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GRADUATE COLLEGE

CZECH PHYSICIANS:
THE IMPACT OF CULTURAL CHANGE
ON TEACHERS IN A PROFESSION

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

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Norman, Oklahoma
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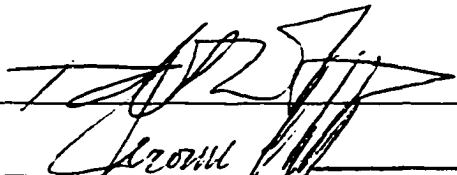
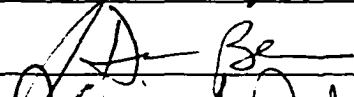
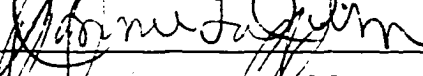
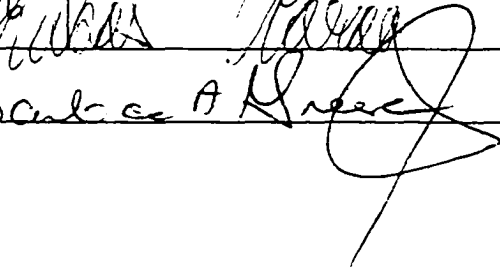
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CZECH PHYSICIANS:
THE IMPACT OF CULTURAL CHANGE
ON TEACHERS IN A PROFESSION

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATION LEADERSHIP AND POLICY

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Abstract

How cultural change impacts teachers in the medical profession was the focus of this study. The purpose was to examine social culture and ways teachers change. Participants were 8 physicians (6 male/2 female) from 8 departments at the 2nd Medical Faculty, Charles University, Prague, CR, who were interviewed to learn how change from a socialist form of communism to a capitalist democracy had impacted teachers training the next generation of doctors who will practice under the new social order. Because of the differences between communism and democracy, participants were asked to discuss how their personal ethics and values have changed and how this is reflected in teaching and medical practice under conditions of on-going social change. This study was qualitative and used grounded theory methodology and constant comparative data analysis. Findings are: pressure to change is extrinsic, intrinsic and reciprocal; it affects all areas of professional practice and teaching; the amount of actual personal change is controlled by the individual; and personal decisions to change are affected by forces from societal change. The conclusions are that change is normal in professional life; and teachers provide a tie to the history and traditions of a profession and promote future growth of the profession.

CHAPTER ONE

Introduction of the problem

One thing that is new is the prevalence of newness, the changing scale and scope of change itself, so that the world alters as we walk on it, so that the years of a man's life measure not some small growth or rearrangement or moderation of what he learned in childhood but a great upheaval. J. Robert Oppenheimer (Bennis, 1993, pp. 22-23)

Introduction

The generation that knew the last period of precommunist freedom no longer teaches in the Czech Republic educational system. Currently, the majority of teachers filling the medical professorate would be people who trained under the communist system of education. Are these professors able to make the changes necessary to train their students to serve under a system that is different from the one in which they learned and practiced their profession? If they have changed, how and why have academic physicians changed in their ethics, values and teaching practices to meet the demands of this new form of society in which their students will be caring for patients?

Background

Together, we live in families, communities and societies. We not only speak the same language, but we understand the same things because we live through the events that create our history together. This generation differs from the one before and the one after, but we have a common understanding of what creates home and country. In the Czech Republic, the citizenry has banded together on at least two occasions in order to attempt an extensive change in the political and social life of the country. The Prague Spring of 1968 may have not been a success in achieving the social change sought, but

the Velvet Revolution on November 17, 1989 was. In the aftermath of the conflict lies the time of rebuilding and decision making. What will the new society be like? What will be kept from the old system or restored from previous times in the effort to cobble together a new way of living that all can agree upon? The Czech nation is developing as a capitalist system under a democratic form of government, which is very different from the recent past lived under communism. Three areas of interest in how these changes will be successful concern the nexus of democracy, ethics and values, as well as the education necessary to support and aid this change and future growth in the society.

Democracy and Education

Democracy is not a new concept in the Czech Republic. While developing the first government and legal systems from the founding in 1918 to 1920, political leaders based the constitution upon the French and United States forms of democracy (Čornej & Pokorný, 2000, p. 44). Tomas Garrigue Masaryk, President Liberator of the Czechoslovak state, believed that “democracy is the political form of humanity” (Čornej & Pokorný, 2000, p. 44). The shift to communism must have been a difficult transition because not only was it run by an outside power, but the goals for society were in opposition to those chosen by the Czech nation from its founding. In a New York Times article printed on November 4, 1962, Adlai Stevenson said that the goals of communism and democracy could not be compared since they were so different. Stevenson described the major interest of people living in a communist social system as being the growth of power, while the members of a democratic social system sought to further the growth of communities (Bennis, 1993, p. 20). Therefore, this is a change that was required if the Czech Republic was to continue to change and develop as a full member of the modern

world. Being able to adapt to change is the most important characteristic in determining the ability of a society to survive, and democracy is the only organizational system that is compatible with perpetual change (Bennis, pp. 23-25). Why would it be necessary for the Czech Republic to return to a democratic form of government in order to survive? While socialist and capitalist democracies can both exist, it is the flexibility and fluid nature of the capitalist democracy that enables the society to cope with the demands of change that modern civilizations experience (Bennis, pp. 20-21).

If a democracy is understood to be the larger community of the society as a whole, how does this impact the individual living in this circumstance? In this instance, four perspectives may be considered: democracy as the rights of the individual; democracy as the actual achievement of those rights; democracy as the ability of the people to remove the government from office when it is not meeting the needs of the populace; or, democracy as participation through majority rule (McGinn & Epstein, 1999, pp. 1-2). "Democracy becomes a functional necessity whenever a social system is competing for survival under conditions of chronic change" (Bennis, 1993, p. 22). Many times democracy is associated only with the idea that it is the vehicle for the protection of human rights, while it is actually a more "efficient" social organization form in the manner of being able to survive and prosper (Bennis, p. 20). The attainment of democracy occurs when the individuals involved understand and accept both their rights and responsibilities as members of the society and when they extend these same rights and responsibilities to others (McGinn & Epstein, p. 2).

The necessity for the members to understand, accept and to share the rights and responsibilities available in a democracy stands in direct opposition to the expectations

that have been expressed in many surveys done in post-communist countries as to what rights should come with citizenship. One survey done after 1983 found that citizens of the Soviet Republic revealed the opinion that the United States could learn much from the Soviet Union regarding free comprehensive medical care, free public education, control of crime, upkeep of cities, and public transportation (Millar & Wolchik, 1994, pp. 5-7). Some of these issues, categorized by Millar and Wolchik (1994) as welfare entitlements, show that these people expected the government to provide for their care, rather than understanding that the responsibility to provide for themselves and their families belonged to them. In a survey done between 1991 and 1993, the political features deemed to be the most important in the determination of what constitutes a democratic state were the presence of at least two strong political parties, competitive elections, freedom to criticize the government, minority rights and tolerance (Millar & Wolchik, p. 15). These beliefs were held more strongly in Bulgaria, the former German Democratic Republic and the Czech Republic (Millar & Wolchik, p. 15). Czech citizens differed in respect to other post-communist societies by their responses that showed this is a society which prefers the placement of responsibility on the individual, rather than on the government (Millar & Wolchik, p. 8).

There are concepts associated with democracy that help give credence to the importance of the shift to this form of social organization. In the minds of many people, democracy carries the connotation that it is an inefficient manner of conducting the business of social organization because it is associated with values of choice and freedom, collaboration, and science as an ethic of testing and predicting reality (Bennis, 1993, pp. 1-2). In spite of these inefficiencies and because of the forces that coexist in the

democratic system, many still believe it would continue to be a viable social form. These forces include economic, social and political forces, which strengthen a system that is both practical and uncontrollable, so that an inefficient democratic system would continue to stand against many challenges (Bennis, p. 20). Pluralism is one theory of government that defends this combination of capitalism and democracy because of the way they interact. By understanding the production of public goods as a market place model, the voter is indicating the personal choice of a political or public good through the vote each person casts (Carnoy, 1985, pp. 28-29).

A challenge to the capitalist democratic system exists in that the association of these two ideas creates a dialectical relationship is forming a set of internal incompatibilities characterized by change (Carnoy, 1985, p. 4). Democracy “represents a social form that is always coming into being; it changes according to the phase of the underlying conflict” and this is the reason it survives external pressures (Carnoy, p. 5). Yet even the friends of American democracy express concern that the form in use today is being “exported” in a different form. Czech President Vaclav Havel has written that

Democracy is seen less and less as an open system that is best able to respond to people’s basic needs – that is, as a set of possibilities that continually must be sought, redefined and brought into being. Instead, democracy is seen as something given, finished and complete as is...that the more enlightened purchase and the less enlightened do not (McGinn & Epstein, 1999, p. 24).

Given that democracy is interpreted differently by different societies, what is the vision that governs its expression today?

One of the great tenets of the democratic system is that while all are not equal in the social and economic arenas, democracy provides opportunity for justice and equity. It is in this provision that existing inequalities between individuals may be compensated

(Carnoy, 1985, p. 27). One of the institutions that help to provide this compensation is education. In a capitalist society, education serves to bring about equality through improving the social position of lower groups and making knowledge and certification available for and to these groups so they may participate fully in both public life and work (Carnoy, p. 27). If education is distributed evenly throughout a society, it enables even countries having lower levels of educational attainment to have high levels of democracy because it makes access to political and economic power more equal (McGinn & Epstein, 1999, pp. 7-8). Each aspect of life in a capitalist democracy serves to further entwine the individual with others in the society as they navigate the interrelated legal, economic and educational systems. Even as education serves to support the goals of democracy, this aspect also creates the conflict that is evident in many educational institutions. In the American form of democracy, the legal system governs conflict between individuals in social and political areas, the price and wage system of the market place settles economic conflicts and consensus is used to develop resolution of conflict in education (Carnoy, p. 33). Through this decision making process, the individual is in control of how much and what kind of education each chooses to pursue (Carnoy, p. 33).

Even though conflict appears to be the one unifying theme in the story of democracy, capitalism and education, the missing element is culture. Each historical period and the peoples existing at that time in social groups must be understood apart from any other. For adults, change, learning and development occur in the specific social and historical context in which the individual finds him or herself (Tennant & Pogson, 1995, p. 5). These terms refer to ideas not easily expressed. Each idea forms one section of the vision that results in observable differences in the qualities the society values

(Tennant & Pogson, p. 5). Adult education theorist, Jack Mezirow wrote that even before the social values can be affected, the responsibility and effort of change rests with the individual. Liberal democratic social theory states that when a society is made up of autonomous, responsible people, who choose to change their own perspective on meaning, they begin to change their world (Mezirow, in Merriam, 1993, p. 52). In contrast, communism, with its forced set of mandates and restrictions, had no means of including the individual in the changes being made in society or for his or her “good.”

In considering how important transformational learning is in the conduct of a democratic society, it is important to understand how closely it ties to the basic structure of a democracy. Mezirow, Freire and Daloz have all developed social theories that deal with transformational adult learning (in Merriam, 1993, pp. 51-52). The common elements of their theories are a humanistic vision of people, a belief that people are able to change and free to act on the world around them, an understanding that people create knowledge together, and a democratic vision of society in which individuals are joint members in a collective future they create together (in Merriam, 1993, pp. 51-52). Mezirow defines the way that transformative learners change as becoming more inclusive, discriminating, self-reflective and integrative (Mezirow, in Cranton, 1997, p. 5). These qualities pair well with the four dimensions of fundamental democratization outlined by Freire: economic, which requires discrimination between alternatives available; social, inclusion of other people; political, integration of current needs with possible alternatives for governing and providing for the society; and, cultural, where together people must consider what values are important for ethical and harmonious life (Freire, 1973/1997, p. 13). Similarly, Mezirow wrote that alone, the person must

overcome biases each may not be aware of in him/herself, but together, the society can reach consensus and objectivity (Mezirow, in Merriam, p. 52). From the democratic vision enunciated by Daloz, individuals must make a shift from an idea of an autonomous self to an understanding of how all members and elements of the society are interconnected. He believes that the world needs to become more adequate, more just and more compassionate, qualities supported under a democratic society and excluded from one developed along communist ideals (Daloz, in Merriam, p. 52).

An issue ignored during the change in both Czech education and society was the important element of how social culture is tied closely to education and democracy, which was the political system the citizens of the Czech lands had employed prior to World War II. Had the leaders of the Communist party approached the changes in a way more suited to adults who had lived as part of a self-directed, democratic society, the historical result might have been very different. Social and historical changes create the situation where each succeeding generation must be different from the previous (Knox, 1977, p. 11). This is especially true when change is in the form of political control of the nation and is as encompassing as a shift from democracy to communism.

Mezirow's theory of knowing incorporates the idea that reality cannot be a "fact" since it is constructed by people and their societies (Mezirow, in Merriam, 1993, p. 50). "Learning and cognition are fundamentally situated within, and related to, social and historical contexts" (Mezirow, in Merriam, p. 18). One of the primary tasks of a democratic society is the construction of shared values and objectives, yet with the changes forced upon the Czech society, there was no opportunity for the members to work toward this change together (McGinn & Epstein, 1999, p. 3). Paulo Freire

envisioned the creation of culture as the work of man creating and recreating the world in which he lives, which is the step in development the Communist party made for the Czech culture by requiring change (Freire, in Merriam, p. 51). Mezirow also supported this view of how meaning and culture are created by the individuals in the society through acquisition and validation in human interaction and communication. This is due to the understanding that reality is changed, or replaced, when ideas or contexts change (Mezirow, in Merriam, pp. 50-51).

The nature of conflict changes each period in the way that the institutions involved in the State, schools and production are different due to the previous conflicts experienced in that society (Carnoy, 1985, p. 47). Societal and cultural changes happen in conjunction with the actions of men, which serve to create meaning and culture (Freire, 1973/1997, p. 5). Therefore, the experiences of Czech physicians must be interpreted in light of how the history of communist education has colored the changes occurring in the present capitalist democracy, which is still evolving. Change in the educational system must be understood in the context of the social conflict currently being experienced, as well as that of previous periods, since the institutions are now changing in response to those older conflicts (Carnoy, pp. 47-48). In order to grow through the conflicts and keep the educational level high, how are the academic leaders of this profession responding to the challenge of training new doctors to practice in a society that is very different from the one they have previously known?

Values, Ethics and Education

The process of human learning is difficult to separate from the major events of each life and of the histories that tell the story of our lives together. It is from the stories

of these joined lives that the understanding of culture, values and ethics is formulated. As societies grow and change, as with democracy, the historical events and changes must be considered when discussing values and ethics in human social groups. While Moustakas was discussing the research process, his commentary shows that even in this piece of human endeavor consideration of the ties between society and the individual human life cannot be divorced from our thinking: "...the heuristic process is autobiographic, yet with virtually every question that matters personally there is also a social – and perhaps universal – significance" (Moustakas in Cranton, 1997, p. 26).

Mezirow wrote there were four processes of learning that lend to understanding of the development of both values and ethics: elaboration of a preexisting point of view; creation of a new point of view; transformation of a point of view; and, awareness and critical reflection on how the bias of an individual affects their understanding of their own, and the point of view of others (Mezirow, in Cranton, 1997, p. 7). Personal and social meaning are given to individual lives because they are created together and the struggle to achieve that creation makes the goal more valuable. In order to change the person, the frame of reference must be changed through a transformation and this transformation is achieved in critical reflection on the assumptions on which beliefs are based (Cranton, p. 7). It may be that all people do not reach the point of being able to reflect on the creation of their own values and ethics, but it is the person who understands his or her own values and beliefs who is the most autonomous (Merriam, 1993, p. 29).

In regard to how values and ethics are created, an understanding of how they differ is important. Each is important to the development of the other, but they are created in separate and distinct ways. Even though a value should be a belief that is not

transitory, it may not be consistent throughout the life of the person (Dracopoulou, 1998, p. 16). The set of values an individual holds may have been developed from a combination of elements originating in home life and items chosen purposively from the unique set of experiences each one has in living. While the individual is alive, values will continue to be acquired and changed, yet that person may not be able to discuss the values selected as important because the process is on-going (Dracopoulou, p. 16). Like the culture of a society, values cannot be removed from the moral community of thought in which they were developed because it is within this community that the individual finds the tools with which to evaluate the moral problem situations of life (Dracopoulou, p. 63).

While values are developed within a combination of home life and experiences in the community, the values held by an individual may be very different from those of the group or from other groups in the same society (Dracopoulou, 1998, p. 34). Surveys conducted in the Czech Republic from 1991 to 1993 showed that the values of generations in the same society were very different due to age group, educational levels and the degree of urbanization (Millar & Wolchik, 1994, pp. 23-24). Support for reform, change, democracy and a shift to a capitalist market place was found in three groups: younger people, those who were better educated, and those more highly urbanized (Millar & Wolchik, pp. 23-24). Obviously, groups who lived in the same society and had many of the same experiences had chosen to value very different ways of living. It is interesting to consider that the older members of society, who had direct personal experience with Stalinist methods and degradation of the Czech cultural life, did not support a change to a new democratic and capitalist form of life (Connelly, 2000, p. 14). This is important to

the question of how and if academic physicians, who may be older members of the society, will be able to change in their efforts to train students who will serve patients in a capitalist democratic system. Will one of what was to be the greatest legacies of communism, a change in the values, attitudes and behaviors of the population, survive or be replaced through the societal changes? (Millar & Wolchik, p. 12)

Just as people develop personal values differently, societies also develop differing values. What is important in the United States may not be valuable to other nations. In 1991, James McGregor wrote an article that examined how closely Czech values actually resembled the purported values that communist life and education were to have instilled in the society. He acknowledged the problems in dealing with an incomplete research history in trying to develop a picture of how the Czechoslovak Republic had actually changed under the communist regime, but also acknowledged the strength of existing studies in the values of the culture (McGregor, 1991, p. 186). The officially held values under the communist system were: equality; emphasis on the collective; sense of responsibility to others; social and political activism; labor; exploitation of man by man; and rejection of individualism (McGregor, pp. 195-196). Czech and Slovak citizens held the values of equality and labor (McGregor, pp. 195-196). The “exploitation of man by man” was a strongly held value when the term is used in the Marxian sense, rather than the dictionary definition (McGregor, pp. 195-196). Otherwise, the official values were not held in Czechoslovakia. McGregor did believe that the data showed that Czech and Slovak citizens had not become model socialist citizens. They still held values that would not be considered foreign in Western cultures (McGregor, p. 197). His conclusions were that while it was impossible to affirm that the official values of the communist system

had been accepted by the culture, it was just as hard to prove that they had been rejected (McGregor, p. 197).

One area that shows globally how values have developed differently is in the healthcare system. Because healthcare systems are created within the culture, each will incorporate values inherent to that society (Morrison, 2000, p. 2). Because the United States has a distinct history and social structure, healthcare has developed values that include: pluralism and choice; accountability of the individual; ambivalence toward government intervention; acceptance of progress, innovation and new technology; volunteerism and communitarianism; paranoia regarding monopoly; and competition (Morrison, pp. 4-5). In contrast, global healthcare values include: universality; equity in availability, if not in service provision; acceptance of government intervention; skepticism regarding competition; budgeting to reduce overall cost without reducing overall health; rationing; and, assessment of technology and control of innovation (Morrison, pp. 2-4). Obviously, social structure has had a great deal of impact on how healthcare systems have developed in different ways.

Several values exist that may be evidence of how other nations have been impacted by political situations more controlling of the life of the individual than democracy. These include: healthcare as a right, instead of a benefit of life in the society; equity; and, public administration of healthcare as a service, rather than a market place good (Morrison, 2000, p. 6). There are two additional values that have developed as a result of the growth of a global community, which exemplify how societies can grow to hold similar values. Consumerism results from rising education and income levels, as well as increasing sophistication in communication (Morrison, pp. 5-6). This is one value

that has both a positive and negative side, in that it serves to also make gaps between rich and poor greater.

A second new global value in healthcare is the Internet culture that has developed due to the greater access to information and commerce without regard to national boundaries (Morrison, 2000, pp. 5-6). Through the growth of the Internet, the world is becoming a global village, rather than a place of separate kingdoms and nations. How are we preparing students to work and live with people who are very different from themselves in beliefs and values?

Ethics differ from values in not only how they are formulated, but in why. While values are important beliefs chosen by the person and upon which, consciously or unconsciously, decisions may be based, ethics are a statement created by a group that defines a set of agreed upon beliefs (Dracopoulou, 1998, p. 8). This qualifier indicates that ethics are a conscious choice of the group formulating the statements. From this set of chosen beliefs, a document is created that includes: universal principles the members of the group feel must be defended; standards by which to judge the correctness or incorrectness of actions taken by group members; and, a practice guideline that gives evidence of the principles in action by the members (Dracopoulou, p. 8). The development of an ethic is a practice taken seriously by professional groups because it gives the outside world a way to judge the practice of the group. Even in traditionally capitalist societies, “caveat emptor” should not be the ethic for any profession, much less for the practice of medicine, where practitioners are so intimately involved in multiple aspects of the lives of their patients (Caplan, 1997, p. 21).

An ethic should be developed in a way that follows principles accepted by people who are outside the membership of the professional group. Without this, the public will lose faith in the ability of the profession to meet the needs of the client. Wilcox and Ebbs (1992, pp. 39-40) have included five principles for developing an ethical code: respect autonomy; do no harm; benefit others; be just; and, be faithful. After the development of an ethical code, the issue arises of how to actually follow the code in making moral decisions. Wilcox and Ebbs (p. 38) also created a list of steps that can help decision makers in the ethical arena. These steps include: define concrete issues; review alternatives for resolution; for each alternative, consider it in regard to the set of values and principles important to the issue; each person should be comparing the group decision to his/her own moral judgement by imagining him or herself in that position; and, then the group should act on its best judgement (Wilcox & Ebbs, p. 38). No decision can be perfect, but ethical decisions have an impact on the lives of people at the most visceral, emotional level of their beliefs in right and wrong.

Just as culture cannot be understood outside the specific historical time period, neither can decisions of ethics and morality. In the same way democracy and culture must change due to conflicts and events unique to a society, the moral and ethical nature of the people is constantly in a state of evolution from external pressures of the social and historical context (Dracopoulou, 1998, pp. 9-10). Given the intensely personal nature of the physician-patient relationship, should the ethics of the medical profession be more stable than the ethics of other professional groups? The Hippocratic oath is one taken that says the physician will work to prolong life and minimize suffering. Does the understanding of how to “prolong life” change with technological advances that may

extend the actual number of days lived but reduce the quality of that life? Or does the promise to minimize suffering of the patient change when new drugs can be prescribed but additional side effects are possible? Who has the right to decide what constitutes suffering? “Advances in medical technology are constantly expanding the scope of what medicine can accomplish; the purpose of medical ethics is to determine what medicine should accomplish” (Torr, 2000, p. 13).

In the specific, an ethic in medicine should include certain priorities intended for the protection of the patient, which can also protect the physician since it will serve as proof of compliance to the best of his/her ability to the ethical code of the profession. History is rife with the stories of inhumane treatment of others by people who were in positions of power and authority, but did not act in an ethical manner. The academic physician is one who would hold two of these positions simultaneously. First, the position of being in control of the knowledge and understanding of medicine needed to aid the patient in recovery or acceptance of a situation beyond his or her control places the physician in power over the patient. Second, as a teacher of medicine, each one is in a position of power over the students who are concerned how the instructor will evaluate their actions and knowledge. Therefore, awareness of the need for ethical behaviors should be especially acute in those physicians who also teach.

In this situation, the professor or teacher of medicine must consider how to act ethically with patients and students and also how to teach these behaviors to students. Some behaviors important for medical students to carry into practice include: use of truly informed consent, where the patient both understands the choices and is allowed to make the decision as to which one is used; full and accurate disclosure of information, even

when it is a painful task; protection of all individuals involved in the procedure; and the understanding of how a position of power can be translated into coercion of the patient (Caplan, 1997, p. 19). The qualities of a moral socialist physician outlined by Lisonkova (1982) do not follow with these behaviors. Her list included devotion, patience, ability to make quick decisions, and finally, deliberation and honesty toward both society and the patient (Lisonkova, p. 282). The suggestion that the physician needs to be able to make quick decisions could be construed as coercion if the patient is left out of the decision making process, yet it is described as a way for the moral socialist physician to instill confidence in the patient (Lisonkova, p. 282). Deliberation could be understood as a way of not sharing all information known about the situation with the patient, if it is thought that the patient would not understand. It is suggested that this enables the physician to responsibly deal with any situation, which circumvents the inclusion of the patient or family in decision making (Lisonkova, p. 282). Finally, the exhortation to be patient with people who do not have a good prognosis might suggest that the power and authority rests with the physician, again avoiding the possibility of having to include the patient in decisions (Lisonkova, p. 282). With this in mind, it is questionable exactly how honest the socialist physician was really expected to be with either the patient or the society.

The inclusion of ethical decision making practices suggests that the physician, especially one holding concurrently the position of professor of medicine, is aware of being part of a larger system where all members are equal, no matter where authority has been granted. Just as is true in the consideration of how democracy is important in the development of a society undergoing changes, the value of ethics is larger than just the means of aiding practitioners in making decisions. When an entire society is faced with

changes on so many fronts - social, economic and political - the incorporation of an ethical code helps the members of the profession understand how they fit into the new society and the demands that will be made of them. While it may be in response to conflict that affected an earlier time, the ethic will continue to be effective in determining how to approach the future.

When political systems change in ways similar to the change that has occurred in the Czech Republic, these changes affect the culture and the citizens in multiple ways during an extended period of transition. But human life continues and the society must find ways to continue to meet the needs of the citizenry. How has one component of this cultural group navigated the new paths and continued to educate their students to become physicians in the Czech Republic? What has happened in the hearts and minds of Czech physicians who teach in the Charles University Medical School that has enabled them to continue performing their responsibilities? How and why are they different now than they were before 1989?

Problem statement

For any societal change to become the norm, members of the society must be educated in the new ways. Teachers must be able to guide the members of the society in beginning to participate fully in the democracy as individuals, rather than members of a collective. In the Czech Republic, how and why have the physicians who serve in the medical professorate changed the way they train students in response to democratic political and capitalist economic ideals to ensure that citizens receive adequate care? How is the relationship of culture and change seen in the practices of physicians serving in the medical professorate?

Purpose of the study

In an area where education of the practitioner is of paramount importance, Czech physicians serving in academic roles have experienced a number of changes to the structure of their profession and the educational system they serve. Yet, they continue to prepare students in the art and science of medicine to face a world that may continue to change for some time to come. Because it is unknown how and why they choose to follow this path, the purpose of this study is to examine social culture and the way teachers of medicine come to change the way they practice the teaching arts. The three major areas of interest in this study concern differences in how and why physicians change, how the professional culture of medicine changes, and whether events in the larger Czech society have changed how academic physicians teach after cultural transformations have taken place.

Research questions

For purposes of this study, the research questions developed can be understood to address one overarching area of societal change and the way it affects personal change, professional culture change and change in teaching practices.

1. As reported by physicians in interviews, what impact has the societal change experienced in the Czech Republic had on the physicians who teach in the medical schools?
2. How do Czech physicians describe their own methods of change in the pursuit of a medical profession in a society undergoing transformation?
3. If these physicians have changed, what motivated those changes and how do they say the changes are reflected in their teaching practices?

4. In what manner do academic physicians report they transmit or teach ethical behaviors to their students? How has the expression of ethical beliefs changed in the academic arena according to what teaching physicians report in interviews? Are these reports supported by observations of encounters with students and in documentation from the institution?
5. How do physicians report cultural change influences the way they train students when there is a political and economic shift?
6. How do physicians report they understand their position as transmitters of the new culture to students?

Significance

All teachers face change during the practice of their profession. Whether it is as simple as having a new principal take the helm of a public school or a change in the way the subject matter in an introductory engineering or nursing class is taught, teachers must respond to changes forced on them from the outside on a regular basis. The contribution of this study will be an understanding of how and why the teacher who is a member of a profession changes in response to societal influences. This contribution will be of benefit to two groups: schools, which train both students entering professional practices and the professionals who choose to teach; and adult educators, who work with continuing professional education. It will also add to the understanding of how personal and professional change is accomplished among the teachers of medicine in other cultures. From here, we can begin to prepare teachers in the professions who are more fully aware of their own impact and significance to the society in which they practice the art and science of education.

Because this study examines the experiences and thoughts of a professional group that has experienced the shift from a communist to a democratic society, it will include development of an explanation of how members who have chosen an academic career change to reflect and promote the central tenets of the society in which they practice. While medicine in the Czech Republic did manage to maintain much of its independence from communist control, the teachers at the university level have had the experience of living, practicing, and teaching in a society that has, and continues to have, many changes in the process of becoming a democracy and capitalist society. A second implication important to this study is that there will be the development of a better comprehension of how teachers in a profession can be aided in their understanding of how they serve and support the structure of society through their practice.

