

Teaching medical ethics symposium

A student-led approach to teaching

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Authors' abstract

It is increasingly agreed that ethics has a place in undergraduate medical education. There is, however, debate about how it should be taught, and by whom. We present our experience of teaching ethics in a general practice module over six years.

During this period there has been a shift from a teacher-centred to a student-centred approach in which students choose ethical issues to explore within a framework provided. The issues raised are discussed with examples, and the future directions of our ethics teaching outlined.

Introduction

There is increasing agreement amongst various sections of the medical profession – students (1,2), the General Medical Council (3), and the British Medical Association (BMA) (4) and from patient representatives (5) – that ethics should form part of undergraduate medical education. It is less clear who should teach this subject, what methods should be used, and where in the curriculum this should take place. Should teachers be medical or non-medical (5); should lectures or small-group teaching predominate (6); should it be a pre-clinical (7) or clinical subject; should it be case-based or start from general principles? Is ethics about the analysis of ethical problems or about treating patients as people (8) (or both)? Different medical schools have adopted different strategies (9,10) and the Pond Report (11) has recently called for a period of experimentation and evaluation.

We describe below the development of our teaching of medical ethics during students' clinical attachment to the Department of General Practice and Primary Care at the Medical Colleges of St Bartholomew's and The London Hospitals. We have been teaching ethics formally for six years in a half-a-day seminar, and more recently have shifted to a full-day seminar.

Which strategy?

Teaching strategies can be divided into three groups:

Key words

Teaching medical ethics.

didactic, interactive teacher-centred, and interactive student-centred. A didactic lecture or case presentation, whilst being an efficient forum for imparting facts, is relatively less useful in a philosophical area such as ethics where concepts and analysis of problems are central. A more interactive approach has great educational advantages.

If an interactive style is chosen, it may be based on material prepared by the teacher or by the student. Historically, we have shifted from teacher-centred to student-centred material. This shift has demanded a development in teaching techniques.

Teacher-centred strategy

When we began to teach ethics, we chose an interactive strategy, based on material prepared by the teachers. A series of scenarios involving ethical conflicts were prepared, and presented to the students for role-play. One student acted as patient, another as general practitioner, and the consultation was videoed. The way in which the 'doctor' tackled the problem was discussed in a small group; alternative strategies were considered and the ethical advantages and disadvantages of the various actions analysed.

This method interested the students, and allowed the teachers to define objectives clearly in relation to specific topics. They were then able to prepare information on the topics and likely areas of discussion. However, with the teacher deciding the topics and controlling the debate students often appeared to experience a sense of 'one-upmanship', and therefore rejected the 'answers' presented to them. Also, after a number of sessions on the same material, teaching in this way began to lose its freshness. The failure of this method to develop satisfactorily was marked by an increasing tendency to discuss interviewing skills rather than ethical issues. After two years we therefore introduced a separate interviewing skills course and adopted a more student-centred strategy for teaching ethics.

Student-centred seminar

In the first week of the module a sub-group of students are given the task of presenting at the ethics session in the final week. During the second and third weeks,

spent working in a general practice, they select one or more cases for discussion. They are provided with a brief introduction to medical ethics and a consequentialist framework for analysis (fig. 1) based on Brody's work (12).

Figure 1.

1. Perceive that an ethical problem exists.
2. List the possible courses of action.
3. Choose one course of action.
4. Frame an ethical statement which is generalisable in terms of:
 - a) The conditions under which the statement is to apply.
 - b) What is to be done.
 - c) Who is to do it.
5. List the consequences (both long- and short-term) if this ethical statement is accepted.
6. Consider the consequences in line with a list of personal values. (A list of 'moral values' is included in the handout.) If the statement is in line with personal values for all significant consequences then the statement is valid.

Teaching in this way can be difficult and challenging for the teacher, who does not control the session, but remains responsible for ensuring that the discussion is educationally valuable; it should neither become diverted into a sterile 'angels on pinheads' debate, nor become bogged down in the reiteration of entrenched positions. Techniques for advancing the discussion are necessary if it is not to generate more heat than light. Some of these are established methods of group leadership (13). Specifically ethical techniques are also valuable: changing the 'weights' in the case under discussion in a thought experiment, or breaking the problem down into rights and duties, or consequences, under the heading RIGHT and WRONG, GOOD and BAD. The following examples illustrate the types of material students have presented and the use of these techniques.

