Teaching medical ethics: University of Nijmegen, The Netherlands

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Abstract

During his internship the medical student often feels a basic need for ethical discussion. The department of medical ethics at the University of Nijmegen offers a monthly discussion in single clinical departments. The ethicist is then assisted by staff responsible for guiding the interns. These discussions, based on daily experience, aim at critical evaluation of ways the profession is being exercised. As such they form an essential counterpart to the more theoretical learning in classrooms and seminars during previous years. The method is rather flexible. Either an inventory of problems is made, followed by a selection and discussion of one problem. Or a discussion is initiated by an introduction by either staff or ethicist. The actual programme and its origin, the objectives and some of the problems of such a programme are presented in this article.

Medical ethics in the new curriculum

As of September 1977 the Faculty of Medicine of the University of Nijmegen (The Netherlands) introduces the final year of a revised curriculum that began in 1972. From the very beginning this programme held the institutional structuring of Medical Ethics an integral part of medical education, throughout graduate and postgraduate formation. During the final year medical ethics is called 'professional experience and ethics'. As a programme it originated from an experiment over the past two years, during which informal tests took place in three departments, *viz.* pediatrics, obstetrics-gynaecology, and psychiatry.

Within the total programme of Medical Ethics (see Table 1) these monthly discussions (of 1 to 1½ hours) have helped the intern to focus on the moral implications of this first practical experience within the profession. Thus, from about the middle of the 10th up to the end of the 12th semester the programme is being offered in six departments, *viz.* internal medicine (24 interns during 12 weeks), pediatrics (9 interns during 6 weeks), neurology (6 interns during 6 weeks), psychiatry (9 interns during 6 weeks), surgery (10 interns during 12

weeks), and obstetrics-gynaecology (12 interns during 12 weeks).

Origin of ethics for interns

Although the interest for ethical discussions among faculty and students is as old as this university, the proper format and structured curriculum of medical ethics for interns sprang directly from a recent experiment.

Within the revision of the total curriculum the department of medical ethics was allowed the test of a programme for interns in three departments. These were pediatrics, obstetrics-gynaecology, and psychiatry, and the test started in 1975. It was agreed from the very inception that the need of interns is of such a specific nature that it cannot be fulfilled save within the very department in which the intern works. Therefore, no effort was made to bring all interns of all departments together for some general meeting. If an intern faces the issue of medicine within a given work environment, he should also be given the opportunity to express, discuss, and solve the problems within that very same context. Hence the focus on separate discussions of ethical questions as interns experience them within each individual clinical department. Discussions become more realistic through this well determined albeit limited approach.

The Report to the Programme Committee of the medical school mentioned some observations of importance.

- 1) The commitment of the departmental faculty plays a major role in the success of the programme. Not only the organisational aspect but more so the attendance and performance of interns reflect the general attitude of staff towards ethical discussions in their daily practice.
- 2) Another major insight concerns the qualities of the programme. Flexibility in topics and methods ought to be a prime quality of this ethical training. In this respect the programme may be compared to the clinical case conference. It is a total misconception to think of the ethical discussion as the quiet hour for contemplation, away from it all. On the contrary, like the clinical conference this conferral of ethics and experience is only a moment of reflection within all that is going on.

Table I *Ethics in revised medical curriculum at the University of Nijmegen*

Year	Semester	Class-room* teaching & lectures	Seminars	Microsym- posia and/or chapter in codex†	Discussion of practical experience	Individual scientific stage	Means of evaluation
I	1			Human sciences and Philosophy (Symposium) 4 h			
	2						
II	3						
	4	Basic notions of Ethics 9 h	3 Seminars each 12 h	Medicine and Society (I) 4 h			Essay-exam on Course/Group Eval. on Semin.
III	5	Ethics and Sexuality 5 h		Chapter on Sex			Essay-exam
	6			Respiratory Diseases 4 h			
IV	7						
	8			Team-teaching: prenatal diagnosis muscular dystrophy			
V	9	Medics and Ethics 12 h		Medicine and Society (II) Confidentially			Essay-exam
	10					3 months in Dept Ethics	Report and evaluation of stage
VI	11			Professional Experience and Ethics 20 h			
	12						

*All lectures and microsymposia are part of integrated block-teaching

†A micro- or minisymposium is presented by all members of one integrated block. It usually fills four morning hours, the last of which is reserved for plenary discussion. In some blocks the Department of Ethics contributes through writing a chapter for the students' textbook (Syllabus) which is revised yearly and printed by University Duplicating Services.

Objectives

The two years of experimentation in three clinical departments enable one to realistically describe both general as well as more specific objectives.

