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London Landscape

4th annual primary care ethics conference: ethics education and lifelong learning

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Key message(s)

- Learners and teachers in primary healthcare need ways of accounting for societal change and to take on board the insights gained from empirical work, whether this is about different kinds of fatherhood or work on the causes of moral distress in healthcare workers.
- Although the prescriptiveness of the ethical method means that the subject of medical ethics can be taught, learned and tested by non-experts, this may stifle creative thinking and even unjustly penalise those who go beyond the core readings.
- Primary care has strong historical associations with medical education and by extension, medical ethics education in the UK.

Related *LJPC* papers

De Zulueta P, Primary Care Ethics (2008) *LJPC* 1:5–7.
Papanikitas *et al*, Ethics of the ordinary – A meeting run by the Royal Society of Medicine with The Royal College of General Practitioners (2011) *LJPC* 4:70–2.

ABSTRACT

Primary care ethics is a field of study that has recently found new life, with calls to establish the relevance of ethical discussion in general practice, to gather a body of literature and to carve out an intellectual space for primary care on the academic landscape of bioethics. In this report, we reflect on the key strands of the 4th primary care ethics conference held at the Royal Society of Medicine, on a theme of ethics education and lifelong learning: first, to produce insights that have relevance for policy and practice; and second, to illustrate the idea that not only is ethics relevant in primary care, but primary care is relevant in medical ethics. Core themes included the advantages and disadvantages of prescriptive ways of doing ethics in education, ethical reflection and potential risk to professional status, the need to deal with societal change and to take on board the insights gained from empirical work, whether this is about different kinds of fatherhood, or work on the causes of moral distress in healthcare workers.

Keywords: ethics, education, primary care, general practice, role models

Introduction

Primary care ethics is a field of study that has recently found new life, with calls to establish the relevance of ethical discussion in general practice,[1] to gather a body of literature[2] and to carve out an intellectual space for primary care on the academic landscape of bioethics.[3] These repeated calls have been based on the idea that academic bioethical study tends to focus on the dramatic and technology-focused dilemmas of biomedical research and hospital medicine. This neglects the commonplace dilemmas that occur in primary care but may often remain unnoticed. Everyday unproblematic practice is based on internalised values and ethical norms, which may need to be re-evaluated. New technologies and culture change shape the ethical landscape outside the hospital setting as well.

Accordingly, a group of general practice academics and educators responded to the need behind these calls in 2011 and have now run five primary care ethics conferences in association with the Royal Society of Medicine and the Royal College of General Practitioners (RCGP). The conferences have dwelt on 'The ethics of the ordinary' (2011), 'Solidarity and personal choice' (2012), 'The ordinary and extraordinary' (2013), 'Compassion in healthcare' (Edinburgh 2013) and, most recently, 'Ethics education and lifelong learning' (April 2014). In this report, we reflect on the key strands of the day – first, to produce insights that have relevance for policy and practice; and second, to illustrate the idea that not only is ethics relevant in primary care, but primary care is relevant in medical ethics.

Opening keynotes

In his opening keynote, Nathan Emmerich outlined the historical connections among medical ethics, medical education and general practice. Formal histories of British medical ethics focus on the London Medical Group (later to transform into the Institute of Medical Ethics). The London Medical Group is characterised by individuals such as Raanan Gillon, a general practitioner (GP) with expertise in ethics [4]. Raanan Gillon made philosophical ethics accessible to doctors via a series of *BMJ* articles and promoted Beauchamp and Childress' four general principles (referred to as the four principles) that doctors broadly agreed upon and could use to analyse any ethical problem. The principles were: beneficence (do good), non-maleficence (avoid harming), the respect for autonomy and justice (the idea of treating people and allocating resources fairly). Emmerich connected the London Medical Group major with innovations such as the Oxford Practice Skills Course,[5,6] and how these may have influenced national guidance for ethics education such as 'Tomorrow's Doctors'. Emmerich illustrated the influence of particular GPs on both medical ethics and medical education with reference to WG Irwin, the illustrious professor of general practice at Queen's University Belfast.[7,8] Ethics education as reflective practice in the UK owes as much to the medical education movement as to bioethics, and GPs have been influential figures in ethics education. The question this raises is whether this results from the individuals' personal attributes, or whether some aspects of primary care (or of GPs as practitioners of a craft) lend themselves to ethical discussion and reflective practice.