Results of a student-centred strategy

Certain issues recur in the cases the students bring – patient autonomy, confidentiality, allocation of resources and the sanctity of life are the most common. Sometimes the cases presented are instances of commonly discussed ethical problems:

Student A

'I saw two men dying at home of similar bowel malignancies. In one case he knew of the diagnosis and in the other case he did not. I was struck by the different feeling in the two houses. The man who was not told was depressed and his wife, who knew the diagnosis but insisted that her husband was not told, was very agitated.

'I would like to consider the ethics of telling people

they are going to die, and what rights the relatives have in this situation'.

This student initially believed that the relative of a dying patient had no rights at all. However, when asked about telling relatives the extent of the injuries received by a patient in a road accident she said that she would do so. Consideration of this apparent inconsistency led her to concede that patients' relatives may have some rights. A very fruitful discussion of how far those rights extend followed.

Student B

'A woman of 25 with two children under 5 asks her general practitioner (GP) for an abortion. She refuses to arrange this and offers no alternative. Two weeks after the birth the mother and the child are seriously assaulted by the father. I talked with the mother who resented the GP's attitude, and felt that she had predicted this outcome'.

A discussion followed on the doctor-patient relationship, the sanctity of life, and truth-telling. By changing the social situation of the family and placing the student in the position of having to do the termination personally the issues were generalised. The student concluded with the following question:

'All GPs, because of their lifestyle and/or religious or moral beliefs, will have preconceived ideas on abortion. How far should they try to impress their own standards on patients?'

Student C

'A 15-year-old girl had come to the surgery alone asking for the contraceptive pill which had been prescribed. When her parents found out they were extremely upset. Today they came with their daughter who is now pregnant and not yet 16! The parents are requesting termination. I would like to discuss the ethics involved in dealing with the new situation.'

Issues raised included confidentiality, the age when someone is competent, and the rights of parents and relatives. The 'weightings' were altered by imagining that the young girl came alone on the second occasion.

Other cases involve common decisions in general practice with a moral element which is less often discussed:

Student D

'A 24-year-old man came to the surgery with a wart. It had been present for three months. He had already tried wart compound without success. Should my GP have referred him to a dermatologist?'

Allocation of resources is not frequently presented as

Figure 2.

I asked 40 women and 23 men attending surgery about confidentiality:

1. Do you think information given to the doctor should be strictly confidential?

Percentage answering yes

Male	Female	up to 30 years	30-60 years	above 60 years	Total
75	97	100	96	84	89

2. Under certain circumstances would you allow the following access to your medical records?

Percentage answering yes

Yourself		Overall	Next of Kin	Other family
up to 30 years	above 30 years			
100	46	63	65	14
Employer	Social Worker	Nurse	Medical Student	
6	29	81	70	

3. In the event of a serious illness do you think the doctor has a duty to inform . . .

Percentage answering yes

up to 30 years	You 30-60 years	Above 60 years	Total	Your family	You, if next of kin is ill
89	46	32	70	78	86

the main problem, although it is often a factor in other problems. It is particularly educational to discuss such issues in relation to an everyday example rather than a life or death situation.

Although presenting cases seen in practice is the commonest format students are free to reject this if they wish and some do so, often with great success. For example one student conducted a mini-survey of surgery attenders' views (Fig. 2). Both students and teacher were surprised by the answers. A heated discussion about truth-telling and confidentiality followed.

Another student drew on her own experience as a patient:

Student E

'While I was a medical student I became pregnant. I did not know the first thing about obstetrics and at sixteen weeks I was told that I had a serum alpha-feto protein level two and a half times the normal limit. I was furious that I had not been involved in the decision to do the test and I refused all further investigation as abortion was not an option I wished to consider. I was extremely anxious at times but always glad that I knew that there might be a problem. In fact I had a healthy baby.'

This openness about a personal problem and some very succinct thought about the ethical issues involved in open and concealed screening programmes developed into a discussion about the nature of the doctor-patient relationship. As students described how it was done at the hospitals where they had studied obstetrics, it became clear that there were a variety of ways of giving information about such screening programmes.

Often analysing the case presented in formal though simple ethical terms is of value:

Student F

'A request for a visit is received from the friend of a patient, a 58-year-old teacher with angina who attends surgery rarely. When the doctor goes the patient is extremely angry about the unexpected visit and refuses to let the doctor in.'

'I would like to discuss what a doctor should do when a visit is requested by someone without the patient's knowledge.'

This dilemma was considered in terms of right, wrong, good and bad; for example the problem of weighing the GOOD consequence of an improvement in the patient's health against the BAD failure to fulfil a duty to respect the patient's autonomy. This led as it often does to a discussion of deontological or

consequentialist approaches to ethics. Changing the 'weight' of the third party forces the students from the particular to the general. Would you behave the same way if the relative was the spouse? What if it was a co-habitee, or a gay relationship? What if the patient was 15, or 85-year-old? The student settled on this statement:

'If a visit is requested by someone other than the patient, every effort should be made to contact the patient before eventually going round to the house. I feel that the fact that someone may be too ill to get help is an overriding consideration in this situation: it is more important than the fact that you may not be respecting someone's privacy.'

