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 years: 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

Key words

Teaching medical ethics.
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
don’t.’ I had agreed, provided the trainees
themselves produced some examples of moral
dilemmas or difficulties they had encountered.
Introducing 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
two 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
subscribe 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.

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.
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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of Medical Ethics.