John Gillies, the Chair of RCGP Scotland, is also a medical educator with an interest in medical ethics. In his keynote, he reflected on the changes in society that make ethics education relevant. General practice, according to research conducted by RCGP Scotland with GPs, GP trainees and patients, occurs in a context of individualism and econom-ism.[9] Professionalism is 'sandwiched' between managerial-ism and commercialism. GPs work with complexity in a culture of suspicion, possibly made worse by incentivised state paternalism. The example of this was the way in which the Quality and Outcomes Framework in the UK incentivises GPs to give patients medicines in order to change biochemical and physiological indicators. Since Hippocratic times, the espousing of robust ethical principles has been offered as a way to both generate public approval and resist the pressure to act based on perverse incentives. In arguing for a nuanced primary care ethic, Dr Gillies stated that general practice is different from hospital medicine in key ways. Many GPs still live in geographical proximity to their patients. The biological metaphor of generalism is organismic rather than mechanistic – the patient is a functioning whole, not an aggregate of parts that occasionally need fixing. He described general practice as the only medical specialism that transcends mind–body dualism. He quoted Reeve's definition of generalism.[10–12] A generalist clinician focuses on the person in a way that is continuous and biographical, and in which healthcare is a resource for living rather than an end in itself. Because the aim of generalist medicine is patient-flourishing, GPs and other clinicians in primary care face more complex and nuanced ethical issues than some of the more stark and dramatic dilemmas of hospital medicine. Dr Gillies, 'Could not help but mention,' that all this was in context of primary care facing restricted resource allocation and receiving a small proportion of the total healthcare budget in the UK despite carrying out the vast majority of healthcare contacts. In essence, dramatic ethical dilemmas could also occur in primary care.

Breakout sessions: key concerns in primary care ethics education

The breakout sessions captured key concerns within ethics education: the assessment of ethical reflection by means of portfolio entries, the nature of ethical support provided by the RCGP, the role of 'the humanities' in ethics education and some of the diverse approaches to delivering ethics education in the primary care setting.

Kim Stillman illustrated the issue of assessment by portfolio using her service evaluation of the new Membership of the Royal College of General Practice (nMRCGP) e-portfolio learning log. She found that serious ethical concerns were not documented in the log but were instead shared with a colleague or supervisor. Trainees perceived reflexive practice as important, but thought that the learning log's prescriptiveness and quantitative focus interfered with meaningful reflection. Some trainees, however, were using the log in a positive way as a 'confidant and comforter' in times of difficulty. GP-trainee e-portfolios represent a paradox in that they represent a confidential record of reflection, but one that is also open to scrutiny by people who have a duty to act where they see evidence of unprofessional or dangerous behaviour – the perceived 'safety' of the e-portfolio needs to be better understood by learners and examiners.

Dennis Cox led a horizon-scanning discussion that examined the array of ethics committees that provide approval or support: research ethics, resource allocation, clinical ethics and college ethics committees being the key subdivisions. The discussion included whether a Royal College should lead or reflect the ethical views of its members and whether a college ethics committee should inform or even generate an ethical position for a Royal College. The only clear consensus lay in the need for clear engagement by the ethics committees of professional bodies with both their constituent professionals and the policy-makers. The group felt that this engagement needed to be two-way. The other question of some importance lay in the source of a committee's credibility – should this lie in expert knowledge of ethics and law, seniority within the profession or representativeness of the host organisation's membership? The group were unable to reach a consensus. The discussion has clear implications for ethical leadership, depending on whether ethical ideas are eternal and based on reason alone, or on the values of any (or many) particular cultures and groups.

John Spicer presented some material on how the medical humanities can support ethical reasoning and clinical learning. Specific mention was made of how art can illuminate the four-stage process of observation–description–interpretation–reflection and how music and opera can reveal truths about emotional development, narrative and the skills of working collaboratively. Participants were given published articles on neurological issues in visual art and the value of literature in medical teaching and learning to take away and reflect upon further.[13]

In discussing ethics education in primary care, John Gillies highlighted the tension between formal and informal curricula and whether ethics education should be formal or informal. This group discussed ethics as a transferrable practical skill and reflected on the need to use clinical scenarios to spark interest and then develop the ethical discussion from there – the group referred to practical wisdom and asked if virtue could be taught. The notion of 'constructive subversion', constructively challenging those things which we do not believe are right, was discussed. Interaction and peer support are important in ethics education and developing critical thinking skills. Building relationships helps facilitate reflection. The use of Balint-type groups is one way to achieve a safe forum for reflection. The group also suggested moving away from the prescriptiveness of the four principles espoused by Gillon[14] towards a broader type of discussion. Doing this requires learning to work within the current model, but also to expand our thinking beyond it and develop the skills to learn to work with the next model that will 'inevitably' appear.

Afternoon keynotes: translational ideas

The afternoon session aimed to be translational – promoting ideas across the academia, education and practice divides.

