One feature of the 1984 General Medical Council (GMC) medical ethics education conference published in this issue is the lack of differentiation between two quite different concepts of medical ethics. The sense of medical ethics relied on by many of the contributors is that quoted by both Professor Welbourn and Dr Law from Professor Dunstan's definition in the Dictionary of Medical Ethics (1): 'The obligations of a moral nature which govern the practice of medicine'. As Sir John Walton points out in his introduction to the symposium doctors have been taught medical ethics in this sense at least since the time of Hippocrates. The profession determines, in the light of such advice as it chooses or is obliged to consider, the appropriate moral principles and rules whereby it shall be governed, and then sets out to ensure that its members accept and implement these moral rules.

The most important techniques of such medical ethics education are - it is probably fair to say - 'socialisation' and 'role modelling'. Powerful psycho-social pressures are brought to bear on medical students and doctors in their pre-independent professional training to accept and to act according to the moral norms of the profession, of the specialty and even, in many cases, of the individual teacher (2). It is in this sense of professional moral obligations that medical ethics tends to be depicted in the various national and international codes of medical ethics and enforced by the GMC. To avoid begging any questions this sense of medical ethics might be called 'medical ethics 1' (it might also be called normative medical ethics, medical morals, or traditional medical ethics).

The second concept of medical ethics - call it 'medical ethics 2' - is a much newer arrival in medical education. Drawing heavily on the discipline of ethics proper, essentially medical ethics 2 (which might reasonably be called philosophical medical ethics or perhaps simply critical medical ethics) is the critical study of moral problems arising in the context of medical practice. It requires analysis of the moral reasoning which underpins any substantive medicomoral claim, including that of the underlying ethical theory, and it requires rigorous consideration of counterclaims and counterarguments. Central to medical ethics 2 is of course critical study of the content of medical ethics 1, including any avowed or implicit ethical theory in which it is embedded. The main techniques of critical medical ethics are intellectual, rather than psychosocial, and are based in rigorous argument and counterargument (not, incidentally, the same thing as 'heated discussion').

There can be little serious doubt that the medical profession has and must have special collective moral obligations, including an obligation to educate its members to accept those obligations and to ensure that they behave accordingly. However, there are strong arguments for judging such education to be inadequate if it fails to include critical scrutiny of these obligations (3). That is to say a full medical ethics education might not only furnish doctors with a set of moral obligations governing medical practice (medical ethics 1) but should also enable them critically to assess (at least at a basic level) such codes within the context of a variety of explanatory ethical theories, including their own and those which may be espoused by their patients and/or their colleagues.

While it may be plausible to argue as Professor Fentem argues in his paper that medical ethics 1 can be adequately taught by doctors without the assistance of outsiders who have had special training in critical ethics, it would be highly implausible (and indeed downright arrogant) to suggest that medical ethics 2 can be taught without any such expert assistance. One result of distinguishing these two concepts of medical ethics is that it becomes perfectly possible for the medical profession if it so desires to retain control over the teaching of medical ethics 1 without feeling that this is collectively thereby committed to rejecting the expert assistance of philosophers, theologians and others specially trained in critical ethics, both in teaching medical ethics 2 and in helping the profession to scrutinise rigorously the content of medical ethics 1.

References