Teaching old dogs new tricks—a personal perspective on a decade of efforts by a clinical ethics committee to promote awareness of medical ethics

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Abstract

To incorporate medical ethics into clinical practice, it must first be understood and valued by health care professionals. The recognition of this principle led to an expanding and continuing educational effort by the ethics committee of the Vancouver General Hospital. This paper reviews this venture, including some pitfalls and failures, as well as successes. Although we began with consultants, it quickly became apparent that education in medical ethics must reach all health care professionals—and medical students as well. Our greatest successes came in the formative years of a medical career (ie, in medical school and residency training programmes), but other efforts were not wasted, particularly among nurses and other health care professionals.

Although this is a personal review of the experience in one institution, the lessons learnt in Vancouver are applicable to the further development of medical ethics in the UK.

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Some 12 years ago, a small group of people sat contentedly in a meeting room at the Vancouver General Hospital. They had originally been called together from various disciplines to develop a policy for the hospital on cardiopulmonary resuscitation (CPR), specifically on “do not resuscitate” orders. The work was complete, and the final document was now ready to go to the hospital board for ratification and implementation. For its time, the document we had prepared was quite radical. It was developed through our own discussion of the issues, through review of the literature and with outside help in dealing with ethical issues and concepts. At that time there was no medical ethics committee in our hospital, but we received valuable instruction and guidance from the ethics committee of the local children’s hospital (which even then was well established). This aspect of the process was a revelation to me, and I think to others of our group. Although I had been practising critical care medicine for more than a decade, this was the first time I had been exposed to the systematic analysis of clinical problems based on a thorough review of the relevant ethical principles. Not only

had the process proved to be very rewarding, but it had resulted in an excellent final document—clear, practical, based on the current literature and solidly defensible on ethical grounds.

Our confidence was well founded, for the policy served the hospital well for a number of years before needing revision. On the other hand, our attendant euphoria was short-lived, for we soon came face to face with an important practical issue: how could we, or should we, get acceptance of our document? Excellent though it was, it was based on ethical principles with which most members of our medical staff were unfamiliar. How, then, could it be understood, let alone acted upon, when its premises and foundations were unfamiliar to those to whom it was directed? Put another way how does one educate an ethically naïve clinical staff? Or, rather, how does one change the ethical climate of a health care facility from one of ignorance and suspicion (or even hostility) to one in which ethical principles are not simply understood, but are actually used to underpin hospital policies and to guide clinical decision making?

At this point I must acknowledge that things did not happen exactly as I have described. Nevertheless, the above scenario brings into sharp focus the educational task our nascent ethics committee (for that is what we became) had to face. The problem is a universal one, and arises whenever a new discipline or process is introduced into an environment of established practice. It will therefore come to light repeatedly around the UK as (hopefully) medical ethics becomes a more prominent part of life in the new National Health Service (NHS). It is arguable that any new clinical ethics committee will inevitably face the same problem as we did, and will, like us, need to educate its clientele on ethical issues. And this is no small problem.

Our original document on CPR was primarily directed at consultant physicians and surgeons. However, by its very nature, a cardiac arrest immediately involves other personnel (for example, nurses and junior doctors). Furthermore, our document advocated involving the whole clinical team in any decision to withhold CPR. For this to occur, all members of the team would need an equal understanding of the ethical principles underlying our document. Therefore, for ethical guidelines to be successful, it is apparent that the entire clinical

workforce must be taught medical ethics. At the Vancouver General Hospital this involved about five thousand people. Finally, it is also obvious that this educational effort will be never-ending unless medical schools and other training institutions change their curricula to produce ethically literate graduates. So, in response to an immediate practical need, we began a process that continues to this day in Vancouver. And now that I have relocated to the UK, it has started all over again in my local trust.

In what follows I have tried to outline some of the approaches taken in Vancouver to improve ethical awareness among clinical staff. The assessments and opinions are my own, and no doubt some of my colleagues would have a different perspective. No attempt has been made to review or analyse the literature, or to draw evidence-based conclusions, so this paper remains a descriptive account of attempts made in one institution to solve the practical problem outlined above. Certain lessons were learnt which, should prove to be applicable even across the Atlantic. (In this context it should be pointed out that Canada is not to be confused with the USA. Despite differences in detail, the Canadian health care system is based on the same general principles as the NHS.)