Assumptions

The following six assumptions will guide this study:

- First, the participants in this study will tell the truth as they remember it to have been and will honestly assess how they have changed in the ensuing years.
- Second, an individual changes in ways that can be related, observed and traced through time when the culture of the country in which he/she lives undergoes a complete change in systems.
- Next, the practice of medicine is very similar around the world, except for where political and economic systems exist that preclude that similarity of practice.
- In a similar vein, the relationship of teachers and students is comparable around the world except where systems exist that make this untenable.

- Additionally, an educational system will change to conform to the prevailing political and economic system in place in a country.
- Finally, some of the teachers in practice honestly held beliefs consistent with the communist system, while there were others who, in order to practice their profession, outwardly followed those beliefs while holding others.

Definitions

- Academic physician: a person who has chosen medicine as their career and is a practicing teacher.
- Capitalism: a “system of markets, private property rights, decentralized power and individual responsibility for human behavior” (Seldon, 1990, p. 4).
- Change: "a difference in what was--an alteration in feeling, thought, or action" (Fox, Mazmanian, & Putnam, 1989, p. 1). "...an increase in knowledge, the acquisition or improvement of a skill, or a change in attitude or behavior" (Zinn, in Galbraith, 1998).
- Collective: "a social entity growing out in specific socially economic conditions and meeting certain internal, socially psychological criteria" or "a pedagogical means" of educating the members of the group in the principles of collectivism. This definition is important in understanding both healthcare and physicians. Socialist healthcare used terms of collectivism, collective, and teamwork. In regard to socialist physicians, the "physician must be prepared for his profession so as to be able to lead, control and organize the working collective entrusted to him" (Vykydal, Vykydal & Pohanka, 1988, pp. 465-476).

- Communism: “a radical branch of one of the great ‘reform’ movements of post medieval Western history” (Robertson, 1992, p. 60).
- Culture: “the more or less patterned actions of persons and groups” (Buckley, 1998, p. 82). Culture is created when people agree to be concerned about the same values, cultural foci, and themes which is then expressed through behavior, words and symbols in social settings (Spindler & Spindler, 1987, p. 2). “Culture in fact is the name we give to what gives meaning to our lives and provides us with a map to find our way therein” (Kumar, 1984, p. 36).
- Democracy: a system of values governing behavior including: full and free communication, regardless of rank or power; consensus instead of coercion or compromise in management of conflict; permission and encouragement of emotional expression; and, human bias accepting the inevitability of conflict but willing to mediate on rational grounds (Bennis, 1993, p. 22). "The practice of common citizens living, working, learning, and ruling themselves in ways more just and equitable than those derived by oligarchies, monarchies, aristocracies, or dictatorships. A democracy protects free expression, the general diffusion of knowledge, the marketplace of ideas and the open pursuit of truth so that citizens continually educate themselves to participate, learn, and govern in ways beyond the limited ideas of individuals" (Glickman, 1998, p. 21).
- Education: promotion, guidance and/or facilitation of some sort of change in individuals (Zinn, in Galbraith, 1998, p. 39). The Northwest Ordinances of 1787 states the purpose of education in the United States is to:

Create and perpetuate a nation dedicated to particular principles; develop a citizenry capable of self-government; ensure social order; equalize educational

opportunity for all; and, provide information and develop the skills essential to both individual economic enterprise and general prosperity (Glickman, 1998, p. 21).

- **Ethics:** "...the normative analysis of the moral agency of individuals and institutions and the values they seek" (Wilcox & Ebbs, 1992, pp. 4-5). "...tells us what we ought to do...based on our belief about what is good and right" (Pratt, in Galbraith, 1998, pp. 115-116). There are a variety of ethics that may come into play in a given situation: justice, caring, or duty (Galbraith, pp. 117-123).
- **Learning:** internalization of ideas, practices and information that the individual encounters through daily living or planned pursuit of knowledge. Learning is a change in consciousness in the learner (Merriam, 1993, p. 53).
- **Professional:** a person trained in a formal institution to carry out the business of society through the definition and solution of its problems (Schön, 1983, pp. 3-4).
- **Professorate:** the level of teacher who fills a position in a university system
- **Society:** "a higher level system of interrelated 'components' (i.e., individuals and groups) bonded into a larger whole through the mental bondings of group, structural, and cultural role and personal interrelationships" (Buckley, 1998, p. 13).
- **Teaching practices:** the activities undertaken as part of the endeavor to help students learn.
- **Transformational learning:** A process that effects change within a frame of reference, the experiences adults have had in life and that define our world (Mezirow, in Cranton, 1997, p. 5). Learning that produces change more far reaching in the learners than learning in general and the changes impact the rest of their lives (Merriam, 1993, p. 47).

- Values: "an enduring belief that a specific mode of conduct or end-state existence is personally or socially preferable to an opposite or converse mode of conduct or end-state existence" (Rokeach, in McGregor, 1991, p. 181). "Once a value is internalized, it becomes, consciously or unconsciously, a standard or criterion for guiding action" (Rokeach, in Galbraith, p. 40).
- World outlook: "a specific phenomenon of social consciousness and as a personality trait which represents a dialectically uniform system of knowledge, convictions, evaluations and standards conditions and motivating human activities" (Valenta, 1986, p. 222). Valenta suggests there are several things that must be emphasized in world outlook education: "it is an approach to the world, a type of thinking and acting;" that it concerns "what attitude to the world is being formed by the educational process used;" it "requires a new method of contemplating the discipline, knowledge of general theoretical, methodological and world outlook principles of science," and theory creation; and at the university level, the world outlook must be formed by making the proper relationship to practice (Valenta, pp. 224-225).

Limitations of the study

The history and development of the culture of two countries, specifically the United States and the Czech Republic must be and are different. Therefore, it will not be possible to make direct comparisons to either physicians in the U.S. or the systems of education. It will be important to keep the study focus on how social and cultural changes impact the profession and education of future members. A second limitation of the study is that it is a first step that will lead to more work in the area of preparing teachers in a profession to recreate their professional knowledge and culture in new members in

situations of great change and conflict. Given this, the study will not be immediately usable to reform how teachers are trained in order to help them learn to change, and be accepting of change, more easily. This is a limitation that should be overcome with more research as a better understanding is developed of the relationship between teachers and cultural change.

Summary

How physicians are trained affects the way they practice. How and why does the professional teacher of medicine change in order to assist their students in learning to adapt to a new practice environment? While many studies have contributed to the understanding of this project, elements will be drawn from the study of how physicians change and learn in professional life by Fox, Mazmanian and Putnam (1989), reflection in practice by Schön (1983); and, life-span development theory by Sugarman (1986). The practice of the educational arts is one influenced by the society in which it is pursued. What was not known was whether these theories would hold true across cultural lines since each was developed from studies using participants in Western cultures. An understanding of how and why teachers who have experienced change due to outside forces have adapted in their approach to their profession has been developed to help prepare future teachers to enter a career in a field where change comes swiftly in many areas.

Because there has been no study to determine whether cultural differences exist in the way physicians change, as well as how academic physicians adapt to societal changes, this was a qualitative study, which produced an explanation of how teachers in a profession change in order to adapt to outside social forces. By using qualitative methods

it was possible to obtain an understanding of the impact on education of cultural and professional changes experienced by academic medical faculty from their own words and experiences.

CHAPTER TWO

Historical background of the problem

When a person became a Communist he wanted to be a good Communist. We believed we were building on the ruins of a system that had failed but that had left a deep imprint on our way of thinking. We were, we thought, burdened with obsolete ideas, prejudices, weaknesses. Why had we surrendered to Hitler? Why had we allowed ourselves to be locked up in concentration camps and prisons? Because we were weak, spoiled, degenerate. If ever we wished to achieve anything, we had to change (Kovaly, 1988/1997, p. 76).

Introduction

One of the great ironies of the Czech Republic is that the country and its leaders have always supported academic vision and the dreamers who saw the vision, yet in the last century communist education has tried to erase this academic individuality from the culture. In the 1600s, Jan Comenius established the modern educational system used in the Czech lands and envisioned a universal educational system that led toward advances in early childhood education and second language learning still used today. A second outcome of his work in education was that he strove to keep the Czech people and culture from being assimilated by Germany and the German culture (Shimoniak, 1970, 293-294). Tycho de Brahe, whose remains are buried in a place of honor in Tyn Cathedral in Old Town Square, and Johannes Keppler relocated to Prague at the request of the king, Rudolph II, in order to be able to follow an academic path in mathematics and astronomy (Čornej & Pokorný, 2000, p. 28). Even Jan Hus, a man burned as a heretic for preaching religious reformation in 1415, impacted education by creating the system of diacritical markings that made Czech a uniform written language and served as dean in what was to become one of the great universities of Europe (Čornej & Pokorný, p. 22).

History of the University

Even before these events were taking place, around Europe communities of scholars were creating international centers of learning in various cities. The 13th century has been described as the “golden age of the university” so it seems especially befitting that the first university to appear in parts of Europe outside the Latin and Western countries should be in “Golden Prague” (Boyce & Dawson, 1937, p. 11). It is believed that students and teachers had been participating in a “studium particulare” held in St. Vitus’ cathedral since 1074, but the university now known as Charles University was not chartered until 1348 (Boyce & Dawson, pp. 11-13). Charles IV, recorded in history as an educated man who spoke French, Italian, German, Latin and Czech, eventually became Holy Roman Emperor in 1355, which served to strengthen the prestige of the Czech lands (Čornej & Pokorný, 2000, pp. 19-20). Since Prague was his residence, Charles worked toward enhancing the city through building projects that included the New Town and Charles University (Čornej & Pokorný, p.20).

When the wording of the university charter is examined, it becomes evident that Charles IV had the purpose in mind that this new institution would be an international center modeled after those “studia” found in Paris and Bologna, the two most international schools in existence to that date (Boyce & Dawson, 1937, pp. 20-21). Charles IV provided that “all doctors, masters and scholars going to Prague should be under the protection of the king and that they should have all privileges, immunities, and liberties customarily enjoyed...” in his effort to draw students and scholars from both surrounding and distant countries to his new institution. It seems to have been a provision that accomplished his purpose given that the record shows students came from Germany,

Poland, Hungary, Lithuania, Italy, France and England (Boyce & Dawson, p. 23). In this way, Charles IV intended to make Prague, where the university was situated, the cultural center of his kingdom (Boyce & Dawson, p. 21).

In order to provide the structure to support education, the university administration was headed by the “Rector,” who was required to be 25 years old, celibate, a cleric and of legitimate birth, but not necessarily a graduate (Boyce & Dawson, 1937, pp. 25-26). Therefore, the first rector was a student in the faculty of medicine, one of the first faculties to be developed, along with theology, canon law and arts (Boyce & Dawson, p. 24). In the faculties of arts, theology and medicine, study was guided by the Deans, who were further aided by examiners and beadles (Boyce & Dawson, pp. 25-26). There was also a body of advisors appointed to give aid to the Rector and to generally supervise the finances of the institution (Boyce & Dawson, pp. 25-26).

For an institution founded to become one of the jewels in the Czech capital city, the history of Charles University has been rife with upheaval and change. Prior to his death in 1415, Jan Hus served as Dean of the arts faculty and took actions that pushed for Czech control of the university, a move which would change the originally intended international character (Boyce & Dawson, 1937, p. 34). On January 18, 1409, King Wenceslas issued the Decree of Kutna Hora, changing the university constitution so that there were three votes on issues before the university councils, giving majority control of university disputes to the group aligned with Hus (Čornej & Pokorný, 2000, p. 22). The change stipulated that German, Polish and Barvarian groups would share one vote, with Czech participants retaining the remaining two votes (Boyce & Dawson, p. 35). Whether

this was the intent of King Wenceslas or not, it served to create an atmosphere in which foreigners felt excluded and they responded by immediate withdrawal from studies (Boyce & Dawson, pp. 35-36). It is recorded that German students left “zu Fuss, zu Pferd, und zu Wagen” - on foot, on horse and on wagon (Boyce & Dawson, pp. 35-36). Additionally, the Rector and students were required to take an oath to university statutes, King and realm, another move that would make foreign scholars and students uncomfortable in an institution where they had previously been welcomed (Boyce & Dawson, p. 37). Through this period of university change, Jan Hus was also an actor on the stage of the religious world through his efforts to preach reform of the Roman Catholic Church. While the university continued to support him, theologians did not, a change which would result in his death. According to Boyce and Dawson (p. 37), the death of Hus removed the only figure who may have been able to carry the university through the loss of students and the changes that followed. By 1416, Charles University had lost the right to grant degrees or to hold property (Boyce & Dawson, p. 37).

While Protestantism was gaining popularity quickly in Czech lands, King Ferdinand I of Hapsburg was working toward the restoration of a catholic seat of orthodoxy in Charles University (Boyce & Dawson, 1937, pp. 38-39). He interfered in the professional salaries paid teachers, which were already low or non-existent, and took action to withhold university degree-granting privileges until 1537 (Boyce & Dawson, pp. 38-39). One step in his efforts to restore Catholicism to the Czech lands was to create the Clementinum in order to house studies in philosophy and theology, the latter being directed by Jesuits brought in from Rome (Boyce & Dawson, p. 40). The plan was to abandon the university but it was saved in 1609 when Rudolph II granted a “Letter of

Majesty” that placed Charles University under supervision of the Bohemian Estates (Boyce & Dawson, p. 41). Reorganization of the faculties of medicine and law was accomplished, new theology professors were retained and professors were no longer required to be celibate (Boyce & Dawson, p. 41). These actions would only be in effect until the Battle of White Mountain on November 8, 1620, when the Jesuits were given control of the university (Boyce & Dawson, pp. 41-42). The next major change in university structure would take place on February 23, 1654 when the older Charles University and the newer Clementinum would be combined by Ferdinand III (Boyce & Dawson, pp. 42-43). At that time, Charles University was granted the control and governance of the “worldly” faculties of medicine and law, while the “spiritual” faculties of philosophy and theology were to be the purview of the Clementinum (Boyce & Dawson, 42-43). Actual reforms would not occur until Empress Maria Theresa brought the university under the governmental control of the Hapsburgs (Boyce & Dawson, p. 44). In 1784, German became the official language of instruction, replacing Latin (Boyce & Dawson, p. 44).

During this period of control by the Hapsburgs, Joseph II issued a Patent of Toleration, on October 30, 1787, allowing Jews and non-Catholics to attend university lectures without having to take the oath of adherence to Catholicism if a degree was granted (Boyce & Dawson, 1937, p. 44). In 1848, events in the Czech lands were leading to a revolution of the citizenry who wanted more recognition of minorities and the Czech nationality from the ruling Hapsburgs. Czech people were to petition Emperor Ferdinand for the use of the Czech language equally with German in schools. By June of 1848, Czechs in Prague and Imperial troops would bring the revolution to an end (Boyce &

Dawson, p. 46). The short-lived revolution did have an impact in that “lehrfreiheit,” the principle of freedom in teaching, gave professors the right to lecture to their classes in any language they chose (Boyce & Dawson, p. 47). From 1861, chairs would be established where instruction would be held only in Czech, which would lead to the university becoming a bilingual institution (Boyce & Dawson, p. 47). Later, J. E. Purkyne, a Czech physiologist, described this division of languages as a necessity in order for Charles University to finally become a Czech institution (Boyce & Dawson, p. 49). In 1872, a petition was given to Emperor Francis Joseph by the city of Prague and Czech scientists asking for the establishment of a Czech university (Boyce & Dawson, p. 50). April 11, 1881 saw the signing of an imperial order to create a second university, which would use only the Czech language for instruction. This new institution would bear the name Karolo-Ferdinandea, from the old union of Charles University and the Clementinum in 1654 (Boyce & Dawson, p. 51).

Even though the major academic institution has seen great upheaval and change through the centuries, it has always been obvious that education is an important part of the Czech culture and identity. Therefore, in a land where education has historically been supported, it is not surprising that Tomas Garrigue Masaryk, the first president of the Czech nation in 1918, believed his position was to be the visionary and thinker for the entire country. Not attached to a political party, he was free to consider what was best for all in the nation and to be the guide in achieving that goal. In developing a national education system, President Masaryk steered the country away from Russian “dictatorial ideas” and did not allow the implementation of imperial Russian or communist educational practices (Shimoniak, 1970, p. 294). In the days prior to World War II,

English and French philosophies were popular and influenced free societies, literature, art, technology, and more importantly, education (Shimoniak, p. 294).

After the founding of the Czechoslovakian State, the universities did not have a respite from the conflict and change that characterized the previous centuries. Just 2 days after the creation of the Republic on October 28, 1918, the German Karl-Ferdinand University was forced to hand over the ceremonial keys and historical documents, which stripped it of any standing in the eyes of the citizenry (Boyce & Dawson, 1937, pp. 59-60). Because the new nation was trying to develop an identity, political relationships were unclear and unsettled, which did nothing to calm the association with the German minority living there (Čornej & Pokorný, 2000, p. 39). Further insults were given when the national council sent soldiers to search not only the buildings, but also students and professors entering and leaving, including personal items such as books, portfolios and pockets (Boyce & Dawson, p. 61). The mood toward students in what was once intended to be an international institution had changed radically and German students suffered beatings on the city streets (Boyce & Dawson, p. 61). In order to defuse some of the unrest surrounding the school, German professors voluntarily took the oath of allegiance to the new republic before it was required of them by law and asked that they be allowed to continue teaching in the university no matter what would be happening in future political events (Boyce & Dawson, pp. 64-65). This sacrifice was to be in vain as political events led to an attempt to move the German University from Prague to Reichenberg in 1919 which was not supported by the government (Boyce & Dawson, pp. 71-72).

A new effort led by university personnel to split the University in 1920 failed when Dr. Masaryk, a former professor, refused to permit the event to occur due to the

feeling in both government and the Czech people that 6 centuries of tradition was too much to relinquish to the political mood of the day (Boyce & Dawson, 1937, pp. 74-75; p. 82). It seems contradictory that during this same time period, the Czech people established schools where members of every ethnic language group could educate their children in their respective native tongue, Czech, Slovak, German and Ukrainian, and at every level of education (Shimoniak, 1970, p. 294). As was reported in the leading newspapers of the day, not everyone felt that the rival universities should be cleft asunder. The Pravo Lidu newspaper editorial read: "Both Prague universities, independently of their names, should rank jointly as the heirs of the fame of Karl's foundation. They should be regarded as sister universities, united in a single aim and not divided" (Boyce & Dawson, p. 82). Editors of the Nova Svoboda wrote: "We accept the view that both universities are the successors of the Karl University, and that in leaving to them equally the historic name, the Austrian government acted very sensibly" (Boyce & Dawson, p. 82).

Effects of outside control

This unsettled, but progressive period of education would last only until 1938 when the nation would become the German Protectorate of Bohemia and Moravia. In 1939, bickering about university names and insignia became lesser issues when Adolph Hitler closed all Czech universities and colleges. As had been true in the past and would be again in the future, university students became leaders of the political uprising against the occupation by Nazi Germany (Čornej & Pokorný, 2000, pp. 59-60). At a demonstration to celebrate the founding of Czechoslovakia held on October 28, Jan Opletal, a student of medicine, was killed by a German policeman (Čornej & Pokorný, p.

60). Further demonstrations at his funeral led to the closing of all Czech higher education institutions, nine student leaders were shot and many students were taken to the concentration camps (Čornej & Pokorný, p. 60). In order to assure that the Czech intelligentsia was under control, the universities were closed on November 17, 1939 (Čornej & Pokorný, p. 60). Only the German university was re-instituted by Hitler in order to serve "Nazi ideology" (Kop, 1947, p. foreword). While becoming a German protectorate saved the country from the damage war caused in other parts of Europe, the harm done to the moral life of the Czech lands was high since it left the upper levels of society not knowing what their position or their purpose was in the society (Connelly, 2000, p. 78). Thus it was a difficult beginning to a time of control by outside governmental forces, which would last until the Velvet Revolution in November 1989 and the overthrow of a communist society imposed by the Soviet Union.

Part of the goal for this period of communist control involved remaking the Czech society into one that followed Marxist-Leninist theory, according to the development plan established by the 15th Congress of the Communist party of Czechoslovakia (Lisonkova, 1982, p. 282). This plan included goals to improve the quality of life both economically and morally because, to develop fully, the people had to understand the principles of socialist morality as outlined in the moral codex (Lisonkova, p. 282). To achieve this quality of life, communist education was necessary because it was the way all people acquired knowledge and it was a method "of changing the world" (Lisonkova, p. 281). In order for this ideal situation to exist in society, Czech schools must be reformed to carry out the mandate of communist education.

In the effort to change Czech society, the school system would have been of great benefit since it was a highly developed and comprehensive system. The organization of Czech schools included nine years of basic elementary level schools, general schools, apprentice training schools, vocational schools, general secondary schools and a well-developed university education system (Shimoniak, 1970, p. 297). The university system included four types of institutions: general universities, technical universities and colleges, art schools and teacher training colleges (Shimoniak, p. 298).

The major purpose of Soviet schools and colleges was to shape the knowledge and how young people saw the world through an all embracing and multifaceted process of education (Avis, 1987, p. preface). A major goal of this system was to train young people to have a certain outlook on life through the development of communist morality, collective spirit, comradeship and humane relations (Lisonkova, 1982, pp. 281-282). Attention must be paid to the formation of the world outlook because it was "the heart of the matter as far as its objectives and components are concerned" and it served as the hinge upon which all other elements of communist education were based (Valenta, 1986, p. 221). Czech students were to be educated in the spirit of Soviet Russian patriotism, love for Socialist countries and, finally, love for the Czechoslovak Republic (Shimoniak, 1970, p. 295). This was accomplished through "vospitanie," a program designed to build character in 11 ways that encompassed political, social, physical, religious and personal realms of education (Avis, pp. 1-3). The impetus for this program lay in the way teachers at all levels carried out the moral imperative for training the student, both inside and outside the classroom (Avis, pp. 6-7). Therefore, teachers were key figures in the effort to change Czech education to more closely resemble the structure of Soviet schools.

University teachers held unique place in social change

It seems beyond belief that in Czechoslovakia after the Communist coup in 1948, people were once again beaten and tortured by the police, that prison camps existed and we did not know, and that if anyone had told us the truth we would have refused to believe it. When these facts were discussed on foreign broadcasts, over Radio Free Europe or the BBC, we thought it only more proof of the way the “imperialists” lied about us. It took the full impact of the Stalinist terror of the 1950s to open our eyes (Kovaly, 1988/1997, p. 14).

At the university level, the professorate posed a special problem to the reform of education. The history of the professorate in Czech universities was one that, while they did not actively oppose communism, neither did they actively cooperate with the party (Connelly, 2000, p. 6). It was not until the spring of 1948 that many in the ranks of the professorate joined the party and this action was only taken then because they were threatened with removal from their teaching posts (Connelly, p. 40). In their efforts to subjugate the educational institutions and force changes that would create a system more like that in Russia, violence had begun to be used as a means of coercion and Czech professors began to join the party as a refuge against the violence (Connelly, p. 145). Another important element of this shift to the Communist party was that this particular action was seen as one where the individual would not be judged as having acted against the national interest of the Czech lands (Connelly, pp. 144-145). Professors hoped this would ensure that they were “left in peace” to follow academic pursuits of teaching, research and publication for the compromise of party membership (Connelly, p. 151). While it seemed a small price for the larger benefit of being able to continue academic activities, it was but the first to be paid.

When the Communist party took over political control of the Czech lands, they entered a nation with a modern society where the social classes were well defined. In part

this was due to the extensive system of higher education that the upper and middle classes had come to expect as a form of birthright for their children (Connelly, 2000, p. 6). It was also a society that had well-developed traditions and social expectations, so the deterioration of the social traditions of the educational community, where professors had previously been treated with respect, was a hard change for the society to accept (Connelly, p. 181). Eventually, students began to call professors with the common form of address, “ty”, rather than the formal and respectful form, “vy”, or “Pane Profesor,” a titular distinction considered befitting the position of a professor (Connelly, p. 181).

In higher education, the Soviet system had the goals of producing specialists who had the "necessary views and skills in the ideological, political, social and moral realms" (Avis, 1987, p. 212). Graduates of this program would be both dedicated professional workers and principled, informed political activists (Avis, p. 212). Healthcare, and the young physicians providing it, received special attention because "The morality of the socialist physician is above all the morality of the socialist man" (Lisonkova, 1982, p. 282). But even as early as the 1950s, there began to be proof that the formation of the proper world outlook in medical faculties was especially difficult. Instead of being understood as the integrating factor for all communist education, it had been reduced to a political attitude (Valenta, 1986, p. 221). At the medical faculty, world outlook training should have complemented training in the general advantages of socialist healthcare, the possibilities of man's development under socialism, and ethical problems of medicine (Valenta, p. 223). "Scientific world outlook is not what follows only additionally from scientific cognition" (Valenta, p. 224). Somehow, medical education was not reaching the

students in ways that helped them to understand this relationship of world outlook and medical practice (Valenta, p. 225).

One tenet of the communist medical system was that it provided care without charge and without choice of physician or treatment plans, so the physician provided care for an entire nation pragmatically, rather than for the needs of the individual. "The socialist physician is not a private earner, as in the capitalist society. He takes care of the health of every man, free of charge, irrespective of the cost" (Lisonkova, 1982, p. 283). Yet there were years after 1948 when the top specialists in the land, in both medicine and the sciences, were forced to depend on their families remaining in rural areas of the country to keep them alive (Connelly, 2000, p. 10). The system that provided for the care of "every man" was not providing for its own. In the Socialist system, medicine had become a low-status profession, "simultaneously both powerful, when it dealt with patients, and powerless, when it dealt with the polity" (Field in Barr, 1995, p. 374).

Due to the nature of medical education, the faculty could not be completely purged in order to place teachers who would hold to the party line (Connelly, 2000, p. 71). Older teachers were seen as unpredictable since it was never sure that they were not still teaching students traditional values, instead of the new values of socialist beliefs (Connelly, p. 71). As other faculties experienced closures of entire programs or massive losses from purges to rid the university of the non-compliant, older professors, medicine remained virtually intact at the professorial level losing only four of the faculty, one full professor and three docents (Connelly, p. 132). In 1948, the medical school was three times larger than the law program at Charles University in Prague. Even with this disparity in size, medicine was to lose only the one professor who had earned the

habilitation, which is a second dissertation, while the law faculty lost one professor and 12 lecturers with this important academic degree (Connelly, p. 63). This ability to retain experienced and proven teachers in the medical faculties would be one decisive factor in the maintenance of both the academic life and the professional standing of the field in the coming years.

Even with the ability to retain medical professors, the practice of medical education would be changed due to changing demographics and characteristics of the institution. Not only were there purges that removed professors from teaching posts, but the student body was not without losses experienced in the years that followed the advent of the change to a Soviet-style education system. In 1937, the student-teacher ratio in Czech institutions of higher education was 17:9, by 1952, this had risen to 37.4:1, and in 1956 the ratio became 48 students on campus to every teacher available in the system (Connelly, 2000, p. 63). During the academic year of 1948-1949, one-fifth of all students in the medical school located in Brno were removed from course work and one-third of the teaching and research assistants lost their positions (Connelly, p. 63). By 1954, 34 percent of the students remaining in medical school failed their first year exams (Connelly, pp. 63-64). When considering adult development, Alan Knox (1977) wrote that change must be followed by a stable period of performance as proof that the person experiencing the change is once again competent, but these numbers do not indicate a system that had successfully negotiated a change in Czech higher education.

In the effort to achieve a true communist and collectivist education at all levels, according to Vykydal, Vykydal and Pohanka (1988) there were three major problems associated with university education. First, the nature and organization of university

studies is one of individuality on the part of the learner. The structure of university classes did not lend themselves to the development of collectives, in the social or educational sense of the term (Vykydal, Vykydal & Pohanka, 1988, p. 473). Second, there was a fear that the personality of the student was already formed due to their age. Yet, even this could be overcome by communist education, since the university student was also considered to be of an age when "the need and importance of natural relationships to their equals culminate" (Vykydal, et al., p. 475). Here, the position of the university teacher was vital to the achievement of personality change in university students. Finally, the remaining problem was the teacher who practiced at the university level. It was understood that methods chosen for use with younger students would not be accepted readily by the university student, so the teacher must be one who held a high standard of pedagogical competence and preparation in his/her own training to work with students (Vykydal, et al., p. 475).

Due to the particular nature of medical education, a clear vision was not given of how the basic tenets of communist political education would be transmitted without a uniform and united front being presented by the professors in the faculties of medicine (Vykydal, Vykydal & Pohanka, 1988, p. 476). Yet one crack in the system was evident in 1953 when the traditional degrees of doctor and habilitation were replaced by the degrees used in the Soviet system, "kandidat" and the doctor of science degree (Connelly, 2000, p. 65). Medical students revolted at being forced to graduate after the six years of work they had completed in school, many times at more than 48 hours per week spent in classes, without being accorded the "dignities" that previous classes had been given (Connelly, p. 65). Those Czech students wanted the traditions of the program and the

society that had graduated the generations of doctors before them. In the Czech society at large, there was the sense that the Soviet system of education had become a threat to the national culture (Connelly, p. 19).

