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 sensitize 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 the 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 the 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 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 aetheist 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.