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WEB PAPER

The anatomy and physiology of conflict in medical education: a doorway to diagnosing the health of medical education systems

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ABSTRACT *This qualitative study uses data from students, teachers and administrators to deepen our understanding of conflict in medical education, its nature and its consequences. It especially looks at systemic issues which may foster or hinder the health of an educational system or of any organization. Its intention is to provide better understanding of the medical education system so that this knowledge can be used to enhance the health of future medical education systems. It is preliminary to a study that would focus on ways of improving the healthiness of future systems. The findings underline the importance of moral education in the training of our future physicians (McWhinney, 1986). The importance of example by faculty and staff and moral development of the physician flows from the authors' data and their interpretation of its meaning. Also, it further underlines the importance of faculty and medical educators modeling both caring and exemplary moral behavior within our educational institutions. Bandura (1986) developed the notion of modeling and showed that, 'even at a preconscious level, we learn moral behaviors through observing and imitating authority figures and/or significant others' (Crysdale, 2006). This is especially important because caring, or compassionate presence, is so essential to healing.*

Practice points

- This paper discusses interviews with medical learners, educators and administrators and is part of a large interdisciplinary study on conflict in professional education.
- The authors found that studying how conflict is handled is a doorway to understanding medical education as a system.
- In some instances, learning can be experienced as painful and dangerous, leading to a culture of fear rather than one of caring.
- Markers of health of the medical education system are described, and include realistic expectations, transparency, natural justice, participation, direct and clear communication, and discussion of the moral implications of behaviors.

Introduction

A major impetus in the caring professions involves teaching students how to care for others. In a recent study on conflict in the helping professions that included medicine, education, nursing and social work, it was found that the teaching system students experience is at times not one of caring. In medicine, such a lack of caring within the teaching system may be hidden from view, often both from a teaching–learning perspective and from a professional one. This evokes the question 'Can an educational culture which is not compassionate and caring produce compassionate practitioners?'

While this study is about conflict in educational systems, our probing has provided a look at the very nature of conflict, what underlies it, how it is manifested within systems and how insidious it can be.

We focus on the question 'What is conflict within the medical education system?' We make no attempt to address the question 'Is the phenomenon of conflict as we have described in this paper present in any specific educational program?' Nor, 'To what extent are the phenomena discussed in medicine generally?' As a result of this study, however, the reader will be better equipped to recognize when conflict is the symptom or result of an insidious process, enabling a more constructive approach when conflict occurs. This enables a person to take preventive measures. It is a qualitative study, and any efforts at generalizability must take into account the low response rate. The full study involves interviews in four disciplines: education, medicine, nursing and social work, but this paper will focus on the findings in medicine. Based on these data, we will form tentative hypotheses on the nature of conflict in the medical education system. While our data are qualitative in nature,

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the underlying philosophical assumption is that of critical realism (Lonergan, 1958, 1972, 1993).

Lonergan claims that human consciousness is divided into distinct types of operations, which occur spontaneously to yield cumulative and progressive results. First is experience, which is the data of our senses or from consciousness itself (memories, images, knowledge gathered through trusting others etc.). This experience is the matter with which two further types of operations are engaged. First, through questions for understanding, an individual comes to discern some intelligible, coherent pattern in the evidence at hand. Beyond questions for understanding there is the innate quest to understand accurately. This involves making judgements amongst the array of possible explanations discovered in the data. Based on the empirical grounds for the experience at hand or held in memory, some explanations are ruled out. If enough evidence is available so that further questions we have on the matter dry up, we can determine clearly what the answer is (Crysdale, 2006). The authors invite the reader through the same process as they respond to the questions that arise in them as they reflect on the data we present in this paper and weigh our interpretations in light of their own experience and understandings.

Recognizing the openness of our method to new data, we present an initial attempt at theory building based on our findings. We are not seeking to present solutions but rather a clarified view of conflict, its impact on the experience of the subjects in this research project, and what we postulate the different patterns of experience may mean with regard to the health of a given medical education system.