Consultants

Sadly, little progress was made with this group. It is hard to find a forum for consultants at which ethical issues can be presented and discussed. Medical staff meetings tend to be poorly attended and to be preoccupied with practical and political issues. Attendance at “grand rounds” is generally poor. We did arrange regular ethical sessions at medical grand rounds, but the results were predictable—medical staff were generally outnumbered by others (for example, nurses, physiotherapists and pharmacists), and among the medical staff junior doctors generally outnumbered consultants. In fact, many consultants rarely, if ever, attended such rounds. My brief exposure to grand rounds in the UK suggests that the situation is no different here. Therefore, trying to raise awareness of medical ethics among UK consultants by this route is no more likely to be successful than it was in Canada.

Specialty-specific rounds are potentially more fruitful. Generally there is better consultant representation at such rounds, but this is offset by the fact that each specialty-specific round is of interest only to its own consultants who make up a small fraction of the total number employed by the hospital. Hospital-wide ethical input can therefore be provided only if members of the ethics committee are able and willing to attend many such rounds in different departments on a continuing basis. Such a process is very time-consuming and inefficient as a means of general ethical education, but it does have the advantage of specificity. If a clinical case can be found which is relevant to the practice of that particular specialty group, it is possible to raise, review and discuss general ethical issues in the context of that case. This avoids two common problems. First, it is human nature (especially among highly trained professionals) to believe that

one knows more about a subject which is peripheral to one's own discipline than is actually the case. Thus, consultants may not attend a session devoted to ethics because they believe the material is already familiar to them. In this context, specialty rounds provide an opportunity to review and expand consultant knowledge of medical ethics indirectly, as a byproduct of discussing a relevant clinical case. Secondly, some consultants tend to believe that medical ethics is all right for others, but is not relevant to their domain. Once again, reviewing cases from their own practice can often highlight the relevance of ethical principles to that discipline.

Another relatively unsuccessful approach taken in Vancouver was to have the provincial medical licensing body sponsor an annual lecture series in medical ethics. Various prestigious ethicists came to Vancouver through this programme, and provided excellent and thought-provoking presentations in small group sessions as well as in formal lectures. The major benefit, however, was to the already converted, and there was not large attendance from outside this clientele.

Finally, national and regional meetings were considered as a forum for providing ethical education to consultants. At first sight, this approach appeared successful (ie there was a room full of people and the feedback was positive). However, closer examination was less encouraging. Attendees were generally few in relation to the total registration at the meeting, and the audience was primarily drawn from those who were already interested in medical ethics. Medical ethics is not a glamorous discipline. Unfortunately, since many meetings have multiple parallel sessions, the latest medical advances generally take precedence over ethical sessions.

Although I am definitely jaundiced about the overall success of our attempts to provide our peers with ethical tools to use in practice, not all our effort was wasted. While certain individuals and groups were uninfluenced by our activities, there were others who became conversant with ethical principles, and used them in clinical decision making at the bedside. Over time, such individuals exerted a profound influence on the culture of their own clinical area. Because they acted as role models, promoted better team interactions in their discipline and brought ethical principles into the clinical arena, slowly but steadily their colleagues came to accept and use ethical principles, even though this process happened unconsciously and by osmosis.

Junior doctors

Since junior doctors will become tomorrow's consultants, it is logical that educational efforts in medical ethics should be focused on this group. In our experience this tactic proved to be not only logically sound but also rewarding.

