
Teaching medical ethics symposium

Teaching medical ethics to medical students and GP trainees

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Author's abstract

This paper relates two experiences of teaching medical ethics, the first to a small group of clinical medical students, the second to a larger group of GP trainees.

'Write something about how you actually teach medical ethics', said the editor persuasively. As my deadline approached, I began to regret agreeing. Besides being persuasive, the editor is daunting: both a philosopher and a real doctor, he believes that medical ethics should be taught rigorously, alike in its clinical and in its philosophical aspects. In my initial feeble attempt to resist his invitation, I had asked if Dr X might not be a better writer on the subject. The editor, rather tartly, had replied that he 'wasn't much impressed' with what the physician in question thought of as medical ethics teaching: not really philosophical medical ethics or even critical, just hints and tips to the chaps. But here I was, neither a real doctor nor yet a proper academic philosopher – just a theologian with some student and hospital chaplaincy experience, who from time to time was involved in local ethics sessions for medical and nursing students. And about to be exposed, just like the poor old sophists whom Socrates ran rings round.

Well, so be it. Just on the point of giving up, I was asked to take part in two ethics sessions, one with first-year medical students, the other with general practitioner (GP) trainees, both on the same day. If that was not what the editor had asked about, I doubted what else could be. What follows may not be what he wanted, but let me just write about it as it was.

Wednesday morning, 11.15 am. Eight first-year medical students are doing a project on infertility. It is called 'a problem-based learning project with clinical correlation', in other words something designed to give the students an early taste, amid the aridities of science, of what they came into medicine for – contact with patients. The projects, which may be on a great variety of clinical topics, are spread over the first and second terms: the students, in small groups, have some

seminars, interview patients and staff, read up on their particular problem, and present a report to the other students in their year at the end. 'It's very labour-intensive, you know', says the nice gynaecologist responsible for the group. 'Will you do a session with them on ethics?'

What are the ethical issues related to infertility? Fortunately I have been involved in the Institute of Medical Ethics (IME) study called *Life before Birth: a Search for Consensus on Abortion and the Treatment of Infertility*, just published. After the group and I introduce ourselves to one another, I get them to tell me what they have learned so far – some basic facts about the causes of infertility, the techniques available, counselling procedures, the chances of success. As this seems mostly to be about *in vitro* fertilisation (IVF), I decide to sketch in the background, the prehistory of the ethics of IVF: what Feversham thought about AID and AIH ('What's AIH? a student asks), back in 1960, how it never was officially organised, the questions about consequences for the couples, the children and society, the churches' misgivings about separating sex and procreation. Somewhere in all this I try to introduce ideas about rationality, personhood and the moral community. And so on to Warnock, surrogacy, embryo research.

Before this gets very far, the students are interrupting. Last year one of them was involved in a study related to the possibility of prenatal diagnosis of Huntington's chorea. This leads to a discussion of the ethics of positive and negative eugenics. How do we know what is best for individuals, for society? Maybe I get across a point about possible conflict between the doctor's concern for his particular patient (medical beneficence) and for society (justice). The students seem to see the difficulty. We go on – inevitably – to abortion. The students, as ever, are divided. 'Fertilisation is the only logical point'. 'But what about all the lost embryos, twinning?' 'It's very personal, your own belief.' Questions about the role of authority and of argument are discussed. There is no resolution. We go round and round the question of why fertilisation seems so crucial to some people and why others see life as a continuum. Is an embryo really a person? Is an infant? What are the criteria? I recommend a short reading list, dutifully written

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down: Mahoney's *Bioethics and Belief*, O'Donovan's *Begotten or Made?*, Warnock's *A Question of Life*, *Human Procreation* from the Council for Science and Society, the new IME report. Clearly, some of the questions we have discussed are new to some of the group. 'Is this our only session on ethics?' one asks. The project is flexible. I agree to meet them again before the end of term.

3 pm. Thirty or forty GP trainees. 'Perhaps you might introduce the session by saying something about Gillon's *BMJ* articles on confidentiality, consent and the Arthur case', the trainer responsible had asked. 'I've suggested they read them, but maybe they haven't.' I had agreed, provided the trainees themselves produced some examples of moral dilemmas or difficulties they had encountered. Introduced by the trainer, I summarise for ten to twelve minutes, mostly as requested, allowing only the odd brief cadenza of my own. All is based, I say, on the four principles, not abstract but reflecting 'generally held community ethical principles'. Traditionally medical ethics was all about not harming and doing good if possible (non-maleficence and beneficence): the new things for doctors to think about are respect for autonomy (being good for the patient and society as well as a right) and justice. Autonomy is a matter not just of thinking how you would feel if you were in the patient's shoes, but of how *he* feels in his. (One of the trainees repeats this later in the discussion *verbatim*.) If doctors' primary loyalty is to their patients, ought they to close ranks when their brethren cause medical mishaps, and ought they not to admit their own mistakes? And 'should we not build in to medical training and standards a requirement to be nice to our patients'?

There are a few sympathetic smiles, but also a lot of silence. A real doctor would cut more ice, I suspect. But I persist, having no option: Gillon's critique of the General Medical Council's eight exceptions to confidentiality, his suggestion that tact probably avoids a lot of problems, his counterarguments to medical arguments for overriding consent. I say my piece and the response is not hostile, but the audience only really gets going when the first of their number hauls out the overhead projector to present her case – about her misgivings concerning termination for a slightly feckless lady. Surprisingly, something I have said is taken up. 'Can I ask you,' says another trainee, 'since we are talking about consent, if you asked the patient whether you could discuss her case with us?' The point is made.

About half of the ninety-minute session turns out to be on abortion. The GP trainees – or those who are willing to declare themselves – seem as divided on the subject as the first-year students were, although even the firmest anti-abortionist admits being willing to prescribe the coil. I fly my own kite. Just because there is no point between fertilisation and birth (and maybe not those either) which logically marks a change in moral status, it doesn't follow that any relevant moral judgement is entirely relative, entirely personal. Exercising moral judgement means taking a variety of different kinds of moral argument into account, and while recognising their complexity, trying to be clear, comprehensive and consistent, albeit always fallible. If you prescribe the coil but pull out all the stops for the premature baby, at what point or stage does a second patient have a claim on the doctor? How much weight do you give to the stage of fetal development, the parents' attitudes, estimates of consequences and so forth? Might it not just be possible, over time, to agree on some more consistent public criteria than at present for making case by case decisions? It would be fairer to women seeking abortion, and might avoid some problems for doctors if such criteria were known. These suggestions have some, but not many takers. The trainees themselves reject the argument of one that viability is what counts because until then the fetus is dependent on the mother: basically the same argument, they point out, would allow infanticide.

The rest of the session is about breaking confidentiality in the case of a potentially dangerous patient and about how to deal with an adult schizophrenic whose parents have rejected him. I suggest that the latter might be regarded differently if the schizophrenic were rejected by a wife. This provokes some discussion of how moral judgements are coloured by cultural assumptions. But mostly, they argue, frequently getting pretty quickly to the nub of the relevant moral argument and sometimes picking up on the philosophical arguments heard (or perhaps read) earlier. One of the trainees gives a couple of entertaining mini-lectures on the finer points of medical law, some of these apparently unheard of by the others hitherto. One or two of the others sound a bit punitive. I would prefer to have one of the more sympathetic ladies as my doctor. 'Better than last year' the trainer encourages me afterwards. 'But then abortion always gets people going.'

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