Method

An invitation was sent to approximately 100 students in their final year of medical school. Six students responded that they were willing to be interviewed. This is not surprising given the nature of the topic. While the research plan was to interview the preceptors and administrators with whom the student had experienced conflict, the students declined to provide the names of their supervisors. While this strategy of asking students to provide the names of their preceptors worked well in nursing, social work, and education, none of the medical students felt comfortable approaching a preceptor or allowing the researchers to approach the preceptor with whom the student had conflict. The emotional reactions of some of the students to the suggestion of approaching their preceptor, and their obvious reticence to do so, we as researchers subsequently interpreted as a finding in itself. We therefore approached three experienced teachers who also have considerable experience as preceptors to provide us with their perspectives. All three agreed to be interviewed. Those who chose to respond were informed of the nature of the study, and were provided with a standard consent form, which they completed. A series of interviews was then conducted. One student was interviewed three times, three were interviewed twice and two were interviewed once. Themes were identified from these narratives. Completely new narratives were then created that captured the themes found in the initial analysis but now conveyed in a fictional story. Identifying features were removed. A focus group was then conducted by a member of the same profession as the participants but with new participants, with representation from each triad of student, teacher and administrator. This paper cites the narrative from that focus group. We believe that the issues raised by the focus group reflect those in the initial interviews, which we believe would not add to the discussions presented in this paper.

Background

We often have very high expectations of the physician or student physician. The enculturation of a physician is very stressful, as we would imagine. Stress derives not only from the job itself but, for the student, from ongoing evaluation by the preceptor or teacher. The ubiquity of evaluation, regardless of content, introduces stress into this relationship. The possibility of bias amongst all concerned is an ongoing reality. When conflict occurs, the parties involved often reach out for support from a third party. When an alliance is formed with one of the conflicted parties, a relational 'triangle' forms. This triangle may help to perpetuate the conflict. If a person in authority is triangulated, the third party is at high risk. Rather, a 'de-triangulating' approach is required. Other teachers may also be triangulated, and both students and teachers often feel that they are not getting the support they need. When conflict leads to winners and losers, and power is uneven, the potential for personal harm is real, presenting both personal and professional challenges. Indeed, the stresses involved within the medical education system at times result in serious illness, and even suicide (Earle & Kelly, 2005). Interpersonal conflicts within medical communities can lead to hostile relationships and even violence. Homicide has resulted. For instance, a physician is serving time in prison for murdering a colleague here in Alberta.

Medical education has been compared to an abusive and neglectful family (McKegney, 1989). Let us now examine the evidence for this assertion. The quotations cited in this article emanate from the focus group, which involved several administrators, a faculty-teacher (preceptor), and a resident (student who has recently graduated from medical school).

The data

Challenges for the student

(1) *Unrealistically high expectations.* While all professions have high standards and expectations of students and members of the profession, medicine places the bar extremely high. As one resident described it, there are expectations of being 'godly'. And this creates a culture in which error is shameful and unwelcome. This attitude becomes clear in a discussion between an administrator and a resident:

> Administrator: Maybe we're supposed to be different or something.
> Interviewer: What are we supposed to be besides different?
> Resident: Godly.
> Administrator: We don't talk about our errors . . . . And we're starting to create a culture of supporting talking to each other about our errors, because if you start talking about it, all sorts of interesting stuff comes up. And people feel, they look around the table and say, that happened to me. Wow! This is

> happening to all of us, but we don't talk about it. We're starting to talk more about patient safety, maybe then we can start talking more about conflict as well.

(2) *Stress.* Stress is certainly a factor in all forms of professional education. Medicine could be considered to have added stress because health and life itself may be at stake or serious harm may occur. The relationship with patient or student requires full attention and 'presence'. By presence we mean caring attentive listening (Westley, 1996; Sawa, 2004). When healing is an expectation of the encounter, the challenge is even more acute. The challenge of being present when faced with illness and disease requires healthy emotions from students and teachers. This is not always possible, as reflected in the words of the following participant:

> Administrator: Well, I think medicine, from being a medical student, through to clerkship, to residency, is very stressful. I mean, you're stressed all the way along, [in the process] learning a hell of a lot of knowledge and skills. And clerkship? Taking on more responsibility. And dealing with a different population. It can be really difficult. In residency . . . stress, it seems to me, leads to fatigue. It leads to bad judgment, it leads to conflict, because your mood changes. You're not as happy as you used to be. You're more confrontational, you're more argumentative. And then the system itself . . . it's not very user-friendly.

(3) *Competition.* Rivalry has become endemic in our culture (Girard, 1961, 1979, 1986, 1987). In the medical education system, as with the entire university, student competes with student, faculty person with faculty person. One of the participants in the study stated:

> Administrator: As soon as you have competition, you have the breeding ground for conflict between teachers and students, because they will always argue against their grades.

(4) *Evaluation.* Evaluation of the medical student or resident is often a source of tension and conflict. As one senior administrator put it:

> Second Administrator: At one moment you're helping, open, friendly, communicative. And then you have to fill in the report about that student, which puts you both in conflict. And it would be so much easier if the student could see you as a coach. You're both going together against the world record in kayaking or something. You're cheering on the student. You're not judging that student on what you taught him. And I think that's a very difficult role to play, and judge the performance.

