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The teaching of medical ethics

The following two papers, the first from Sweden, the second from the United States of America, form the first of a series on the teaching of medical ethics.

In Sweden the teaching of medical ethics is not obligatory but many professors and clinical teachers include it in their approach to the practice of the different branches of medicine. In the United States hundreds of formal courses are being offered and research projects and the tools of research are beginning to emerge.

Dr Blomquist defines the concept of medical ethics, and proposes criteria for its application, for example, to euthanasia. Dr Veatch and Miss Fenner outline the courses and provision for the teaching of medical ethics to undergraduate and postgraduate students both in the medical schools of America and in other university schools.

In Sweden

Clarence Blomquist *Karolinska Institute and the Outpatient Unit, Department of Psychiatry, Karolinska Hospital, Stockholm, Sweden*

Definitions

It is often convenient to use different definitions for different purposes and in different contexts. To define 'medical ethics' we should start from the two definitions of 'ethics' or 'moral philosophy'.

'Ethics' may first be defined as 'a science dealing with a specific set of verbal expressions, namely, propositions that explicitly or implicitly contain a certain class of words, such as 'good', 'bad', 'right', 'wrong', 'obligation', and 'ought to'. Secondly ethics may be described as 'a system for the regulation and control of human behaviour in order to safeguard and realize certain values'. The first definition stresses the 'meta' aspects of moral philosophy, the second its normative functions. Moral philosophy has three main branches:

1 META-ETHICS

Each science has its meta-science, the 'science of the science'. Meta-ethics is the science of ethics, the analysis of ethical propositions and systems. This fundamental branch is what most moral philosophers, at least in Sweden, are occupied with.

2 EMPIRICAL ETHICS

An interesting and important task for the student of ethics is to look around and see how people actually solve ethical problems and make ethical decisions, how they learn ethical norms, and what arguments, if any, they use for or against ethical opinions. What ethical traditions are there in a certain population, are they codified or not, is there any connexion between confession and action, or may be between certain kinds of personalities and certain kinds of ethics, between ethics and politics?

3 NORMATIVE ETHICS

To formulate norms and recommendations for human conduct, to 'sell' them and persuade people to follow them and to condemn those breaking our holy rules are what most people think of as the sole mission of a moral philosopher. Of course it is an important part of his job, but without thorough meta-ethical clarification and good empirical anchorage it is of no use and may indeed be worse than before because it can create disbelief in the whole topic.

MEDICAL ETHICS

'Medical ethics' may be defined as 'ordinary ethics in a medical context or applied to the medical profession', where 'context' means a verbal connexion.

The questions to be asked and answered

All ethical criteria are impossible to apply unless we not only define certain central medical concepts – 'life', 'death', 'health', 'disease' but also the limits of the medical profession, its aims and its relationships with other sciences and other functions in the community. Further, what do we mean by medical ethics? Is it what is codified by the World Medical Association and if so, who or what authorized that organization to say what is right and wrong? Is it instead the medical application of the Natural Law, or is it what the Catholic or some other church says it is, and what then is the difference from a meta-ethical point of view?

What are the doctor's considerations and obligations, and how are they or could they be motivated? If there are conflicts between different considerations, for example, if the doctor cannot save both the unborn child and the mother, or if his

patient is drinking himself to death and the doctor feels obliged to save his life, do guidelines exist for solving such conflicts based on deontological, teleological, or some other meta-ethical outlook and how are they justified? What is the explicit, or as a rule implicit, priority of values and norms in existing codes of medical ethics and are these consistent or contradictory? Do they fulfil the criterion of universality and are they relatively complete and simple? Finally is it possible to formulate one medical ethic, which can supersede all existing medical ethics?

Empirical medical ethics

Medical ethics is an important field for empirical studies, which can be divided into three groups each containing questions to be answered.

1 ETHICAL CODES, NORMS, AND BEHAVIOUR

There are many codes of medical ethics, and it can be asked what is common to them. Do doctors read them? Nowhere in Europe today is there formal teaching in ethics for medical students. How then do doctors learn ethical norms and how do they make decisions? To which value or values – health, life, freedom, power to the people – do they give priority? Are there ethically interesting differences between male and female doctors, young doctors and old doctors, between different specialities?

2 MEDICAL SOCIOLOGY

How is the doctor's role looked upon by the doctors themselves and by their patients? Which attitude – authoritarian, democratic, *laissez-faire* – is preferred and which is most effective? What is the social function of the hospital and how are the different groups of staff and patients structured and stratified? Is Mr John Smith, the patient with an inoperable cancer, the same person as Mr John Smith, the carpenter? How is a person changed when he takes upon himself the role of a patient?

3 MEDICAL PSYCHOLOGY

By the use of this term I mean the understanding of how a person who has become ill reacts to his illness and what happens in the contact between him and the medical staff. The doctor-patient relationship is a short encounter between human beings. What then is a human being and what happens in the patient and in the doctor during this meeting? Is a completely open communication possible and is it desirable? Is the type of relationship which both parties feel most pleasurable also the most effective? Will it have the highest benefit in relation to the costs for the patient and for society?

