions and presentations. Assessment takes place via end of semester written exams.

In the laboratory based programmes professional behaviour is assessed formatively during industrial placements and conduct of research. There is summative assessment in practical exams. In programmes where there is patient contact (Nursing, Dietetics with Nutrition, Chinese Medicine, and Chiropractic) professionalism and ethics are embedded in the clinical and hospital placement trainings. Assessments are then carried out formatively through observation of professional behaviour and through reflective diaries.

## 5.4 Results of the SWOT Analysis of Professionalism and Bioethics in the IMU

The authors performed a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis (Casebeer, 1993) on aspects of P&B in each programme in the IMU. Key findings from the analysis are summarised below.

- **Admissions** – perhaps lack of discrimination in P&B aspects in the admission processes. A more stringent interview process may be required. Some programmes inculcate P&B in the early stages e.g. white coat ceremony, oath taking ceremony, and peer mentoring.
- **Curriculum and Curriculum Delivery** – aspects of P&B are integrated but need faculty training, time, and buy-in. Training needs to be more contextual and relevant to real-life practice. Delivery methods vary between plenaries, small group teaching, portfolio learning and web resources. Delivery methods struggle for lack of facilitator skill, time and adequate role models. Some programmes struggle with poor student awareness and engagement, teacher-centered learning, and poor inter-programme interaction.
- **Assessment** – currently a mix of formative and summative assessments, but current methods do not reflect real attitude and behaviour. Faculty members lack the experience, expertise, and time to assess students

adequately. Assessment of this area is often given lower priority by students and faculty in place of other traditionally core areas.

- **Management Processes Where the Student is a Stakeholder** – most students are aware of processes within their curriculum and have the opportunity to provide feedback on their experiences. There are concerns about the transparency of the selection process for partner schools in some programmes.
- **Faculty Behaviour** – faculty members are good role models with few exceptions, but there needs to be greater awareness of aspects pertaining to P&B. Opportunities exist to appoint key faculty members to spearhead improvements in this area.

The authors also performed a survey looking at the teaching of bioethics and professionalism in the IMU. The full results are available on request. The following are the main findings from the respondents:

- Majority of respondents thought that teaching in P&B was absent in their respective programmes. There was variation on their perception of when and who delivered the teaching.
- Most respondents agreed the current curriculum is producing minor behaviour change and a more formal teaching programme was required. Most respondents (75%) have not accessed the e-learning resources available.
- 57% of respondents have not received any formal training in P&B (most are in Bukit Jalil), and those who had received training received it from workshops, seminars, and short courses.
- Responders felt their knowledge on bioethics was lowest in the areas of end-of-life care, human reproduction, substitute decision making, and resource allocation training. Only 22% of respondents felt confident about teaching P&B and 47% felt they were able to with additional resources.
- In terms of respondent's priority for more education, these were highest in research publication, learner-supervisor relationship, relationship with colleagues, justice, research ethics, responding to cultural differences, and assessment of capacity/competence.
- Most respondents were in favor of integrating humanities, but faculty were concerned about sufficient faculty members and training to successfully achieve this.



## 5.5 Institutionalisation of Professionalism and Bioethics into the IMU's Culture

### Action Plan

The concept of professionalism is intrinsically scientific, clinical, ethical and social. To institutionalise the culture of P&B within IMU, all stakeholders will have to play their role effectively, from the highest level of leaders to the ground level staff. The IMU Core Values serves as a useful guide for this purpose. The following are key areas to consider:

- For students, the teaching of P&B should be on the best evidence available.
- The P&B activities are to be spiralled through the whole period of their training.
- Use interprofessional learning to provide authentic clinical experiences.
- Define the roles of faculty members clearly and train them accordingly.To enable the faculty to play these roles effectively, strategies for faculty training and development need to be put in place. The institution can help by:
  - Developing a specific faculty development programme for this subject.
  - Establish a faculty evaluation programme with clear criteria for performance evaluation in this subject.

- Change the environment to support faculty roles (e.g. organisational development, curricular reform, clerical and technical support, research assistance and faculty reward system).
- Promote and facilitate the organising of IMU Cares projects.

## 5.6 The Way forward

The following are further challenges that will be faced in moving forward:

- **Faculty buy-in:** the results of the SWOT analysis showed that many of the faculty need to be trained further, particularly in the teaching and assessment of P&B.
- **Curriculum** – what is the best form of assessment? What is the ideal way to teach – lectures or clinical situations?
- Using inter-professional learning is challenging – bringing two different groups of students together is logistically difficult and discussions may not be relevant to all groups present.
- **Staff recognition** – should recognition be given for staff involvement in P&B?
- **Role Models** – finding the right role model within different disciplines; faculty from the IMU also come from different cultures around the world.
- **Faculty training** – difficulty in scheduling such training due to the vast amount of cross teaching involved, especially with the Teacher Information Management System (TIMS) that automatically schedules staff for their teaching and learning activities.
- **Student Recruitment** – currently only medical and dental students undergo an interview whereby they are presented with scenarios which test their decision making skills. This may soon be surpassed by the Multiple Mini Interviews. There is no comparable selection process for all other programmes in the IMU, should this change?
- How does one transform values to behaviour? How does one interpret a person's values based on their behaviour? It is impossible to know a person's true attitude based on their behaviour (or lack of it). The following are additional concerns that need to be appropriately addressed before implementation of teaching of bioethics in the IMU
- Who should be teaching bioethics to the faculty? Can an expert from one field teach other experts in other fields? Would the examples be applicable and consistent?
- Since each discipline has its own set of rules and regulations that govern the conduct of their members, are ethical standards of behaviour standardised across disciplines? Or does each discipline focus on different perspectives?
- **Monitoring and evaluation** – who should be monitoring the implementation of bioethics in the IMU curriculum and how can they assess whether the students are meeting the learning outcome?
- In addition, at what level should the implementation of bioethics be done? At the university, school, or department level? It is important to take into account the values and bioethics that differ across different professions. A one size fits all approach to teaching bioethics would not work.
- Engagement and transformation of graduates in ethical behaviour is a challenge the IMU faces. Current mechanisms do not permit evaluation of graduates of the IMU.

## 5.7 Conclusion and Recommendations

The challenges in teaching P&B are numerous but societal expectations are high as current professional-patient relationship necessitates the involvement of the patient (and community) in decision making. Each of the schools in the IMU has some form of P&B incorporated into the

curriculum. However, except for the School of Medicine, the Division of Nursing and School of Pharmacy there appears to be a need to develop more explicit contents that need to be incorporated into the respective curricula. The SWOT analysis clearly shows weaknesses in faculty training and expertise in delivery of P&B and recommendations for improvement are made. Apart from making the teaching of P&B explicit and implicit there appears to be a need to extend the inculcation of P&B to the corporate sector, healthcare facilities and support staff so that the culture of professionalism is infused throughout the university. Much progress has been made in providing opportunities to exhibit caring and humanism by way of formal classes, humanism awards and the various community projects that the IMU is involved through the IMU Cares. All stakeholders have to play integral roles in making the teaching and learning of P&B a success. This requires buy-in by all members of the IMU community and would be aligned to the IMU core values.

**Recommendations**

- The curriculum of all Schools will incorporate teaching of P&B from the beginning of the course and adopt strategies that would result in transformation of graduates who adhere to societal expectations of being professional and ethical in practice.
- Schools that have discrete modules as part of the curricular need to look at a broader perspective for sustained effects on the graduate.
- The contents of the UNESCO Core Curriculum for medical programme should be used for content development; units that have commonality and are relevant to alignment with the core values of the organisation should apply to other health related programmes.
- Core values need to be internalised through existing opportunities and encounters.
- The development of expertise in teaching professionalism, bioethics, humanism, medical law, and patient safety is required through formalised programmes. The training of bioethics should be compatible with local societal and cultural values, and not limited to what is deemed to be accepted international values.
- The establishment of a chair for the teaching of P&B needs to be considered for continued dynamism. A core group of experts need to be trained and licensing should be considered by the IMU's Centre for Education (ICE).
- Development of a 5-year plan: Based on literature review of programmes that have successfully implemented ethics training, it is prudent not to 're-invent the wheel' but instead learn from the experiences of others in developing a 5-year plan of implementing a standardised bioethics curriculum. Hinman (2009) presented a grid that can serve as a framework that shows how centralised ethics courses can be built upon within the curriculum to ultimately incorporate community outreach and volunteerism among students for real-world application.
- n addition, the framework by the Teaching of Engineering Ethics Working Group outlines an ethics curriculum map that lists four different levels of increasing complexity and focusses along with the suggested learning outcomes, content and processes in order to implement a workable ethics curriculum. These frameworks can serve as possible templates for the implementation of the teaching of bioethics here in the IMU. Nevertheless, the previous issues raised in this section should be addressed as much as possible first in order to be clear about the outcomes that are realistic and achievable.

## 5.8 References

American Board of Internal Medicine (ABIM) Project Professionalism, 2002. Retrieved from www.abimfoundation.org

American Board of Internal Medicine. Professionalism in Medicine: Issues and Opportunities in the Educational Environment (Philadelphia, American Board of Internal Medicine), 1994.

American Medical Association (n.d.). AMA's Code of Medical Ethics. Retrieved from: http://www.ama-assn.org/

Anscombe, E. Ethics, Religion and Politics. Oxford: Blackwell, 1981.

Askham, J & Chisholm, A. Patient-Centred Medical Professionalism: Towards an Agenda for Research and Action. Picker Institute Europe, 2006. Available on www.pickereurope.org

Ban, Ki-moon. The Secretary General's Five Year Action Agenda. United Nations. 25 January 2012. Available on www.who.int
Benjamin, WW. Healing by the fundamentals. New England Journal of Medicine, 1984; 311(25), 595-597.

Casebeer, A. Application of SWOT analysis. British Journal of Hospital Medicine 1993; 49(6), 430-431.

Cash, R, Wikler, D, Saxena, A & Capron, A. Casebook on Ethical Issues in International Health Research World Health Organization, 2009. Available on www.who.int

Doukas, DJ, McCullough, LB & Wear, S. Reforming Medical Education in Ethics and Humanities by Finding Common Ground with Abraham Flexner. Academic Medicine 2010; 85(2), 318-323.