(5) *High stakes.* The stakes are exceedingly high in all professional education, but from what we see from this study, they are particularly high in medicine, perhaps because of the potential disastrous results when life and death are at stake. The impact on both student and teacher can be devastating:

> Administrator: Worse than an ulcer, I mean if the student gets strung out or threatened, it can lead to suicide, breakdown. I mean it's often, you don't think about this until you see a student who's broken down.

Does medical education sometimes actually hinder, rather than foster, the development of caring and compassion amongst students? And if the answer to this is 'yes', we must go further in asking 'Can we teach caring in teaching systems that often do not display caring?'. The end result may be the opposite of what we are trying to produce. Students may develop excellent technical skills, but lack the motivation to care. Students may actually regress in altruism as they move through the medical education system.

(6) *Learning as painful and dangerous.* The intensity of feeling in the medical education system cannot be overestimated. A resident expresses her feelings as a member of a student/preceptor group while on rounds in the hospital:

> Resident: I felt like I touched a hot flame. I felt maybe somewhat attacked, because I didn't have any chance to . . . express to them why I thought that . . . why I thought that should be in the differential [diagnosis]. And you know, prove why I thought that. And as soon as it came out of my mouth, it was like a hammer came down on my toe, you know?

(7) *A culture of fear.* Emotions are responses to areas of vulnerability in which we have suffered or might suffer harm (Nussbaum, 2004). The sense of danger mentioned above can generate fear in those who are vulnerable. Our study has shown that both student and teacher can be vulnerable:

> Resident: I guess I must have been afraid of that preceptor, and didn't want to talk to them again . . . . There's a big power dynamic between the residents and the staff. And so, if I feel threatened, then I feel afraid.
> Faculty: What was it, you said you were afraid, what were you afraid of?
> Resident: Being yelled at again, maybe.
> Administrator: But that raises up a lot of anxiety, and like Fred [pseudonym] said, you know, these people are in the top 1%. You're going to come through medical school and every grade, being high achievers. And they've been right and they've had good marks and they've had praise heaped on them. And now you're in this situation where you feel like you're at the bottom of the ladder again. How do you slowly climb that? And it's a scary journey and so to have to constantly every day be on the lookout for even more opportunities to feel belittled, is very tiring and [you] can start to feel wounded after a while and it really takes its toll in confidence.

Lack of confidence can interfere profoundly with an ability to be present in a caring way. The mind can be too cluttered with self-doubt to be relaxed and in the present moment with the patient.

The culture of medical education

(1) *Secrecy and demoralization.* Medical education can be personally challenging, both spiritually and morally. We are persons because we are in relationship with others

(MacMurray, 1979) and because we exercise choice. The medical education system is isolating:

> Isolation within medical education begins early. In undergraduate school, 'Pre-meds' take courses designated as prerequisites for their future careers rather than pursue a course of study. At first, this 'differentness' feels like 'specialness,' but it can deepen into a profound sense of isolation during the trials of medical school and postgraduate training . . .. Medicine's isolation is systemic, a result of physician's choices and the culture within which they are imbedded. When they avoid interactions with other disciplines, they espouse distrust of others' values; teachers of medicine behave like parents in an inbred family—reflexively defensive. (McKegney, 1989, pp. 454–455)

Extreme stress, as well as a culture of silence, can lead to moral regression (Bird, 2002). For some it becomes a culture of fear, an environment in which feelings are not well understood or reflected upon:

> Many writers have suggested that residency training, particularly internship, is unnecessarily arduous. It is certainly painful, resulting from neglect of physical and emotional needs. (McKegney, 1989, p. 453)

The most striking feature of emotional neglect or abuse in the medical education setting, compared with the other helping professions, is that it is for the most part denied or veiled in secrecy. It is like a secret in the family. And secrets can become toxic, as reflected by the following participant:

> Resident: I think there's a lot of black boxes. Because there's so much, individual, you know, pockets of activity. It's not very transparent because there are so many pockets of it today. How would you really look into it? And I think, I think that . . . like there are times when things are investigated . . . and then things become uncovered, and they become transparent. But I don't think they start out that way. I think things start out covered up as black boxes and most often these things don't get investigated because it's a lot of work to investigate.