GENERAL OBJECTIVES

By general objectives are meant the goals of the entire medical ethics programme which are (also) being achieved through this final programme of 'professional experience and ethics'. One such major objective is to teach students *how to work with theoretical knowledge within a practical situation*. The department of medical ethics believes that practical discussions constitute an integral part of all theory. While this may still sound trivial to anyone who believes that all knowledge should serve a purpose, it should be pointed out that practical purposes also influence theories, both while these are being formed as well as when they are being

applied. Thus, *a constant inter-change between theory and practice* is the cognitive skill aimed at through this programme. It is considered more important than the one way traffic from theory to practice in the so-called useful application.

In passing it should be noticed that medical ethics in this respect joins one of the basic goals of the whole revised education programme in the Medical School of the Nijmegen University, *viz.* 'integration of the theoretical instruction'.¹ Sub-objectives of this goal of problem-solving are the well known ability to identify, weigh, collect elements for solution, and finally develop a strategy towards the solution of the problem.

A second general objective is to confirm the student's need for *continuing moral education*. Since the ethical debate will prove to be an ongoing feature in later daily practice, there is no better introduction than by handling this facet of real life where and

whenever it occurs from the very beginning of the intern's experience.

SPECIFIC OBJECTIVES

By specific objectives are meant the goals of this particular part of the Medical Ethics programme. The first somewhat comprehensive formula which comes to mind is: to teach interns *how to clarify and orderly structure all components of decision-making in medical practice*. Several steps towards such clarification may perhaps be described as sub-objectives of the programme 'professional experience and ethics'.

What K D Clouser described so well as *sensitising and structuring*² of issues constitutes, no doubt, the first step of ethical awareness and competence the intern should strive for. Clouser sees these activities as the two roles of medical ethics in general. Yet, it seems quite plausible to consider them, within a programme of education, as the gateway toward clarifying decision-making in medicine. One important aim at this point would be to *avoid moralising*. This means that problems of a technical nature ought to be looked after with technical means only. Undue moralising occurs when in order to prevent a rupture of the uterus, final contraception is ethically approved of through hysterectomy but disapproved if done through laparoscopic sterilisation.

Another specific sub-objective flows from the general objective about the necessary *interplay between theory and practice*. If previous lectures and seminars have helped the student to know and recognise ethical theories, then the discussion at this first confrontation with practice offers the intern *an exercise* in both applying and testing, possibly revising, ethical theory and conviction. As breathing and heartbeat are vital to our life so is the interaction between theory and practice for all sciences. A purely theoretical ethics is irrelevant to the physician as physician. Yet, a purely practical ethics is degrading to the physician as person. Nevertheless, both varieties of ethics are sold on many market places.

Thirdly, the programme aims at teaching the intern *how to enter the ethical forum where opinions and actions are being challenged*. The very term 'ethical forum' suggests areas where dialogue and justification occur. While debating with one's own conscience, while arguing in the inside circle of colleagues, or in the semi-public meetings of health organisers, and certainly in the public policy debates of health care, the physician has the floor of this ethical forum. In order to contribute to such dialogue the intern ought to learn *how to objectify his own ethical experience in terms of structures, values, decisions, policy*. Whereas such ability to objectify was always important, the need for it has become, nowadays, an integral part of medical practice. The days of autonomous clinical decision by doctors only

are rapidly fading. Patients and laymen alike are invading medical decision-making.³ The clinical view has, thereby, been reduced to just one among other basic viewpoints to be considered.

A fourth and final specific objective of the medical ethics programme is to teach the intern that *it is right to decide with as much (or as little) information as is available at the time*. Medicine, perhaps more than any other field of human enterprise, has to be ready and willing to run risks. Clinical absolutes do not exist. The information, if not scarce, is very often limited. And very often there is no time to postpone the intervention. Clinically, it is considered normal that some consequences are unknown, unforeseeable, hence unintended. But then, if the ethical quality of a decision relies upon previous clinical information, how could one expect the ethicist to offer certainties which medicine was unable to give? Like physicians, the ethicist takes part in the quest for good medicine. If conditions of uncertainty are an integral part of most medical action, they also are a part of the moral dimensions of that action.

The actual programme: method and topics

The interns of the six departments mentioned in the introduction, come together once every month for a session of 1 to 1½ hours. Since the programme for interns runs without interruption, so also does the 'professional experience and ethics'. They take place all year round.

METHOD

During the experimental period two slightly different methods were tried. Since they can easily be combined it has been decided to maintain them both, for the time being, as methods available to the discussion. The preference of staff, interns, or ethicist would remain decisive.

One method proposed by the ethics department, invites interns then and there to report recent cases which they feel contain ethical issues. Usually, between three and six such problem situations are reported. One of them is chosen either spontaneously because the topic is of obvious general interest, or through conscious determination of a topic which deserves priority. In a somewhat non-directive way opinions, judgments, critiques, justifications can be stated as long as they are ethically relevant. The participant is asked to show the relevancy of dubious material. If he fails to do this, the discussion is redirected to the point where it began to drift. The ethicist regularly summarises the arguments, and invites participants to weigh the importance of a given argument with regard to the case under debate. A final evaluation of both content and method concludes each session.