To medical psychology also belongs the problem of death and dying, the whole science of thanatology – the psychology of dying, the right attitudes to the dying, the question of telling the truth, the death anxiety among the staff. These are topics of great importance for medicine, and the branch of medical ethics where at the moment most scientific work is being done.

Normative or applied medical ethics

In this sense medical ethics supplies answers to questions about how doctors ought to act in certain, well defined situations. Euthanasia may be taken as an example of a situation where we try to apply ethical criteria.

Euthanasia I would define as certain actions a doctor makes for a living patient if, and only if, that patient is incurably ill or defective; the patient wants to die; he dies as a direct consequence of an action (or of an action and his illness together); the doctor's motive is mercy or some other 'noble' motive; the doctor knows that the patient will die; he intends that death should be the outcome of his action or accepts it as inevitable.

Euthanasia then is found to be the sum of different categories of action which may result in 1) active or direct euthanasia; 2) the acceleration of death; 3) death as the foreseen but not the intended result of treatment; 4) passive or indirect euthanasia. From these definitions an ethical proposition may be formulated, namely, 'euthanasia is right'. Then the relevance, validity, and strength of each of the counter arguments against the proposition must be tested in relation to the different categories of euthanasia: euthanasia is murder, it is wrong to kill; euthanasia is against the values of medical ethics; it is against the Fifth Commandment, as God decides when life shall cease and suffering is important for the spiritual life; to commit euthanasia will influence the doctor in a negative way and it will kill the patient's trust in his doctor; euthanasia would lessen the motivation for research, unconscious impulses can play a role, euthanasia can be misused, or the doctor can be wrong in his diagnosis and prognosis.

The same manoeuvre should be repeated in respect of the arguments in favour of our proposition: mercy, economic considerations, 'unworthy' lives, freedom of choice, progress of research.

The arguments which were considered valid for and against euthanasia should be weighed against each other and it will be found that in certain situations certain forms of euthanasia are ethically justified and some other forms are not.

Other examples of actions where such an analysis of the arguments for and against are suicide, therapeutic abortion, sterilization, castration, artificial insemination, blood transfusion to members of the Jehovah's Witnesses, the right to live (and die) after the patient's own choice, the right to be informed.

A vast and increasingly important topic is the ethic of biomedical research including advanced

and experimental surgery, genetic engineering, and chemical, bacteriological, and even psychiatric-psychological research, the result of which can be used in warfare and torture and for other inhumane purposes.

The doctor's obligation to his colleagues, his family, his society, to the mass media also have ethical implications.

Formal teaching of medical ethics

There is no obligatory teaching in ethics for medical students in Sweden or other north European countries, but many professors and lecturers in internal medicine, paediatrics, surgery, psychiatry and so on discuss ethical problems in their ordinary teaching. As a rule they have no training themselves in ethics and therefore such teaching may be somewhat variable and altogether dependent on the lecturer's own interest in the field. There is just one academic teacher in medical ethics in Scandinavia, but his potential teaching and research must be done outside his full-time work as a clinical psychiatrist and lecturer in psychiatry.

Research ethics

As to research ethics, the situation is better. Every medical faculty in Sweden (but not in the other Scandinavian countries) has ethical committees, and practically no medical research can be done without ethical analysis and approval. Needless to say the members of these committees are self-made men ethically. The Swedish Society of Medical Sciences has a Delegation for Medical Ethics with five delegates elected by the Society and representing internal medicine, surgery, paediatrics, psychiatry, and clinical pharmacology, one from the Swedish Medical Research Council (he is also a medical professor), and four laymen elected by the main trade unions and the Penn Club.

There has been much discussion whether laymen should be included on the faculty committees, and recently it was decided that there should be one layman on each committee. If by 'layman' is meant a non-medical expert, in my experience a lawyer is often of great assistance.

Developments in Sweden

Next autumn a voluntary course for medical undergraduates in medical ethics and the theory of science will be arranged. Sixteen sessions – lectures, discussions, workshops – will treat the following subjects: logic, semantics, the theory of science, analysis of argument, meta-ethics, ethical control, the politics of research, medical psychology and sociology, the sociology of research, euthanasia as an example of applied ethics, personal integrity, the Declaration of Helsinki, experimental surgery, genetic control, routine medical treatment versus clinical research, and the social responsibility of researchers.

The creation of a scientific institution of medical ethics with an ordinary professorship has been discussed but so far without any result. Such a professor must, in my opinion, be a medical man with a philosophical education and great clinical experience and continual contact with practical health care, hospital work and medical research. To help him he might have lecturers and assistants trained in psychology, sociology, philosophy, and law. It is easier for a medical doctor to learn ethics than for a moral philosopher to learn enough medicine to be of real help to the medical profession.

The time has long passed when medical ethics could be taught only by the good example of elderly colleagues. Nor can it remain just a hobby for some busy clinicians or an amateur job for retired doctors. A strong scientific foundation is mandatory.