McKegney lists denial, along with unrealistic expectations, dysfunctional communication patterns, rigidity and isolation, as the major dysfunctions in the medical education system (McKegney, 1989). Denial is the red flag identifying the addictive organization. Given the work involved in investigating often complex situations, as mentioned above, avoidance may also play a role:

> The addictive system operates from the same characteristics that individual addicts have routinely exhibited. The major defense system of the addictive system is *denial* which supports a closed system. (Schaef & Fassel, 1990, #657, p. 62)

> The major characteristics of the addictive system include confusion, self-centeredness, dishonesty, perfectionism, and ethical deterioration. Other characteristics include crisis orientation, depression, stress, abnormal thinking process, forgetfulness, dependency, negativism, defensiveness, projection, tunnel vision, and fear. (Schaef, 1990, #657)

Discussion of issues that raise awkward or negative emotions, especially anger (an emotion which can be rooted in either emotional abuse or injustice), tend to be avoided. As we know, suppressed anger may be expressed in passive aggressive behavior. Communication then becomes indirect or masked (Sawa, 1985). The expression of an appropriate degree of anger, when it is rooted in the perception of being unfairly treated, is healthy. Emotions signal to ourselves and others the value to us of what we are discussing or thinking about. Fear of humiliation or judgment may make a person perceive the culture of medical education as unsafe. Emotions are kept locked up inside if possible. People become defensive. The cost of secrecy and lack of transparency affects both sides in a conflictual situation. Authority may fear reprisal in the form of poor evaluations from the student or even a counter-attack through the structures in place within the system, if there are any. Without transparency, authority is more easily abused. People may be treated disrespectfully. The principle of respect for persons as guiding moral behavior, while it seems to be common sense, is the highest stage of moral development, and is believed to be attained by only a few (Kohlberg, 1984). It requires a moral 'conversion' to an entirely new horizon (Crysdale, 2006). Yet such moral development is critical in the demands of being a physician and healer:

> The basic principle underlying health care ethics is respect for the dignity of each human person. In recent history this principle has been acknowledged and enshrined in law as the fundamental basis of all codes of individual human rights. This dignity is based on the spiritual uniqueness of each of us as persons. (Catholic Health Association of Canada, 1991)

When discussion of difficult issues is routinely avoided, especially those with moral implications, the consciences of those in the environment are weakened (Bird, 2002). Even in our focus group, participants found themselves skirting round the difficult issues and trying to focus on solutions before the problem itself was clear:

> Administrator: But we're not talking directly about conflict [in the residency]. Probably the closest we've come is talking about patient safety. And sharing our experiences in patient safety by . . . bringing up some conflicts. But I know residents talk among themselves a lot about conflict, and some of them come to me and talk about conflict. But we don't talk about it in a formal sense.

In the event that the uncomfortable issues are not discussed between concerned parties but rather behind the back of the third party, if ever, inter-personal triangulation spreads throughout the work environment (Sawa, 1985). Third parties are drawn into conflict between two others by siding with one or the other. These triangles create often hidden alliances which are unhealthy. Repression may also occur, contributing to the denial in the system.

Table 1. Some suggestions for maintaining a healthy education system.

(a)	Avoid secrecy and lack of transparency
(b)	Ensure due process
(c)	Be thorough in data gathering
(d)	Review policy regularly
(e)	Reflect periodically on the morality of the system. Is it fair? Respectful? Empowering of individuals? Inclusive?
(f)	Minimize threat, confrontation and fear
(g)	Make respect for persons a central feature
(h)	Those with power should strive to de-triangulate those in conflict
(i)	Discourage gossip, encourage direct communication
(j)	Do not remain silent when others are treated unfairly
(k)	Use specific examples to document concerns in a manner that the student (or faculty) can clearly understand
(l)	Discuss expectations at the outset of educational experiences
(m)	Ensure resources are in place to help prior to negative feedback
(n)	Install a student and faculty development position to act as ombudsman
(o)	Provide a forum at which the student (or faculty) has an opportunity to know what the complaint is and the opportunity to respond
(p)	Make moral development part of the curriculum along with ethics

(2) *Clashing styles for learners and teachers*

> Resident: And I think it depends on the faculty and the safety of the relationship. I think that there's different types of preceptors, [some] that are coaches. I think each preceptor develops their own style. Some of them will conform more to the coach, some will conform more to the judge . . .. I think if you feel that the preceptor is constantly judging you and not coaching you or vice versa, I think that it can get very muddled up and . . . the communication suffers.

Poor communication is a feature of a work environment in which moral muteness flourishes. Gossip replaces direct communication between those who should be, but are not, talking. Gossip triangulates people and can mystify the situation. People's reputations can be destroyed.