I shall never forget the first large youth rally that March.... All these young people had been born and reared in a society walled in by censorship, where the expression of any independent opinion was routinely treated as a crime. What could they know about democracy? How could they even know what they wanted... They knew exactly what they wanted and what they did not want, what was open for compromise and what was not. The spring of 1968 had all the intensity, anxiety and unreality of a dream come true (Kovaly, 1988/1997, pp. 210-211).

After the Prague Spring uprising in 1968, Victor Drapela (1971) became interested in how the failed revolution had happened in Czechoslovakia and what it said about the people living in the society. He examined elements of Marxist theory, methodology and ideology and made conclusions about how the people living in the Czechoslovak society had developed at that time. Then, capitalism was seen as the direct opposite of socialism in three areas: social systems; ideological foundation; and, the differences between collectivism and individualism (Drapela, 1971, p. 361). While capitalism was viewed as a system where the person was torn apart by involvement with the system, socialism descriptors in Marxist literature used adjectives such as “therapeutic, anthropocentric and growth-promoting” (Drapela, p. 362). Not only was socialism a system of thought, it was one that tolerated no philosophical discussion (Drapela, p. 362). The individual personality promoted through capitalism was no match for the sensitivity, altruism and selflessness of the socialist person who developed by and lived a collectivist life style, according to the official writings (Drapela, p. 362).

In the creation of the ideal socialist man, the Communist party was to be instrumental in helping each child develop a philosophy of life and here, once again, the

teacher was to act as the guide for this development (Drapela, 1971, p. 363). In the Soviet school system, each teacher was charged with the advisement of students (Drapela, p. 363). It did not seem that this program was working as effectively as the Party wished when the young intellectuals of Czech society began to call for reformation to the socialist ideology that included socialist humanism, tolerance and the freedom to pursue ideological experimentation (Drapela, p. 365). It is especially telling that this revolt was not begun by the generation who had lived under the last democratic government, but by the young people who had grown up in the socialist education system (Drapela, p. 365).

After the invasion of Czechoslovakia by armed forces in 1968, there was once again a purging of teachers considered dangerous or ineffective in promoting the tenets of communist education and life. Termed a “self-evaluation,” teachers who had supported reform prior to 1968 were given the alternative of recanting or resigning (Drapela, 1971, p. 366). Drapela reported that “The drive has been particularly intensive and effective in colleges and universities” (Drapela, p. 366). It seems that this period, when people sought reform and change of the social system, was once again a difficult time to be a teacher in the Czech lands.

Since the Velvet Revolution, the Czech Republic has made many political, economic and public welfare changes. According to news reports, aspects of this change have been difficult transitions to make. As early as 1990, recommendations were voiced to implement reforms that would help humanize medical services and raise salaries for physicians (Prowse, 1990). Hospitals have faced shortages of important drugs and having the water shut off because the bills remain unpaid and nurses abandoned the country for wages that enabled them to live at the same level as others in the society (Simons, 1992).

By 1995, deaths from smoking-induced cancers were rising among the former communist states, while these deaths had leveled off in the U.S. and Western Europe. Also, there was a rise in associated diseases of the lung and cardiovascular disease (Reynolds, 1995).

Amid the turmoil of changing to a market-driven system of care, physicians are struggling to reestablish ethical guidelines and self-governance not promoted under communist rule. Debates between the Health Ministry and doctor's associations raged concerning how ethical and licensure issues would be decided (CTK National News, 1995). Physicians went on strike over pay and the new insurance system, but physician association members did not agree on what actions could be ethically undertaken to bring public attention to the plight of the profession (Rich, 1995). In the midst of these changes, Prague teaching hospitals faced a reduction of 3,000 patient beds, with a total of 20,000 acute care beds across the country to be cut by 2000 (Legge, 1997).

Yet in the Czech lands, physicians had managed to keep much of the control of their own profession, lost in other Soviet states (Barr, 1995, p. 374). After the revolution, physicians still held positions of prestige in a system that had developed in ways that closely resembled Western medicine. The structure of the professional hierarchy was based on age, gender, type of training and qualification, specialty, salary commanded and type and geographical location of the health institution in which each worked (Barr, p. 374). Even with ten years of turmoil in the healthcare system, the First Medical Faculty of Charles University was the first program to receive accreditation from the U. S. Department of Education (CTK National News, 1999). In spite of the recent history of social change, people are working toward excellence in the training of the next generation of physicians.

Summary

From the beginning, conflict and change have been themes in the history of university education in the Czech Republic. Much of this has followed the political issues of the day, but the determination of the members of Czech society to keep Charles University operating has served to overcome these obstacles. While the history and tradition of education is very important to the Czech people, it seems that the decision to teach in the University has many times come at a high price for those who choose this life. Even through times of hardship and repression, teachers in the professions continue to train the next generation of lawyers, architects, economists and physicians.

CHAPTER THREE

Literature review

Introduction

When an entire society changes, the reports are heard on the news and read in newspapers. But societal change is much more than just a newsworthy item. Changes that impact the entire social system will have effects that cause ripples of changes in the lives of individuals in the culture for many years to come. These are the changes that touch the human heart because they are the most personal, they change who we are as citizens, professionals and teachers.

For the development of this study, three major areas of questioning hold interest: first, are there differences in the way physicians from non-western cultures change, learn, and reflect on their practice after experiencing a cultural shift; second, have cultural changes caused change in the professional culture of medicine in the Czech Republic; and finally, have events in the larger Czech society changed how academic physicians teach? Theories from three perspectives will be considered in helping to answer these questions: how physicians change and learn by Fox, Mazmanian and Putnam (1989); reflection in practice by Schön (1983); and, life-span development theory by Sugarman (1986).

Change and learning

In order to understand how and why physicians change and learn, Fox, Mazmanian and Putnam (1989) interviewed 340 physicians who were located near 26 different medical centers in the United States and Canada. In examining the data from

these interviews, 775 reported cases of change were analyzed (Davis & Fox, 1994, p. 19). The two assumptions used to guide the study were that changes made in medical practices were common and observable, and that many of these changes require the physician to learn new information and develop new skills (Davis & Fox, p. 19). Three ideas emerged from the data that formed the basis for the development of a model of how physicians change and learn. First, change is not made without reasons. Second, just because change is deemed necessary or important, it is not achieved without the development of new knowledge or skills on the part of the professional. Third, change occurs in a range of dimensions from those considered minor to those considered to be life altering (Fox, Mazmanian & Putnam, 1989, pp. 8-9). Also, the study demonstrated that change is a regular part of the practice of medicine and is pursued in a systematic process by the practitioners (Davis & Fox, p. 19).

From this study, several overarching forces for change were described by participants: professional, personal and social. In addition to these three categories, there were also changes attributed to a mixture of professional and personal reasons and a mixture of personal and social reasons (Fox, Mazmanian & Putnam, 1989, p. 9). The forces described by physician respondents included: curiosity, personal and financial wellbeing, the stage of their career, a desire to enhance or develop a new competence, patient and colleague expectations, and the expectations of the healthcare institution in which they performed professional duties (Fox & Bennett, 1998). For the physicians in this sample, professional forces and the combinations of professional/social and professional/personal far outweighed learning done for purely social or personal reasons (Fox, et al., p. 17).

After becoming aware that a force for change had initiated a change process, the physician begins to develop an image of the change as it would take place in his/her life or practice (Davis & Fox, 1994, p. 19). These images of change were different based on what force had initiated the change and whether the change required a larger, more complex change or a smaller, simpler change (Fox & Bennett, 1998). If the physician was able to imagine the change clearly, the ensuing change process was more efficient and took a shorter period of time (Davis & Fox, p. 19). If the change was not imagined clearly, the process took a longer period of time and was less direct (Davis & Fox, p. 19). The next step in the process was a personal evaluation of the knowledge and abilities needed to make the change (Davis & Fox, p. 19). This evaluation is comprised of four steps: estimation of knowledge, skill or performance in relation to the change; estimation of what is already known in the particular area; estimation of the difference between the two points; and, a resulting level of anxiety based on the determination that what is known does not meet the new level of need (Fox & Bennett, 1998).

Depending upon where the physician placed his or her own expectations for performance, the difference between what was known or able to be done and what was needed varied. Those who hold themselves to higher levels of performance and knowledge envision higher requirements in terms of personal skill and knowledge, those with the desire to be competent rather than expert have less high expectations of the amount of change required (Davis & Fox, 1994, p. 19). If the physician was one who saw the difference between what was known and what was desired as large, the personal effort to learn would be greater (Davis & Fox, p. 19).

Change involved “organized, information-based thought” on the part of the participants (Fox, Mazmanian & Putnam, 1989, p. 47). Even though change and learning may occur in one area of a physician’s life or practice, it may not be followed by a corresponding change in an associated area of his or her life or practice (Fox & Bennett, 1998). The authors gave the example that a change in ability to perform a procedure did not mean the procedure would be incorporated into the medical practice of the individual (Fox & Bennett, 1998). Rogers (in Fox & Bennett, 1998) describes five features of innovation, or change, that affect the way a professional adopts the innovation: complexity; relative advantage when compared to practices and procedures currently in use; chance to observe before adopting the innovation into his or her personal practice; how compatible the change is with procedures and products already used; and, having opportunity to try the innovation prior to adoption. This has helped lead the planners of continuing medical education to focus on change in physician performance, rather than in patient outcomes, since one change does not necessarily lead to the other (Fox & Bennett, 1998).

Not only was learning an integral part of the process of change described by physicians, it was sometimes the impetus for change (Fox, Mazmanian & Putnam, 1989, p. 47). But whether the change came before or after, learning was central to the development of a solution to the problem (Fox, et al., p. 48). If personal forces of emotion or attitude were the beginning of the change, the result was a larger and more complex change than if the learning was in response to a physical problem in the life of the person (Fox, et al., p. 52). When made in response to professional or social forces, the resulting change was smaller and less complex in nature, while regulations requiring

change were met with resentment and change only at the level of accommodation (Fox & Bennett, 1998). Accommodations were described as small, simple changes made in a compliant way and were probably associated with a negative attitude toward having to make the change (Fox, et al., p. 21). Adjustments moved from small to moderate changes of an incremental nature which were usually viewed as a positive change, but generally had little emotion associated with the change (Fox, et al., p. 21). Redirections were larger changes requiring a complex change, termed structural, and usually had a positive emotion accompanying the change (Fox, et al., p. 21). The category of the largest changes made were transformations which involved changes that affected many areas that were interrelated and carried a strong emotional association, which was usually positive in nature (Fox, et al., p. 21).

Learning was both a part of changes made by physicians and a process that involved three phases: “assessing the need for new competence,” “gaining new competence,” and “implementing new competence” (Davis & Fox, 1994, p. 20). The authors noted that different learning resources were chosen for each of the steps of the change. In the assessment phase of change, physicians reported they used many types of resources, obviously seeking to learn as much as possible in the effort to make well-considered decisions, but relying heavily on formal education programs and colleagues (Davis & Fox, p. 20). Moving into gaining new competence, the physicians relied more on colleagues and reading than formal educational sources for information (Davis & Fox, p. 20). Finally, when the change was being solidified in the implementation phase, colleagues were still the most predominate source of information, but once again, formal resources of educational programs and journals were used again (Davis & Fox, p. 20).

Recent studies on practice based learning have helped to further explain three facets of the process: self-directed learning, group learning, and organizational learning (Fox & Bennett, 1998). The model of self-directed learning, or the self-directed curriculum, is composed of three stages: learning to understand and estimate personal need to learn before adopting a change; learning of new competencies to change; and, learning to overcome the problems of using the new skills, alterations in the practice environment, or to adapt the new practice so that it is more comfortable (Fox & Bennett, 1998). Through self-selection of learning resources by the physician, the curriculum is developed and managed by the learner (Fox & Bennett, 1998).

As an element of medical practice, the use of group learning is familiar and common. Informal group learning is conducted in journal club meetings while more formal, didactic lectures are conducted as grand rounds, where the participants are able to learn new information about an aspect of practice (Fox & Bennett, 1998). The facet of organizational learning acknowledges the importance of the setting and culture of the work done by physicians and how their learning is impacted from working with patients, other professionals and in consultation with their colleagues (Fox & Bennett, 1998). Given opportunity to work together, the members of an organization can learn new ways of performing the function of the organization (Fox & Bennett, 1998). The authors give multiple examples of how healthcare organizations have come to work as learning organizations through the use of review procedures in patient care and satisfaction, and infection control; continuous quality improvement processes; in the communication of standards expected through rounds and morning reports; and by the use of outside resources for consultative purposes (Fox & Bennett, 1998).

From the data given in interviews, Fox, Mazmanian, and Putnam (1989) were able to develop a model that describes the process of change and learning experienced by the physicians in the sample. Change began by the physician experiencing force from one of the five categories described as personal, mixed personal and professional, professional, mixed professional and social, and social (Fox, Mazmanian & Putnam, 1989, p. 171). When a personal vision of the change to be made is developed, then the physician evaluates the level of discrepancy between what they know and what they should know in order for the change to be successful (Fox, et al., pp. 172-173). When existing skills and knowledge are adequate for the considered change, it will be implemented. Otherwise, education in order to learn how to successfully negotiate the change will be pursued (Fox, et al., p. 173). This model has been validated in further studies done with Canadian radiologists (Fox & Rankin, 1997). A greater understanding has been added through the understanding of self-directed, small group, and organizational learning (Fox & Bennett, 1998).

The role for education in personal change is great. How much more important will the role of the teacher and education be in changes that involve the entire society? How will teachers respond to forces for change when they must be reassessing their own skills and knowledge and determining how to continue to train their students, as well? Given that societies develop in different ways due to the variances of the events that occur, will Czech physicians report that they respond to the same forces for change or that they choose the same methods of learning? Because of the recent dramatic societal changes undergone in the Czech Republic, will these physicians resemble Western physicians as closely in their personal lives as other studies report they do in their professional lives?

The impact of social change on educators has not been extensively researched. Kaufman (1996) reported on findings from one study of how social change had affected Hungarian teachers during and after the change from Soviet control of the country. She interviewed Hungarian teachers in schools who were struggling to make the transition between the expectations of the Soviet system and the uncertainty of what the future held. One finding from this study is that education in Hungary was viewed as both the means to the development of a new, stable economic and social structure and a source of problems that could prove to be significant during the transition (Kaufman, 1996). She discussed three areas of interest in how Hungarian teachers were responding to change: advance preparation was not making a large difference in change; school reform was not being embraced readily; and, social expectations had changed rapidly (Kaufman, 1996).

While still under the control of the Central Education Ministry of the Communist party, schools had become “self-managing institutions” as early as 1985. In this new management system, teachers were encouraged to share ideas and communicate more freely with their peers, but teachers did not feel that this would have prepared their former Communist supervisors for educational partnerships (Kaufman, 1996). Reform was seen to be more a dream than a reality in a society where no one could remember having made an independent decision. One teacher reported, “We can change the labels. All of them. But sometimes that is all that gets done” (Kaufman, 1996). One area that did change rapidly was the expectations of communities and parents that children be educated in a way that gave them the skills they would need to participate in a market economy, rather than a communist economy. Suddenly, it was important for children to

have the “right” teacher and the community was interested in how teachers were performing the job (Kaufman, 1996).

Kaufman’s (1996) conclusions from this study were that some Hungarian teachers did see that there would be more freedom in leadership opportunities, but others understood this to bring only negative changes of fewer resources and more demands. She felt that teachers at different levels were beginning to lay blame on other sections of the educational community which was leading to more conflict between teachers (Kaufman, 1996). With no external “system” to unite against, teachers were now faced with having to compete with each other for positions where their own skills and knowledge would make the difference in who was hired. (Kaufman, 1996). Rather than being a move into the freedom to joyfully teach what was important to the society and to themselves, teachers were unsure of the future and what it held for them in Hungary. In regard to physicians in the Czech Republic, the question arises as to how much difference membership in a profession will make in their ability to negotiate the changes more smoothly. Having a respected position in the culture may relieve them of some of the stresses in having to change their teaching methods.

An important facet of the educational process is the teacher-student relationship. The perceptions that students carry away from educational interactions with the professor may be powerful in how the student makes decisions about whether to pursue further studies or change career paths. This is a complex and changeable relationship, but two studies have chosen to use quantitative methods in researching this issue. Beaudoin, Maheux, Cote, Des Marchais, Jean and Berkson (1998) attempted to ascertain how senior students and second-year residents perceived the humanistic behaviors of their teachers

using a mailed survey composed of ten items that used a six-point Likert scale for responses. Of the 774 individuals who received surveys, 259 senior students and 238 second-year residents returned the survey, for an overall response rate of 64 percent (Beaudoin, et al., 1998). While patterns of responses to the items are similar, the senior students were much more critical of their teachers in several ways. The students criticized their teachers' apparent lack of sensitivity, how the teachers appeared unconcerned about adaptation of patients to psychological aspects of illness and in how teachers did not seem to support or understand students who were having difficulty (Beaudoin, et al., 1998). Not only does it seem to be a poor choice of methodology for the focus of their study, but the few number of items incorporated into the survey do not appear to be extensive enough to reveal an issue this complex.

Wright, Wong and Newill (1997) examined the association between a student's chosen faculty role model and the clinical field the student selected in which to pursue their own practice. For the purposes of their study, Wright et al. (1997) have approached the development of the questionnaire so as to gain as much information about the issue as possible. Of the graduating class, 93 percent (136 of a possible 146) chose to participate in the study by completing and returning the forms. The term "role model" was defined for the participants and the questionnaire was of sufficient length (60 items) to explore traits, characteristics, interactions with the individuals selected by the students as their role model (Wright, et al., 1997). Yet, the findings were more concerned with student selection of a role model and whether the chosen individual had counseled or advised the student during the medical school years. Students were asked to rank factors they considered important to the selection of a role model. The characteristics they identified

as most important were personality, clinical skills and competence, and teaching ability. Of lesser importance were characteristics of area of specialty, research and publication experience and academic rank (Wright, et al., 1997). As before, the failing of the quantitative method in this study is that the participants had no way to add new dimensions to the study, or to give added detail to the information that was being provided. The authors have no way of being sure that they actually examined the issues that students felt were the most important aspects of choosing a role model in medical school.

Professional culture

Schön (1983) described the relationship the professions have with society as being one that has become essential. Social progress is sought through the way that the professions define and solve the problems of life (Schön, 1983, pp. 2-3). But when there has been a crisis of faith in the professions and the members do not meet their own standards for ethical behaviors, the question arises as to whether or not the knowledge of the profession is really adequate to meet the needs the professions have helped to create in society (Schön, pp. 11-13). How does a physician carry out his or her duties in a system that has become a breeding ground for changes when the knowledge each one must command is constantly required to increase to stay current?

The dilemma of the professional today lies in the fact that both ends of the gap he is expected to bridge with his profession are changing so rapidly; the body of knowledge that he must use and the expectations of the society that he must serve (Brooks in Schön, p. 15).

There are still those individuals practicing in the professions who are able to span the chasm and actually find the solution necessary for the particular problem each one faces (Schön, p. 18).

How is this knowledge the professions master different from the knowledge any individual acquires during the course of a life? First, it is a systematic development of a command of the field of knowledge particular to that profession and, second, it is used in a way that is a technical application of the knowledge to problems (Moore, in Schön, 1983, p. 22). There are four properties considered essential to the knowledge base of a profession: “it is specialized, firmly bounded, scientific, and standardized” (Schön, p. 23). Further, this knowledge has the qualities of a basic discipline the profession builds upon to derive an applied science used in daily problem solving crowned by the skills and attitudes the professional uses in performing the tasks of the position (Schein in Schön, p. 24). Even with the ability to use this type of multi-layered knowledge base, situations arise that do not “fit” the normal scenarios. Here, the professional must be able to work past just fitting the problem onto the normal paths of a solution, they must be able to creatively assimilate the applied science of the profession in a new way to find a solution because unique problems will always exist (Schön, pp. 41-45).

While it seems to be an invisible, unknowable method of problem solving, it is actually a specialized way of thinking through a problem. Schön (1983, p. 49) called this reflection-in-action, a process made of three steps, knowing-in-action; reflecting-in-action; and reflecting-in-practice (Schön, 1983, pp. 50-59). In knowing-in-action, the professional is able to put what each knows into the action he or she takes, but it does not require a prior thought process (Schön, p. 49). Reflecting-in-action is the response to the surprise that occurs during the performance where the professional makes small adjustments to performance even while it is happening (Schön, pp. 54-55). Finally, the professional reflects during the practice of the profession. It may help them move away

from a narrow understanding of the work and be able to mentally examine the small errors they do not have time to consider during the knowing-in-action phase (Schön, pp. 59-61). This phase may take various amounts of time, depending upon the measurement of the professional activities (Schön, p. 62). For a teacher, this reflection may cover the academic semester, or the entire academic year.

In considering this process, other authors, writing specifically about how physicians learn from experience, have expanded the reflective process to include five steps. Fox (in Davis & Fox, 1994, pp. 114-116) describes the five steps as including knowing-in-action, surprise, reflection-in-action, experiment and reflections-on-actions. The first stage, knowing-in-action, matches what Schön describes for other professionals, in that the knowledge and skills are automatic and lend to the effective practice of medicine (Davis & Fox, p. 115). The irregularities of practice come into play with the presentation of a surprise seen in a unique case, a conflict of what is known and what is discovered through the process of patient examination, or an ambiguity not easily explained (Davis & Fox, p. 115).

Reflection-in-action comprises the third stage of the model where the physician reviews what is known with the new information discovered in the second stage, the surprise, and works toward developing an appropriate response (Davis & Fox, 1994, p. 115). The fourth stage, the experiment, is when a decision is made in order to address the specific situation currently being encountered with the patient (Davis & Fox, p. 115). This step may range from a change in the medication regimen to simply clarifying understanding by restating a question in new terms (Davis & Fox, p. 115). The final step, reflections-on-actions, allows the physician to incorporate the learning that took place

with this patient encounter into the way they approach cases in the future (Davis & Fox, p. 116). Fox writes that in this manner, physicians are able to expand their understanding and to “expand the zone of mastery” in which they practice the “art of medicine” (Davis & Fox, p. 116).

For a teacher, the ability to communicate this process of how reflection-in-action is accomplished would benefit students preparing to make entry into the profession. Many times, the teacher is unaware that the mental processes, which the student sees evidence of in the teacher’s actions, evade the understanding of the novice (Schön, 1983, pp. 124-125). The student knows there is something beyond the words to explain the solution that has occurred, but does not know how to ask for a demonstration of this reflection-in-action to become a verbal reflection-in-practice with the teacher (Schön, p. 126). The ability to understand where and how the student is not able to make the mental progression from problem to solution is important in any culture, not just one where changes have been experienced on the magnitude of the change in the Czech Republic. How will teachers who are dealing with multiple changes themselves be able to help their students learn to become proficient at the mental processes it takes to perform the responsibilities of a profession smoothly? Will they be more or less aware of the need to educate their students in this path of reflecting-in-practice?

Because it is a change that affects an entire profession, the writings of members of the profession about the professional culture give an image for the outsider of what constitutes appropriate behaviors and beliefs. Given the assumption of this study that the practice of medicine is similar across the world, unless influenced by outside forces, these articles will help frame an understanding of how Czech physicians learn and change

in the practice of the teaching arts after a massive cultural shift. A second assumption is also important, that the teaching relationship is similar between professors and students worldwide. Information about how this relationship is formed and experienced, and how the student is changed through the relationship will help in understanding the choices made by the participants in this study. Therefore, studies concerning the formation of attitudes held by medical students toward ethical behaviors, how students perceive the medical professor, how medical school curriculum supports the transmission of professional culture and behavior to the student, and the impact of change in the professional culture of practicing physicians have been chosen for examination.

How do we learn about attitudes of medical students toward socially responsible behaviors? Crandall, Volk and Loemker (1993) used an attitudinal scale with self-reported responses to measure how students perceived societal expectations, their own responsibilities, their personal efficacy and what students thought the provision of basic services and more expensive medical procedures should be. The sample was 83 first and fourth year male (67 percent) and female (33 percent) medical students who volunteered to participate in the study. The survey was constructed as items using a five-point Likert scale or as true-false items. Counts were given for numbers of items in three of the four sections of the test, but not for the fourth section, so the survey was comprised of more than 49 items. No reliability, validity or test-retest validity information was included in the article, but it was noted that this could be requested from one of the authors (Crandall, Volk & Loemker, 1993).

After examining the data by statistical methods, the authors determined that there were significant differences between the two classes of students on the issues addressed.

Yet without giving the students opportunity to have a voice in the process of determining what the issues were, how did the authors know they had really determined what was important to the members of their sample? Since the items were closed-ended, there was no opportunity for students to say what the important issues were that pertained to their perceptions of societal expectations, responsibilities, personal efficacy or understanding of what provision of basic services and more expensive medical procedures should be.

A second study that addresses the issue of medical providers who provide care to medically underserved populations used focus groups as the qualitative method in learning about the personal characteristics of these individuals. Li, Williams and Scammon (1995) held a series of three focus group sessions with 24 (11 male and 13 female) medical providers in which they explored their common experiences in dealing with an underserved population (Li, Williams & Scammon, 1995). The rationale for choosing a focus group technique was to provide participants an opportunity to voice their experiences and to allow the group discussion to stimulate further thoughts about the issues from the individual participants. The three groups were made of nine individuals (six male, three female) in group one, four (three male, one female) in group two and 11 (two male, nine female) in group three. The group members came from the disciplines of medicine (family physicians, psychiatry and pediatrics), dentistry, physician assistants, and nurse practitioners (Li et al., 1995).

Their findings showed that these healthcare providers stated their own beliefs about human rights and personal values, backgrounds and experiences led them to devoting part of their lives to practicing in medically underserved communities. The

participants also believed that a holistic approach to medicine was important in working with these communities (Li, et al., 1995).

With a similar purpose, Eliason, Guse, and Gottlieb, (2000) sought to address the values of practicing physicians. This is a concern to the study undertaken in the Czech Republic since what is taught in the medical school should be evident in the actions of the physicians after they have entered practice. Using a stratified sample of 1224 randomly chosen physicians divided into 12 age groups, a survey was mailed with a postage paid return envelope. The survey used the Schwartz values questionnaire, for which no validity or reliability information was provided except to say that it had been validated in multiple cultures and "described previously" (Eliason, et al., 2000). The questionnaire asks the respondent to rate 56 personal values from -1, indicating opposition of personal values, to 7, indicating supreme personal importance. A response rate of 58 percent (712 returned surveys) yielded results that showed no significant difference between the 12 groups of physicians in their responses (Eliason, et al., 2000).

While Eliason et al. (2000) reported physicians who rated "benevolence" as the most important value they held also reported higher satisfaction with their professional life, the use of a quantitative study methodology limited the information gained from the respondents about professional values to those included in the survey. Having a survey mailed to participants did not allow for clarification of answers or further exploration of their choices and beliefs. Although the instrument used had been validated with multiple cultures, it still limited the ability of the participant to add facets of importance to those being examined by the survey questionnaire.

Following in a similar vein, how medical schools teach professionalism and professional values to students has been examined in two studies. Rowley, Baldwin, Bay and Cannula (2000) conducted a review of evaluations done by attending physicians for 24 residents over a 50-month period from 1994 to 1998. The median number of evaluations each resident received was 19.5. Evaluations were done at the end of each rotation and were composed of items that rated the residents on skills and knowledge of the surgery rotation, as well as on professionalism shown by the resident during each of the rotations. Items were scored from 1, a more negative score, to 5, a more positive score (Rowley, et al., 2000). The statistical tests gave evidence that residents rated higher on professionalism indicators were also rated higher in skills and knowledge with the converse being true for those rated lower (Rowley, et al., 2000).

The major concern in using these evaluations gathered over a span of time is that, while it would give room to see growth and change in the resident, these evaluations are not done anonymously. The normal procedure is for both the resident and the attending physician to complete evaluations concerning the rotation and, in order to know who has not returned the forms, names are attached to all documents. There is no way to blind the departmental evaluators and staff as to whom the physician or student was on the evaluations. Comments made on a form where a name is attached may not be as truthful as on one where no name is given. It is not clear how much this really reveals about the way professionalism is taught at the medical school.

Similarly, Swick, Szenas, Danoff, and Whitcomb (1999) conducted a study of how schools of medicine teach professional values to students. To ascertain whether and how medical schools were teaching professionalism to students, a survey was mailed to

125 US medical schools in the fall of 1998. The response rate was quite high (92.3 percent) for the first phase of the study and of the 116 responding to the initial survey, 41 schools also provided materials in the second phase that were analyzed qualitatively to further enhance the information received in the surveys (Swick, et al., 1999). The first survey was sent to the associate dean whose position had the responsibility for overseeing the medical school curriculum at each school. The authors chose to survey the deans on four elements of professionalism: subordination of self-interest to the patient's interest; adherence to high ethical/moral standards; response to societal needs; and, core humanistic values. These particular items were chosen because the authors believed each was an essential element of professional values and that the schools would formally address each.

If the dean indicated that professionalism was addressed, the school then received the second survey, which was designed to learn the format chosen to transmit these values, when they were taught and the goals/objectives used in the educational settings (Swick, et al., 1999). Supporting documents were examined for key words indicating teaching professional values or subjectively by the opinion of the author that a course offering should be conveying these values through content and objectives.

