Teaching and learning medical ethics

Teaching medical ethics to experienced staff: participants, teachers and method

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Abstract
Almost all articles on education in medical ethics present proposals for or describe experiences of teaching students in different health professions. Since experienced staff also need such education, the purpose of this paper is to exemplify and discuss educational approaches that may be used after graduation. As an example we describe the experiences with a five-day European residential course on ethics for neonatal intensive care personnel. In this multidisciplinary course, using a case-based approach, the aim was to enhance the participants’ understanding of ethical principles and their relevance to clinical and research activities. Our conclusion is that working with realistic cases encourages practising nurses and physicians to apply their previous knowledge and new concepts learnt in the course, thus helping them to bridge the gap between theory and practice.

Keywords: Case method; medical ethics education; neonatal intensive care personnel

Introduction
There is growing interest in education in the field of medical ethics within the health care profession. A search on MEDLINE in July 2000, using "(teach* OR educat*) AND ethic*", resulted in 5672 hits. In the Journal of Medical Ethics we found 149 contributions. Almost all these articles deal with proposals for or experience of teaching undergraduate students. Within medical faculties the establishment of ethics programmes is also becoming increasingly common, and medical ethics has been a highly successful addition to educational curricula worldwide. This is, for instance, indicated by a survey of 206 medical schools in Asia. Unlike undergraduate students, however, experienced staff have few opportunities for further education which addresses their special problems. In answering a self-administered questionnaire on ethical decision making in neonatal intensive care (EURONIC project), a number of nurses and physicians from eight European countries emphasised the need for more training in medical ethics related to their own field. Thus, it seems that many fully trained professionals could be better equipped when facing ethical problems in their everyday practice. Over the last ten years, the Journal of Medical Ethics has only had three articles describing courses for experienced personnel: one in which senior doctors were introduced to narrative ethics,1 one for registered nurses using role-play,2 and one in which medical house officers were randomised and given different courses in medical ethics.3 More are needed. In our opinion, it is very important that we share our experiences with each other.

Objectives
The main purpose of this article is to describe and discuss educational approaches that may be used in teaching medical ethics after graduation: who should be taught, who should teach, and with what methods. As an example of one way to answer these questions, we describe our own experiences with a European residential course that took place in Florence, Italy during one week in the spring of 1998. The course was a cooperative project between an ethicist (TN) and a neonatologist (MC), in collaboration with an epidemiologist (RS).

Who should be taught?
All health care professionals have to face ethically problematic situations, and therefore may certainly benefit from education in the theory and practice of ethics. It is particularly important, however, that the specialists who face the most difficult decisions, such as those around the beginning and end of life, receive specific support and training. The Florence course was specifically targeted at experienced doctors and nurses from neonatal intensive care units in Europe. In all 20 males, and 22 females (15 nurses, 26 physicians, and one statistician) from 12 different countries participated. Five came from outside Europe (one from Canada and four from the USA). Funds to support attendance for both participant staff (16 junior fellowships) and faculty were made available by the programme for Training and Mobility of Researchers (TMR) of the European Union. We are aware that substantial funding for teaching of this kind may be the exception rather than the rule. We believe, however, that the main elements of our experience may be applied on
sented. More than half of the working time was
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participants to discuss the relevance of knowledge
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Who should teach?
There now seems to be general agreement that
teaching medical ethics should be an interdiscipli-
ary activity. Experienced health care professionals
and persons well trained in the humanities are
required. The ideal is to have courses involving both groups of professionals as teachers in the same
lecture or seminar. This, in our opinion, is
important when teaching undergraduates, but especially desirable with reference to experienced
staff. The faculty of the Florence course included
well-known researchers and experts with different
professional backgrounds: health care (epidemiol-
ogy, neonatology, and obstetrics) and medical eth-
ics (philosophy and theology). The teachers came
from different European countries (Italy, the Neth-
erlands, Spain, Sweden, and the United Kingdom),
thus emphasising the relevance of cultural back-
ground.

What methods should be used?
There seems to be general agreement that a variety
of methods may be used in teaching medical ethics.5
The choice of focus, however, is more controversial.
Should teaching start with practical activities and
only use principles and theories as illuminators of
the problem at hand,6 or should it proceed from
ethical principles or theories to practice?7 We
believe that the two approaches not only could, but
also should, be combined. Thus, the Florence
course had three main objectives. First, we
provided the participants with knowledge of the
main principles and theories of ethics. Second, we
presented cases for identification and analysis of
ethical issues. And third, we encouraged the
participants to discuss the relevance of knowledge
about principles and theories when trying to iden-
tify and solve the ethical problems in the cases pre-
presented. More than half of the working time was
devoted to the presentation, analysis and discussion
of clinical and research cases. This was preceded
each morning by two introductory lectures review-
ing the theoretical foundations and the basic
principles of medical ethics.8,9 A guest lecture in the
late afternoon opened the theme of the day to
personal views and ethical issues as debated in dif-
erent European countries. The main focus of the
course was the case-based approach, as inspired by
casuistry, i.e. “the method of analyzing and resolving
instances of moral perplexity by interpreting
general moral rules in light of particular circum-
cstances”.10 Another source of inspiration was the
case method developed at the law school of
Harvard University, USA, as early as 1870:8