(3) *Politics and policy.* From an administrative view, the criterion for action may be a matter of policy. But policy has to be interpreted, and politics may play a deciding role:

> Second Administrator: For example, clerkship. I had a student, and the student was getting into trouble. She had one, sort of red flag, come up. And the preceptor, that preceptor was one out of six or seven, downgraded it. Which was very good - she wasn't participating [and this needed to be heard by her]. She went into [a specific medical rotation], and got a positive report . . . And when the preceptor or teacher, when this was brought to his attention, I want to say pressured, he changed his evaluation to unsatisfactory! [So while at first the student had passed the rotation, she was now told she had failed.] So the student was caught! One day she was satisfactory, the next day she was unsatisfactory, and that's not transparent! And that is the typical example of policies being, well not policies being broken . . . but it's the politics. So to me politics and policies sort of go hand in hand. And I've seen so many students being, what I think from my perspective . . . for one reason or another, being dealt with in an unfair way.

For policy to be effective, it should be the result of careful reflection and understanding of the experience of teachers and students in the system. The data for reflection should not be selective. Bias must be minimized at the outset, by recognizing it for what it is. Theory, as in science, is subject to change when new and conflicting facts emerge as new information becomes available. Policies must be changed as new understandings emerge. When the political arena lacks transparency, it can lead to unfairness. Based on our findings, the suggestions given in Table 1 might be helpful.

> Second Administrator: [Name of a university Council] is the highest court of appeal before going to the courts. And I'm sure they're not followed in a lot of medical schools. And this is the black box of which we're talking. And things go on which you don't know anything about. But they go on, and I think . . . well for this student, obviously, [it was] a hell of a distress.

In Canada, we are protected from 'outrageous conduct causing severe emotional distress' by law:

> One who by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another is subject to liability for such emotional distress, and if bodily harm to the other results from it, for such bodily harm. (Linden *et al.*, 2004)

> Second Administrator: No, the system isn't there [to handle this problem]. And the resident . . . all those years of study and investing . . .. It comes to light [only] when, if, it's [the decision to fail the student] challenged. And [when it's challenged] that's the only time that you realize that maybe natural justice wasn't followed. Because some external auditor reviews the situation and says, 'Look here, you didn't do this, this, and this. Therefore, the decision you reached should be reconsidered.'

> Natural justice refers to procedural rights, or due process (Jones & de Villars, 1999): The principles of fundamental justice include, at a minimum, the notion of procedural fairness including a fair tribunal; acting in good faith; and the opportunity to state one's case before a tribunal. (Jones & de Villars, 1999, p. 61)

The use of an external auditor in this case is extremely unusual, and is a painful process for the person who believes he/she has been wronged. While it is true that the public must be protected from harmful clinicians, there is a system of examinations and physician regulations which ought to fulfill this requirement. Understanding a given case requires attention to all the data and the removal of bias. While administrators are responsible for producing competent students, we have to ask ourselves if there are other ways of doing this, since the cost of the present process is often so high. A climate of fear is not conducive to the practice of good medicine. Fear is the enemy of relationships, and fear of being shamed or humiliated is fear of being degraded as a human being. One wonders whether the evaluation of students should be such an overriding factor in medical education. Further, we may ask ourselves if being shamed actually helps us learn? We think not.

> Faculty-preceptor: Everything important is dealt with in the corridor of the executive offices. There's a system, a CEO, who controls the meeting. Who controls the agenda? Who controls the outcome? I've seen that happen. The medical system is very hierarchal.

Hierarchy in organizations can lend itself to ethical decay (Bird, 2002). The entire organization takes its moral tone from the person at the top (Schaef & Fassel, 1990). Even good policy can be interpreted differently (and thus unjustly) by or for different people. Policy may be written in order to ensure justice. It must also take into consideration the data of the individual case in all its richness. The good is always particular. The facts in this particular case must always be attended to. Bias is being demonstrated when only the data that support an *a priori* judgment are gathered in order to justify action:

> Second Administrator: This takes me back to my previous career where policies and politics seem to go hand in hand. And [in] every policy that is written, 'normally' is a very common word. 'Normally, the student will . . .' 'Normally . . . the student will be faced with decisions to repeat a course, take a leave of absence, withdraw, or be thrown out.' And the options and the unevenness of handling policy, to me, is a major source of conflict. It leads to the student getting into trouble. The students can get into trouble because of the inconsistencies between how one student is treated, and how another student is treated, or was treated. And I have seen, because of the looseness of application of policy within the medical school, great unfairness for some students. Students being thrown out! Dismissed! Where I felt policy was not being followed by people because of the interpretation. So I see this is a great area of conflict generation for some students.