Professionalism was reported as being addressed by the majority of schools in orientation through "white coat ceremonies," which are ceremonies used at the beginning of the medical education process to formally welcome students into the profession. Fewer schools had elements incorporated into classes and less than one third reported a course or a series of integrated courses designed to teach professional values. Most responding school deans reported their program could benefit from better evaluation instruments,

faculty development, or teaching materials. The examination of supporting documents showed that there was great variation in how these issues were addressed by the curricula. Approximately 75 percent addressed ethical and moral standards, while less than half dealt with how to respond to societal needs (Swick, et al.,1999).

While the information learned in this study does aid understanding of how professional values are taught in medical schools, the authors chose the items to focus on only four elements of professional behavior: subordination of self-interest; adhering to ethical and moral standards; response to societal needs; and, evidence of core human values. Perhaps a better understanding of the values actually taught by the schools would have been provided by a study adding an additional element of interviews with selected teaching physicians at a sample of the schools responding to the survey.

Finally, Castellani and Wear (2000) conducted a study on the impact of the changing professional climate on physicians who are practicing in the new culture of changing insurance formats and companies. They conducted this study as a grounded theory in order to learn what physicians felt were the elements of the current professional struggles encountered in the field. In order to develop the theory of physician views on the changes to professionalism due to changes in corporate healthcare systems, the authors and three trained assistants (one medical student, one part-time staff member, and a postdoctoral student) interviewed 50 physicians in various stages of their career. A semi-structured interview schedule was used and modified as needed through the interview process (Castellani & Wear, 2000).

Their findings were discussed with students and physicians teaching in the medical school where they are employed in order to verify themes and categories

developed during data analysis, but the description of how the data analysis was conducted was unclear (Castellani & Wear, 2000). The professional crisis being experienced in medical practice today is divided into two major categories: professional struggles and the skills/knowledge needed to address these struggles. The current professional struggles of physicians had three major components: the clash of professional culture and double agency, decentralization and narrative dysfunction caused by changes in the system in which they work. The skills and knowledge needed to address these issues include how to navigate the new systems morally and how to be sociologically conscious (Castellani & Wear, 2000). These may very well be the same type of issues Czech physicians are having to deal with as their own medical system is changing, but while the issues are important the method of coming to these conclusions was not clear from the article.

Change from external pressure

Sugarman (1986) describes a theory of how individuals change and grow through seven stages in response to outside forces. One exercise conducted with the readers of the book, Life-Span Development, is to draw a chart of the important events of his or her life, which is a visual lifeline (Sugarman, 1986, pp. 1-2). One question asked of the reader is to consider “What (or who) triggered the peaks and troughs in the graph?” (Sugarman, p. 2). The expectation is that the participants will be able to then attach significance to people or events that occurred outside of themselves that both positively and negatively impacted their lives. Assumptions about life-span development include: there are no set plateaus reached by the individual, after which a decline must occur; individual growth is multidimensional; development occurs concurrently on many levels; the individual is

changed by his or her environment and changes this external environment during the course of human life (Sugarman, pp. 2-3).

Like the views expressed on culture, Sugarman writes that the person and the specific historical environment of his/her life cannot be understood apart from each other. History and human life are inextricably interwoven by the creation of meaning in, and by the individual creative response to, the environment (Sugarman, 1986, pp. 8-9). Four systems are described in which the individual participates during life: microsystems, mesosystems, exosystems, and macrosystems (Sugarman, p. 9). A microsystem is made of the immediate environment of the person and contains both personal and physical features. Personal interactions both affect and are contained in the physical environment, which is surrounded by the institutions each person is part of, followed by the culture in which they live (Sugarman, p. 10). The major institutions, such as home and work, constitute the mesosystems, which surround the microsystems (Sugarman, p. 11). Exosystems are created of institutions in which the individual may not be actively involved, but which do influence the life each one leads. These include labor market, government, media and medical service organizations (Sugarman, pp. 11-12). Finally, the macrosystems are those that convey the norms of life within the society and influence the individual because they create the overarching shape of the culture and life within it (Sugarman, p. 12). In the Czech Republic, the physicians who have experienced the shift in political and economic systems will have had to change on multiple levels in order to adapt to the new environment surrounding them.

One type of life event that Sugarman discusses is the normative history-graded influence. Unlike age-graded influences, where the individual experiences change due to

biological changes and are closely tied to chronological age, history-graded influences affect all of the members of a society, but not in the same way (Sugarman, 1986, p. 47). While the events are experienced at the same time, each person must determine for him or herself how the event is interpreted and how each will change in response to the event. This is similar to the experience Czech physicians will have had with the social change from communism to democracy. While each one has had to live through the experience as a society together, each one must determine how to allow the societal changes to affect his/her response to external events. As Sugarman (p. 47) points out, "History-graded influences make the past an uncertain and unreliable guide to the future, especially in times of rapid social change." It is impossible for us to know how each person will interpret the events that have happened around them, or how each one will understand his or her own place in the sequence of events.

The psychosocial model of individual development envisioned by Sugarman is one where the influence of outside forces upon the person is important. Without the trigger event, the individual would not have the impetus to change and life would continue to remain constant. Yet, after the initiating event has occurred, the path followed by each person is individual to that person, no two people will experience the same historical events alike (Sugarman, 1986, p. 141). The model contains seven steps in the cycle of response to change: immobilization, reaction, self-doubt, letting go, testing, search for meaning, and integration (Sugarman, pp. 141-142). The personal process of change begins with a period of immobilization, where the individual may be in shock when the mind must be allowed to comprehend what is happening around the person (Sugarman, p. 143). Three elements of the event serve to determine how long the period

of immobility will last: how sudden the event was, how large it is perceived to be and how negative it is for the individual (Sugarman, p. 143).

The second stage is moving into a reaction, which could be either elation/despair or minimization of the event. This phase of the model shows how the reaction can be one that lifts the person up or causes them to fall, depending upon the direction of the emotional response. An event that is understood as a pleasure, brings a range of feelings, as does one that is a sorrow (Sugarman, 1986, p. 144). For both possibilities, the second stage ends in a period termed minimization, since the mood of the individual must become more centered before entering the next phase. The third phase is self-doubt, a period which may grow imperceptibly from minimization and may include a range of emotions that serve as markers. These may include depression, since the realization of a life change has begun to set in, anxiety, anger, or sadness (Sugarman, p. 144). Because of the vast number and combinations of emotions a person can experience, it may be difficult to determine exactly which one is currently being experienced. Letting go, which is the indicator that the person is moving forward out of the connection to the past follows self-doubt. Until the person allows the past to become less important than moving into the future, letting go cannot occur (Sugarman, p. 145). Each one must allow him or herself to become committed to a new future and begin to cope with the changes experienced.

Testing allows the individual to consider alternatives for the future. While change is still very much a part of the growth process, at this point the person is making a conscious decision to move forward and beginning to work toward how the new life and new possibilities will be addressed. Testing comes after the lowest point of the model and

the common feelings are those of becoming attached to the new reality (Sugarman, 1986, p. 145). Phase six, a search for meaning must be experienced in order to allow time for the person to make sense of the recent events each one has experienced. This step allows for reflection and thought about what has occurred and leads finally to integration of the change (Sugarman, pp. 145-146). Events once again begin to feel normal and natural, not traumatic any longer. In achieving this point in the cycle, Sugarman writes that the person will now be ready to deal with the next event that changes life. The salient points of the model are that the seven stages do not occur only one time, but occur many times during life; that transition from one to the next does not move smoothly and may vary in length of time needed for each; and, usually the person will end at a higher point than when the cycle began (Sugarman, pp. 141-145). Yet it is unknown if this model is one that strikes a note of accuracy and familiarity with an American reader because this society grew out of the common roots of English culture with which Sugarman has experience. Will cultural variations show a different pattern of change in the individual or will this theory hold true across country boundaries and cultural heritages?

Having previously done research on ethical reasoning with public officials in the United States, Stewart, Sprinthall and Siemienska (1997) undertook a study in Poland shortly after the society changed from a communist to a democratic form of government. The historical record indicated that public personalities verbalized the importance of principles in social arenas. The authors expected to find that the newly appointed and elected officials would vary in their own adherence to principles as the basis for decision making when compared to U.S. counterparts who choose "law and duty" as the basis for ethical decisions (Stewart, et al., 1997, p. 445).

The authors felt that there was a gap in knowledge about how public officials made ethical decisions about other issues and how these decisions are different in cultural settings outside the United States. Using Lawrence Kohlberg's model of moral maturity as a basis for their work, the authors believed that they would find information that would help them determine if public officials in new democratic settings were actually operating at higher levels of moral maturity than officials who performed their work in settings where democracy was not a new element. In order to test this theory, Stewart, Sprinthall and Sieminska (1997) modified an instrument used in earlier studies of ethical reasoning with U.S. public administrators and designed this study as a replication of the original work. The survey was reformatted by changing content, wording and translated into Polish to be usable in the new setting. Then the survey was pilot tested and further small changes were made from suggestions of the participants. In order to test their understanding of developments in ethical reasoning in Poland after the fall of communism, the authors chose five factors to examine during the study: organizational roles; demographics; personal history; organizational context, as more vs. less urban; and attitude toward decommunization. Stages of ethical reasoning were defined as concern for: obedience and punishment; cooperation and reciprocity; enduring personal relationships; law and duty; and the final level, which combined levels five and six, was abstract principles of societal cooperation (Stewart, et al., 1997, pp. 446-447). Data was collected through interviews conducted with 289 public administrators and 196 newly elected officials in 12 towns located in two provinces of Poland, followed by focus groups used to verify the information given in response to the survey instrument used to guide the interviews (Stewart, et al., p. 448).

Findings revealed that there was little difference between the two groups (Stewart, Sprinthall & Siemienska, 1997, p. 449). The only area where there was a statistically significant difference between the groups was how gender influenced the responses, with elected and appointed women choosing principled ethical reasoning more often than men, who chose law and duty as the basis for their decisions (Stewart, et al., p. 450). Because of the nature of the two countries, no comparison could be made concerning attitudes about decommunization. In statements voiced by the Polish sample, the authors found elected officials were stronger in their feelings about actively seeking decommunization than were appointed officials. Officials strongly in favor of decommunization reported the highest levels of ethical reasoning, using principled reasoning instead of law and duty as the basis for their decision-making (Stewart, et al., pp. 450-451).

Even though the authors expected to find highly principled ethical decision making in place, what they found strikingly resembled their previous work in the United States, where officials hold more to law and duty as the basis for ethical decisions. It appears that being a public figure creates an impetus to do what is expected in the society, no matter where the society is located. One of the surprises for the authors was how law and duty was reported as the most common basis for ethical decisions, when a previous study of students in Poland in 1989 showed an absence of law and duty as a basis for ethical reasoning. What they surmise this may indicate is that law and duty are an integral part of the functioning of a democracy, no matter how long that democracy has been in existence (Stewart, Sprinthall & Siemienska, 1997, p. 451). The second major surprise was how men and women interpreted the finding that women held to higher ethical standards than men did in decision making. Men saw this as proof that decisions

came more easily for them, while women held that the harshness of a woman's life in Poland made their character stronger than that of the men (Stewart, et al., p. 451).

Where do new doctors learn the values and behaviors considered important to the profession? One important listing of these values is found in the Hippocratic oath, but little is known about what students actually learn as the values of the profession in the process of medical education. David Stern (1998) undertook a study to discover what values of the profession are actually transmitted to students in the process of receiving a medical education. He examined the Hippocratic oath, "Principles of Medical Ethics" formulated by the American Medical Association, and the documentation of one medical school curriculum to determine the values recommended as central to the profession of medicine, which he compared to observations of teachers and students in one Midwestern school of medicine (Stern, 1998).

Previous literature showed that medical students might not be learning values actually recommended as important during their school career. The extended hours of responsibility, service and study necessary to complete the course work does not encourage the growth of a physician who is empathetic and compassionate while training in biological sciences teaches that the end is more important than the means of learning (Stern, 1998). What medical education deems important for the "ideal" physician does not follow what the students actually learn, which is "individualism, efficiency, competitiveness and deception" (Stern, 1998). The problem was not knowing whether medical educators were not teaching the norms of the profession, or whether students are not learning what is being taught (Stern, 1998).

The study was conducted as a qualitative study at one medical school campus, chosen for the convenience of having access to the documentation, professors and students necessary to achieve the goals of the study (Stern, 1998). The study was conducted with internal medicine professors and students involved in the clinical and residential training years. In-patient wards were chosen as the site for observations. Data collection began by analysis of the recommended curriculum of values in order to determine what the global and local curriculum values contained. Then, the taught curriculum was determined through observations of patient care teams, composed of the attending physician, senior resident, two interns, and from two to six medical students per team. A total of ten separate 3-hour observations were conducted with each of the eight patient care teams during a six month period of time in two medical facilities where students and professors worked. The research team, comprised of a physician or one of two non-physicians working on the project, conducted observations. After each observation, tapes and field notes were analyzed for values excerpts and categorized as to which value was actually expressed in the interaction (Stern, 1998).

The author focused the discussion of findings on eight of the values found in the global and local curriculums and how these were represented in the taught curriculum observed in the practice settings (Stern, 1998). The most consistent value recommended in the global curriculum is the teaching of honesty or integrity, followed by accountability or responsibility to patients, care and compassion for patients, continuing education, importance of public health and self-policing of the profession. The local curriculum recommendations closely matched the global curriculum and included honesty, accountability, self-policing, compassion, and public health. Yet when

documentation for resident education was examined, the values were placed in a different order of importance than that suggested for medical students. Honesty is not emphasized by resident materials and the concept of service is not articulated clearly, but is more inferred by the listing of resident duties. Yet, from the amount of discussion in the materials, service becomes very important to the facility when a student enters residency. Residents are encouraged to practice in a way that is appropriate when working with other healthcare professions, although this is not an important element of the global curriculum (Stern, 1998).

When the global and local curriculum values are compared to what was observed with the patient care teams, a different picture emerges of what students actually learn from medical education. Instead of working toward becoming a professional healthcare team, residents undermine other physicians not in their own specialty area and other health professionals. Inter-professional respect becomes disrespect and service becomes a burden to the resident during these final years of training. Residents were also taught that hard work and industry were desirable traits to learn, while this appeared in neither of the global or local curriculum (Stern, 1998).

Because education, even at the level of the medical school, is still very much a place where the teacher is the final authority of what the student will learn many new physicians and medical students are receiving training in values not important to the profession. The author raised the question that if a recommended value is not being taught, is it because the teachers assume that students only need those lessons when a lack has been seen in behaviors of the students? He also raised the issue that it may be the teachers, unaware of the global and local curriculum recommendations, are not teaching

the values physicians should be learning. The difficulty is that in a field surrounded by science, the art of teaching values seems to be missing (Stern, 1998). These issues will be important in learning how Czech physicians have changed their teaching practice habits after the societal changes they have experienced. It seems the added impact of an understanding of the thought processes of the teachers would have strengthened the development of this particular study. In giving the physicians an opportunity to explain their reasoning behind what was said to, and with, students, it may have added to his understanding of how the values curriculum was, or was not, being delivered to students in the most effective manner.

Any educational endeavor is one where the players are involved in multiple, complex relationships. How does the institution structure the educational process to fit the expectations of accrediting bodies and societal demands on those trained in the program? How does the teacher fulfill the expectations of not only the institution, but also the society and the student, while maintaining the quality and high standards of the discipline? How do teachers transmit a new set of values and ethics to students who face a world very different from the one in which the teacher was trained and practiced? And why do they even try to meet these demands? These are the questions to be asked of academic physicians in the Czech Republic today because they have lived the answers and can point toward how to help teachers in similar situations in other places and times.

CHAPTER FOUR

Methodology

“Whether he be brilliant as a theoretician or just an adequate collector of field data, the initiated professional is, to me, one who has felt as well as seen the alien society he has studied” (Firth, in Kimball & Watson, 1972, p. 30).

Introduction

We are not the same today as we were yesterday. As individuals and as a society, the vagaries and fluctuations of historical events make us different. We protect our children with car seats, we seek to educate people on the importance of preventative healthcare and wellness and we learn how the genetic code is formed because someone discovers new information and a change is made. By listening to the experiences of teachers who have lived through the shifts of political and economic systems and learning how they have changed in the way they approach the training of students, we hoped to learn something new to use in changes that will come in our own future.

Rationale for methods

All research seeks to understand the world around us in a better way. In our attempt to understand the social world, there are many elements that serve to make our understanding more difficult. Social reality means many things to the individuals who are part of the events; it encompasses multiple levels which are inherently and massively different; man, as an individual and as a member of a group, brings a creativity to development of the social order not found in nature; and new social orders are constantly being built by the participants (Dayna Krishna in Kumar, 1984, p. 35). Therefore, it was

important to use a form that allowed for the distinct voice of the participants to be included as an integral part of the research process.

An understanding of human social life is developed upon hearing the descriptions participants give of the specific events they have experienced (Hammersley, 1992, p. 16). Understanding is also the way social reality is accessed and how each person moves beyond any previous understanding developed to better understand beliefs held by other people (Skinner, 1985, p. 29). In developing this new understanding, personal meanings are not given up, but a “fusion” is created between the meanings of the person and those of the society in which each one is alien (Skinner, p. 25). Having created this fusion, the person is forever enriched and further changed by the process of growth required. Skinner (p. 24) states that understanding requires an open mind and the ability to put oneself into the place of the participants “based on a common sphere of experience.” Hammersley (1997, pp. 8-9) outlines five assumptions which are helpful in considering the way personal understandings are created: the individual must both interpret the stimuli and create a response to the events they wish to understand; in order to understand actions, the cultural perspective they are based on must be understood; we are puzzled by societies which are alien to us; conversely, familiar societies may be misinterpreted by reducing the events to stereotypes; and finally, a distinct relation to the world is formed by each group, whether it be ethnic, occupational or a small, informal group.

These assumptions concerning understanding are important to this study since it was conducted in a society in which the researcher was not a member. My own assumptions must be based on the culture in which I have lived and therefore, my understanding of the world is derived from this set of assumptions (Hammersley, 1992, p.

46). While I have made every attempt to be unbiased and to remove myself from the research process, I am but one person involved in the process. When I entered into the process of learning as much as possible about how social change has affected the participants in this study, the actions, both theirs and mine, cannot be removed from the values that we both ascribe to the situation. Guba and Lincoln (1989, pp. 123-24) describe facts as theory-laden, existing within a value system, and embodying a value position. Therefore, facts cannot be discovered in a way that remains value-free (Guba & Lincoln, 1989, pp. 123-24). Also, the truth that I have received from the participants is not the only truth that exists surrounding this set of events. Many stakeholders are involved in the institution where these participants are but one small group of the individuals who have established their own set of values and could have agreed to become part of the study (Guba & Lincoln, p. 127). So there will always be a truth that is not described by this particular study.

A central purpose of qualitative research is to find ways that specific events of human social life describe the experience of the entire world (Hammersley, 1992, p. 16). In order to do this, we examine a particular phenomenon of interest. A phenomena is defined as an entity perceived where the composition and cause are not fully known or understood. Further, it is composed of a set of things or events and “endowed” with a set of properties learned by using a set of information items (Ramkrishna Mukherjee in Kumar, 1984, p. 10). Understanding of the phenomena requires that the event be understood without preconceptions, yet without those same preconceptions, we lose the understanding of any influence the event has had on history; therefore, understanding would be impossible (Skinner, 1985, p. 25). Understanding is enhanced by the use of

qualitative description which seeks to describe the phenomena in ways that are new to the reader and help us to see the parallels that exist between seemingly disparate sets of events (Hammersley, p. 13). Hammersley (pp. 22-23) gives three reasons to stress the use of description in qualitative research: first, through induction, the description of the event, a theory emerges so description becomes the first stage of theory development; second, the reader, who would otherwise have no experience of what had happened in a specific place, gains a vicarious experience; and third, description becomes explanation by helping the reader understand the event in context. While theory building must begin with description, the description cannot be a theory (Hammersley, pp. 12-13). The theory that results must be one that delineates the “universal” relations between the categories of phenomena existing wherever these occur (Hammersley, pp. 12-13). The description of the phenomena will give the features of the phenomena; the specific things involved, objects, events, and the time, place or location in which the events occurred, but it is the explanation that shows why those particular features are there (Hammersley, pp. 12-13; 27).

Any intervention undertaken within a specific context is changeable, will affect, or change, the context just as the context is changed by the intervention (Guba & Lincoln, 1989, p. 45). It is also important to understand that change cannot be engineered. Because individuals are never affected by change in the same way, it is a non-linear process where each person involved must be actively developing his/her own understanding in ways that increase in sophistication dependent upon the new information introduced (Guba & Lincoln, p. 45). In order to learn from the individuals, who have had the experience of

change during a time of social reorganization, a qualitative grounded theory study was conducted.

Because there had been no study to determine whether cultural differences exist in the way physicians change, as well as how academic physicians adapt to societal changes, a grounded theory study was conducted using constant comparative methods and triangulation. Quantitative methods, which deal with scores on tests and the relationships seen between groups, would not have provided a clear description of what had occurred in the lives of these physicians. Therefore, qualitative methods, which allowed for the participants to voice their own experiences, thoughts and feelings, enabled obtaining an image of the changes experienced by academic medical faculty in their own words. In this respect, perspectives from both history and qualitative research help the reader understand the study more fully (Hammersley, 1992, pp. 32-33). First, the unifying purpose is to describe the social events and processes as fully and as clearly as possible. Second, the theory developed should account for as much detail as possible found in the complex cultural and social events described by participants. Third, the original words of the participants have been retained in order to remain true to the uniqueness and interesting perspective they have had on the phenomena (Hammersley, pp. 32-33).

The tradition of phenomenology in qualitative research gives an understanding of an event, or phenomenon, from the perspective of the participants, yet in this instance it was not just an understanding of the event sought. Here, the response of the individual affected by the phenomenon, specifically the impact of social changes resulting from the political shift from communism to democracy, was the focus of the study. Therefore, a

grounded theory study was appropriate. Grounded theory is a research method developed by Glaser and Strauss which provides for the development of a "theory" that allows better understanding of how the phenomenon is structured (Creswell, 1998). The grounded theory involves the processes of induction, deduction and verification and represents as fully as possible the complexity of the actual phenomena and produces a theory that is both universal and abstract (Hammersley, 1992, pp. 20-21). The description of the theory may take the form of a narrative or a diagram that shows how the researcher envisioned the concepts fitting together from the information given by participants in the study (Creswell, 1998). By the questions chosen for use during the research process, a preexisting theory about the phenomena is shown and this theory belongs to the asker (Guba & Lincoln, 1989, p. 125). The grounded theory is developed by a constant comparative method of data analysis, where each new set of data is compared to those collected previously. When no new information is gained from the interview process, data collection ends (Creswell, 1998).

The purpose of ethnographic, or qualitative, data analysis is to produce models and concepts to allow new understanding of phenomena and historical events (Hammersley, 1992, p. 15). These methods are not used in order to predict or control events, but are important to use when social change occurs which predicates the need for new models to understand social events (Hammersley, p. 15). While data collection was on going, analysis began using the constant comparative method. To achieve the "constant" level of comparing the information in each data source to the next, a series of steps in the process is outlined by Creswell (1998). First, the open coding process is used to form categories made of subcategories that are linked to the over arching category.

Here the data is examined to describe the dimensions of the categories fully (Creswell, p. 57). Next, axial coding is used to create a schema that defines causal conditions that influence, interactions resulting from, context and intervening conditions of, as well as the consequences of the phenomenon (Creswell, p. 57). Selective coding is the third step where the hypotheses of the phenomenon are assembled into a story that explains how the categories fit together (Creswell, p. 57). The final step is the creation of a visual conditional matrix where all aspects of the phenomenon are tied together (Creswell, p. 57).

From this process comes the substantive level theory that leads to being able to test the theory in quantitative ways since the variables associated with the phenomenon are now delineated (Creswell, 1998, pp. 57-58). Strauss and Corbin (1998, p. 22) explain this as the development of statements of relationship that show “who, what, when, where, why, how and with what consequences” when a theoretical framework is created. The theory created should be concerned with the relationships between the phenomena described by participants and provide evidence to support those claims from the body of data provided by participants (Hammersley, 1992, pp. 71-72).

In order to address issues of validity, Hammersley (1992, p. 69) sets out three tests for the validity of qualitative data: is it an accurate account or representation of the phenomena to be described; is it representative of a selection of reality rather than a reproduction of reality; and, is there adequate evidence given of the reality under consideration? Threats to internal validity in qualitative research appear in different ways than in quantitative research. How much is the researcher "reading into" the data? How different is the actual data than what the researcher thinks he/she understands the data to

be? Flick (1998) defines three errors that pertain to the validity of a qualitative study: envisioning a relationship where none exists, called a type 1 error; rejecting correct relationships, a type 2 error; and asking questions that do not actually address the topic under consideration, a type 3 error. In order to avoid both the type 1 and 2 errors, analysis was verified by the participants to clarify misunderstandings or misinterpretations due to cultural differences of the researcher and the participants. A second way of avoiding type 1 and 2 errors was the addition of a sixth member to the doctoral committee who was born in the Czech Republic, lived in Prague and is a physician trained at the Charles University Faculty of Medicine. Type 3 errors were avoided by developing the interview questions from the literature relevant to the study and reviewing these with the doctoral committee members and physicians from other cultures teaching in the University of Oklahoma College of Medicine before leaving the country to conduct the study.

The phenomenon under investigation was how and why academic physicians changed their ethics, values and teaching practices due to changes in the culture in which they practice the art and science of teaching. The overarching question dealt with how societal change affected the individual. Under this umbrella, the research considered personal change, professional culture change and teaching change.

Because this study dealt with a distinct population, purposive sampling was the method chosen to select participants. Creswell (1998, p. 62) describes “purposeful sampling” as the selection of “cases that show different perspectives on the problem, process, or event” and adds that chosen cases may also include ordinary, accessible or unusual cases, as well. The participants were chosen in order to help develop the explanation of how social change affected the personal life, professional career and

teaching practices of physicians in the Czech Republic (Bogdan & Biklen, 1998, p. 65). Physicians who trained and taught under the Soviet medical education system and now teach in the Charles University Second Faculty of Medicine were asked to participate. In order to learn as much as possible, the sample was structured to include maximum variation among the participants (Glesne, 1999, p. 29). Differences in age, gender, area of specialization and length of time in both practice and teaching were considered in the selection of participants. The process of theoretical sampling depends on the sample being constructed in the field in order to add to the data collected while the interviews were being conducted (Strauss & Corbin, 1998, p. 203). On-going comparison of categories is important in theoretical sampling because it allows for the categories to be developed as fully as possible, differences between and within categories to be found, and the range of variability to be determined (Strauss & Corbin, p. 202). These people have had the experience of training and teaching under one system and now having to teach their students to serve under a different system. It was not possible to exactly describe the configuration of the sample until data collection began since each added participant was chosen in order to gain the most information about this type of change (Flick, 1998, p 64). Due to the nature of grounded theory studies, data collection continued until no new information was received from the participants. The study sample was a group of eight physicians and the participants were not divided into subgroups for the purposes of this study.

Procedures

In order to learn as much as possible while in the field, four methods of gathering data were planned. First, a survey was conducted with the physicians during interviews.

This allowed for development of an understanding of how Czech physicians change compared to the findings from the study by Fox, Mazmanian and Putnam (1989) which was done with physicians in the United States and Canada. Second, participants were interviewed at sites and times convenient and comfortable for them. Third, observations of the teaching practices of physicians working with students were done in classroom settings. Finally, documents including institutional course materials were examined.

Given the time constraints of the life of a physician in an academic setting, use of a written survey allowed for data to be gathered on personal preferences and practices in how the physician changes. The survey was created using the interview questions in the Physician Change Study as a basis (Fox, Mazmanian & Putnam, 1989, pp. 179-182). While it was not a complete recreation of the interview questions, it was used to gain a basic understanding of any differences existing between U.S. and Canadian physicians and their counterparts in the Czech Republic. The survey was conducted and discussed during the first interview, so that the participants were free to provide additional information they felt important but the majority of time in the interview was spent on issues not covered in the survey. This part of the study was not intended to be a full replication of the Fox study due to the small sample size, but rather a means of confirming or disconfirming that physicians are similar in the ways they change in other cultures. This survey form and the associated cover sheet of explanation for participants are found in Appendix D. The translated survey and cover sheet are found in Appendix E.

The second method of data collection was interviews with the participants where they described the changes and their reasoning behind the choices they made. This was the primary form of data collection. The list of interview questions, divided into groups

with the associated research question, is found in Appendix C. The choice of individual interviews over other forms of interview styles, particularly focus group research, was made to avoid the uncertainty of how much any group discussion influenced the responses of the participants. Because the purpose of the present study was to develop an explanation of how cultural change has influenced medical school teachers and their teaching practices in the Czech Republic, it was important that the participants not be influenced by the thoughts of others. Each one had the opportunity to respond as fully and clearly as possible without having their thoughts and responses colored by what others have said.

