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The teaching of medical ethics

In the Nottingham Medical School

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The subject of medical ethics is intended to run like a thread throughout the whole undergraduate period at the Nottingham Medical School which was established in 1970, the first such foundation in Britain this century. Dr J S P Jones, who is the Clinical Subdean, and Dr D H H Metcalfe, of the Department of Community Health, describe the plan of the course leading to qualifying, and how the thread of medical ethics has been woven into that fabric. The final objective of the course is to train men and women to become technologically capable and at the same time alive to the human needs of their patients. The authors define the two crucial characteristics of the fully trained professional as a person – self regulating and self policing – who advises and does not command those who come to him as patients.

The new medical school in Nottingham is the first to be established in the United Kingdom this century. The first group of students were admitted in October 1970 and they graduated in July 1975. The first and second years of the five-year course consist of a basic medical sciences course, the third year of a special medical sciences course, and the fourth and fifth years of a clinical course (Jones, 1975).

Objectives of medical education in the Nottingham course

Among the objectives of medical education stated by the medical school, the following have been selected as being relevant to the teaching of medical ethics. They are that a doctor 'should have developed an attitude to medicine which is a blend of the scientific and humanitarian; should be imbued with the high ethical standards required of a doctor; should have learned how to deal with patients and their relatives with sympathy and understanding; should appreciate that medicine is a continuing education and that he has an obligation to remain a student to contribute if he can to the progress of medicine throughout the whole of his professional career'.

A merging of problem areas in the curriculum

The overall responsibility for the teaching of medical ethics is vested in Dr J S P Jones. He also teaches the legal aspects of medicine, and there is therefore a deliberate merging together of problem areas which include moral issues, doctors' attitudes, professional standards and legal obligations. To those who would wish to separate these issues, and possibly deal with each in isolation, this amalgamation of subjects is probably open to criticism. We feel, however, that the practising doctor is continually being confronted with situations which require assessment from numerous standpoints, and the teaching is therefore directed towards this end with contributions by teachers in many disciplines throughout the five-year course. It will be noted that the *intracurricular* aspects of medical ethics are taught mainly by medical members of the staff, although contributions are also made by social science graduates, especially in theme C of the basic medical science course (vide infra). An opportunity for students and teachers to listen to informed non-medical opinion – especially theological and philosophical aspects – is provided by *extracurricular* discussion groups (vide infra). Experience will show whether this is the best way of balancing the subject and the progress of these two forms of presentation will be kept under review.

From the medical students' point of view it is important to remember that their attitudes will be largely governed by the social mores of the community in which they live. They are expected – in addition to their scientific and clinical academic training – to grow up and face difficult situations in a matter of only a few years. Within a relatively short time of leaving the schoolroom they have, for example, to learn to talk to and listen with understanding to ill and often elderly patients, or to enquire with tact into the intimacies of marital problems, or – as junior house officers – to cope with the anguish of a dying patient and his family with a maturity in excess of their years.

A number of years later (depending on the chosen specialty) the medical graduate will accept total responsibility, willingly given to him, for finding the right balance between technological

capability and the human needs of his patients. There are two crucial characteristics of the fully trained professional:

1) He does not work under the control of others. He therefore has to be self regulating and self policing.

2) He advises those who come to him as patients; he does not command.

The system of self monitoring necessary to fulfil these professional attributes is the core of medical ethics. It is the development of thought, feeling and instinct which balances the equation which the doctor must solve between intrusion into his patients' private life – whether emotional, physical or social – which go beyond the social mores, and the expected benefit to that patient.

The extent to which medical ethics can be taught is debatable, but this paper describes the way in which the subject is dealt with in the Nottingham Medical School. It is accepted that details may be varied in succeeding years in the light of experience and changing needs, but the curricular framework is sufficiently malleable to allow such modifications should they become necessary.

Medical ethics – a thread running through the undergraduate period

The subject of medical ethics is not taught as a course in itself but it is intended that it run like a thread throughout the whole undergraduate period. The ethical aspects of a wide variety of topics are considered as part of their teaching, particularly when important issues are involved. In small teaching groups a close rapport between students and staff facilitate informal discussions.

The objectives of the teaching of medical ethics are:

KNOWLEDGE

A doctor should know the limits of acceptable clinical behaviour in common situations; he should know that in uncommon or difficult situations the onus is on him to refer to his colleagues for guidance.

SKILLS

A doctor should consider with honesty and clarity the balance between his personal involvement and his patients' needs and make appropriate decisions.

ATTITUDES

A doctor should recognize that, in coming to him, the patient is voluntarily surrendering a large part of his autonomy in the expectation of relief of suffering, and that this places on the doctor a heavy responsibility not to abrogate that trust.

Readers will be able to judge, from the following description, to what extent the Nottingham course is likely to achieve these objectives.

Introductory course

In the very first two weeks in the medical school, every student takes the opportunity of viewing the whole range of medical care by visiting general practitioners' surgeries, health centres and patients in hospital. These introductory visits, and the discussion seminar that follows them, are designed not only to demonstrate the range of health services, and the roles of different sorts of doctors, but also the responsibilities they have to discharge and the problems they face. It is hoped that the student will begin to realize that there are not always clear-cut 'right answers' in medicine.

During this two-week initiation period, the students have two lectures – followed by a discussion – on medical ethics. Since these form the foundation of the teaching of the subject, their contents are described in detail, and they encompass: *a*) the need and the reasons for high standards of self-discipline in medicine; *b*) the way in which guidance for the setting of these standards has been evolved, illustrated by discussions on the Hippocratic oath, the Declaration of Geneva and the Declaration of Helsinki.

THE HIPPOCRATIC OATH

It is emphasized that most of the fundamental concepts of the oath are as relevant today as they were in 400 BC, and that this ethical guidance has stood the test of time by remaining unaltered over many centuries.

