

## GMC: Medical ethics education conference

# The teaching of medical ethics

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### Author's abstract

*Students at Newcastle are exposed to patients during their first week at medical school and attached to a family within the first month. The object is to sensitise them to patients as people rather than vehicles of disease. Medical ethics is introduced as part of the multidisciplinary Human Development, Behaviour and Ageing Course by a lecturer who shows a film which poses an ethical problem. At subsequent tutorials led by the Department of Family and Community Medicine's general practitioner lecturers the subject is discussed as ethical issues arise in the course of their work.*

Medical ethics is taught in medical school at Newcastle in the two pre-clinical years as part of the Human Development, Behaviour and Ageing Course. Students are exposed to patients in their first week at medical school, following the principle that the sooner the learner experiences the end-point of his studies the better.

A patient of one of the general practitioner lecturers in the Family and Community Medicine Department who is suffering from a common chronic medical condition such as stroke or rheumatoid arthritis, is introduced in the lecture theatre to the class. He or she is then taken through the history of his illness, by his GP, and then questioned by the students about how it affects his life. Within the next few weeks pairs of students are introduced in her home to a patient expecting a baby within the next three months. Her GP has explained to her the object of the attachment which is to teach students that medicine is about people. They may be ill or anxious or, as in her case, expecting a baby. It is not just about disease. Her job, we tell the expectant mother, is to help the students to treat patients as people and to be sensitive to their worries and fears.

The pregnant patients accept the task with enthusiasm especially when we tell them that we are trying to produce doctors who will respond to their patients' needs. This strikes a chord. Nearly all patients have, at some time or another, had experience of impersonal mechanical doctors. We explain that the

students will know much less about pregnancy than they do and point out that only two months ago they were waiting for the 'A' level results which got them into medical school.

When the students meet their expectant mother they talk to her about her feelings, her experience of previous pregnancies, her expectations of this one and her relationship with her GP and the midwife and health visitor. Sometimes the students actually attend the confinement if mother and father are willing and the students can be contacted in time. During this first term they attend lectures by obstetricians, paediatricians and psychiatrists about the physical and psychological development of the baby. They continue to visit the family for the whole of their first year and plot the baby's developmental progress on Denver charts. They learn, sometimes with surprise, but always with pleasure at the beginning of their medical career that they can communicate with patients and they describe their experiences at seminars and tutorials with their GP tutors.

In the third term of the first pre-clinical year medical ethics is introduced in a formal lecture about its principles. This is followed by two practicals in the first of which a film is shown of a neonatal paediatrician and one of the clinical tutors examining a baby with spina bifida. The extent of the deformity is demonstrated and its effect on the baby's function and development discussed by the two doctors. Possible options are put to the students. Should this infant be operated upon or allowed to die in the ward, or taken home by the parents to have palliative treatment when necessary? What is the parents' reaction to their baby's deformity. What ought to be said to them? An academic question so far. Then the question is posed to the assembled class: 'Put yourself in the position of the paediatrician you have just seen in the film. What would you say to the parents, who must decide their child's fate, remembering that most parents will rely heavily upon their doctor's advice? Any one of you might some day be the doctor in a similar situation. How would you deal with it?'

Open discussion is then encouraged in the lecture theatre during which viewpoints range from the belief that every possible operation ought to be done to keep the baby alive at one extreme, to the belief that the

### Key words

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child ought to be allowed to die at the other. Emotions aroused by questions and arguments within the lecture theatre are often heated. The students then break into their GP tutorial groups where the discussion continues. They have spent three terms studying normal pregnancy and childbirth over the past year and are suddenly confronted by a severely handicapped infant and one whose fate requires a decision. This is reality, not theory any longer. They are made to face a situation which cannot be solved by science. Why not? Medicine is a science, or so they have always been told, yet here is a decision which will depend on the emotional, religious and moral views of parents and doctors. It adds a new dimension to the study of medicine.

In the second pre-clinical year each pair of students is attached to a patient with a chronic disease whom they visit several times. Other ethical issues arise. The concept of the autonomy of the patient is one of them. Should not a particular patient be in sheltered accommodation? Ideally he should but he has always been a loner and resists all attempts to persuade him to leave his home. But his house is filthy and he abuses neighbours when they complain of the stench. They go to the social workers who call in the GP. Is there not a medical reason for this man's antisocial behaviour? The answer is no. Should he not be in hospital with that terrible cough he's got? His chronic bronchitis cannot be treated any better in hospital, and anyway he does not want to go there.

Patients raise the question of euthanasia. Some actually produce the formal declaration advocated by the euthanasia lobby. Others ask their GP not to resuscitate them if they have a heart attack or to

withhold antibiotics if they get an infection.

*In vitro* fertilisation seems likely to be a major issue next term.

Students realise that ethical issues are considerably easier in the abstract than in real life. The Roman Catholic who starts with absolute certainty that termination of pregnancy is always wrong begins to modify his opinion when faced with a 40-year-old woman or a 15-year-old girl asking for termination. The rational atheist begins to wonder if he isn't being too casual about the fate of an unborn child.

In the course of these two years the concept of the sanctity of life, absolute or relative, the autonomy of the patient, the rights of the unborn infant and other issues on which doctors have conflicting views, are discussed and seen not to be subjects for religious dogma or agnostic iconoclasm or emotions or prejudice. It is fascinating to watch the changes in individual students' viewpoints and the maturing of their attitudes to non-scientific issues.

What sort of medical ethics are we teaching or, rather, helping students to think about and discuss? It must vary with the bias of individual tutors. Mine is towards the ethics of society as expressed by Parliament, just as another's may be towards Roman Catholic dogma. Our aim is to encourage students to think about ethics and not necessarily accept traditional answers. We are conscious of our own lack of formal teaching in ethics and moral philosophy and some of us would like to broaden the teaching team by including moral philosophers, theologians and academic lawyers like Ian Kennedy who first publicly questioned the right of doctors to decide their own professional ethics without consulting those other people who are their patients.