The term 'normally' was introduced into academic regulation in the early 1970s in Canada. While this allows some discretion to administrators, it can also be abused.

(4) *Lack of control, lack of communication.* For the most part, administration is located at the top of a pyramidal organization, which can often circumvent direct contact with students. The same can be true of the faculty. 'Messengers' convey information between the top and the bottom of the pyramid. If department heads are chosen by the faculty, they may have support from them. If chosen by the Dean, they may feel obliged to fulfill the Dean's agenda, leaving faculty without support. The department head may have ultimate say with faculty as advisers. Department chairs are required to include faculty in decision-making. Both Deans and department heads may use power autocratically. In such a system, politics dictate how power is influenced and exercised:

> Administrator: I mean the people at the bottom don't get much say in the management of the system. They can't bring these problems to the floor. It's 'Ah, it's the way we do it, guys'. So I think conflict is part of those two systems, part of stress, fatigue, including the profession itself. It's the hierarchy, the policies of the medical school. Medical school is one of the most political animals I think I've ever run into.

Triangulation, fear and intimidation, secrets, unfairness, abuse of power and moral silence do not encourage authentic behavior. By authentic is meant a willingness to look at all the data attentively, and to address the questions that arise from the data. Failure to do this leads to a flight from insight, rather than insight into what is going on (Lonergan, 1972). The evidence from which to make a good judgment and action plan is incomplete. Decisions are bound to be off the mark. People within the system are not encouraged and supported; emotions are hidden; people do not trust one another. A system that functions in this way models similar behavior for those being trained within it. This could be viewed as the 'hidden curriculum' (Aultman, 2005):

> Administrator-physician: He [the interviewer] said it's the profession, not just simply the educational system. So as he was saying that I was thinking of last year's headlines in the [newspaper]. About uncovering mistakes. And the media having uncovered mistakes with appendectomies, dialysis . . . . I mean it just goes on and on and on. All these things are not admitted to.

Medical education is like a family that has a secret, and secrets in families further shut down communication (Imber-Black, 1988). Communications are severely impaired. Rather than openness, gossip in the corridor may replace face-to-face discussion. As one faculty member put it:

> Preceptor: I was thinking that perhaps it's errors in evaluation that have become the problem . . . anything that is gossip between two people in a corridor should not be paid any attention to whatsoever.

Implications of these findings

(1) *The grinding down of spirit.* One of the major concerns which arise from this study of medical education is that of a paradoxical effect. While producing excellent doctors technically, it may have a negative effect on producing compassionate healers, even though students often enter with such high ideals:

> Resident: You have to start with it [altruism] . . . because if anything, I started out way more idealistic and way more altruistic than I am today. Because the process is tiring and it's, it's tiring. And when you're fatigued, it's harder to be nice, and it's harder to be altruistic, and if I didn't start off really wanting to help people, I don't think I would be motivated to care . . ..

(2) *The 'squelching' of feelings.* Healthy emotions are essential to those who help the wounded:

> Resident: . . . It's very emotional, conflict. And I think emotional language is very difficult for people like us to express. Especially in professional contacts. It's something that I don't think we understand that well. Or it's difficult to put into words, and it's much easier for us to talk about the solutions because we're very solution driven. You know, we see patients and well, there's your solution. Not every doctor, well that's not true, not every person, is good at understanding that. I know myself, that's what I'm thinking, is I actually have difficulty probably understanding the actual feelings. And the conflict, and I jump to [solutions without self-reflection]. What am I going to do about this?

(3) *Open conflict.* Medical care requires teamwork. Doctors often share in the care of patients as part of on-call groups or specialty groups. A general tone of unresolved conflict is not conducive to good teamwork. Our findings suggest, but do not prove, that conflict is pervasive:

> Physician-administrator: And there's conflict between faculty, I mean faculty are always fighting with each other. In a faculty council meeting, people are always arguing and fighting, and it can get very bitter. And that must create an atmosphere within the institution that a student may feel threatened. So the student tries to hide in order to survive. And this furthers moral muteness.

And conflict is not confined to the academic setting:

> Faculty-preceptor: there's a survey in the States, of doctors. And they asked 'what's your main problem?' Ten per cent said 'patients', 60 per cent said 'colleagues'.
> Administrator: You know, I did a year of rural locums around [name of province] and I could drive into the town that I was working in that week or that month, and I could tell you if the doctors got along or not within 30 seconds without having met anybody. You know how? If there's one clinic they get along, if there's three clinics they don't.
> Faculty-preceptor: [A colleague] told us that in [name of place] he was in a city with two [clinics]. Each has contempt for the other group.
> Faculty-preceptor: There are many doctors in [name of place] that have actually come to physical blows. In practices. This is what I've heard.