With the study being conducted in a country where the researcher is not a native speaker of the language, one strength of the study emerged accidentally in that interpretation for the participants and interviewer was not necessary since the physicians were adequately skilled in using English for oral communication. In developing an understanding of the phenomenon of social change, the importance of being able to communicate in the same language was vital. Through our language, we are able to express our culture and everything we understand (Skinner, 1985, pp. 29-30). This one event does not presume that all the stories told are perfectly understood, but it did serve to keep the interviews from any further bias in the way that the interpreter would have phrased ideas that may have varied from the original intent of the participant.

In order to incorporate the constant comparative method of data analysis, three interviews were planned with each participant. The first interview was a broad description of the experience of changing from a communist education and political system to the present system. The Czech physicians also described the ways they have

changed in personal, professional and teaching practices. A set of questions was created to guide the interview at this point, but this interview guide was not mandatory for use with each participant. In order to gather as much information as possible, it was important to allow the interviews to be flexible so that participants felt the freedom to express themselves about their lived experiences as fully as possible. The second interview was used to ask questions that have been developed with other participants that were not asked in the first interview and to clarify any unclear points, as well as to verify the development of categories of data. Participants were allowed to clarify and add to the information as much as possible (Wilson, 1992). A written version of the data analysis was sent to participants for them to examine and allowed each to make any final comments. This allowed the researcher to verify coding and development of relationships between the themes in order to remove as much personal bias, and allowed the participants as much voice in the data analysis as possible.

Next, observations of physicians working with students in classroom and clinical settings were planned to provide information about current educational practices. Direct observation would have allowed for a record of teaching practices employed, issues addressed, as well as the number and variety of methods that are used in the exchanges with students by each physician, but given the differences of classroom scheduling, this method was a very minor source of information. It was hoped that this would be one method of verifying the participant's reported educational practices were actually being done in the classroom and would have allowed the researcher to see the educational process in action. One physician in the sample gave permission for his class to be observed. Other members of the sample either did not wish to participate in this manner

or were only involved in teaching in clinical settings. Due to new patient confidentiality laws in the Czech Republic, observations in clinical settings were not requested.

Last, examination of departmental and institutional documents ascertained changes in how the university stressed the importance of teaching ethics. Several participants were asked if they had personal documents available they would be willing to share as proof of personal changes they made, but none reported keeping such documents.

Because grounded theory calls for the use of the constant comparative method of data analysis, an interpretational form was used in this study. Strauss and Corbin (1998, pp. 67-68) describe the importance of microanalysis for three purposes: in order to develop the theory fully, to address researcher assumptions in order to remove these from the process, and to identify participant assumptions in order to begin making provisional hypothesis about what the assumptions mean. Each interview was transcribed upon completion and a copy of the full transcript provided for the participants. From these transcriptions, major ideas were extracted for each participant, who was asked to verify whether they felt these were the salient points of the interview. Each participant was given opportunity to indicate that these were the most important ideas, to clarify any misconceptions being developed and add any further thoughts they may had in the ensuing time period. The purpose for including member checking in the data analysis is that it enabled the researcher to verify a correct reflection of perspective, allow participants to identify sections they do not wished published for personal or political reasons, and it helped to develop new ideas and interpretations (Glesne, 1999, p. 152).

In order to compare the ideas resulting from each interview, a chart was created to have a compact visual representation of the major ideas from each participant. By using a computer program to create the chart, it was possible to move items on the chart so that categories could be developed and refined without having to recreate the chart every time. This also proved helpful in condensing categories as data analysis continued and higher levels of themes emerged. NVivo qualitative software was used to help organize ideas and categories developed as part of the study.

The phenomenon under consideration in this study was the importance of cultural changes and how these impacted the way each physician practiced the art of teaching. The site chosen, the Czech Republic, was one where members of the society had experienced a change affecting the entire country and which was still creating waves of change throughout the healthcare system. Because the teachers had the experience of training and teaching under a different system than the one in place now, the unit of analysis was the group who had undergone this change. Eight individuals were originally planned as the sample and more were not needed to reach data saturation. The case is the Second Faculty of Medicine of Charles University, located in the Motol district of Prague, Czech Republic.

Hammersley (1992, p. 64) combined the criteria for evaluation of qualitative research projects. His resulting list includes the following seven elements. What is the degree to which generic or formal theory is produced? To what degree is the theory developed? Are the claims made novel to the study? Are the claims made consistent with observations and are examples included in the report of the study? Does the report seem credible to readers and to participants? To what extent are findings transferable? And

does the report contain enough information to assess the reflexivity of the account? (Hammersley, 1992, p. 64). An important aspect of being able to evaluate the research report is whether or not sufficient evidence is provided to convince the reader that claims are true, that the evidence included is central to the argument presented and that the evidence is supportive of the type of claim made, whether to define, describe, explain or develop theory about the phenomena (Hammersley, pp. 70-71). The final issue Hammersley (p. 54) discusses in evaluating the research report is the question of how ethics and ethical principles are incorporated in guiding the action of the research. It seems especially important to this particular study to know that the actions taken were conducted in fair and just ways in the pursuit of the study (Hammersley, p. 54).

The question of ethical space is central both to the role of evaluation (i.e. how it justifies its social warrant) and to its goal (i.e. how it serves particular needs). In relation to role, we need evaluators to be independent of the ethics of the prevailing political culture – otherwise judgement tends to be suffused with similar assumptions to those prevailing (Hammersley, p. 65).

Limitations regarding the methodology included that the survey developed from the study by Fox, Mazmanian and Putnam (1989) was not be used with a large enough sample to be a replication of that study in this culture. It did give an idea of how this particular, and very small, sample was similar or different from the original study, but it could not be used in order to make comparisons about physicians between cultures. Another issue is that this sample was comprised only of physicians serving in an academic setting, rather than in a variety of settings, as the Fox study included. This is another way that it was not truly a replication and was a limitation of what could be compared to the findings of the original study. A second limitation of the study is that because of limited time, observations were not extensive, and were not conducted with

each physician. Therefore, actual examples of how ethics and values are being taught could not be gathered while in the field.

CHAPTER FIVE

Findings

Introduction

The Velvet Revolution is 12 years in the past, but the winds of social change have not died away. Imagine someone standing in the eye of the storm, the chaos swirling about. One wave of change has passed overhead, whether the person perceives it as total destruction or just a rearrangement of what is still there depends on his or her outlook on life. However, there may be more change to come as the trailing edge of the storm moves closer. We cannot still the winds or stop the changes that may approach. We can prepare for the next wave by evaluating where our strengths lie and where to brace the walls we wish to preserve.

At the Second Medical Faculty of Charles University, eight physicians agreed to participate in interviews about the effect of social change on their personal and professional life and in their teaching. Each one was representative of a different medical specialty, including dermatology, immunology, medical chemistry, nuclear medicine, pediatric neurology, pediatric oncology, sports medicine and surgery. In order to have representation of as many qualities of the institution as possible, two of the professors were selected because they teach in the preclinical section of the medical school program, with the remaining six in the clinical program. In the group teaching in the clinical program, two are pediatricians and the others work in adult treatment areas. There were two female and six male participants whose ages ranged from 42 to 61. A representative of one of the largest and one of the smallest hospital departments is included in the

sample. Except one, all participants had worked in the medical school since their completion of residency requirements. All participants signed a consent form and allowed an audiotape to be made of the interview. The consent form was witnessed by a member of the support staff of the department or of the medical school. For use in the study, a pseudonym was chosen for each participant from a web site containing a list of the 20 most common Czech family names, of which eight were chosen randomly.

Interviews ranged in length from 45 minutes to 4 hours. Interviews longer than an hour were completed in two sessions. Following each interview, a transcript was created from the audiotape record, which allowed for use of the constant comparative method of data analysis. The interviews were strikingly similar in the issues the participants discussed, although personal reasons for choosing those issues varied. Of the sample of eight, two of the interviews (the fourth and seventh) were different from the remaining six in that their answers referred to the society at large more often than the other participants did. These two participants did not vary greatly from each other. When the eighth interview returned to the issues discussed by the five remaining participants, interviews were concluded, since it appeared that no new information would be forthcoming in any future interviews.

After each interview was transcribed completely and accurately, the participants received a copy of the transcription in order to allow each to check for accuracy and to add or remove any materials each did not want included. None of the participants chose to remove any of the responses given during the interviews from consideration in data analysis.

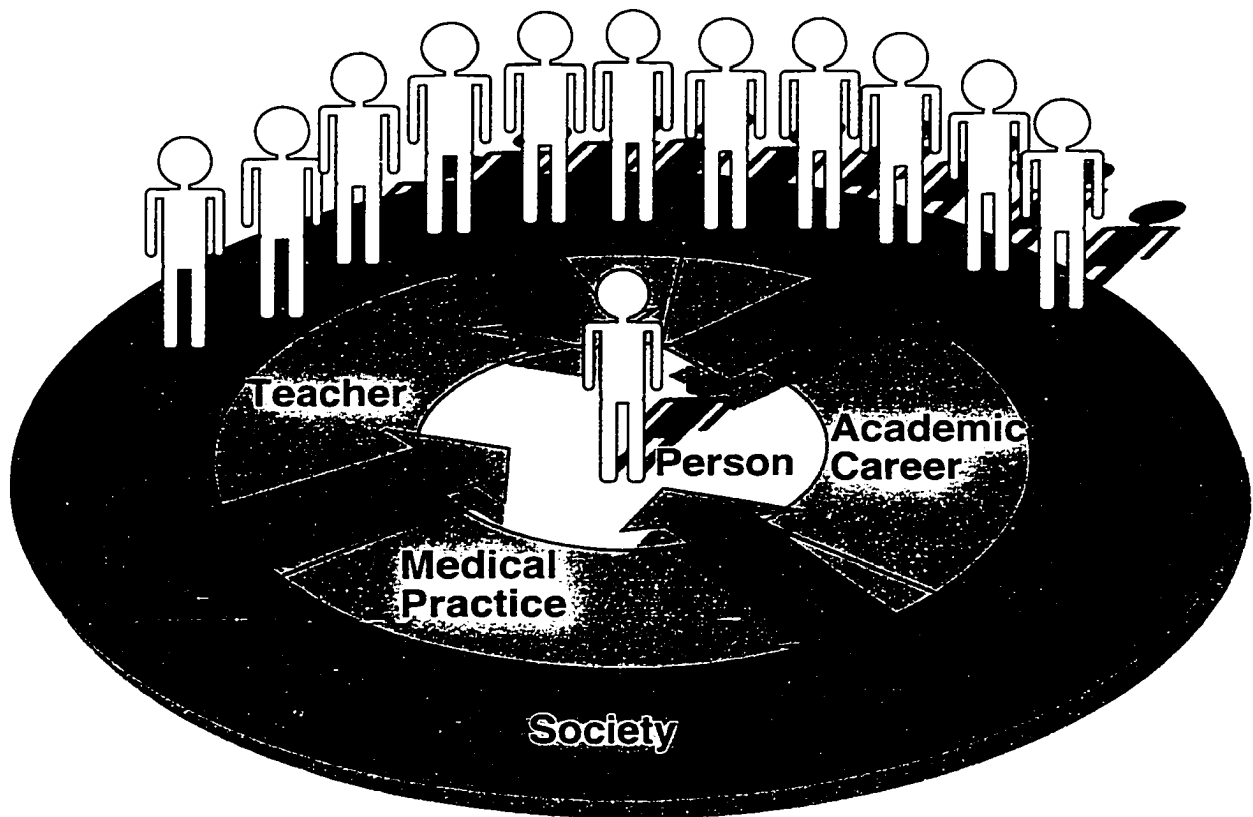
Following this, data analysis was begun by examining each interview and summarizing the main ideas in each section. In order to begin conceptual ordering (Strauss & Corbin, 1998, p. 19), the interviews were read a second time in order to define properties. At this level, the words of the participants were used as often as possible and many times, the main ideas of the sections were included in the properties. Each interview was then organized by research question into a list of the properties found in each area of questioning. From this list, a set of categories was created which helped the development of beginning themes. Dimensions for each property were not always found, since many of the interviews did not contain this information. Here again, participants received a copy of the categories and how their answers had been organized. The categories, properties and dimensions of the eight interviews were then combined to discover overall themes in the information by creation of larger groups. The interviews were checked at each step in order to confirm that the new themes developed were supported by the original data. Intermediate models were developed for research questions one through four and a final model was developed for the overall process.

Research question one: Impact of social change

How have social changes affected the physician teaching in the medical school now? Members of the society are affected in more than one aspect of their lives when the social system undergoes change. Participants discussed factors of how social change has affected them in three areas: medical practice; the relationship with the institutions in which they serve; and teaching. In this situation, two main sources of pressure were discussed, extrinsic and intrinsic. Extrinsic pressures for change may come toward the individual from more than one area of social life; in the case of the Czech Republic,

participants discussed the changing economic arena as an example of this. Political change was felt to have little impact on their academic career and teaching. There were also intrinsic pressures for change related to his or her inner drive to excel in the profession. Two areas of pressure to change seemed to be reciprocal in how both society and the individual are affected. Because new freedoms and possibilities exist and new sources of information are available to both sides, the social setting is changed. Not only is the physician different in his/her approach to patient care, members of the society change their expectations for how medical care should be conducted.

Figure 1. How pressures for change move between the person and society



Medical practice

Dr. Marek claims to be 61, but acts like a much younger man. The office looks much like a “second home” where he had collected supplies to provide some small

comforts in the long hours spent in that room and department. His answers show him to be a person who values the traditions of the medical heritage built at this university and someone looking toward the future. The most important change he discussed in his medical practice was the ability of his specialty to simplify work for other physicians referring patients for treatment and diagnosis. Changes in drugs and imaging procedures provide a better understanding of problems the patient may have. “We make the situation for the other specialists simple.”

Dr. Benešová’s office is in an older part of the building, which was being remodeled nearby. The sounds of construction work come clearly through the walls and floors, but she does not seem to be aware of the noise. Evidence of on-going projects are neatly arranged on the desk and table. She looks at you intently when speaking and her vision of change in the clinical field is not sweeping and dramatic but constant, small adjustments to her practice in order to improve. “I think there are not really big changes, but there are always implementation of new, continual implementation of new results, of scientific research or new experience to daily clinical practice. Which are not big changes, but continual professional changes.” She discusses how changes in the social situation of the country have allowed for a wider variety of treatment to be available for patients “...because one was too expensive and another was not performed here. So now we have all access to all kinds of current treatment to our patients.”

The office of Dr. Janák is one where streams of people come and go in a short period. The office windows are large and open onto a beautiful, wooded area. Just as the windows offer a view of the outside, his comments show him a person who values the window on the world he has from contacts with others in his field outside his workplace.

This is not a new circumstance; there were contacts with other physicians outside the Czech Republic before but the countries have changed. Previously, the “good contact” was with physicians in Russia and East Germany, but now these contacts may also happen in countries that lie to the west. “...but this contact with foreigners mean that we are rich. Experienced. We are able, of course, visiting different countries. It means that I am educated. I was in Finland, I was in Canada. I was in different countries and, of course, I am not visiting factory. I am visiting the similar people as I am.” Today, physicians are able to use new technologies to stay in touch with colleagues around the world. “We are discussing these problems and this is important and, immediately, I am able to get some fax to send...” His understanding of how he is affected by social change as a physician reflects his position as a teacher in the basic medical sciences. He has adapted to the new conditions. “Of course, it is typical for adaptation from biologic point of view. Are you able to be adapted? Or you die. This is biologic rule.”

Dr. Veselý’s speaking voice sounds like he has spent years outside in the cold and rain coaching a team of children learning to play a sport. His office is part workroom, part conference room and a place where the workday activities center. Decorations are minimal, but give evidence to the emotional ties in his life. The only photograph hung where visitors can see it is of his two daughters. Otherwise, two paintings, gifts from his teacher, grace the walls. While his answers show him to be a person who does not retreat from hardship, he also seems somewhat unsure about the eventual outcome of the change his society and the healthcare system are undergoing. Dr. Veselý talked about how any decision to change healthcare should be based on where the Czech Republic is in development and what is needed in their own society. “What is a new system? If you

look at the system of West Germany, we have to realize that we are not economically strong enough to copy them. Neither Germany, nor France, or the United States. It is incomparable, simply. And still if you open the *New England Journal of Medicine*, it is full of ideas of like how to reorganize it. So where to go to learn how to do it here? It is a very complicated situation.”

The conference table located in one end of Dr. Novák’s office gives testimony to the size of the department and the work that must be done by the team. His desk is also a testimony to the orderly mind of the person using the space. Every item is neatly and carefully arranged. He appears to think carefully before answering, but also shows flashes of humor in the easy and quick laugh that happens. He seems to be both realist and optimist in the way he describes his experiences with social change. One concern he voices is in how it is hard to currently know what is best for his profession. He thinks there is a problem with the social acceptance of the medical community. “What I can see and say is it is some shift in how it is nice to be a doctor... it is very nice to be a lawyer. It is fine to be a lawyer, but not a doctor. If a doctor, maybe orthopedist, or someone from a little specialization, but not to be a surgeon.” All doctors are not respected equally and his specialty is hard hit by this attitude since it is one of long hours without economic benefit from those hours. What he thinks this will lead to is a shortage of people who will be willing to enter the field. “Maybe it is not a good answer, but we feel it will be a problem in a few years when, or if this policy will be not changed...It is comparable to Western European countries not having sufficient numbers of doctors.”

Relationship to the institutions served

These physicians serve a dual capacity in teaching at the Medical Faculty and working for the Faculty Hospital, where their students receive clinical training. In considering the physician and the institutions they serve, social change has led to the loss of some elements of work that were comfortable and familiar. The work place environment Dr. Janák discusses sounds more like a family relationship. Before, colleagues celebrated together and supported each other. Now, individuals are less inclined to spend time together because more choices are available for private pursuit. While there is a sense of sadness about the loss of this working relationship, now he is able to devote his time to what he thinks is important. No expectations exist to promote propaganda or to join a political party to further his career. "First of all, nobody will ask me if I will stress that only the best are coming from East and only the bad what is coming from West." A second change for the better is that career advancement is no longer tied to political party affiliation. "Nobody will ask me when I would like to be a professor in my subject if I am the member of the party. But question will be completely different. 'What about your list of publications?' It is your business if you are belonging to Communist party, or so on, but you should be good enough."

While Dr. Marek admits his medical habits are ingrained due to the training he received in his youth, he sees that younger physicians will not be as attached to the school in which they train. For his generation, it was the professors who gave a touchstone to the medical education process. Now, an academic position means there is a push to publish in respected foreign journals. "To be at the university now and to do this academic career, it is more hard because you must publish. You must publish in foreign

journals with high impact factor.” Unfortunately, Dr. Marek sees this as a loss for the Czech physicians serving in smaller villages and communities who rely on the university to provide new information for them. “But the disadvantage is that the people do not want to publish in Czech. This is bad because common doctors in the countryside and the smaller places have difficulties to buy foreign journals. It is horribly expensive and they don’t speak foreign languages.”

Her manner and actions give the impression that Dr. Bartošová is a person who enjoys living and works in the center of a busy and creative hub of professional activity. She smiles easily and moves in a way that gives evidence of her self-poise, confidence and energy. While much about the social change has been very good for, and to, Dr. Bartošová, she also understands that now there are new pressures for the institution and specialty in which she serves. The healthcare system is still in flux and it has become a political battle to defend the specialty against the interests and needs of every other specialty group. “Speaking about clinical practice, it is a much different story because we really are in big troubles now...In the past, pathology of the skin was done only by dermatologists. Nobody took care until the money came into the business...Pathologists told us, ‘No, it is our branch. Unfortunately, we are not good enough, but...it is pathology, so we will do it.’ And you can fight any branch, allergology, immunology, infectious diseases, and so on.” Financial problems, which plague the entire education system, are especially acute since the need for equipment is great. “And we are always with the red figures in the budget of the hospital. I know the reasons; it is not only because of insurance, but when we moved here, they did not give us a proper equipment, so if you don’t have devices, you should rely only on your hands and eyes.” At one time,

hospitals became the fail safe for the system of patient care. “Before the Revolution, we were working like every local doctors without any...differences. The spectrum of diseases, the spectrum of diagnoses was the same. After the Revolution, we had only...difficult patients or, of course, expensive patients.” If the private doctor did not meet their needs, patients returned to the hospital, which served as a treatment facility for the most difficult and expensive problems.

There is some uncertainty about the future of health care and education for Dr. Veselý and he discussed his belief that change should not occur in every part of Czech society at one time. Some parts need to become stabilized in order to find the best ways to change the remaining systems. “It is interesting to me to see how people come to the same conclusion like me. I was very independent in those days and the majority of my colleagues disagreed with me that healthcare should be the last branch which should be privatized.” The best way to protect the healthcare system is to allow for gradual changes in practice styles, giving practitioners time to realign their roles in society to fit new needs and demands. In his opinion, educational reforms have targeted areas that worked well and ignored areas of pressing need. “What we really need is to have a much bigger amount of money invested to the universities because it is the only way how to bring really top people to the really top positions.” Funding at the university does not allow for teachers to be paid in parity with the rest of society, so their position is deteriorating. Yet, the university is asked to admit more students without resources to provide for educating the additional numbers. “And the situation accordingly is very difficult to ask for new people for being here as assistant, as a teacher and as a doctor in the state hospital

because both his (hospital) salary is low and the teaching salary is even lower. And if I compare it to average salary in the state, it is now much worse than it was 10 years ago.”

Teacher of medicine

She believes teachers must change with society and Dr. Bartošová feels she is changing as a teacher. “Because I think that first of all...it is necessary to improve the way of teaching or to change the way you are teaching and to add new knowledge, new information and so on. I think it is automatic. If you are teaching, you could not be teaching what you taught 10 years ago.” It is more important that students receive from her what is not found between the covers of a book. “I think mainly the way of behavior to the patient is more important than the dose of any antibiotic they will be taught.” In a system where patient expectations have changed greatly, it is important for students to learn the behaviors she seeks to instill in them. Students should be responsible, honest, not overestimating themselves, and learn to treat the patient with honesty as a partner.

While Dr. Bartošová feels the teacher should change, Dr. Benešová feels the students already have. She sees students as different in important ways. Evidence of this is in their attitude toward class attendance and rules. “Now students once they come, once they do not come and so it is more difficult to have a continual education.”

Unfortunately, these changes do not seem to have improved student morale. “During my career as a teacher, I would say there is more liberalization among students, which I consider to be worse for teaching because there is not a good morale and good rules.”

His attitude is positive toward much of the social change and his words sound like T. G. Masaryk, President Liberator of the first Czechoslovak democracy. But even as an optimist, Dr. Marek understands the emotional state of Czech society has not balanced

yet. He sees himself as “too old to change,” but now he has the freedom to apply the principles he has always held, whether he could teach these openly or not. Changes in students have had a good effect because they are more experienced and settled when they enter medical school. “Nowadays, they know much better what they want. They know that to do medicine in my country, they will not make big money. So they must be somehow more idealistic or idealists.” Having lived before entering school gives students the ability to be clear and focused on what they want from the process. While he thinks students are better prepared by their experiences, Dr. Marek does not say they are influenced much by those changes. Therefore, he does not see his teaching to be influenced much, either. “And these problems do happen, but these do not have any influence on my way of teaching and I don’t think it influences my students as much.”

Like Dr. Bartošová, Dr. Novák also discussed the way in which he has changed as a teacher. He feels the need to impress upon students that activity has a cost, which must be understood and evaluated as they provide care for patients because “...not only from the medical point of view, but maybe more than before, we are speaking about a very practical seeing or calculating of our activities. About needed economy, about database medicine and about the knowledge if it (the procedure) is necessary or not. Because everybody should know if it is cheap or expensive, or so on. So everybody should calculate, ‘If this, this, this or not.’ I speak about it with my students and I hope my colleagues do the same.”

Pressures of social change: Extrinsic

Extrinsic pressures originate outside the person and may be found in institutions that influence the practice of his/her profession. Dr. Bartošová discussed changes in the

insurance system that have affected patient treatment. “But speaking about insurance, how it could influence the quality of care, I think it is important now, for example, practicing doctors have got budgets for drugs, for medicines. And if you spend your budget for a quarter year and there is nothing, and if you are a private doctor, you are not going to treat the patient.”

A second institutional change has come in the demise of the communist system. According to Dr. Marek, new physicians have no assurance of a position and each must find his or her own place to work. “For instance, when we graduated from the university, you were sent to a certain hospital or medical center or so. They didn’t ask if we wanted to be there. ‘Go to Benesov City and be there, go to Slovakia and be a doctor there.’ No discussion.... But we were sure that we will have a job. Nowadays, it is not sure. You finish the school, but it doesn’t mean there will be positions for you.”

Dr. Klíma’s office windows look out over the courtyard of the hospital complex and the curtains are pulled back so the room is bright. A Van Gogh print hangs on one wall of the office, which is neatly organized. His thought about his career as a teacher shows in clear and thoughtful answers. His answers also give evidence of the deep concern he has for his patients and their families. The change to a capitalist market has had both good and bad effects on the future faced by his students, according to Dr. Klíma. The socialist system provided a low standard of living for all members of the society, but life was cheaper. The capitalist system brings higher risks now, but has had a positive influence on the society and his ability to train students. “You may know, that in some respects, the socialist system is very interesting, but you are in very poor system with a low standard of life for everybody. In capitalist system you have very big

differences, but from the medical point of view, it is very important to have money for this new techniques. Especially in the beginning after the Velvet Revolution, in '91, '92, '93, we obtained a lot of new equipment for our hospitals. So it is a positive influence." Patients and students are benefited by new resources available for teaching. "For our students it is important because if we have some patient with cerebral bleeding or other disease is coming to our hospital...I can make the correct diagnosis in 20 minutes, using modern techniques and to show this on magnetic resonance or on the terminal directly to the students."

Another way that external social pressure in the economic arena is changing the future for medicine in the Czech Republic is in how young doctors now have the possibility to leave the country to work in places willing to pay more for their services, according to Dr. Janák. "They have opportunity to leave Czech Republic, not as emigrant...but yesterday, I read this paper where was advertisement, maybe Germany...they offer to our new doctors opportunity to start outside. Of course, from Germany it is good business. Therefore, they pay nothing and the full doctor they will obtain." This is an issue because Czech students do not pay tuition, so the nation that paid to educate the physicians will not benefit from their future services.

Intrinsic pressure

One overarching theme in the answers of these physicians was the dedication they have to excel in their profession and in their teaching. Dr. Benešová phrased this as freedom to make choices based on new information available because "...its this free or free thinking, let's say. Or free mind, an open mind, and also there's better access to

informations, so you can think on that and you can do it, if you want to and it is an advantage to all of these changes...”

Dr. Veselý also knows social change has brought the possibility to change personally, but his desire is to withstand that pressure. He hopes to not change because there is still much readjustment to be made in the entire social system. “I told you I think that the society needs 40 years. I am not ‘going back to Egypt where there were sweet melons.’ I try to be realistic and I try to study it from inner side, which is very different from outside the changes.... I am glad it came so relatively early, that society was not destroyed fully. On the other hand, it came at the moment where not all things were done in the last 40 years should be thrown away.”

Evidence of Dr. Kučera’s busy schedule is in how tightly it is filled. He comes from one meeting in across town and has the next group waiting before the end of the interview. Yet he is gracious in his responses and answers in ways that show careful thought about the teachers he works with and the students they train. One element of change will allow teachers to pursue personal excellence by being researchers in the university system. “And all research was performed in the Academy of the Sciences, according to the Soviet Union. Yes? And so the first one what was changed was that now, naturally, the research is performed also in the universities in different ways. The grants and the research plans and the research centers was developed in the universities and, so I think, this is very important for us.” As researchers, they will be able to keep personal interest in their academic career alive because it will allow them to bring the newest information to the classroom and clinical settings. “And the scientist is every time informed to the day in his branch. So the students will receive everything what is new in

the special branch.” He also believes that teachers should be people striving to be excellent diagnosticians and clinicians to train future practitioners.

Reciprocating pressures of social change

As an overarching theme, it is impossible to ignore how freedom has changed the many aspects of their medical practice, academic career and teaching. Freedom has brought vast sources of information, which has changed both the physician and the patient, and brought new possibilities for everyone. As practitioners and teachers, the power of information was seen in the answers of every member of the group and how their patients are able to find answers to their health concerns and problems. Having available information has changed both sides of the equation for these doctors.

A second reciprocating pressure for change was in new possibilities for life and how new physicians can respond by developing their own profession. Dr. Marek and Dr. Klíma both saw changes in the way that people with disabilities are now included in the society. Dr. Marek sees his students as having more interest in working with people who have disabilities because of their increased personal experience. “They are very much interested in working with disabled people. This is great; it did not exist before the Revolution.” Dr. Klíma talked about the way he is trying to change life for people with disabilities. “In our country, there are a thousand children, this is a heritage from the previous system, with Down’s Syndrome in the institutions... So what I am trying to teach my students: to speak with the mother; to accept the child as a partner; to try to understand the special needs of the children and the family; and, to help the mother and child to keep the child at home.”