THE DECLARATION OF GENEVA

Because of the rapidly changing pattern of human behaviour in the twentieth century, and particularly because of the potential misuse to which scientific and medical skill can be put, the Declaration of Geneva is regarded as the internationally accepted code of ethics on which our students should base their future practice of medicine.

DECLARATION OF HELSINKI

The students, at the very beginning of their medical course, are curious to know about the relationship between the doctor and the patient with regard to medical research and to clinical teaching. During this introductory course, therefore, time is spent in reviewing the Declaration of Helsinki and also in outlining the safeguards which are recommended by the various ethical committees now being established for the benefit of the patients (or subjects) and for the supervising investigators.

With regard to teaching on patients, the students are advised of the essential contribution to their education that is made by patients, and of the way that this contribution should be respected. They are informed of the guidance given to the members of the clinical teaching staff on the relationship between the teacher and the patient, as outlined in

the Department of Health and Social Security leaflet *Teaching on Patients*. The virtue of courtesy is one which is strongly encouraged throughout the entire course.

At this very early stage of our students' medical course, when they are being introduced to a variety of new experiences, they find that in the sessions in medical ethics they are able, without having any specialized knowledge, to hold positive views and contribute to discussions of the topics in a constructive way. Our aim is to encourage the student to think about the ethical aspects of the many subjects that he will encounter throughout his training and subsequent professional career, and particularly to encourage the student to discuss these matters as they arise.

Basic medical sciences course

While the basic sciences courses in theme A (the cell) and theme B (man) touch on the development of ethical behaviour in terms of precision, carefulness and consideration (for the students work on both patients and each other in their investigative work), in theme C (the community) the student is introduced to the concept of making choices in the provision of medical care within resource constraints, and taught to collect and analyse data to inform those choices. Obviously ethical problems have to be faced in making such choices, and their discussion is an integral part of theme C teaching. Examples include the problem of selection of patients for renal dialysis, or on a broader issue, how should limited financial resources be used in a Third World country? Should the major investment be made in high-technology curative medicine, benefiting a relatively limited number of patients, or should priority be given to low-technology preventative medicine? What are the moral issues which guide the mode of selection?

Special sciences course

Because of the wide range of subject matter which is covered in the first two years of the medical sciences course, there is only limited opportunity for a student to investigate any particular subject in depth. Therefore, in Nottingham each student spends the third year pursuing a subject in a single basic medical science department. The project undertaken may involve working with clinicians either in hospital or in general practice, and there may be occasions when students interview patients or review clinical records. Before embarking on this phase of the course, reinforcement is given to ethical principles, and students are particularly reminded about the need for high standards in the field of clinical research and about the confidentiality of information derived from patients, either directly or from clinical records.

Clinical course

Apart from discussions engendered by the students themselves during the clinical course there are certain topics which are especially identified for ethical consideration. Amongst these are: attitudes to sex education, contraception, abortion, marital guidance; ethical problems concerning transplantation are discussed at the time that students are learning the clinical aspects of the subject; the dilemmas which confront medical practitioners if some of their patients are involved in criminal proceedings, for example, when medical evidence is required in such cases as baby battering, are ventilated in integrated teaching sessions. A further example is a session on the needs of the dying patient and his family, taught by a psychiatrist, a priest and a general practitioner. Here the central point is that the doctor's responsibility changes from the control or correction of the patient's pathophysiology, to the analysis of, and response to, his physical, emotional, social and spiritual needs. The students are helped to understand and accept that, whereas in *acute* situations the technology of medical care takes priority, and the quality of patients' subjective experience, while very important, may need to be a secondary consideration (as the motto of the Royal College of General Practitioners has it, *Cum Scientia Caritas*), in terminal care, the quality of the subjective experience is the paramount objective, and the medical technology is deployed solely in pursuit of it.

During the one-month attachment in general practice, the students do not merely 'sit in', but join a structured course based on the seven appointed teaching practices. Several of the sessions are designed to inform the student of the 'patient-eye view' of medical care so that they can understand the depth and meaning of the franchise the patient gives the doctor. These include 'in-depth' studies of individual patients or families with severe problems; the close attachment of each student to a patient going through an outpatient referral or an emergency admission; and the analysis and discussion of doctor-patient interactions using videotaped interviews between the student and a simulated patient.

Extramural sessions on medical ethics

Discussions with the Professor of Theology and with the chaplains of the University of Nottingham have revealed a desire by students and staff in many faculties to be involved in debates on current problems affecting ethical standards in a variety of spheres, including medicine. While it is clearly necessary for some intracurricular teaching in medical ethics to be a part of the medical school's programme, there is also a strong case for a more widely based forum to be available so that a broad spectrum of views may be expressed on matters

which are of general concern to all. A series of debates is therefore being arranged on the university campus, open to staff and students of all faculties, as well as to all medical practitioners in Nottingham, so that ethical matters of current interest may be debated. Subjects such as 'The care of the dying and their families', 'Genetic engineering' and 'Euthanasia' will be discussed.

Conclusion

The inclusion of medical ethics in the medical school undergraduate curriculum is regarded as an important educational contribution to the humanitarian aspect of medicine. The early stage of the course at which it is introduced to the students is of prime importance. It is a subject which demands that each individual must make up his or her own mind on their attitudes to the various problems that they will encounter. These attitudes will be influenced to a large extent by the example and guidance of their teachers and colleagues. It is therefore desirable that each student becomes aware of the potential moral dilemmas at an early stage and he can then develop his thinking throughout his undergraduate training and subsequent professional life.

We shall be observing the graduate careers of our students with great interest, and will continually review the format of the undergraduate course in the light of experience.

References

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