And the results can be devastating and tragic. Rivalry is rampant, and it does affect patient care and the delivery of health:

> Physician-administrator: It's even worse in [name of province] . . . [looks at interviewer].
> Interviewer: Murder? [This refers to the alleged murder of one physician by another with whom he was having ongoing unresolved disputes]
> Physician-administrator: Yes, it happened to one physician.

(4) *Moral development of physicians.* Though it hardly requires spelling out, an initial reflection on the meaning of the data suggests that conflict is not, in itself, a good thing in medical education. Deeper reflection suggests that conflict itself is neutral, and perhaps unavoidable. It is how conflict is handled that can be destructive. In fact, conflict, when handled openly and correctly, and when properly understood, can lead to growth by limiting our egoism within relationships (Buber, 1958). It is when conflict is resolved through the use (and especially abuse) of power that damage occurs. It is when conflict and disagreement are not safe that people become silent in the face of unethical behavior. Respect for the dignity of persons is a foundational principal in ethics.

What happens to our consciences when, out of fear, we become unwilling to speak about our disagreements, choosing rather to attack the other through hidden means rather than learning to 'attack gently', with the use of humor to deflate anger, for instance? Bird points out how the members of the entire system suffer a dampening or weakening of conscience (Bird, 2002). When conscience is weakened, what is morally wrong is confused with what is morally acceptable. It is in the very nature of humans to have conscience. It is a crime against humanity when conscience is destroyed (Arendt, 1976, 1994).

When our conscience is weak, can we be empathetic, compassionate and caring? Will an educational system that leads to a regression in moral fiber produce adequately caring practitioners?

Development of theory

As our method intends, the data from our experience naturally raise questions that can lead to understanding. 'What factors underlie the conflict?' 'What factors seem to perpetuate conflict?' 'Under what circumstances does conflict lead to the damaging of students' learning, the damaging of students'/teachers' health? To unjust outcomes?' What, then, are the possibilities or hypotheses given the data and questions that arise in this study?

A theory of caring in medical education

Caring or compassion, which is the essence of healing presence, requires that we are able to make good decisions.

In order to function in a caring way, we must be able to discern what is real and what is not. We must not be blinded by our own egos and our own biases. We must be able to communicate. We must be attentive to not only the data but also to the questions that arise spontaneously in our consciousness when we survey the data. We must be able honestly and carefully to weigh and consider the data in order to judge what is real, and what we should do in the given circumstance. By being attentive, intelligent, reasonable and responsible, we become authentic human beings. Authenticity allows us to know what is, and to know each other. It is only in this context that we can be truly caring. Readers are encouraged to reflect on their own experiences of being cared about in their educational experience.

Learning takes place within a cultural and moral community. What lies beneath the curriculum (the hidden medical curriculum) (Aultman, 2005) may impair the medical student's ability to form a genuine relationship with patients and others. The physician–patient relationship, if it is therapeutic, requires exploration of emotions, beliefs and behaviors beneath the surface of narrative. To neglect this is to relegate the physician to a spectator who is not really present in a compassionate way for the patient (Aultman, 2005). Is this 'good enough' medical education? We think not.

What should we do?

Lonergan shifts the focus of moral development from a set of rules or principles to a process of questioning and discovery (Crysdale, 2006). This process yields cumulative and progressive results and involves a method that, rather than being a set of rules to be followed blindly, is a framework for creativity (Lonergan, 1972). From experience arise two types of questions, questions for understanding, and questions having to do with value and deliberating on how we should act. Distinct from, yet related to determinations of fact, we spontaneously engage in questions of evaluation: what should we do? All persons are oriented towards interacting with, understanding, valuing and creating their world of meaning. That the human person knows and creates his/her world is fundamental to any modern notion of moral formation. The givenness of our culture, including that of our educational system, must be taken into any account of moral development. Social dissonance is as formative as cognitive dissonance in creating moral behavior (Haan *et al.*, 1985). As a seasoned bioethecist pointed out recently:

> Most medical students have a level of ethical ability that floats between the conventional (what they have learned) and the mythological (what they think being a doctor entails). Some students (often older ones) have got enough experience to be cautious ethical learners. Many of the younger ones operate on instinct that does not serve them well until they have a chance to hone their ideas with experience and training. (Miller, 2006)

We have made the case that the system of medical education as it stands may, in some cases, not be paying adequate attention to the moral development of physicians. Further work on the prevalence of the issues we identify will be necessary, as is the need to study how to facilitate the development of healing behaviors in our students. It is not just the student who needs support, it is also the teacher; it is also ourselves facing the problem.