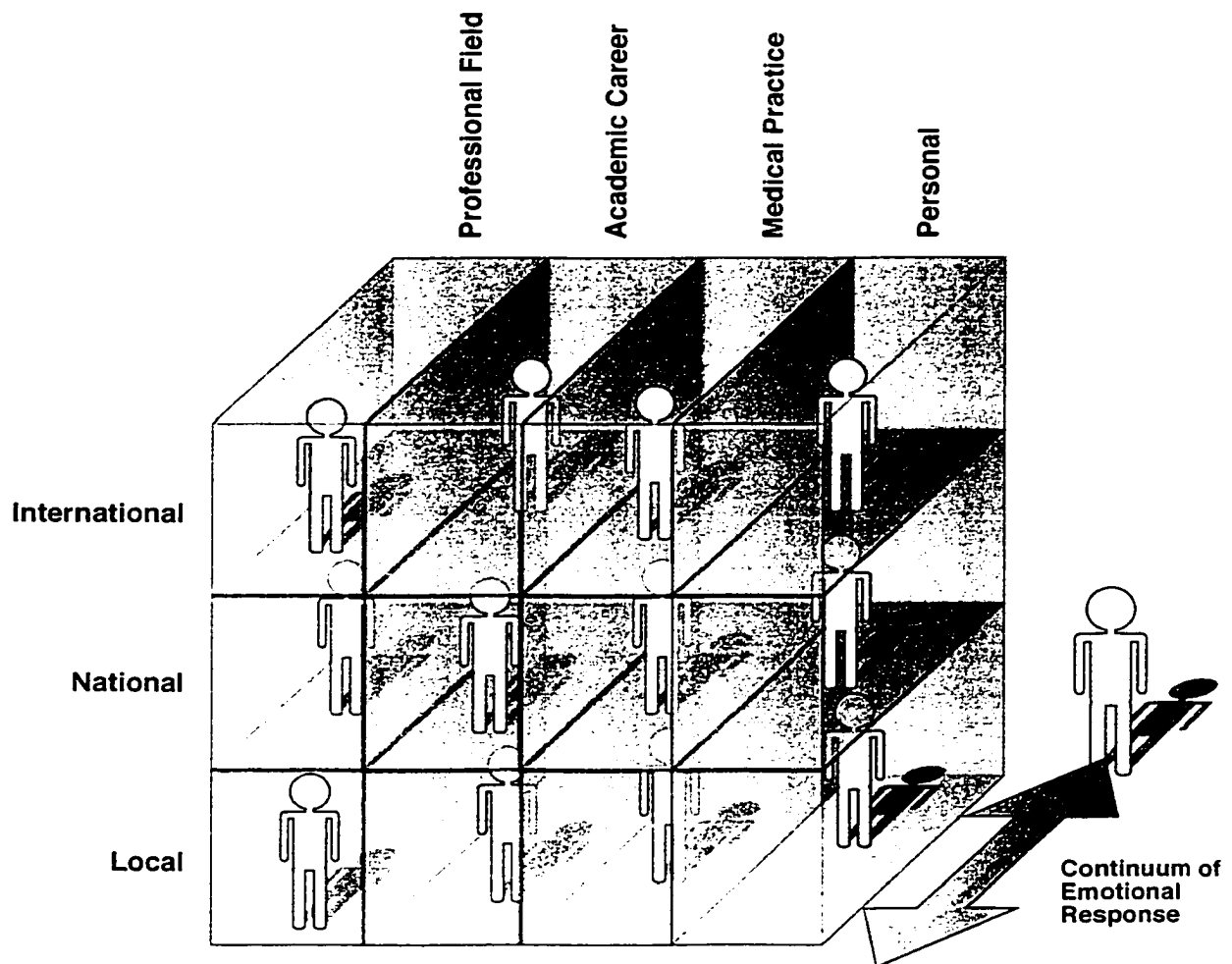
As a teacher, Dr. Novák talked about his desire for students to become more fully in control of their professional practice. Under the socialist system, the practitioner was a “dispatcher” who made the initial diagnosis and then sent the patient to the next level. Dr. Novák would like to see his students provide more in the way of service to both the patient and to the profession. “I hope that they can see and bring more responsibility to being a specialist – like being a general practitioner – and to provide more medicine. More and more medicine, depending and limited only by their activity.” He sees that his students can change the profession through their own motivation to be active, participating and creative doctors. “I think it can be expected. Having sufficient motivation, they could move to more activities. No only to be so-called ‘dispatcher’ – to send patients to the specialist, but to guarantee treatment for nearly all. I think it is possible.” Given that social change is described as having brought both benefit and disadvantage to the practice of medicine, the relationship with the institutions served and to the teacher, these physicians also understand that this is a process that will take time to adjust before any real solutions are found.

Research questions two and three: Methods and motivation for personal change

The relationship between personal change and how it is reflected in his or her teaching practices is a complex one. Many times, the change is clear-cut, but the corresponding motivation may encompass multiple areas of their life. The data clearly fit into two different categories, which could be further divided into levels, and a third category was helpful in further explaining the relationships seen between answers. Therefore, the responses are organized into the visual of a cube. One axis of the face of the cube has areas affected by change: the professional field, academic career, medical

practice and personal life. Along the second side of the face are the levels of the change: international, national or local. The third axis of the cube is a continuum to show the emotional response of the individual to change. Position along this continuum is determined by whether the change is seen as a positive or negative by the person.

Figure 2. Personal change categories, levels and emotional response



Professional field

The participant whose answers show the most change in the professional field was Dr. Bartošová. For her, social change and the ensuing freedoms has lead to change in

every area of life. “I think that my answer will be very specific and not so, let’s say applicable to everybody because my life has really changed completely in the last year....I just won a competition for organizing European Congress ... and this Congress will be held in Prague.” The professional changes affect everything in which she is involved because she is now able to be more involved in developing her specialty across Europe and the world through work in the specialty professional organization. “Really everything was changed since that time because I started to travel a lot. And thanks to that position, I entered different new committees and societies which are working in our field. So it means, if you are speaking about professional point of view, really everything was changed for me.”

While the level of his involvement is not as dramatic as Dr. Bartošová, Dr. Veselý also sees benefits to international possibilities. “My future plans are easy: to continue the changes I am slowly starting in our department and to find grant sources and also some international cooperation.” He knows international contacts will make it possible for a small group to work in further development of the specialty through research and discussion. “As for international cooperation, before 1989, it was not a problem that we could not travel...but we are a small department and our problem is a personnel problem.”

Many of the participants are currently serving in positions of importance on the national level in their specialty organizations. Dr. Benešová describes her position as an “officer,” Dr. Veselý serves on the national board of directors for his specialty, and Dr. Novák is the president for his organization. One, Dr. Klíma, is serving as a member of the Ministry of Health for the Czech Republic.

Academic career

Being able to talk to other physicians around the world has given Dr. Janák the certainty that he is teaching the same information. He is able to compare the textbooks he uses and discuss information equally with others in his field. However, it has also taken away local input to the teaching of medicine. “Textbooks were written by people from our faculty. Now, I prefer to teach from so-called international textbook. In my case, it is *Harper's*. When somebody is coming from different countries, their first question will be, ‘What is your textbook?’ And I will say, ‘*Harper,*’ he will not ask no more. Therefore, it is clear for him there is normal textbook. Or maybe that we will discuss if *Striata* or *Harper* is better, but it will be professional discussion. Then I will say ‘My textbook is Janák *Biochemistry*.’ ‘Who is Janák? Oh, yeah, it is YOUR name’.”

Being able to conduct research is an important change at the national level for Dr. Janák. He values involvement in science for physicians in an academic career, but one sorrow exists in the fear that the use of Czech in teaching medicine will end at some point in the future. “Still, our (young) generation is still not able to read without problems not translated books. Therefore, the Czech terminology – if we will jump to the English terminology, it is sometimes complicated for these people to be able to express these precise terms in Czech. Therefore, they will forget it and this is the problem of Europe. English will be the domination.”

As she seeks to advance her academic career, Dr. Benešová has chosen to develop qualifications allowing her to become a full professor in rank. She is completing a process that is important at the local level and shows her dedication to a teaching career. But Dr. Kučera has a vision of teaching as more than an 8-hour workday. “I think that the

good teachers must have two or three parts of their making. The first one is, naturally, the good education in the branch. The second – the contacts with the students. The personal contacts with the students...And the third, naturally, is the ability of the teachers to teach good. Yes? Many times very good scientists can't teach. So the ability to give the matter of the subject on a good level is very, very important.” Dr. Kučera also believes it is impossible to be a good teacher and a bad person. “And probably what I want to say is that the teacher is obliged to teach not only in the time of teaching, but in all his life. The students see the teacher not from 10 to 12, but from the morning to the evening. So the personality of the good teacher is only one. It is impossible for me, in my view, to divide the personality of the man, a good teacher and a bad man.”

Medical practice

Increased international activity allows Dr. Bartošová to consult with others in her field about difficult cases. “I just take picture and at least a pathological slide and when I am going abroad to congresses to meet the people, ... I can just tell, ‘Hi, what do you think about this?’ and it helps me a lot.” While this was not an expected outcome, it is an important element to her.

Dr. Veselý sees that other countries are now reaching the level his program attained years ago. “Let's say, in Belgium now, they start now to deal with projects we were dealing with one generation ago. Like to have reference values for habitual activities, etc. So the benefit of my position is that I feel the possibility to continue the tradition.” Being able to send his colleagues to another institution for training continues to be a problem. “I have a very good friend in Brazil developing the same specialization. Thus, I would like to send my colleague to him. The problem is that we need some time

to be stabilized and to develop our department internally. And then, eventually later on when I would see that I can miss him, I would send him outside.” The access to unlimited information has already given some greater contact with the outside world through the availability of research. “The most important change for me is...having here full-text journals and having MedLine on the Internet. It was so difficult and boring and time consuming to get the latest literature. It is now nothing. I can sit here and I have directly 2,000 journals directly in full-text version. Information technology, that is the biggest progress. Free Internet, no problem. The availability of information.”

For Dr. Klíma, new availability of equipment and medications has affected his ability to practice medicine. “And the result is much better so that the number of patients, which are well treated and compensated is higher. So it is not only high tech and new medicines and drugs and so on. But we can also see the results from the point of seizure reduction.” Because there are new ways to manage and treat his patients, they have benefited in multiple ways.

How does a physician decide when a change is a positive or negative change? In one area, Dr. Bartošová, Dr. Klíma and Dr. Kučera seem to hold different opinions about patient support groups organized since the Velvet Revolution. Dr. Bartošová talked about patient groups working with professional societies to provide information to members of the society and Dr. Klíma discussed how these groups help support patients and families when the expense of care becomes too much. “What is sometimes is a neurology problem is that you get faced with the problem of homeless people, people who are from the social point very fragile. Nevertheless, in pediatrics, we fought this problem through child brain foundations....And we can offer to the families of these children with cerebral palsy

some additional money to help them.” Yet, Dr. Kučera sees the organization of support groups as a negative since it seems to indicate that the patient does not trust the physician or that there is a problem in the relationship developing between doctors and patients. “If this society is here, then the people in the society must think that the doctors are danger and will make somebody bad to the patients.”

The trend of families to seek medical care in other countries is a detriment to Dr. Veselý’s department and specialty. “And some rich families now try to send the child for the heart surgery to western countries. According to my opinion, such decision increases their health risk because this department has huge experience with excellent results.” Along with this loss in the patient base, he knows, because the department operates as a service to other specialties, it is difficult to depend on insurance payments to provide sufficient income to continue departmental activities at past levels. “Here in Motol, in this department, our results are satisfactory for other departments. But the bureaucracy is difficult in the sense that health insurance companies would like to put our work to their system, and we are out of it (the insurance system). This is the main trouble for me at present.”

Dr. Bartošová has noticed patients are becoming more aggressive in the way they approach their own medical care. “They are more impatient so they want to save their time, of course. Because a lot of people are working in a business and they are not just looking for time to spend in the hospitals.” This change in patient treatment of the physician and health care team members concerns Dr. Kučera. “But it is only another view of the ethics in the medicine and this is that the patients now are many times very bad to the doctors and to the nurses. And, naturally, the medicine must serve, but doctors

and nurses and other health workers are not servants. So not only ethics, but also the good contacts and it is a very good example for these situations.”

While he seeks to protect the long tradition of excellence in his department, Dr. Veselý knows institutional changes at the hospital level make it difficult for a small department to operate. “I understand we have to start to think in economical way. Not only in thinking what is best benefit for my patient. It is very complicated question because if we should think economically it starts to be little bit unethical. For example: should I ask for bigger salary for my colleagues or for more expensive treatment, which eventually would give back, would be of some benefit for treatment?” These new decisions are especially complex in a department where the need for advanced technology is great. “We (I mean functional diagnostic labs) are very specific in the sense that we are very dependent on technique and technology.” One new area of stress for him is in how to make decisions that will continue to benefit patient care and meet new economic demands from the hospital administration.

While there are such great areas of stress and change in the practice of medicine, there are physicians who understand this is a growth process. Dr. Benešová describes the changes to her practice as adjustments. “I think there are not really big changes, but there are always implementation of new, continual implementation of new results, of scientific research or new experience, to daily clinical practice.” Dr. Novák favored the term evolution. “To say there is a milestone and to say ‘From this moment, it all goes a different way’...it is not so that I feel this is the same situation, no it is not the same. Every day there is something new. But I think it is a normal part of medical progress. I am not able to say to you ‘This, this, this moment.’ All these progressions represent some

little step, movement forward, but nothing special to state there is something new.

Evolution.”

Personal

The change of her international professional activities was far reaching for Dr. Bartošová. She described differences in professional growth, her ability to teach, and in the life of her family. “I have got quite a nice type of family and my children are even growing and...it influenced everything because they had to realize that I am not so much at home. On the other hand, I took them to marvelous places with me.” She sees that the future will be very different for all of them because of the changes she has been able to make in her own life. “This dermatological world is very small and if my colleague...will organize a meeting in Sorrento, all the colleagues were there with their whole families, including Americans even. So it is nice because even children know each other.”

Even though he regrets lost opportunity to travel and train abroad, Dr. Veselý has experienced great personal joy in the growth of his family. “On the other hand, I understand the period shortly after 1989 as my personal victory in the sense that I was married in 1983 and we wanted to have children and our first daughter was born 9 years ago. So it was exactly the time that eventually I would have chance to go out for my professional career. But at the moment my daughter was born, I decided that I prefer my family to my eventual experience going abroad again.” There is some sorrow over what he perceives to be the loss of the history and tradition of his department. “Ten years ago, there was the same amount of cardiologists like of sports medicine doctors. Now the situation is just the opposite. Instead of excess sports medicine specialists, we don’t get sufficient amount of money even for basic health care and research for exercise and

sports. And moreover, we are traditionally dealing with functional diagnostics...and I would like to benefit from the previous know-how, from the history, from the tradition, and not to let all the specialization fall down.”

How does a leader evaluate his or her own effectiveness? In a large and increasingly complex department, Dr. Novák has had to change his thinking about leadership. “I want to know about all, to be really the manager, to be able to control the pulse on the hand of every one of my coworkers, but it is nearly impossible to do with 35 doctors and 100 nurses. From this point of view, it represents a very significant change in my thinking. To delegate my task and tools from my hand to other hands and to do it with the knowledge, or knowing that it is ok. I want to see it with my own eyes only. It is not the German type of leading, I know it. I do not want to be the ‘boss’ (boss vs. leader of the department). Despite it, I think that this form of driving is a little complicated because this department is too large. This is the responsibility – to do it the same perfect way, like before, but having a bigger department.”

Dr. Veselý has come to the realization that he has been given a gift many will never experience. He is able to watch history unfold in his own lifetime. “I was born in Europe and I have the European traditions and I have...it is very difficult, it is emotional. It is clearly emotional....You asked me why I stay here? You cannot find it anywhere else in the world – maybe Israel – the dramatic socioeconomic changes. I was born in a very rigid, how to say it? Socialism, Communist party. I slightly, but still I remember my sister is eight years older, so I remember 1968, all these changes. I deeply do not agree with people saying it was only a silly, stupid group of Communists. No. It was something very special and very emotional and it was really a very interesting attempt to change the

social situation. Then I remember all the horrible, rigid era of late 70s and beginning of 80s. And then I also remember all the wild capitalism which is here....It was so interesting so see all the situation. That is why I am sitting here, I guess.”

Impact of change on their teaching

There are two areas that show how personal change is reflected in the teaching of these participants. Dr. Klíma mentioned the ability to teach without government imposed restrictions. “So if I remember the situation 12 years ago, in 1988, I was very limited because of lack of information, no journals, no Internet. I had lack of technical equipment, lack of anti-epileptic drugs, for example. Lack of freedom, how to decide. Now really, it is that I am free and I can decide absolutely independently, even in the social situation. And I am not limited by the communistic government, for example, which restricted some aspect of medicine so that is the most important change.”

For Dr. Bartošová, freedom seems to give a new joy to her work. “It is like a new dimension of the work. I am much more free. So this is better even. I am much more free.” The benefit of being able to choose her own way of working carries into the way she feels about herself. “I feel younger than in the past.” Being able to discuss the good and bad points of their own system is a different perspective for Dr. Janák. “We are now free and we can compare what is our advantage and our disadvantage in our system. Language and all other factors.”

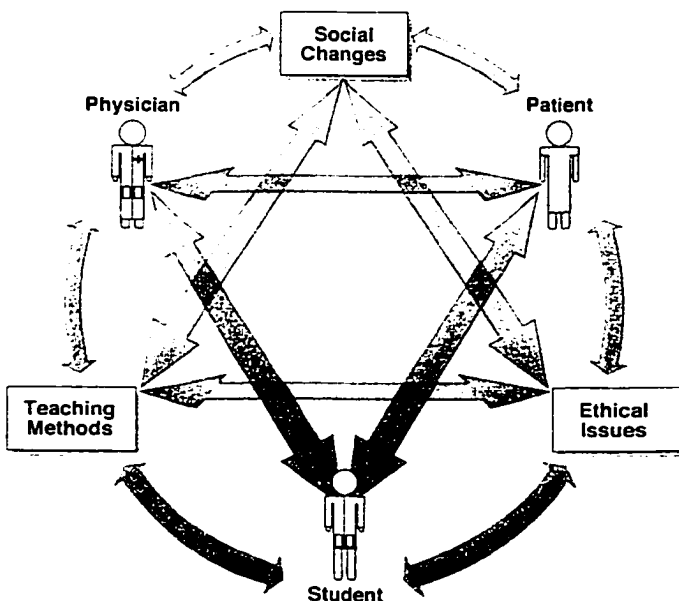
Finally, teachers should be changing in order to be involved in teaching. One way Dr. Kučera sees this is in advancement on the career ladder. “In our country, in our Republic, there are many colleagues in the Faculties till the leaving of the Faculty as assistants. And this is not good. If somebody is in the University and makes the medical

practice, education and science, after 8, 10 years, (he) must be a professor. If not, he has nothing to do in the faculty and he is obliged to go into practice. Do you understand what I mean? To be an assistant from 23, 24 (years of age) till 60, 65 years, it is no good. This is a stagnation.”

Research question four: Manner of transmission or teaching of ethics

The issue of how to teach ethics is an area where the answers given by participants showed the level of importance, and sometimes personal ambivalence, this has to each of them. The history of communism in the Czech Republic greatly complicates perceptions about this issue. There are three human elements to the consideration of how to teach ethics in a society that has undergone such dramatic cultural change: the physician-teacher, the patient and the student. Three elements that are social in nature are also associated with this issue: impact of social changes, ethical issues and teaching methods. The issues interplay to create a situation where the pressure from each upon the individual may be different at various times or circumstances.

Figure 3. How elements of the change process interact and affect each other



Impact of social changes

Dr. Veselý's specialty is one that has a long-standing relationship with elements of society where many times the ethics were bent to allow the desired outcome of the situation. "Now I am more free to discuss whatever I want. It means to express my real ideals and to express what I think and not to express what somebody wants me to speak. That is the main difference. But generally, in my particular subject, unfortunately example of the topic of top sports remains pretty unethical, both now and during the previous era." Because of this, Dr. Veselý expresses opinions that show he feels that members of society have a great deal of work to do before ethics in the Czech Republic can be a source of pride. "It should be part of development of our society. Because, unfortunately, after the Velvet Revolution, original ideas were very ethical. In the beginning, it was so clear and so honest.... And we know the faces of the people in policy and they don't behave ethically, many of them. And a generally accepted level of unethical behavior is very high here."

Because of the history of communism, Dr. Marek says that social problems need time in order for healing to take place. "So I think it is good the Revolution came and we mustn't be surprised that it is already 10 years after and still the morale of our society is bad. But after 40 years of the Communist regime plus 10 years of Nazism, here it is 50 years and the morale was very low. And society, from this point, was badly ill so it takes time." In members of his own family, he sees that the lives of simple people in the country are greatly changed and they may not be easily able to adapt.

Like Dr. Marek, Dr. Janák has given great thought to how the older members of society are adapting to the social changes experienced in the last 12 years. "I am not sure

how well you are informed about history of Czechoslovakia. You know that '45, immediately after Second War, practically all nations besides Czech-Slovak people were 'kicked off' from Republic. I will not go into details, but it means that our people were without so tight contact. You know this problem, black/white, different religion, city and so on. From this point of view, we were so-called 'pure,' but seems to me it is a disadvantage. Now these people from different countries are living here and therefore, these people should be adapted. Of course, for young generation is no problem. Seems to me that is no problem with me, but I am still in the contact with different nations. But when you will visit our small towns and villages, still will be something what is not ok. If it is possible to say, for the adaptation to these people is still not easy." Younger people may have many more advantages to which older people do not have access. "Many young people visit different countries and they know without knowledge of English and German and maybe other languages as well. It is something what is such a PC (personal computer) knowledge. To be able to communicate by using PC. And also communicate by foreign languages." Another area of concern for him is in the discussions which are on-going about changes in the system of healthcare. "When you discuss how many students we need for the next future, seems to me that nobody will be able to answer. It seems that it is funny, but it is true. Therefore, also the need for medical doctors is still under discussion. How many hospitals? How far should be hospital?... Now it is open discussion where, which towns should be with the hospital and which not."

Because of her vast international experiences, Dr. Bartošová believes that she is already different than many members of her society. "But I know in my country, it is hard for foreigners to be taken as equal partners. 'Oh, you are from the States?' then

everybody takes you like you are some, like you are a goddess....It is very obvious here. I hope it will be changed here.” Change is difficult for older people, so their outlook on life will exemplify this inability to change. “And I think that the reason is that our eyes were closed in the past and we were just pushed to think in just one way. I remember it very well when I was a child. Even my parents were afraid to speak to me in an open way. They were afraid.” Prejudices that are problematic now may become less as the children grow up in a world greatly different than the one she and her parents knew. “It will take us one more generation to change this way of thinking. I can see it in my children. My daughter is in school with a girl who is Vietnamese.... If I ask my daughter, she will say ‘Lily is a very nice girl, Mommy. May I go and invite her for my birthday party?’ And so it is completely different because children don’t have this bias.”

Dr. Klíma voices concerns about negative aspects of Czech society because he understands people to be more aggressive now than in the past. “So a small part...are a negative part of the community – are people who are aggressive without any restriction and limitations. Unscrupulous, so there are now these people. These people are sometimes bolder and are aggressive so the polite people are very unhappy because they think ‘What can we do?’ ” He also feels that the socialist system was a negative influence on members of his generation. “In past, before Revolution, in the socialist system there was a lot of influence of the Communist party to the teacher to make propaganda, like in Big Brother of Orwell. So there was a lot of everyday influence of the communist idea in medicine and other aspects as well. Every book in past started with that it is ‘According to Marx-Leninist system and the Soviet Union was first’ and so on.” One positive change he finds in society is that through travel, Czech people are able to

observe what is “normal” in other countries and this will influence their actions at home.

“So what is my first important point about teaching ethics to students? That the child, everybody with the disability has to be in the community and we are obligated, or we have to help them keep the child at home – not to give it to some institutions.”

For Dr. Novák, one important social change is in the impact of the market economy and the way it changes the person’s outlook in other areas. “Generally said, I think that the majority of people accept the value of the market like a priority. I am not sure if it is so. Is it healthy or professional or valuable? To be healthy, to be successful, to have money. Priorities or values, maybe. From this point of view, I think all these values stay the same, but maybe a little changing to the value of money.” He understands the importance of freedom but knows that it is not a value that everyone holds in the same way. “Despite it, one more, freedom. But I think that it differs significantly in different groups of people. I think that the higher and higher this feeling is, more and more is required.”

The influence of social thinking, for Dr. Benešová, is that now she sees the need for doctors to move from a traditional role to a more modern role. Physicians are expected to be more responsive, open and available to discuss clinical events with the patient. “I think the most important change is in relationship between patient and doctor because before patient was somebody who was, let’s say, underestimated. Now they are our partners.”

The patient

The relationship between health care providers and patients is one of an imbalance between the two groups. For Dr. Benešová, social change has already affected

the way patients see themselves in the equation. “I think the society wants from doctors to be more responsive for our patients. To be more open, to be partners, to discuss about the clinical state of what happens.”

Dr. Bartošová discussed the way new patient confidentiality laws have made the medical education process more difficult. “Now we have got a new law that even if you will show any record, I mean any medical record of the patient to the students, we should have agreement of the patient in advance. Furthermore, of course, if you should do some procedure with the students, the patient must agree.” While her work has become more complex, she supports the changes in how patients expect to be treated in the healthcare system. “On the one hand, it is ok because the patient is why we are here, not the opposite. On the other hand, it is complicating the teaching process very much.” Dr. Kučera also understood patient behaviors to be a result of changes they have experienced in health care. “The very important thing is that many doctors have a bad contact with the patients in the view of the paraclinical, laboratory and imaging contacts. In my youth, it will be every time so that one, in these contacts, was the doctor and second was the patient. Now, it is so that the patient is alone and opposite to the patient are ten doctors, but only one of these doctors has contacts with the patient. And the nine doctors are, I don’t know where. But the biochemist doesn’t see the patient. The radiologist doesn’t see the patient. The immunologist doesn’t see the patients. And I can continue, and these many doctors are the so-called ‘shadow doctors.’ And the one doctor have many papers, many results and among these many papers is somewhere the patients. And so the medicine, in present, is many times not the speaking medicine, but the silent medicine.

And the patient needs, naturally, the words. And the patient must have the feeling that the doctor feels together with him.”

Ethical issues

Many of the issues addressed by participants were mentioned by more than one member of the group. One of the most often mentioned issues was the need for good communication with the patient. Dr. Marek specifically mentioned the need to tailor the communication to the needs of the patient, while Dr. Janák spoke of the importance to teach the patient how to read the laboratory reports. “Moreover, I am trying to teach them how to explain to the patient what is going on. Why he is referred to this department or that department, how to find the department, how to find the way. It is very bad, it is not a scientific question. It is a very practical question. How long the procedure may take, whether it is painful, comfortable, or whether there is any discomfort. I don’t know if it is ethical or no, but in the first class, it is quite a good starting point for them.” Since they also work in the basic science part of the program, these two doctors also talked about the changes to animal research ethics.

For Dr. Klíma, ethical issues clearly fell into three areas. “I think there are three aspects: the beginning of life, so it means to discuss with students aspects of abortion, how to communicate with pregnant mother and to give the change to mother to make some free solution. And not to be absolute, to cancel abortion or to promote abortion. So it is one point. Second point, I have mentioned before, is the problem of people with special needs, chronic needs. And the last problem is the problem of the end of life. This is a very difficult question.” Another important issue for him is to teach students that the person with disabilities should no longer be confined to an institution.

The answer Dr. Novák gave about ethical issues showed a careful and orderly thought process since he incorporated elements from other major changes the healthcare system is experiencing. “I would like to answer with some scale of importance. First, to recognize what is the most problem from the patient’s side. Afterwards, to be able to recognize what are the consequences of it, and to say what does it mean immediately for the patient, maybe for us – because every procedure leads to some consequences. Next, to be able to recognize some economic importance from both sides, the outcome for the patient, but for us, as well. I mean that basic question about death and so on.”

Students

As the second human element in the diagram, the physicians discussed how the student must now make decisions very different from the ones they faced upon entering medicine. Dr. Veselý discussed the new and complicated personal decisions students are facing since Czech society has changed. “Now the students have to solve their own private problem that they are starting with no private practice, that they need flats and they are going to find their partners and start with their family lives. And this situation needs relatively good incomes. And they have to decide whether to be a scientist or to be a practitioner. Because I think there is a certain economical level below which the life starts to be very complicated. And unfortunately, scientists, with few exceptions, and teachers here, are below the level... And this is a very complicated ethical problem which is very difficult to teach. It is a private decision and, unfortunately, I cannot change it. And this is the biggest ethical problem for many doctors going out from the university to start. Whether to go fast to some money, economically very lucrative job, or if to go for

specialization, which is more ethical, more useful for the health system, but bringing less income."