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**Table 1: The structure and content of the Florence course**

<table>
<thead>
<tr>
<th>Day</th>
<th>Foundations</th>
<th>Principles</th>
<th>Case-studies</th>
<th>Evening lecturers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Why care about consequences?</td>
<td>Beneficence and non-maleficence</td>
<td>Extreme prematurity from induced abortion</td>
<td>Euthanasia and the newborn</td>
</tr>
<tr>
<td>2</td>
<td>Free will and responsibility</td>
<td>Autonomy and respect for person</td>
<td>Intensive care in a situation of fatal disease</td>
<td>Fetuses, newborn and parenthood</td>
</tr>
<tr>
<td>3</td>
<td>Can justice be justified?</td>
<td>Non-discrimination and solidarity</td>
<td>The Arthur case</td>
<td>Priorities in health care</td>
</tr>
<tr>
<td>4</td>
<td>To generalise or not to generalise?</td>
<td>Free time</td>
<td>Fetus/infant in research</td>
<td>The role of prognostic uncertainty</td>
</tr>
<tr>
<td>5</td>
<td>The relevance of ethical theories</td>
<td>Free time</td>
<td>Free time</td>
<td>The EURONIC-project: end-of-life decisions in neonatal medicine</td>
</tr>
</tbody>
</table>

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A CLINICAL CASE

**The story:** A 23 weeks pregnant woman was
referred to a tertiary medical centre. She and her
partner required the interruption of pregnancy
because of a perinatal infection with an esti-
mated 5 to 10% risk of the baby developing a
severe multisystem disease with brain involve-
ment. The interruption was carried out. How-
ever, as the baby appeared alive, according to the
law of the country he was intubated and admit-
ted into the neonatal intensive care unit. The
parents said they did not intend to accept this
baby, and would never come to see him.

**The outcome:** During the following days,
despite full intensive care, the baby’s condition
deteriorated. He developed a severe hyaline
membrane disease, seizures due to a bilateral
intraventricular haemorrhage, and anuria. Eventu-
ally he became comatose. A decision not to
resuscitate him was made. The baby died at six
days of age.

**Assignment for the group work:**
1. Identify the relevant ethical issues posed by
   this case.
2. Choose one issue for ethical analysis.
3. Identify the two most relevant options.
4. Identify the pro and con arguments.
5. Assess the arguments and make a choice.
students were asked to work on real judicial cases rather than simply memorising legal principles and discussing hypothetical situations. This method quickly spread to most of the US law schools, and to other disciplines as well. In the Florence course, each day the coordinators took it in turn to introduce a case in the plenary session. Three clinical cases were presented (one is presented in figure 1). The participants where then divided into four groups, balanced in terms of gender, nationality and professional roles. Each group had to examine the case, and choose one issue for analysis. Second, they had to identify the most relevant options (for example, continue or withdraw life support) and to list the arguments, both pros and cons. Third, they had to assess the arguments and try to come to an agreement regarding action, if necessary by voting. In dealing with the two research cases (one is presented in figure 2), a different scheme was used. Four participants, one from each group, formed a “research ethics committee” questioning the “principal investigators” (played by the course coordinators) about their research project in order to decide whether to give their approval, if necessary after changes.

At the end of the Florence course, the participants received a standard evaluation questionnaire provided by the TMR programme. A large majority considered their knowledge in the field after the event to be substantially higher than before. From the perspective of the organisers, the contributions from the participants, with their high level of competence and motivation, proved to be highly relevant. They represented a qualified group of professionals. Many of them had teaching responsibilities, significant research experience, or were running large and busy neonatal intensive care units.

Concluding remarks

The key features of this course in medical ethics for experienced staff were the interdisciplinary approach, and working in small groups with realistic cases. Confronting these cases, the participants brought into the analysis their own background and previous knowledge. The final selection of one course of action was particularly important because it required them to commit themselves and accept responsibility for their choice.

In principle, the casework can be carried out individually. It is, however, much more interesting, fruitful and fun when done through small interdisciplinary group discussion. In this way the participants may benefit from each other's knowledge, and experience the advantages and the difficulties of medical ethics as an interdisciplinary endeavour, as it is (or certainly ought to be) in actual practice.
Clinical areas other than neonatal intensive care may benefit from the case-based approach used in the course. We wish to emphasise, however, that this method should be applied to mixed groups of clinical specialists working in the same field rather than to groups of nurses or physicians in general. Success in fact largely hinges—as in this course—on extensive and in-depth interaction between all participants, which becomes possible when most of them share the experience of closely similar clinical and ethical problems (figure 3).

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