On the whole, Canadian junior doctors are keen to learn during their residency training programme. The Royal College of Physicians and Surgeons of Canada has encouraged a positive attitude to instruction in medical ethics by ensuring that this subject is included in the objectives for training of all major disciplines. Further reinforcement comes from the college through its requirement for regular

in-training assessments which, in turn, contribute heavily to the final assessment of eligibility to sit the (exit) examination for recognition as a consultant. In this system, one has the triple benefit of a “captive” audience which has an incentive to learn and also has protected time for formal teaching within a defined curriculum. If, in this context, trainees are encouraged to select a problem case from their own experience, and to analyse the ethical issues involved, one has all the makings of an excellent educational experience in medical ethics. A number of clinical areas, including our intensive care unit, incorporated such sessions in their regular teaching programmes for junior doctors on rotation through their area. This not only allowed such trainees to understand and participate in the discussions of ethical issues which regularly took place at the bedside in such clinical areas, but it provided them with a solid grounding in biomedical ethics to take back to their own discipline. This process was time-consuming, repetitive and sometimes very dull, but it did, eventually, produce a cadre of ethically informed residents who, with the passage of time, formed a cadre of ethically informed consultants.

Medical students

Clearly, the education of junior doctors in medical ethics would be greatly simplified if they were already familiar with this subject when they graduated. As the major teaching hospital for the Faculty of Medicine of the University of British Columbia, the Vancouver General Hospital was in an excellent position to further the teaching of ethics to medical students. We were also fortunate in having on our committee a number of faculty members who were not only well versed in this subject, but who also had the position, energy and drive to promote the incorporation of medical ethics into the medical curriculum. Arguably, this was our most successful venture in promoting medical ethics within the medical community.

Our ethics course was in two parts. In the first year, before any exposure to clinical medicine, students were given a brief introduction to the principles underpinning ethical decision making. This was reinforced by a series of small group tutorials in which students were asked to apply those principles to stylised clinical situations. Obviously, their conclusions were often “black and white” and untempered by clinical experience, but at least they were working through issues such as consent, autonomy, withholding/withdrawing active treatment etc. Furthermore, this ethical background was available to them from their first clinical encounter onwards. This ethical teaching was reinforced in the final (4th) year, just before the students began their “clinical clerkship” (a kind of junior house officer role). This time the course had a more clinical emphasis. For example, one session was devoted to death and dying, while others dealt with various aspects of ethical decision making in clinical practice. Once again, the formal teaching was backed up by a series of structured small group

sessions in which real (and often difficult) clinical situations were discussed in depth with a tutor.

This approach to undergraduate education in medical ethics was very costly in terms of the number of instructors needed and the time involvement required of them. On the other hand, this was also one of its great strengths—students learned that ethical decisions do not come by rote, but are honed through group interactions. By discussing with their peers and tutors, they not only processed ethical principles, but they also learned the value of multiple inputs and perspectives. They also discovered that, in the end, there is often no single right answer.

Obviously, other places in Canada took a different approach to teaching medical ethics to medical students, junior doctors and consultants. Our approach is certainly not the only one possible, nor is it necessarily the best—but it does show what can be achieved, in a fairly short time, in one institution, by a committed and enthusiastic team.

Other health professionals

We soon discovered that nurses, physiotherapists, social workers and other health care professionals were keen to learn about medical ethics and to participate in clinical decision making with this knowledge. Our document on CPR advocated a team approach to this issue, and was therefore welcomed in areas where teamwork was already well developed. Furthermore, nurses in particular had structured programmes in place for career development and the maintenance of skills and knowledge. Thus a suitable infrastructure already existed for the promotion of medical ethics. Added to this, our ethics committee was fortunate to have as a member a clinical nurse specialist who had completed a master's degree in medical ethics. The rest, as they say, is history.

However, it would not be fair to suggest that this tide of enthusiasm for medical ethics among other health care professionals was attributable only to the medical ethics committee. Perhaps more than the physicians, these groups recognised both the utility of ethical principles in clinical practice, and the need for a common currency with which to conduct team discussions on ethical issues. They were keen to participate in the latter and therefore recognised the need to become conversant with the former. Ethics therefore became a regular part of their continuing education efforts, both in the hospital and outside it (for example, in regional and national conferences). It appears that if the climate is right, and the benefits are apparent, all it takes is a kick-start to initiate a self-perpetuating process.

Hopefully medical ethics will quickly develop in the UK over the next few years. All it takes is local ethics committees to seize the available opportunities, and to provide the support and drive necessary to bring medical ethics into the centre of the clinical arena.

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