Dr. Janák sees that, as a group in the lower years of medical education, students look for the easy path. The understanding Dr. Bartošová has developed of upper level students is much the same as the opinion expressed by Dr. Janák. "I don't know if students could differentiate anything because they are just students...but I more stress what is important for life, not just for their required, stupid examination. It is difficult, I know, but it is not the merit of their whole life to get 'excellent,' for example. It is just a record to pass through and then to get started (being a physician)." From his years in teaching, Dr. Kučera has seen many intelligent students and knows that this is not necessarily a marker of an ethical man. Along the same lines, Dr. Klíma sees the need for the student to be guided as they grow. "Each medical student has some approach, ethical values, so it is different according to the family values and the previous school. You have some student without any ethical approach and a student with very deep ethical approach. So it is not necessary to teach a lot to this student and sometimes it is a problem to teach this student very much – and it is difficult to teach this student. You have a lot of student who need to increase their ethical values and approaches. It is very important to help grow the approach to ethics of students."

While he knows that his chosen field is both intellectually stimulating and interesting, Dr. Novák also knows that students may not want to devote their lives to a field that has high demands and few economic rewards. "In my eyes, it is the most interesting approach how to attract students – to solve it (the patient's problem) and to promote and do this activity." "Do you feel you have to attract students to surgery now?"

“Both ‘yes’ and ‘no.’ Yes, from the point that we are an interesting specialty. No, from the point we are an encompassing activity and not interesting from the economic point of view. Because, in principle, there is no difference between medical doctors. Everybody has the same salary without difference in whether the specialization is very encompassing, requiring a lot of time. Never ending and never beginning or not. From some age and some level, never ending and never beginning.”

Teaching methods

Traditional teaching methods were commonly mentioned as the preferred way to teach ethics in medicine. Along with these, the new availability of information widely available was discussed. Dr. Klíma incorporates the emotional appeal of getting to meet real families and to hear from them first hand what is important as a way to draw the student to consideration of ethical issues. “Or I can invite mother with some child with special problem so I am discussing with the mother and the child. So I am not speaking about ethics, but I am showing practically what it is.” Concrete examples are used by many of the participants as ways to interest the student in thinking about difficult issues in ethics.

While all stressed the importance of teaching ethics as a natural part of medicine, Dr. Bartošová discussed the value of how the teachable moment is used. “It is hard to answer because it depends on how much practical training you have with the students.... You cannot make it artificially. So I think it could only be done mainly in an out patient department, when they are with you , not just examining but listening and discussing to the patients, so they can just see how I perform.” Along with Dr. Benešová, Dr. Bartošová cited the family and cultural background of the student as an important place

where ethical behaviors are learned. “We should be open-minded, it is an even better source. Because if you have a background from your family and you know what is ethical behavior, let’s say, what is normal behavior to your colleagues, to other people, you don’t need to be taught.”

Dr. Veselý sees ethics as a natural part of medical education, but does not think it should become a curriculum item. “Medical ethics, it was originally one week and now it is two weeks....I think, instead of having it like a subject, it should be part of the subjects.” He thinks that perhaps the wrong people are being sent to the ethics classes. “And maybe, it should be so that not the students would be forced to go for medical ethics lessons, but maybe the teachers should be going to one week training and how to teach it and how to discuss about it and to go to some conclusions and to know each other. That should be the solution, but very non-popular among teachers.”

Finally, the preferred method of ethics education is the example set by the life of the teacher. One unexpected aspect in methods of teaching ethics was that not all physicians said they used discussion as a means of teaching.

Physician-teacher

How do physicians describe the qualities that make up an effective teacher of ethics in medicine? Because of the nature of their social history, this remains an area of conflict for many of the teachers. Dr. Klíma was very clear in the reasons for his personal hesitancy to go past a certain point in discussions of ethics with students. “I have some ethical values and I have spoken about some aspect of daily life. And I think it is not good with my experience as a student, to influence and to discuss with my students my

ideas...so I think that it is very private things. And I am not an expert and I have negative experiences from the previous life.”

Another physician who had great misgivings about how an ethical person learns to cope with the new system is Dr. Veselý. Because physicians, and especially those who teach, are not valued by the society in the same way as other professions, he sees these economic changes as lowering the number of people who will be entering medicine to teach. “...There are health professionals from this hospital who are also teaching for a small part. They do approximately the same and one has 30, 40, 50 percent more salary? And both these doctors have half - or less – income than the people who are working on the outside. It is a little bit ethical problem, ‘Should I stay when I like to teach and I feel that I could teach students to improve their knowledge and I like it? Or should I go out from poor economical reasons?’ And if we don’t have money both for salaries and for literature and for research, that is too much.”

Dr. Marek returns to the tradition of his teachers for his purpose in teaching ethics. “So if I see there is somewhere around there is an interesting lecture, interesting exhibition, some interesting lecture not belonging to medicine, interesting concert, well, I try to remember so I can recommend this to someone else. Some will attend, somebody will not, but this is the way how my teachers taught me at university, so I am just following this line.” Dr. Janák sees the teacher as a guide for students in their efforts to become practicing physicians. “And some people, or some students, are thinking the best will be to open the pub as the lecture hall and the teachers will visit here and only writing the #1 or #2, and so on. Therefore, we are repeating many times, ‘My duty is to be sure that your knowledge is sufficient, not insufficient. I am pretty old and a few years

later, I will visit you as the doctor. And it will be very bad if I obtain very bad treatment.’ I am joking, but you understand what is my approach. ‘I am old-ish boy and I should find good doctors. And you are my dream.’ ” Dr. Kučera relies on the basic nature of the man to match what he says in the teaching situation. “The ethics is necessary to teach every day in the department and the students must, or are obliged to, see what I have told you before. That the teacher is ethical from the morning to the evening, or also during the night.” Finally, Dr. Novák knows that the person who teaches ethics must be one who has already made his own ethical choices. “If you do your work with responsibility, if you do it well, if you are a reliable person – a clear, reliable man – you have nothing to be changed.”

Research question five: Influence of cultural change on training students

When set up by an expert, it is fun to watch dominoes fall. With the right person guiding the process, each one falls into the next one to create interesting visual patterns. But if the tiles are set askew, so that they do not hit properly on the way down, the result is not what is planned. Social change may be more like dominoes that fall before they are intended. Once the movement starts, it is impossible to keep the action from continuing until there are no more dominoes standing. Changes in the social structure of the Czech Republic are now having a “domino effect” on multiple areas of the cultural, political and economic systems.

Many social changes have been discussed, but it is important to know which changes affect the physician who is teaching medicine. Participants were asked to discuss changes that affected the way they train their students originating in the political and economic arenas.

The perception of the social standing of medicine elicited a variety of answers from the group members. Dr. Benešová said that teachers and physicians had always been appreciated by the society in which she lives, while Dr. Marek thought that physicians were more valued in smaller places than in the capital city of Prague. Dr. Veselý felt other members of Czech society place the most trust in doctors and teachers, but while they may hold a position of respect in society, physician salaries are very low, according to Dr. Klíma. This is an answer heard from more than one person. One reason for this may be the continuing conflict between the Czech medical society and the government.

The Ministry of Health, which has undergone multiple changes of personnel, is not perceived as doing enough to support the profession during and through this time of continued change in the system. The system of what were state run hospitals has not developed a new method of operation that other members of the society can support at this time, so the healthcare system does not have enough money to operate. One problem may be that the politicians do not find it politically attractive to ask the Czech people to pay for health care when it was provided free of charge under the socialist system. Dr. Klíma phrased it this way: “Ten years of the previous system, the patients were paying nothing. So it is politically not attractive to ask patients to give money for health care. So our politicians are ambivalent and say, ‘Oh, yes, we would like to have excellent health care as in Germany or in the United States, but there is not enough money, for example, for salaries for physicians.’ So that is one conflict of our Czech medical society and our government and our society. Not our medical society, but I mean our society in general.” Another area of conflict between the political and health care systems comes from the

perception that, while politicians are paid well for their services, they expect doctors to continue to serve without an increase in income, according to Dr. Klíma. “You can see some politicians in our Czech parliament working for 100,000 koruna per month, speaking that the Czech physician is unethical if they want money from the patients. And this, my young physicians are working for 10,000, 15,000 Czech koruna. And it is really serious and unethical because the problem with Czech medicine is that we do not have enough money for everything and everybody.”

While money is still a major issue in the system, these physicians believe that it is unethical for physicians to see patients only in order to profit. Insurance company practices have changed more than one time because, like the Ministry of Health, there has not been found a system that can become self-supporting at this time. Dr. Veselý discussed how skilled physicians may have a lower standard of ethics because their specialization draws great numbers of patients who are willing to pay for treatment. “When I was young, I thought, with no exception, if you are a good doctor you must be a very ethical personality. Nothing like that. I have now met many cheaters in the field of economy. They are excellent doctors in certain specialization. They can solve your problem...but it has nothing to do with their ethics.” This difference in ethical standards does not apply to all specialties because many do not have the possibility to profit from the suffering of their patients. Dr. Klíma feels his specialty is one of these because “...it is not possible to make big money to take care about children with cerebral palsy and epilepsy. So it is much easier in my profession to be ethical and to be not oriented to making money. These are big changes and should be important that some people in private practice are making more money and less medicine.”

In the role of teacher, Dr. Janák discussed how the relationship with teachers at all levels of education is changing from both economic and social changes to the family and attitudes toward teachers. “Some of the parents are a little aggressive against teachers...Some of them are thinking ‘Who is that teacher? It is somebody who is not able to be with higher salary.’” The salary level imposed on teachers has become a means by which to oppress them further, yet the social change in attitude toward teachers is not seen in all parts of the society. Dr. Bartošová feels that Czech children and students are no worse than in other countries and Dr. Klíma stated that medical students should be different than other groups of students because of the profession they have chosen to enter. “I am relatively optimistic and my students, I think, medical students should be different than other students, economic students or students in faculty of law.” To Dr. Veselý, one way in which students are different because of social changes is in their attention to learning medicine. “They don’t want to spend half a day to see something specific. They rather would prefer to give them some short, little...from TV, you understand what I mean? Like in the news, you have 15 minutes and you should tell me what does it mean, sport injury. And they don’t have energy enough to look around and to wait for a real life injury...So they are living faster and more superficially, which is not very useful, especially for medicine.”

In regard to changes they had made to their teaching practices, Dr. Bartošová spoke about how teaching is more efficient with new equipment but it cannot be done without patients. “If you have a PC projector or better equipment, you could do it more efficiently. But on the other hand, in my specialty, teaching without patients is for nothing. So I could not do it without patients, even if I had all the slides.” The need to

reeducate the patient to their part in the process of medical education was also important to Dr. Novák. Many of the participants mentioned the need to include a financial aspect in their teaching but otherwise the group felt they had not changed in their approach to teaching.

The inclusion of this new financial aspect to teaching medicine was one area where the participants held different opinions. While money is already a factor that separates physicians, teachers of medicine and medical students from the rest of Czech society, Dr. Klíma does not think his students are affected by commercialization. He does think that the students who are motivated only by money were always part of the system. "...I can see that maybe 70, 80, 90 percent of our students are not negatively influenced by so-called 'McDonaldization' and TV, entertainment....The students are not aggressive to be unsocial and to be oriented only to have some profit. Maybe only two students from ten students. But maybe it is not a question of this society, this culture, because there were students who were very aggressive in the previous system, which profited some to cooperate with the communist system. It was effective for these people so these people were also in the previous system. So I think that is relatively good." On the other hand, Dr. Veselý does think that there are students who expect to be rich, rather than good doctors and this is changing the reasons for students to enter medicine. "There is a clearly distinguishable subgroup of students. They came for these studies to be new members of economical system. They would like to organize new healthcare system, but not for the profit of patients. Like a capitalist, it should be a factory for money in the field of healthcare, which is very unethical. Nobody, or almost nobody, tries to explain to them

that health should be the primary result for each doctor and not the money income. That is the change.”

Research question six: Transmission of new professional culture to students

In order to teach students to practice in the new healthcare system, a system still under going changes, physicians have considered how their professional relationship with the society, institution and patient is, or is not, different. Then this new understanding translates into teaching practice to help students understand what the future holds for them as physicians. To understand this process better, it is important to consider two areas of change, professional medical practice and teaching practice.

At the national level, the question of professional change is one of where to go next for Czech medicine and doctors. Dr. Veselý knows the Ministry of Health cannot fragment in order to address each specialty just as Dr. Klíma describes the lack of leadership and vision that is needed to rebuild the system. “There are some ideas of Society of Czech Physicians, there are some ideas of the different political parties and there is no consensus. So from this point of view, it is difficult to teach students about healthcare system in the Czech Republic.” How do they reach a consensus in finding a new direction when they are still grappling with issues of what actions are needed for economic reasons and which ones are needed to benefit to the profession? What they have learned is that the Czech system of preventative medicine is strong and that the practice developed in isolation under communism is equivalent to that of other countries. “...and we realized that our medicine is good, our knowledge is good. That we are sometimes better than our colleagues in Netherlands, UK, and so on.” They still believe the physician’s position in society is low, but this new understanding of how they

compare to the rest of the world may help develop a stronger influence over changes to their own healthcare system. There is an influence on professional culture, according to Dr. Bartošová. “Because culture could be explained in very different ways...beginning with the behavior of the doctors to the nurses or the patients. I think it is for sure under influence of new things, events, occasions or possibilities.”

At the Faculty Hospital in Motol, this new understanding of their own practice has lead to changes in how the individual physicians approach the economic aspect of medicine, the change in power structure and the new relationship with their patients. New equipment has brought about changes to the practice of medicine, but Dr. Veselý wonders if it is economically prudent to expect all doctors to buy this equipment? Dr. Bartošová thought the new competition would provide an impetus for doctors to continue learning and to act in ways expected by the patients. “They will have to study international, for sure, to be able to read and to be able to follow new informations. This is first. It could also have good influence because now doctors will have to act nice to patients. I forgot it, but in the past, doctors did not have to act nice to patients.” She also voiced the concern that there were, and would continue to be, situations where the doctor needed to be more “human” and less “machine” when it came to patient care.

Previously, the department chief was the indisputable power in decisions about the work, but now the need to include the group in the decision making process has created a different situation. “The position of leading doctor in the team was without shaking. Completely stable, he was the first and last, in nearly all. He was able to ‘stop the marriage’.” Dr. Novák described how it was necessary to change his thinking about the dynamic nature of work in a situation where there were multiple sources of

information, rather than one all-powerful department chief. “I think that, or in my mind, I recognize it as very significant to shift the thinking, to shift the position to some different form.” Once again, he sees himself as a step in the normal evolution of his department. What this has done is to provide an avenue for more communication between the people who work together in his department. “I think that everybody thinking about it now says that it is necessary to accept different ideas, to discuss it.”

Finally, the practice of medicine is changed by the new relationship with the patient. While the patient may not have been a “member” of the team before, each one is now a participant in his or her own health care according to Dr. Marek. “For instance, before the Revolution, nobody asked the patient if he would allow or not allow medical students to examine him and to work with him. Well, nowadays, the patient must agree, which is a sharp change.” But Dr. Bartošová thinks that the new shift to a Western style of practice will give less time for her patients since the doctor is under pressure to bring a profit to the institution from his or her labors. “We are for sure running to the Western style of work in our specialty and in medicine, in general. For me, it means to not have so much time for patients.” It seems to be a great loss to her that now the patient is a paying client at the hospital.

How do these changes in medical practice translate to the teaching arena in order to help students understand the changing demands on the physician? Their chosen goals for teaching medicine reveal the direction these physicians hope Czech medicine will take in the future in knowledge, professional growth and patient relations. The primary goal is, of course, to have a good background in medical knowledge and skills. According to Dr. Marek, “in Czech, I say ‘You have to know what is in the kitchen’.”

Students must develop an understanding of the basics in order to move up into more difficult and complex learning, especially in areas where technology changes quickly. While the machines may be different, the basic principles remain constant. For the majority of participants, the continuing development of skills needed for practice was an important goal of their teaching, no matter what discipline or specialty.

Many of the physicians also included goals directed toward changing student attitudes. Dr. Klíma included ethical attitudes as the third part of his teaching about knowledge, skills and ethics. “And what is the third side of the triangle is to show them what is the ethical attitude, the ethical aspect of this program because I prefer not to divide health and social care.” Dr. Novák addressed change of attitude toward his specialty as important to his teaching. “ And soon, students say, ‘Theory, it is enough for us. We only need to achieve the state exam in surgery; we will never need surgery like the specialty.’ The goal is to change it, I think that it is a very impressive appeal for us.” For Dr. Veselý, helping students to consider the good of the entire system, when the Ministry of Health is perceived as working toward opposite goals, is a large part of his thinking. “And somehow the students have tendency not to think about it from the general point, saying that if they look to our top management and government, they cannot see the same view for the government. So why should they solve the problem when they can see the Ministry is doing opposite steps? It is difficult to teach them.”

Another important goal of the participants was to help students develop the ability to make the best choice among alternatives in the development of their own career. Dr. Benešová discussed practice options as important to the planning students must now do for their career and Dr. Bartošová further addressed the economic dilemma of the choice

between an academic career and private practice. “If they want to be successful, they will have to make a choice. If they would like to stick to more research projects, clinical research and stay in hospitals and have nothing, or if they will go to private practice.” Without an understanding of the possibilities inherent in each specialty, students may not be able to make an informed decision. Finally, Dr. Kučera addressed the necessity to help students understand that money does not provide a solution for all the problems in life. “I think that one problem which is now in our Republic in this post communist period is that many people think that the money is everything in the life. And it is, naturally, not right. Many things are impossible to buy for money and in medicine, it is naturally this question very hard. The health, you cannot buy. The luck, it is impossible to buy. So I think that this is very important problem, which we are obliged to reach.”

Summary

From interviews with the participants in this study, the issues that are important to them as teachers in the profession of medicine in the Czech Republic have been learned. They understand that the society in which they serve is changing and have considered how they should respond or change based on where they currently understand their level of performance to be in relation to the new social expectations. Each one has discussed the elements of their profession and teaching career that are important in how new physicians are being trained in the Czech Republic and they have also discussed areas that are sources of pleasure or sorrow in how the social life is changing in respect to their chosen work. Change has affected their lives in different ways, but it has affected each one.

CHAPTER SIX

Discussion, conclusion and recommendations

Freedom, however, is not the last word. Freedom is only part of the story and half of the truth. Freedom is but the negative aspect of the whole phenomenon whose positive aspect is responsibility. In fact, freedom is in danger of degenerating into mere arbitrariness unless it is lived in terms of responsibility (Frankl, 1963/1984, p. 134).

Introduction

Like the two sides of the same coin, social change has aspects that are opposite and joined. Depending upon how the individual views the change, each person may be looking at the side of the coin that represents gain or loss in his or her mind. Living under a socialist system created a situation where all were the same in income and lifestyle, but the society lost the chance for personal or individual prosperity or growth. Now people in the Czech Republic are living in a system with developing social classes where they may be rich or poor, having opportunity for great personal possibility and great risk. The choice to build a market economy has an ensuing spiral of economic demands on the individuals and institutions of the country. Previously, families handed down the equipment needed to carry out the family business. Now, each person must acquire the means by which to practice a profession, which, in medicine, may mean the purchase of expensive technology or equipment. The economy is improving, goods are available for purchase, yet with more free time, parents are working harder than ever before on the job, which is changing the nature of the family. Money has new personal value in the society, but people are described as generous, more open and more responsive to the needs of special groups in the population.

While communism was not an open system, it was easier to “read” the actions and choices other people. Democracy gives freedom of expression, but is not transparent since it allows privacy, a right people hold dear. After years as a closed society, racism and discrimination is discussed in world venues, but already children are changing in their approach to those who are different from themselves. In a nation with a literacy rate of 99 percent, books have become an expensive “habit” rather than a national pastime. With open borders, the people can travel, meet new people and understand the world outside the Czech Republic better, but the use of English as the language of business may lead to the loss of the Czech language.

Explanation of the problem

Because of the relationship between democracy and education, teachers in democracies are instrumental in helping their society adapt to change. The central problem in this study concerned how physicians who teach in the medical school are able to help their students prepare to serve in a society different from the one in which the physician trained. In order to better understand this process, several research questions were employed.

Research question one: As reported by physicians in interviews, what impact has the social change experienced in the Czech Republic had on the physicians who teach in the medical school?

For the members of this sample, pressure to change came from three major areas, extrinsic, intrinsic and reciprocal pressures that affect both the individual and the society in which they live. Extrinsic pressures come from sources outside the control of the individual, for example, economic and institutional changes leading to a difference in the

practice environment. Economic pressures from the society had resulted in changes perceived as both beneficial and hindering. Changes in outside institutions, such as the hospital administration and insurance system, have also changed how students need to learn to think in financial ways that were not necessary before. Intrinsic pressures originate in the person, the most evident of which is the desire to excel in the profession and as a teacher. One way this is now possible is through conducting research at the university. Reciprocal pressures of social change impact both members of the society and the teacher. The availability of information to patients and physicians has changed the relationship from both sides, just as new possibilities change the situation for the development of the profession.

Research question two: How do Czech physicians describe their own methods of change in the pursuit of a medical profession in a society undergoing transformation?

Research question three: If these physicians have changed, what motivated those changes and how do they say the changes are reflected in their teaching practices?

Personal change was motivated by needs from several areas of the individual's life, including professional, academic, medical practice and personal. The changes may be on one of three levels of involvement for the person: international, national or local. The final aspect of personal change is in how the person responds to the change emotionally or perceives the change to be a gain or loss. Professional changes were the most important to the participants and had the most impact on their lives in multiple areas and levels. Academic and medical practice changes were closely related because of how the roles overlap for participants as practitioner and teacher. Personal change issues concerned family life and how the person adapted to changes in job responsibilities and

saw him or herself as fitting into the historical moment of the country. These areas have affected teaching by giving the participants new possibilities for personal expression of ideals and beliefs and by allowing personal choice of venues for career participation.

Research question four: In what manner do academic physicians report they transmit or teach ethical behaviors to their students? How has the expression of ethical beliefs changed in the academic arena according to what physicians report in interviews?

The teaching of ethics by the participants is affected by how two systems overlap and interlock. Human elements are the physician-teacher, the patient and the student. Social elements include impact of social change, current ethical issues and teaching methods. Each part of the two systems can influence change in the other elements through the changing relationships and responsibilities. Social change influences how physicians understand their responsibility to teach students, which leads to changes in the teaching methods they choose. Social change also can influence patients by new circumstances that change patient expectations for treatment and care. These new patient expectations give rise to different ethical concerns in the society as people begin to think about the relationship of health care, providers and the patient in different ways.

Research question five: How do physicians report cultural change influences the way they train students when there is a political and economic shift?

Participants do not think their profession is viewed by the rest of society as being on a level with other professions, such as the law, and this is confirmed by low salaries for teachers and physicians, on-going conflicts with the Ministry of Health, and how the treatment of teachers is changing throughout the educational system. Because of the nature of medicine, it is imperative that members of society understand the importance of

their participation in the education of new physicians. The participants do not believe that the kind of student entering medical school has changed qualitatively due to capitalist forces in the economy, but they do see a shift in the understanding of the purpose of the profession in the minds of students.

Research question six: How do physicians report they understand their position as transmitters of the new culture to students?

From comparisons with other countries, these physicians have a new understanding of the quality of their medical practice, which they are able to pass on to students and which may lead to a stronger influence over their own health care system. Competition among physicians gives rise to issues about practice costs in economic terms and patient relationships. What they hope students to leave the education process with is a good background in knowledge and skills, better attitudes about ethics and the relationship to Czech society, and ability to take control of their own careers.

An explanation of how social change impacts teachers in a profession

In the creation of an explanation of this phenomenon, multiple elements of the life lead by a teacher and practitioner will be incorporated. For the members of this sample, it must first include cross cutting pressures of change that affect teaching, medical practice and academic life which are intrinsic, extrinsic and reciprocal. Second, the explanation must allow for the inclusion of multiple areas of interest, professional specialty, medical practice, academic career and personal life, which may be affected on one or more level of activity, international, national or local. Finally, the explanation must allow for differences in individual response to outside pressures of change. In order to do this, categories were developed from the qualitative data from interviews with physicians who

had experience with how social change had affected them as a teacher in a profession. Next, categories were developed from each interview, which were then combined to discover overarching themes and variation between individuals and any new categories that might arise from the group experiences.

Proposition one: Pressures for change

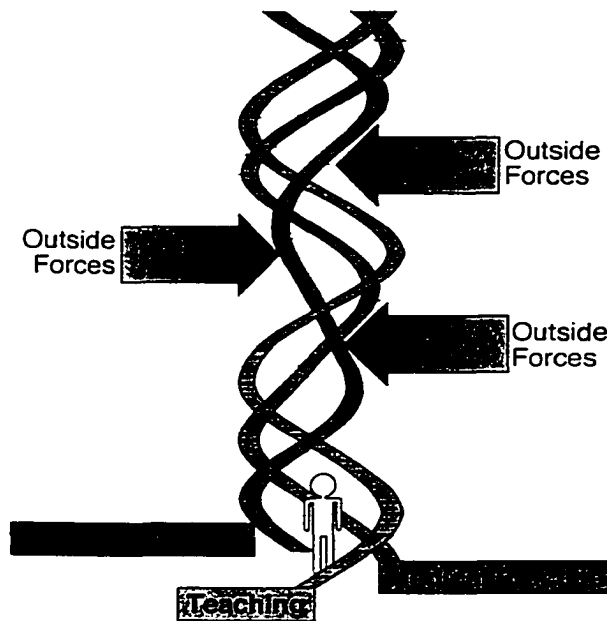
Before a teacher can determine if a need to change exists, he or she must first become aware that there is a social change that is relevant to the position the individual holds. In the case of the Second Medical Faculty, teachers had to acknowledge that social change would have an impact on their practice of medicine or on the training of students. After awareness of a social change exists, each one needs to evaluate his or her personal standing in regard to that change. If the teacher concludes that they are already meeting the new requirements or expectations, no change will be made based on the pressure from changes in society.

Proposition two: Individual adjustment and growth

If a change is needed, then the teacher will evaluate in what area to make adjustments that will fulfill the new expectations. Not all teachers will be affected by change in the same way. Therefore, the explanation needs to be flexible in order to encompass the range of reaction and change the individual will choose to make. The participants in this sample ranged in their definition of the changes they had made from no change to having changed everything in all areas of life. In order to account for this variation, the change experience for these teachers is envisioned as a triple helix with the individual located in the center of the helix, connected to all three strands that surround them personally. One strand is the practice of their chosen profession. A second strand

represents the actual work of teaching and training students to enter the same profession. The final strand is used for the academic and bureaucratic responsibilities that are part of being both a professional and a teacher who fills a role with Charles University and at the Faculty Hospital, Motol.

Figure 4. How social change impacts Czech physician-teachers



Proposition three: Decision to change

This group of participants had many areas where they felt they had personally made no change, so how does the model account for this? Because each person is always making small adjustments, change is a normal part of the life of a physician. Each one is continually changing and adjusting in order to provide the best medical care and to give the best information to students. Therefore, if the person evaluates him or herself as above the mark of new requirements, already doing more than is the new level of expectation, then they will not perceive the need to change again. Because both sides, teacher and society, are changing, although possibly not at the same rate, the next

“adjustment” made may be one of modifying the curriculum, but perhaps not changing teaching or medical practice style. This allows growth to continue, which may serve to keep the teacher above the level of social requirements. If the next change is anticipated and adjustments made, there will be no need to change again to meet social demands. On the other hand, if the teacher evaluates him or herself as below the new social requirement, then larger changes can be undertaken in order to remain at, or above, the new expectations.

Proposition four: Direction of change

The helix changes shape and pattern under the control of the individual and the changes or adjustments each one makes, but a shift in direction may occur from a pressure to change, whether it is an extrinsic, intrinsic or reciprocal. For example, if an economic change is currently the prevailing pressure, then an adjustment can be made that allows more attention to be drawn to economic or financial issues while working with students. When this pressure is perceived as diminished, then another adjustment can be made to reduce the time spent on financial issues.

Change and learning: Fox, Mazmanian and Putnam

While not a replication of the study of physician change and learning by Fox, Mazmanian, and Putnam (1989), this study does serve to aid understanding of how physicians who live in another country are, or are not, similar to physicians in the United States and Canada. The two assumptions, that first, change is common and observable, and second, that many changes require new learning and skills, do seem to hold true in a different culture. The members of this sample did not discuss personal learning, but they did affirm that physicians in a different culture have reasons behind changes they choose

to make and that they were making continual, small adjustments to their practice and teaching. Instead of describing the changes made as important or necessary, the participants were plain about the process of change being a normal part of their professional and academic life. That change occurs in a range of dimensions from those considered minor to those considered to be life altering was one of the strongest similarities between these groups (Fox, Mazmanian & Putnam, 1989, pp. 8-9). It is not known if these similarities are due to actual resemblance to Western physicians or whether it is due to the condition of being involved in on-going social change.

