Editorial

Medical ethics education

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There has never been much doubt that medical ethics in Dunstan's sense of 'the obligations of a moral nature which govern the practice of medicine' (1) has been an important part of medical education for at least two and a half thousand years. But in a second sense of medical ethics – philosophical or critical medical ethics (2) – the subject is very much a newcomer to medical curricula, with the pacesetters having been mostly in the USA over the last twenty years or so. During that period this new-fangled philosophical or critical study of medical ethics has been viewed with considerable suspicion by the medical profession, more so in Europe than America. Increasingly, however, its importance has been recognised, albeit sometimes reluctantly, and now in Britain the barriers are being cautiously dismantled.

In 1984 the General Medical Council held a conference on medical ethics teaching (without however distinguishing explicitly between the two types of teaching) (3). In 1986 the British Medical Association (BMA) called for all medical schools to provide identifiable, substantial and 'non-dogmatic' teaching in the medical curriculum 'devoted to the ethical and legal aspects of medical practice', with the context making it fairly clear that the BMA meant critical medical ethics (4). Earlier this year an Institute of Medical Ethics Working Party Report – the Pond Report – recommended the active development of medical ethics teaching in Great Britain, stating that the longstanding medical norm of teaching and promoting professional standards should be supplemented by medical ethics teaching in the second sense of 'rational argument about ethical questions' and 'the study of ethical or moral problems' arising in the practice of medicine (5).

The Pond Report was based on the deliberations of a multidisciplinary working party of 19 members of whom 10 were doctors (including two medical school deans, a past President of the Royal College of Physicians and the erstwhile Chief Scientist to the Department of Health and Social Security), two nurses, four clerics, one a lawyer, one a philosopher and one the deputy health service commissioner. The group deliberately did not propose a model curriculum, arguing that local conditions and curricula varied greatly and that experiment and innovation

were needed, with reassessment of developments after a further five years. However, the report recommended among other things that throughout medical training 'time should be set aside within existing teaching for ethical reflection'; that such teaching should normally begin from clinical examples, and should be 'exploratory and analytical rather than hortatory'; that small-group discussion was necessary, as was critical reading; and that some form of compulsory assessment was needed 'to verify that students are able to think critically and logically about ethical issues in medicine in the light of counterarguments to their own position'.

The working party also made several recommendations which its members believed would promote the success of such medical ethics teaching. These included the need for careful planning of courses, not forgetting consultation with those who already had had experience of such teaching and selection of teachers who were specifically interested in both ethics and medicine. 'Ideologues' were a particular menace: 'Care should be taken to avoid leaving ethics teaching in the hands of a teacher whose tendency is to promote a single political religious or philosophical viewpoint . . . even some lawyers or philosophers may not always be as even-handed as their profession suggests'. The report comes down firmly in favour of multidisciplinary teaching. Interested medical teachers are encouraged to undertake further study of medical ethics through appropriate courses and/or to involve themselves in co-teaching with non-medical teachers from the 'analytic disciplines' of moral philosophy, moral theology and law, as well as with nurses, social workers, chaplains and other medical-related professionals and also with 'representatives of articulate and considered lay opinion'. Finally the Pond Report points out that although it is primarily concerned with medical ethics education for medical students, postgraduate medical ethics education is also very important and it recommends further assessment of this area of medical ethics teaching too.

The several papers in the medical ethics education symposium in this issue of the journal offer examples of different ways in which the critical medical ethics teaching recommended in the Pond Report is

beginning to be developed in England, Scotland, Wales and New Zealand. They tend to reinforce several of the themes running through the Pond Report. Perhaps the most obvious is the need for medical ethics teaching to be firmly based in clinical practice. All the courses described in the symposium lean heavily on clinical examples of medico-moral dilemmas (and, in the case of the King's College MA course, also on examples of legal cases based on such dilemmas – an approach also recommended in the legal appendix to the Pond Report and by the BMA resolution).

The second theme to be reinforced is the multidisciplinary nature of the courses, whether they have been initiated from within the medical faculties (as at Glasgow, Barts and the London, University College, the Middlesex and the Whittington and Otago) or from other faculties (as with the King's, University of Wales and Manchester courses). The message seems to be that it does not much matter where the idea for the course originates but that interdisciplinary co-operation is vital. A third common theme is the need to respond to student interest – a requirement particularly strongly emphasised in the papers by Downie and Calman, and by Southgate, Heard, Toon, and Salkind.

A fourth theme is that examination or some form of assessment is required in some but not all the courses. This is a contentious matter: examination or other forms of assessment in relation to medical ethics teaching are particularly likely to be rejected by medical teachers who have not had experience of ethics teaching and who assume (a) that it cannot be taught and (b) that if it can be taught it is largely a matter of discussion, debate and opinion and so not amenable to being examined. In their different ways the Pond Report and most of the contributors to the symposium argue that medical ethics can and should be examined or assessed and that in such assessment it is not 'the bottom line' – *The Answer* – to a medico-moral problem that is the target so much as the reasoning used to justify a candidate's medico-moral conclusions in the light of counterarguments. The papers suggest several different ways in which such assessment can be achieved.

The most important reason offered in support of assessment seems to be that lack of assessment or

examination immediately signals to the students that the subject is not thought to be as important as those other components of the medical curriculum which are examined. Even if the students themselves believe medical ethics to be important there is an obvious and powerful temptation to concentrate on examinable subjects at the expense of work on those which are not. Although the Pond Report, like most of the contributors to the symposium, comes out in favour of examination or assessment this is likely to be a much debated recommendation (and it is interesting to note that the philosophical appendix in the Pond Report on balance opposes examinations on the grounds that these will make medical ethics 'just one more thing to learn up, and this might not be conducive to the kind of thought we would hope to encourage').

A new series: papers invited

Critical or philosophical medical ethics teaching is just beginning to take off in Britain and also in other countries in Europe and the Commonwealth. Much careful experiment and mutual learning will be needed to develop successful approaches. One source of important information in this area is the United States and much could be learned both from its successes and its failures in the very extensive experience of medical ethics teaching now available across the Atlantic. This journal will welcome short submissions for a new intermittent series on the teaching of medical ethics; the intention is to provide a national and international exchange of ideas about which ways of teaching medical ethics work well – and which do not.

References

- (1) Duncan A S, Dunstan G R, Welbourn R B, eds. *Dictionary of medical ethics* (2nd ed). London: Darton Longman and Todd, 1981: xxviii.
- (2) Anonymous [editorial]. Two concepts of medical ethics. *Journal of medical ethics* 1985; 11:3.
- (3) *Journal of medical ethics* 1985; 11: 5–41.
- (4) Minutes 337 and 338. Resolution of British Medical Association Annual Representative Meeting, 1986. London: BMA, 1986.
- (5) Boyd K M, ed. *Report of a working party on the teaching of medical ethics* – Chairman Sir Desmond Pond (*The Pond Report*). London: IME Publications, 1987.