Dr Jonathan Ives illustrated the relevance of new studies in empirical bioethics with reference to his work on the moral meanings of fatherhood.[15] Ives' empirical work had identified three key types of fatherhood. A biological father was essentially a sperm donor. Material fatherhood might involve official responsibility to provide for a child, but did not necessarily require anything more than the provision of resources or even a concern for a child's welfare beyond the legal requirement to provide. Dr Ives identified moral fatherhood as a meaningful involvement in a child's life that implied concern for a child's welfare and development. He illustrated this with the story of J.K. Rowling's Harry Potter, who has a deceased biological father, a guardian who has a minimal legal responsibility to provide him with food, shelter and clothes, and at least two 'moral fathers' who demonstrate a more meaningful father–

son relationship. The different kinds of fatherhood have obvious ethico-legal implications in primary care and family medicine whether it cannot be assumed that any one kind of father is also the other two. We consider that the practical relevance is that the concept of fatherhood needs to be treated in a flexible way by clinicians, in a manner analogous to the way that a person's 'next of kin' for healthcare decision-making might be a son or daughter, a divorced spouse or even a friendly neighbour.

Paquita De Zulueta explored the role of 'role models' in ethics education in a lively plenary discussion. Good and bad role models were considered in the discussion. Notably, the discussion raised the problem of how to treat the 'anti-hero', a person who might be considered to be admirable in some respects, but reprehensible in others. It was concluded that unless learners have the tools to evaluate what aspects of a role model are admirable and what are reprehensible, then an 'all or nothing' situation can arise in which learners reproduce bad behaviour or abandon admirable qualities because of a role model's other character flaws. The phenomenon of role modelling was connected with the hidden curriculum – those things which are learned, but not explicitly taught. The audience also reflected that many of the best role models were fictional, citing among others the outwardly cynical but good-hearted surgeon Hawkeye Pierce from the TV series *MASH* and the time-travelling Doctor Who.

The closing keynote was delivered by the film director Marcus Dillistone who argued that film (in a broad sense – moving pictures) is a powerful medium in the transfer of healthcare knowledge, with the power to inform and influence both professional and public audiences. He noted that the wide availability of film-making technology has democratised the ability to make healthcare-related films and argued that this has led to new concerns about content standards. He connected this to the idea that film-makers have a professional duty to ensure that their output is well informed and appropriately presented. He concluded that there should accordingly be a set of standards to which film-makers should adhere and a body of people to ensure this via an officially recognised mark of quality approval.

Posters

Once again, the day invited posters and we were grateful by financial support from the Institute of Medical Ethics for medical student contributions. Posters came from academia, from practice and from medical undergraduates. Notable academic contributions included a poster on narrative medicine by Jonathan Tomlinson and a poster showcasing a project to exchange knowledge between humanities scholarship and healthcare practice by Joshua Hordern. Medical student contributions included controversial topics such as whether to adopt punitive measures towards obese patients and the 'global' issue of ethical procurement in the NHS. One of the posters, 'Do clinicians ever have duty to put their own interests first?' by Emma McKenzie-Edwards, was also listed as a forum discussion in the Primary Care Ethics LinkedIn group and has generated lively discussion and debate (which we invite readers to join).

Core themes and invitation to participate

The prescriptiveness of the ethical method or of reflection or assessment was discussed repeatedly at the meeting. Although prescriptiveness means that the subject can be taught learned and tested by non-experts, it was widely acknowledged that this could stifle creative thinking and even unjustly penalise those who go beyond the core readings.

The safe assurance of status within the profession for the reflexive moral agent also emerged as a concern. This is explained by the idea that educational settings are relatively safe, but assessments carry potential sanctions if a candidate displays attitudes that are not sufficiently consistent with those of their peers or displays skills and knowledge that are sub-standard. How can leaners be encouraged to give answers that reflect their experience and attitudes rather than those that they think the assessors are hoping to hear? When reflections are formally assessed, for example in an e-portfolio, at an appraisal or at an interview, it seems professionally risky to share genuinely problematic scenarios. This risks promoting reflections that only include uncontroversial scenarios that easily lend themselves to analysis using the four principles.[14]

A major recurring theme in the day was the need to deal with societal change and to take on board the insights gained from empirical work, whether this about different kinds of fatherhood, or work on the causes of moral distress in healthcare workers.

The informal network of GPs organising the conference published the proceedings of their first event in this Journal.[16] They have gone on to become a LinkedIn community of 277 members (at the last count). They welcome new and old discussions via both the 'Primary Care Ethics' LinkedIn group and the correspondence options of this Journal.

CONFLICT OF INTEREST

None declared.

GOVERNANCE

Ethical approval was neither sought not needed for the production of this report. The conference organisers did, however check that where research was presented on the day, the research did have appropriate ethical scrutiny.

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