The model created by Fox, Mazmanian and Putnam, (1989) contained four steps in how the physician evaluated what they needed to change: estimation of knowledge, skill or performance in relation to the change; estimation of what is already known in the particular area; estimation of the difference between the two points; and, a resulting level of anxiety based on the determination that what is known does not meet the new level of need (Fox & Bennett, 1998). Because the Czech physicians did not evaluate themselves as needing to change in order to meet the new social expectations, it is unknown if this evaluation process holds true for physicians in this country. Research will be needed with physicians who have evaluated themselves as not having met the social expectations for their actions and behaviors to determine if this is true in other cultures.

Another area that is different because this study concerned how social change affected the individual is in the need of the physician to develop an image of the change in order for it to be an efficient process. It may be difficult, if not impossible, for these physicians to imagine in advance how social change will require them to respond. Given that they are members of the society, there will be an awareness of the major themes and

issues developing in the society, but it is unknown if that will be enough to allow them to be fully prepared prior to new social changes. It may be easier for them to anticipate the changes that will be required, but more research is needed before a clear understanding of this process is developed.

Professional culture: Schön

As a profession, medicine in the Czech Republic has not had to change in order to meet the properties Schön described for the knowledge base of a professional group as being specialized, firmly bounded, scientific and standardized (Schön, 1983, p. 23). They are able now to more fully develop the scientific aspect of medical knowledge at the university level, but this type of knowledge was always part of the profession. The participants understand the importance of passing on to their students the distinct body of knowledge that is the purview of medicine, but they also have new layers of thinking to add to the knowledge that their students must have. Financial aspects of medicine in the Czech Republic are changing and must be communicated to future generations of physicians. Patient relationship issues may not be “standardized” but they are important for students of medicine to learn.

Perhaps during times of numerous social changes the reflection-in-action process becomes more apparent, or the physician is more aware of his or her own thinking, because this group was easily able to delineate their thoughts and the reasons for them. They understand how each specialty represented in the sample adds to the ability of the student to solve existing and future problems of the profession. The participants were clear about the importance of learning problem solving. If it is true that the reflection-in-

action process becomes more conscious, it will greatly enhance the ability of the teacher to communicate the thought processes behind making ethical decisions.

Change from external pressure: Sugarman

The participants in this study confirm Sugarman's (1986) assumptions about life-span development. Each one is actively pursuing personal growth, on multiple, concurrent levels and the environment is changing, as well as being changed by, the individual. The tie to history and culture are evident in the human concern expressed by participants for the loss of traditions and traditional relationships. There is also evidence from participants that supports the linkages Sugarman (1986) described in the four areas of micro, meso, exo, and macrosystems. Although participants discussed changes that have occurred due to social change, this type of change is not a controlling force in how they are changing. These are individuals who do not perceive that outside forces have caused much change in who each one is. Perhaps this can be explained by the idea that, as people who seek to continue growing and changing, they are able to stay ahead of changes coming from society. Instead of being pushed to change, they are changing ahead of society, drawing the whole to higher levels as they personally develop.

Sugarman's (1986) description of normative history-graded events as affecting all members of a society but not in identical ways does hold true in the experiences of the participants. It seems the ability of the person to understand his or her place in society and in the social change occurring has provided these physicians a means of continuing under conditions of great stress. Each one has chosen personal reasons to provide education for students who wish to practice medicine in the Czech Republic but these reasons vary greatly from person to person. It is also interesting that the Czech medical

teachers fit the image of the person reaching a higher point at the end of each cycle, since this may be what helps each one continue to change in advance of social requirements.

Conclusions

Education is a necessity for democracy to exist since the members of the society must be able to participate in the activities and responsibilities of the social order.

Democratic society is able to continue growing and changing as new generations are enlightened to the possibilities of an active, participating life through education. The individuals who choose to teach medicine in the Czech Republic have an understanding of the responsibility of the position each one holds. It may be that this is a characteristic of teachers, in general. The personal choice to teach is not made for the respect and benefit the individual will receive in return for his or her efforts; it is usually a gift of self to the society, the profession and, most importantly, to the students.

From the findings of this study, several conclusions can be made. First, change is a normal part of life for individuals who seek to practice in a profession. It may be a requirement for those who wish to excel, rather than just exist as a member of the profession. Second, teachers provide both the tie to the history and tradition of the profession as well as the impetus for future growth in new professionals. The human contact of the teacher and student gives an emotional tie to a group that cannot be gained from a distinct body of knowledge or even a code of ethical behavior. This may be the key to future development of professions in a world that is changing before our eyes. Third, the experience of belonging to a culture, and the force of experiencing cultural change on a grand scale, is more than a chapter in the history books can indicate. While we may learn to practice a profession in ways that are transportable to other venues, the

experiences we carry away from our ties to the culture will forever change who we are in the future.

I quoted a poet – to avoid sounding like a preacher myself – who had written, “Was du erlebst, kann keine macht der welt dir rauben.” (What you have experienced, no power on earth can take from you.) Not only our experiences, but all we have done, whatever great thoughts we may have had, and all we have suffered, all this is not lost, though it is past; we have brought it into being. Having been is also a kind of being, and perhaps the surest kind (Frankl, 1963/1984, p. 90).

William G. Tierney (1989, p. 15) defines democracy as “those principles that promote social justice, equality, diversity, and empowerment.” To him, democracy is not an act carried out in the seats of government, but it is all of the actions taken “in social formations and practices” (Tierney, p. 15). Democracy is more than a realignment of power relationships because we practice it in the activities that help us to create the social nature of our nations, our organizations and our knowledge (Tierney, p. 15). Participants in this study have an acute understanding of how power relationships are changing between physicians and patients and between students and the teachers who will help these students develop a personal formulation of medical ethics in the Czech Republic. Therefore, they are involved in the development of democracy daily.

The physicians in this study understand that their position as teachers of ethics and the values of medicine should not be one of coercion and force. They hesitate to tell their students what to think regarding ethical dilemmas because of their own experiences in being “pushed to think in only one way.” Yet they also know that the teaching of ethics cannot be left to happenstance and consciously work toward providing a good example for students to pattern their own practice after. Educational theorist John Dewey wrote that the moral purpose of democracy is to allow each person to develop his or her

own “distinctive capacities” through the process of education (Carnoy & Levin, 1985, pp. 15-16). There are probably few teachers who understand the charge of this concept better than those who have taught in a system where freedom of thought was not a choice they could officially make.

It is also apparent from their words, that these are men and women who have experience in grappling with decisions about what is a valid and worthwhile goal for their lives, practice and teaching. Social, political and economic systems are changing, so how do they retain the focus and determination to teach in a setting where the answers are not seen clearly yet? From his experiences in trying to understand human suffering, Viktor Frankl (1963/1984, p. 110) believed that the state of tension created in the struggle to meet a goal deemed worthwhile is how mental health is maintained. Frankl (p. 110) understood that as humans, it is necessary to create meaning in the work each person chooses for his or her life, but this meaning cannot be found only inside the person. Each one needs to be involved with something outside him or herself to find Frankl’s “true meaning of life” (Frankl, p. 115).

The more one forgets himself – by giving himself to a cause to serve or another person to love – the more human he is and the more he actualizes himself. What is called self-actualization is not an attainable aim at all, for the simple reason that the more one would strive for it, the more he would miss it. In other words, self-actualization is possible only as a side-effect of self-transcendence (Frankl, p. 115).

Because they see themselves as part of the society, and what they do as important to the society, these physicians choose to keep struggling to find the new way to practice that is right for this society; they deal with uncertainty regarding how to ethically teach ethics on a daily basis; and they show students how to treat the patient honestly as a partner in health care.

A question that arose in the development of this study was how the change in values, attitudes and behaviors that was to be one of the great legacies of communism would be apparent, or not, in these teachers. From the words of the participants, it apparently never existed, at least on the scale that the Communist party wished. It affirms the strength of the human heart and the ability of people to overcome adversity and hardship when they believe that there is an important purpose for which to live. Even in situations where there is no solution for basic problems that continue to plague the profession and its members, the teachers see that the dedication of their lives to the education of the next generation is a gift worth the sacrifices they must make for this to happen.

Recommendations

Because the history of communism has given the current generation of teachers a divided sense of how to best approach teaching students about ethical issues and decision making, it may be an affirming process to provide some training or continuing education in how to teach thinking skills, especially those used in making ethical decisions. There are several models available that can serve as a guide for teachers who may be more reticent to discuss ethical issues, in fear of being seen as promoting a new type of propaganda. The excellent examples provided by these teachers for their students in the ways they choose to live and practice their profession is a solid base from which to begin, but it is important to remember the need for students to receive instruction in thinking skills as much as any other type of professional knowledge.

Because the study raised as many questions as it answered about teachers and their relation to society in times of social change, it would be interesting to learn more

about these teachers and their personalities in order to determine if they are different from teachers who have not experienced great social change. What is different about them that allows them to persevere through extended periods of hardship and change?

A second question raised concerns how the continuing change to a Western style of medical practice will change the scope of healthcare for the Czech Republic. Will the physicians be able to retain the elements of the past system that are important to them or will the professional culture become increasingly like those in Western countries leading to even more changes facing the practice of medicine?

Finally, since this sample is a group of people who envision themselves as having already exceeded the new social expectations for practice, how would a group of teachers who evaluate themselves as being behind the social expectations be different from this sample? Are the people who see themselves as being unable or unwilling to change in order to keep pace with social expectations unchanging? How are they different in their approach to expectations than these teachers who are not experiencing great problems in how they meet the new social demands on the position? Will the teachers at different levels of the educational system be different than the teachers who serve at the university level?

Summary

Because life will never be without change, this is an issue that will continue to be important in developing further understanding of the human condition. No longer do events affect only a small, contained group of people in one society, but current historical events affect each person living. If not immediately, then through the ripple effect of changes that will take place around the globe. Moreover, teachers will continue to be

leaders in helping societies deal with new changes and expectations for the professions. Until society values the impact of these lives, it will continue to be a difficult, albeit personally rewarding, position to fill. May current and future teachers continue to understand their importance in this process and their ability to help change the future, even in times of great stress and little acknowledgement for their contribution.

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Appendices

- Appendix A: Consent form
- Appendix B: Translated consent form
- Appendix C: Interview questions
- Appendix D: Survey form
- Appendix E. Translated survey form
- Appendix F: Observation chart

Appendix A: Consent form

**Consent Form for research being conducted under the auspices of the
University of Oklahoma – Norman Campus**

IRB # 02-52

INTRODUCTION

I understand this study “Physicians as teachers of ethics and values in the Czech Republic” is directed by Karen Sue Neal. This study is not sponsored by any funding group of agency.

DESCRIPTION OF THE STUDY

I am being asked to participate in this study because I hold a position as a faculty member who works with medical students and has lived in a society that has undergone political and economic change. The study is to examine how social changes have affected my personal beliefs and practices, professional life and my practices as a teacher of medical students.

The study will be qualitative in nature. I will be interviewed as to my attitudes and practices concerning ethics and values and how I have experienced societal change to affect my professional and teaching life. If I permit, observations will be conducted of interactions with students. Participants will not be divided into groups for the purposes of data analysis. Audiotapes will be created of interviews and observations to use in data analysis.

Interviews are expected to take approximately 90 minutes. Observations, if I permit, will last 30 to 60 minutes.

POTENTIAL RISKS AND BENEFITS OF PARTICIPATION

A. RISKS

There are no foreseeable risks to me involved with this study. Inconvenience will involve the time I give to participate in the interviews and observations.

B. BENEFITS

There are no direct benefits to me from participation in this study.

SUBJECT ASSURANCES

A. CONDITIONS OF PARTICIPATION

I understand that my participation in this study is voluntary. I will not give up any legal rights or release any individual or institution from liability for negligence.

I understand that I may withdraw from this study at any time without penalty or loss of benefits to which I am otherwise entitled. My treatment by and relations with the investigator involved in this study will not be affected now or in the future if I decide not to participate, or if I start the study and decide later to withdraw.

In order to participate, I must be 18 years of age or older.

B. CONFIDENTIALITY

To assure confidentiality of information collected during this project, each participant will be assigned a code used with all tapes and transcripts. Also, I will be asked to select a name to use as a pseudonym in reports of the dissertation findings or publications from this data. All transcripts and study records will be kept in locked storage under the personal control of the

investigator. I understand that records of this study will be kept confidential, and that I will not be identifiable by name or description in any reports or publications about this study.

C. COMPENSATION FOR INJURY

There is no foreseeable injury that can come of my participation in this study. I will not be compensated for injury that occurs during the course of the study.

D. COURSE CREDIT/COMPENSATION FOR PARTICIPATION

This study does not have course credit available as a form of compensation to participants. Participants will receive a book as a token of thanks for their time and participation.

E. AUDIOTAPING OF INTERVIEWS AND OBSERVATIONS

Audiotapes made during interviews and observations will be kept until the study is completed and then destroyed. I understand that I may refuse to allow audiotaping and my treatment by and relations with the investigator involved in this study will not be affected now or in the future if I decide not to allow audiotaping.

I will allow audiotaping of interviews only: _____ Yes _____ No

I will allow audiotaping of interviews and observations: _____ Yes _____ No

F. CONTACTS FOR QUESTIONS ABOUT RESEARCH SUBJECT'S RIGHTS

If I have any questions about this study, I will contact Karen Neal at 02/0723 083 253. If I have questions about my rights as a research subject, I may contact the Director of Research Administration in the OU Office of Research Administration at 001-405-325-4757 or you may email irb@ou.edu. Robert Fox, Ed. D. is the faculty sponsor for this project and may be reached at 001-405-325-2769 or email rfox@ou.edu.

COSTS

There is no cost to me for my participation, other than the time involved in the interview and observation processes.

ALTERNATIVE TO PARTICIPATION

My alternative is not to participate.

I have read this consent document. I understand its content, and I freely consent to participate in this study under the conditions described. I will receive a copy of this consent form for my records.

Research subject: _____ Date: _____

Witness: _____ Date: _____

Investigator: _____ Date: _____

Appendix B: Translated consent form:

Formulář pro vyslovení souhlasu s realizací výzkumu pod záštitou Normanského areálu

Oklahomské univerzity

IRB # 02-52

ÚVOD

Jsem si vědom(a), že studii „Praktičtí lékaři jako vyučující etiky a hodnot v České republice“ řídí Karen Sue Nealová. Studii finančně nepodporuje žádná agenturní skupina.

POPIS STUDIE

Byl(a) jsem požádán(a), abych se zúčastnil(a) této studie, protože působím na půdě fakulty a zároveň na této pozici pracuji se studenty medicíny, a také proto, že žiji ve společnosti, která prochází politickými a ekonomickými změnami. Cílem studie je prošetřit, jakým způsobem ovlivnily sociální změny mé osobní názory a postupy, můj profesní život a mé postupy při výuce studentů medicíny.

Povaha studie je kvalitativní. Budu tázán(a) ohledně svých postojů a postupů týkajících se etiky a hodnot vůbec, a také nato, jakým způsobem jsem prožíval(a) a stále prožívám sociální změny, které ovlivňují můj profesní život, a to i profesní život vyučujícího. Udělím-li svůj souhlas, proběhne pozorování mé interakce se studenty. Účastníci nebudou pro účely analyzování dat rozděleni do skupin. Pro analýzu dat budou rozhovory a pozorování nahrávány na audiokazety.

Předpokládá se, že rozhovory potrvají přibližně 90 minut. Pozorování, udělím-li k nim svůj souhlas, potrvají 30 až 60 minut.

MOŽNÁ RIZIKA A VÝHODY PLYNOUCÍ Z ÚČASTI NA TÉTO STUDII

A. RIZIKA

Nepředpokládají se žádná rizika spojená s touto studií. Za nevýhodu lze považovat čas, který této studii věnuji při absolvování rozhovorů a pozorování.

B. VÝHODY

Z účasti na této studii pro mne nevyplývají žádné přímé výhody.

PODMÍNKY

A. PODMÍNKY ÚČASTI

Jsem si vědom(a), že moje účast na této studii je dobrovolná. Nevzdávám se žádného svého zákonného práva, ani tímto nezprošťuji žádnou osobu či instituci odpovědnosti za případné zanedbání svých povinností.

Jsem si vědom(a), že jsem oprávněn(a) kdykoli od účasti na této studii odstoupit, aniž bych za to byl(a) penalizován(a) či ztratil(a) výhody, na které mám nárok. Rozhodnu-li se, že se studie nezúčastním nebo že z ní v jejím průběhu odstoupím, neovlivní to mé vztahy s výzkumníkem, který na této studii participuje, ani jeho jednání s mou osobou v současnosti ani v budoucnosti.

Abych se mohl(a) studii zúčastnit, musím splňovat věkový limit 18 nebo více let.

B. DŮVĚRNOST

Za účelem zajištění důvěrnosti informací, které budou v průběhu studie nashromážděny, bude každému účastníkovi přidělen kód, jenž bude užíván pro audionahrávky a zápisy. Dále budu

požádán(a), abych si zvolil(a) pseudonym, pod kterým budou vedeny spisy disertačních nálezů či publikace zjištěných údajů. Veškeré zápisy a studijní spisy budou uchovávány v uzamčených skladovacích prostorách pod osobním dozorem výzkumníka. Jsem si vědom(a), že spisy k této studii zůstanou důvěrné, a že mne z nich nebude možno identifikovat na základě jména ani popisu, jenž se ve spisech a publikacích k této studii vyskytnou.

C. NÁHRADA ŠKOD

Nepředpokládá se, že z účasti na této studii by mohly vyplynout nějaké škody. Za škody, které přesto v průběhu této studie vzniknou, nebudu odškodněn(a).

D. KREDITY/KOMPENZACE ZA ÚČAST

Účastníci této studie nejsou hodnoceni přidělením kreditů. Jako projev díky za jejich účast a čas, který studii věnují, jim bude předána kniha.

E. AUDIONAHRÁVKY ROZHOVORŮ A POZOROVÁNÍ

Audionahrávky pořízené při rozhovorech a pozorováních budou uchovány do konce studie a poté budou zničeny. Jsem si vědom(a), že jsem oprávněn(a) neudělit souhlas s pořizováním audionahrávek, a že to neovlivní mé vztahy s výzkumníkem, který na této studii participuje, ani jeho jednání s mou osobou v současnosti ani v budoucnosti.

Udělují tímto svůj souhlas s pořizováním audionahrávek rozhovorů: _____ Ano _____ Ne

Udělují tímto souhlas s pořizováním audionahrávek rozhovorů i pozorování: _____ Ano _____ Ne

F. KONTAKT PRO DOTAZY OHLEDNĚ PRÁV OBJEKTŮ (ÚČASTNÍKŮ) VÝZKUMU

Budu-li mít nějaké dotazy ohledně této studie, mohu se obrátit na Karen Nealovou na čísle 02/0723 083 253. Budu-li mít nějaké dotazy ohledně mých práv z pozice objektu výzkumu, mohu se obrátit na vedoucího správy výzkumů Ústavu správy výzkumů Oklahomské univerzity na čísle 001-405-325-4757, popřípadě prostřednictvím e-mailu na adresu irb@ou.edu. Fakultním garantem projektu je Robert Fox, Ed.D., kterého je možno kontaktovat na čísle 001-405-325-2769 nebo prostřednictvím e-mailu na adrese rfox@ou.edu.

NÁKLADY

Z účasti na studii mi nevznikají žádné náklady, vyjma času, který věnuji rozhovorům a pozorováním.

ALTERNATIVA K ÚČASTI

Mou alternativní možností je studie se nezúčastnit.

Tento formulář pro vyslovení souhlasu jsem si přečetl(a), rozumím jeho obsahu a dobrovolně souhlasím s účastí na této studii za výše popsanych podmínek. Pro svou vlastní potřebu obdržím jednu kopii tohoto formuláře pro vyslovení souhlasu.

Objekt výzkumu: _____ Datum: _____

Svědék: _____ Datum: _____

Výzkumník: _____ Datum: _____

Appendix C: Interview Questions

This list contains interview questions used in answering research questions one, four, five and six. Questions two and three were addressed in a survey form completed by the participants prior to the first interview. This allowed for clarification and further information to be gained from the survey questions. Demographic information was added to the survey form.

Research question one: As reported by physicians in interviews, what impact has the societal change experienced in the Czech Republic had on the physicians who teach in the medical school?

1. What kinds of changes have you seen in Czech society since 1989?
2. Are you changing as the society changes around you? How do you see yourself changing?
3. How has the change from communism to democracy affected your practice of medicine?
4. How are changes in social resources affecting your practice or the training of students?
5. How are changes in the political environment affecting your practice or the training of students?
6. What kinds of changes have you made in your practice/teaching with the economic shift to a capitalist system?
7. What do you think your students will face in their future as physicians that is different from the experience you have had in working in this social system?

Research question two: How do Czech physicians describe their own methods of change and learning in the pursuit of a medical profession in a society undergoing transformation?

Research question three: If these physicians have changed, what motivated those changes and how do they say the changes are reflected in their teaching practices?

8. Why did you select this example of change as the most important one you have made this year?
9. How is this change different from other changes you have made? How is it the same?
10. How would you describe this change – as one that is: only personal, a mixture of personal and professional, only professional, a mixture of professional and social, or only social in nature?

Research question four: How and why do academic physicians report they transmit or teach ethical behaviors to their students? How has the expression of ethical beliefs changed in the academic arena according to what teaching physicians report in interviews? Are these reports supported by observations of encounters with students and in documentation from the institution?

11. How is the ability to consider ethics developed? Is it important that students develop this ability while they are still in medical school?
12. What are the ethical issues you think are important for students and teachers of medicine to discuss?
13. Are there ethical issues you think students can learn to deal with apart from the process of learning medicine? What would these issues be? What differentiates these issues from the ethical issues you feel must be discussed together?

14. How do you teach students to evaluate situations that require an ethical decision?
15. How should students learn to incorporate a code of ethics into practice?
16. What ethics and/or values have changed in the larger society? What ethics and/or values are the same in society?
17. Have you felt the need to change your own ethics/values in order to keep pace with societal expectations? How has this impacted the way you teach medicine? What have you had to change in order to train students to practice medicine in this new setting?

Research question five: How do physicians report cultural change influences the way they train students when there is a political and economic shift?

18. Have there been changes in the social expectations for how medical students are trained now? What kind of change have you seen in social expectations for how you train your students?
19. How does the change in the economic system affect your ability to train students?
How does the change in political system affect your ability to train students?
20. Considering the relationship of the physician and the society in which he/she works, are there issues about this relationship that should be included in the medical education process? What are they and why did you choose each one?

Research question six: How do physicians report they understand their positions as transmitters of the new social and professional culture to students?

21. Has your professional culture changed during the time that the social changes in Czech culture have been occurring? What are the changes in your professional

culture? How do you understand this to have affected the teaching practices or methods you use?

22. When the culture of society or the professional culture of medicine changes, how do you think these changes affect the long-term medical practice your students will have? How do you see this change to have affected your ability to train students?
23. Have you made changes in the methods of transmission of professional culture to your students? Why did you feel the need to make those changes? What were the changes you made and how is this different from your past practices?
24. How have you had to help your students learn to practice medicine in a social culture that has been continuing to change while they have been in training? Are there differences in the way you have been training students to practice medicine in the Czech Republic?
25. What are the goals you have for teaching medicine and/or working with students?
26. Are these goals changing because of the changes in society? How do you feel about these changes?
27. Do you think teaching values/ethics should be a goal of medical education? Why or why not?
28. Are you changing strategies in teaching according to changes in society? Why or why not?

Appendix D: Cover sheet and survey form

August 30, 2001

Dear Participant:

Thank you for agreeing to be part of this study, Physicians as teachers of ethics and values in the Czech Republic. I look forward to the opportunity to learn from your experiences and knowledge how social changes have impacted your life as a teacher of medicine.

For the purposes of this study, change is defined as "a difference in what was--an alteration in feeling, thought, or action" (Fox, Mazmanian, & Putnam, 1989, p. 1) or alternately as "...an increase in knowledge, the acquisition or improvement of a skill, or a change in attitude or behavior" (Zinn, in Galbraith, 1998).

To better understand the similarities and differences between Czech physicians and Western physicians, would you please take a few minutes to answer the questions about personal changes on the next two pages? You will have opportunity to add additional information you feel is important during the first interview, which is scheduled on: _____

We will meet at this location: _____

Beginning at this time: _____ To end at this time: _____

Thank you for your help. I look forward to meeting with you soon,

Karen Neal

Demographic information: Please complete the following information about yourself:

Name:

Age:

Teaching position:

School in which you completed your medical education:

Graduation date:

Area of specialty:

Number of years in teaching:

Number of years at Charles University:

What kinds of changes have you made in your personal or professional life in the past year?

Changes in activities as a:	No changes made	Yes, I made changes	If yes, how many:
Manager			
Educator			
Researcher			
Family member			
Community member			
Hospital staff member			
Professional societies			
Board member			
Consultant			

Please describe the change you consider to be the most important you have made in the above categories:

Changes in feelings about:	No changes made	Yes, I made changes	If yes, how many:
Medical practice			
Patients			
Future plans			
Retirement			
Career goals			

Please describe the change you consider to be the most important you have made in the above categories:

	No changes made	Yes, I made changes	If yes, how many:
Changes in patient population:			
Changes made in clinical practices:			
Interviewing/history taking			
Test ordering			
Prescribing			
Therapeutic protocol			
Surgical procedure			
Patient education procedures or counseling			
Follow-up			
Case finding and screening procedures			

Please describe the change you consider to be the most important you have made in the above categories:

	No changes made	Yes, I made changes	If yes, how many:
Changes due to personal aging:			

Please describe the change you consider to be the most important you have made in the above category:

17. září 2001

Vážený účastníku,

děkuji Vám za udělení souhlasu s účastí na této studii nazvané Praktičtí lékaři jako vyučující etiky a hodnot v České republice. Těším se na příležitost získat nové poznatky z Vašich zkušeností a znalostí z oblasti vlivů sociálních změn na Váš profesní život vyučujícího medicíny.

Pro účely této studie je změna definována jako „rozdíl proti tomu co bylo – posun názorů, myšlení, nebo činů“ (Fox, Mazmanian, a Putnam, 1989, str. 1), nebo popřípadě jako „... nárůst znalostí, nabytí či zlepšení dovedností, nebo změna postojů či chování“ (Zinn, v Galbraithu, 1998).

Abychom lépe porozuměli podobnostem a rozdílům mezi českými praktickými lékaři a západními praktickými lékaři, ráda bych Vás požádala, abyste věnoval(a) několik minut na zodpovězení otázek týkajících se osobních změn, které se nacházejí na následujících dvou stranách. Možnost doplnit další informace, které považujete za důležité, budete mít při Vašem prvním rozhovoru, který se koná dne: _____

Místo, kde se setkáme: _____

Čas zahájení rozhovoru: _____ Předpokl. čas ukončení rozhovoru: _____

Děkuji za Vaši spolupráci a těším se na setkání s Vámi,

Karen Nealová

Demografické údaje: Doplňte prosím následující informace ohledně Vaší osoby:

Jméno:

Věk:

Postavení jako vyučující:

Škola, kde jste ukončil(a) Vaše medicínské vzdělání:

Datum ukončení studia:

Specializace:

Jak dlouho působíte jako vyučující:

Jak dlouho působíte na Karlově univerzitě:

Jakými změnami jste ve Vašem osobním i profesním životě prošel(la) v průběhu uplynulého roku?

Změny v činnostech jako:	Žádné změny	Ano, změnami jsem prošel(la)	Pokud ano, kolika:
Manažer			
Vyučující			
Výzkumník			
Člen rodiny			
Člen komunity			
Zaměstnanec nemocnice			
Člen profesního spolku			
Člen kolegia			
Konzultant			

Popište prosím uskutečněnou změnu, kterou v rámci těchto kategorií považujete za nejdůležitější:

Změny názorů ohledně:	Žádné změny	Ano, změnami jsem prošel(la)	Pokud ano, kolik:
Lékařské praxe			
Pacientů			
Plánů do budoucna			
Odhodu do důchodu			
Kariérních cílů			

Popište prosím uskutečněnou změnu, kterou v rámci těchto kategorií považujete za nejdůležitější:

	Žádné změny	Ano, změnami jsem prošel(la)	Pokud ano, kolika:
Změny v počtech pacientů:			
Změny učiněné v klinické praxi:			
Pohovory s pacienty/ zjišťování anamnézy			
Objednávání testů			
Předepisování léků			
Terapeutické protokoly			
Chirurgické postupy			
Postupy vzdělávání pacientů a poradenství			
Další sledování pacientů			
Postupy odhalování medicínských případů a screeningové postupy			

Popište prosím uskutečněnou změnu, kterou v rámci těchto kategorií považujete za nejdůležitější:

	Žádné změny	Ano, změnami jsem prošel(la)	Pokud ano, kolika:
Změny způsobené rostoucím vlastním věkem:			

Popište prosím uskutečněnou změnu, kterou v rámci těchto kategorií považujete za nejdůležitější:

Appendix F: Observation chart

Time	Activity	Observations
1 to 5 minutes		
6 to 10 minutes		
11 to 15 minutes		
16 to 20 minutes		
21 to 25 minutes		
26 to 30 minutes		