Eichler, R & Levine, R. Performance Incentives for Global Health: Potentials and Pitfalls. Center for Global Development. Washington, DC: Brookings Institution Press, 2009.

Epstein, R & Hundert, EM. Defining and Assessing Professional Competence. Journal of the American Medical Association 2002; 287(2), 226-235.

Evans, M. Reflections on the humanities in medical education. Medical Education 2002; 36(6), 508-513.

General Medical Council Good medical practice, 201. Retrieved from www.gmc-uk.org

Geoghegan, T. Post-2015: Framing a New Approach to Sustainable Development. Independent Research Forum., 2013. Available at: www.sustainabledevelopment.un.org

Gordon, JJ & Evans, HM. Learning Medicine from the Humanities, in Understanding Medical Education: Evidence, Theory and Practice (ed. Swanwick, T.), Oxford, UK: Wiley-Blackwell, 2010. DOI: 10.1002/9781444320282.ch6

Goulston, SJM. Medical education in 2001: the place of the medical humanities. Internal Medical Journal 2001; 31(2), 123-127.

Hall MA, Zheng, B, Dugan, E, Camacho, F, Kidd, KE, Mishra A & Balkrishnan, R. Measuring patients; trust in their primary care providers. Medical Care Research and Review 2002; 59(3), 293-318.

Hinman, LM. Implementing Ethics Across the Curriculum [Powerpoint slides], 2009. Retrieved from: http://ethics.sandiego.edu/Presentations/EAC/Tokyo/Implementing_EAC.pdf

Institute of Medicine. To Err is Human: Building a Safer Health System. National Academy of Sciences. Washington, DC: National Academy Press, 1999.

Kirk, LM. Professionalism in medicine: definitions and considerations for teaching. Proceedings (Baylor University Medical Center) 2007; 20(1), 13–16.

Wear, D & Kuczewski, MG. The Professionalism Movement: Can We Pause? The American Journal of Bioethics 2004; Volume 4, Issue 2.

Larkin GL. Mapping, modeling, and mentoring: charting a course for professionalism in graduate medical education. Camb Q Healthc Ethics 2003; 12:167-77.

Medical Professionalism Project: ABIM Foundation. Medical Professionalism in the New Millennium: A Physician Charter. Annals of Internal Medicine 2002; 136(3), 243-246.

Potter, VR. Bioethics: Bridge To The Future. New Jersey: Prentice-Hall, 1971.

Rosen, R & Dewar, S. On Being A Doctor: Redefining Medical Professionalism for Better Patient Care. King's Fund, 2004. Available at: www.kingsfund.org.uk/publications

Rowley, BD, Baldwin, DC Jr, Bay, RC & Cannula, M. Can Professional Values be Taught? A Look at Residency Training, Clinical Orthopaedics & Related Research 2000; 378: 110-114.

Royal College of Physicians of London Doctors in Society: Medical Professionalism in a Changing World. Report of a Working Party, 2005. Available at: www.rcplondon.ac.uk

Sawyer, S, Afifi, RA , Bearinger, LH., Blakemore, S, Dick, B, Ezeh, AC & Patton GC. Adolescence: a foundation for future health; The Lancet, 2012; 379, Issue 9826: 1630-1640. doi:10.1016/S0140-6736(12)60072-5.

Swick, HM. Toward a Normative Definition of Medical Professionalism. Academic Medicine 2000; 75(6): 612-616.

United Nations. Resolution Adopted by the General Assembly A/Res/66/288*: The Future We Want. United Nations Conference on Sustainable Development, 2012, Rio +20. Available at: www.un.org

Van De Camp, K., Vernooij-Dassen, MJ, Grol, RP & Bottema, BJ. How to Conceptualize Professionalism: A Qualitative Study. Medical Teacher 2004; 26(8), 696-702.

Van Mook, WN., de Grave, WS., Wass, V, O'Sullivan, H; Zwaveling, JH, Schuwirth, LW & van der Vleuten, CPM. Professionalism: Evolution of the concept. European Journal of Internal Medicine 2009; 20(4), e81–e84.

World Health Organisation. The World Health Report – Reducing Risks, Promoting Health Life, 2002. Available at: www.who.int

World Health Organisation. The World Health Report – Make Every Mother and Child Count, 2005. Available at: www.who.int

World Health Organisation. The World Health Report – Working Together for Health, 2006.
Available at: www.who.int

World Health Organisation. The World Health Report – A Safer Future: Global Public Health Security in the 21st Century, 2007. Available at: www.who.int

World Health Organisation. The World Health Report – Primary Healthcare: Now More Than Ever, 2008a.
Available at: www.who.int

World Health Organisation. Summary of the Evidence on Patient Safety: Implications for Research. World Alliance for Patient Safet, 2008b. Available at: www.who.int

World Health Organisation. Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks, 2009. Available at: www.who.int

World Health Organisation. The World Health Report – Health Systems Financing: The Path to Universal Coverage, 2010. Available at: www.who.int