The second method was suggested by the staff of obstetrics-gynaecology. A member of the staff

Table II Interns in pediatrics

Problems listed (during 18 sessions)	Mentioned	Priority
1 How much should parents (child) be told, <i>especially</i> about leukemia?	5	5
2 To what degree may doctors decide for their patients?	2	1
3 Hospitalising children: to serve health or humane existence?	1	1
4 Does it make sense to treat a child in coma?	2	2
5 Justification of prenatal diagnosis, possibly advice for abortion?	1	0
6 How does one give genetic advice?	1	0
7 Limits of university hospital in burdening children with research?	4	3
8 Should doctors interfere with families in curing children?	2	0
9 How much do our social, religious prejudices influence medical attitudes?	4	0
10 What if parents (Jehovah Witness) refuse treatment (blood)? Or go to a quack?	4	4
11 Who is ultimately responsible for children: parents, doctors, judges?	1	0
12 Criteria for vital corrective surgery in infants: surgery on mongoloids?	3	2
13 What can a doctor do for a dying 16 year old?	1	1
14 How to avoid shocking arrangements for autopsy?	2	2

would briefly outline a recent case and its allegedly ethical components. Participants are then invited to discuss the case. In fact, save for the specific introduction, these meetings follow the very same pattern as mentioned under the first approach.

TOPICS

As for the topics, it is noteworthy though perhaps quite natural, that each group of newcomers mentions the same specific problems. This may among other things, prove their sensitivity and perception, and/or the presence of a serious issue. Since the widest information of our Ethics for Interns programme originates from Pediatrics, the following list of problems, their frequency and their priority as topics for discussion may illustrate the point just made. (see Table II).

This and similar surveys should allow the department of Ethics to detect specific issues as well as specific needs of interns in a given clinic. Furthermore, it is to be expected that other departments will provide their own specific field problems and corresponding ethical issues. Thus, internal medicine will regularly have to face the issue of transplantation.

Problems

During the experimental phase but also after the official institution of an ethical programme for interns, it remains to be seen how the staff of different departments will cooperate. Some authors have already dealt with this question in a general way.^{2,4}

More specifically within a programme of Ethics for Interns the contribution of clinical staff is essential. If an intern fails to read a clinical situation correctly, which ethicist is going to rectify this error and prevent false ethical interpretations? During the experiment an intern once wrongly

quoted a letter, thereby triggering an irrelevant discussion which lasted until a latecomer of the staff rectified the false information. In this case unnecessary moralising and ethical dramatisation could not be prevented save by clinical staff.

Furthermore, the moral sensitivity of teachers and clinicians obviously affects the interns' approach to ethical problems. Positively, they are a most effective incentive for interns to sit and think, to discuss action taken or to be taken. On the other hand, where such incentive is lacking – be it because of basic or partial aversion of staff and/or administration towards ethics – constructive and adequate discussion becomes much more difficult. Ethician and interns may laboriously walk a path which would be taken effortlessly with the participation of staff. Yet, since the interns feel that past programmes which did not provide Ethics for Interns would not answer their needs either, it is expected that the actual programme will satisfy their needs more adequately. Meanwhile, the department of ethics has to maintain a critical observation on developments in the near future. Especially the type of ethical case conference which will originate in different departments according to staff participation will be watched closely.

In passing it may be noticed that the ethical department prefers the clear situation of three distinct participants: interns, staff, ethicist. Each of them have their own competence even in the interchange of three fields. Therefore, the notion of 'competent amateur' (an ethicist with some medical training, or a medical doctor with some philosophical training), though surprisingly *en vogue* nowadays, does not appeal. True interdisciplinarity does not weaken field autonomy. It rather strengthens it.⁵

Another important educational issue is the evaluation of the student's achievement. One readily agrees with H Brody that well-written objectives ought to specify the means by which the

student is to be evaluated.⁶ There remains, however, a problem in this respect. Indeed, how can one judge formally whether or not an intern has profited from the monthly discussions in six departments over a period of 15 months, with an average of 1 to 1½ hours for each session? How does one check his problem-solving ability?⁷ Also, how does one evaluate his affective attitude towards ethical components of a given situation? Even the rather informal evaluation through an 'essay' will hardly allow for clear and final judgments.

Perhaps it is, after all, a good thing that all formal examination of this final phase is abandoned in the ethics programme. In an informal way attendance, performance, interest, participation and feed-back may possibly be signs of the value interns see in this programme. Since this phase of ethical training is primarily geared towards entering a forum of exchange of ethical opinions and arguments, both intensity and quality of participation may show rather accurately how the training produces its own fruits. It, nevertheless, remains true that this is

not a well objectified way of evaluation, and that further procedures may be necessary.

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