Another approach is to consider each person within the situation, including the doctor, as having rights, duties and goals, and to analyse what these are. Students often feel a duty to a relationship, especially a marriage, and it may be helpful to examine this concept critically (14).

Even with these techniques, a sound knowledge of ethical theory and considerable teaching experience, it may not be possible to make points which the teacher considers important:

Student G

'A 17-year-old girl going on a coach tour attended the surgery asking for a pack of pills to take to stop her period. She did not want them for contraceptive purposes.

'An anxious single father came with his 14-year-old boy saying that he couldn't sleep at night because he had a bad cold. The GP said that it was a minor illness and no treatment was necessary. The father refused to accept this and left very angry.

'I wish to discuss how far a doctor should be manipulated by a patient's or relative's wishes.'

The teacher wished to consider the nature of the doctor-patient relationship but the student saw this solely as a patient problem. Changing the 'weight' by altering the diseases considered did little to capture the students' interest. Although some members of the group discussed the ethical issue it was not particularly fruitful. It may have been better not to have stepped in with a classification but to have let the other students awaken to the ethical problem. The nature of the doctor-patient relationship is a very personal area of medical ethics and it is difficult to discuss when the students are only observers in the situations. They may be reluctant to criticise their general-practice tutors in their absence.

Other presentations have used ethical-decision trees, 'thought experiments' with slightly differing situations and videos made by the students. Some other topics raised are shown in Fig 3.

Future developments

Clinical teaching at one of our medical schools is

Figure 3. Topics brought to ethics seminars by general practice students

The right of doctors to strike
Killing and letting die
Handling people who demand home visits unnecessarily
The Gillick ruling*
The history of medical ethics
Non-co-operation and underage pregnancy
Unexpected results on a test done for another reason
Should we be diagnosing and/or treating mild hypertension
How to approach a woman with multiple sclerosis who seeks advice on having a family

currently being re-organised, and a full day is devoted to ethics in a new community medicine, general practice and psychiatry module. We have defined objectives for the day: (Fig 4). Didactic methods and interactive strategies, both teacher-centred and student-centred, are used at different points during the day.

Ethics is also being introduced into the preclinical course at St Bartholomew's Hospital Medical College. At present there are only four one-hour, large-group case discussions. These are organised by the Department of General Practice, but use cases from various departments of medicine – surgery, neurology, obstetrics, etc, each with a commentary from a professional philosopher. It is of course too early to evaluate these methods.

Conclusions

Ideally we believe that teaching should be done throughout the course by various people from different viewpoints, both medical and non-medical. In reality at least, it is more likely that one individual or department will take an interest in the subject and begin teaching it. Study of the subject in general practice is particularly likely to promote discussion and analysis of ethical issues which have relevance to the community. Ethics is as important in the general-practice consulting room as in the intensive care or neonatal units whence examples are more frequently drawn.

Teaching medical ethics involves an exploration of educational strategies to find the most suitable in terms of educational objectives and resources available. These will vary according to the place in the curriculum. Teachers also need to examine their personal values and attitudes to practice. We have achieved this through regular meetings by members of our staff involved in teaching ethics, and through interaction with the students.

* Which concerned confidentiality and prescribing without parental permission for under-16-year-olds. Editor.

Figure 4. Objectives for ethics day

1. The day should interest and engage the students.
2. The students should be able to recognise the ethical dimension in all clinical decisions.
3. The students should be able to recognise ethical problems in medicine.
4. The students should be able to analyse ethical problems in medicine in terms of rights and duties, and in terms of consequences.
5. The students should be able to identify the following types of ethical issues:
 - a) Confidentiality.
 - b) Informed consent.
 - c) Autonomy.
 - d) Personhood.
6. The students should be able to discuss the pros and cons of disclosure of information in examples of the following situations:
 - a) Giving information to relatives.
 - b) Giving information to statutory third persons.
 - c) Giving information to non-statutory third persons.

Allowing the students to choose the topics for discussion appears to engage students and rapidly develops their ability to recognise and analyse ethical problems. They are more likely to question their own values and assumptions critically, within a student-centred strategy. This can threaten the teacher since it necessitates loss of control and of a defined curriculum. However, this may be a necessary price for the rapid intellectual awakening and change which is a common feature of these sessions.

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