Back then to a key question: what is it to care? What are the data that are relevant to an answer? They are the data of our own conscience, our own consciousness. That might be brought out by reflecting on the situation in which we actually find ourselves. Caring will be heightened by spiritual transformation of the person of the physician. For Lonergan, human development is of two different kinds:

> One he calls from below upwards, from experience to growing understanding, from growing understanding to balanced judgment, from balanced judgment to fruitful courses of action. And from courses of action to the new situations which call forth further understanding, profounder judgment, richer courses of action. The second is from above downwards. This involves the transformation of falling in love: domestic love of the family; the human love of one's tribe, one's city, one's country, mankind; the divine love that orients man in his cosmos and expresses itself in his worship. (Lonergan, 1985, p. 106)

(1) *The need for faculty support*. When the teacher is insecure, the student will sense it. When the student positions him/herself in a power position vis-à-vis the teacher, this positioning will cause conflict (Langehove, 1995). In our study the comment is about the lack of such support:

> Administrator: My first impression is that she's [the teacher] really insecure. That probably more experience teaching would be able to deal with that situation and not get so stressed out. And I don't know how you grow wisdom and experience, but I suspect that this is a new teacher and is maybe confronting this for the first time and in a situation like that I think you have to have a system where you look after the teachers and make sure they're debriefed and you have a faculty program or something to help teachers face these problems and other problems that can generate conflict.

We recognize that all persons in the system are affected when one is. It's like a mobile: touch one part and they all move. In the medical education system, if you stress the teacher you stress the student, and vice versa. If you support the one, you support the other.

(2) *Natural justice*. The medical education system refers to natural justice as a basis for its actions. This is defined as referring to fairness:

> Administrator: Well, as I said, I think it's [natural justice] fairness. And it seems to be decisions based on what we as a community or society feel is fair and just.
> Preceptor-faculty: Characteristics of human fairness. So this would always be policy, no matter who was involved. The needs of everybody involved would be met.

Table 2. Suggestions for healthy educational systems.

(a)	Discourage excessive rivalry. Pass/fail grading
(b)	Unmask the 'myth of perfection'
(c)	Be sure there are carefully designed assessment processes
(d)	Condemn humiliation and shaming as techniques
(e)	Employ a neutral ombudsman with power to act
(f)	Provide opportunities for self-reflection for students and faculty
(g)	Provide personal growth opportunities and access to counselors
(h)	Insist on openness and transparency
(i)	Insist that administrators understand how to 'de-triangulate'
(j)	Review policy frequently
(k)	Ensure faculty also have support and the means to upgrade knowledge and skills on ongoing basis
(l)	Encourage balance amongst students regarding their personal/professional lives. Model the same
(m)	Ensure that due process occurs when student or faculty are being accused of inadequate performance
(n)	Always have clear expectations laid out in writing prior to an educational experience
(o)	Experiment with a 'Pedagogy of Discomfort' (Aultman, 2005)

Preceptor-faculty: By taking appropriate testimony, that all parties will give testimony.

A loose understanding of justice (natural justice) is open widely to interpretation. It could refer to a purely behavioral account. Reward and punishment. While applications are not always even, we suspect that everyone wants fairness, even when they disagree about application.

In fact natural justice refers to due process. This includes the opportunity to know what the charges are and the opportunity to respond to them. Without fairness built on attention to all available facts, when the system is having problems, such as criticism from regulating authorities, scapegoating may occur (Girard, 1986, 1991; Scheler, 1988). Those who are in power often maintain advantage. Without transparency, aggression may go unchecked and violence (the forcing of one person's agenda, viewpoint or wishes upon another) may take the place of justice.

Weaknesses and limitations of our study

The response rate is very low, as anticipated, given the nature of conflict and the tendency to secrecy in medical education. The purpose of this study was, however, to uncover the 'anatomy and physiology' of conflict, as it were, so that it can be better understood. Those residents and faculty with whom we have shared our findings are generally supportive of them. We realize that the dysfunctional patterns we have documented may occur in pockets or with some individuals and not others. A more clear understanding of the frequency of these issues would require another study.

Conclusion

While the purpose of this study was not to find solutions, we nonetheless have listed possible ways of improving the medical education system for reflection by the reader (see Tables 1 and 2). We have unpacked the nature of conflict to expose the inner workings or anatomy of medical education. This is intended to help foster and maintain robust and healthy training institutions. Our study brings to our attention the moral development of physicians and the need for learning environments that model caring for the physicians of the future.

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