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Teaching medical ethics symposium

Practical problems in the teaching of ethics to medical students

K C Calman and R S Downie *The University of Glasgow*

Authors' abstract

Some practical problems in the teaching of ethics to medical students are described. The definition of the objectives of the course remains the central aspect, and is more important than the specific content. The use of student projects, buzz groups, case histories and discussion points is described. There is a need for student assessment or examination at the end of the course. The teachers require a broad background in philosophy, clinical medicine and teaching skills. The learning of the teachers may be as important as that of the students.

Introduction

Over the past few years there has been increasing interest in the teaching of ethics to medical students (1–4). In addition to finding time in the curriculum for the subject, there are the problems of content, method, and evaluation. There is considerable debate as to the objectives of such courses and how the subject should integrate with other parts of the curriculum. In practical terms it is likely that there will be several answers to these questions, and that answers will evolve with time as the objectives, method and content become more clearly defined. Finally, there is the question of evaluation of such courses. This will, of course, depend on the objectives but the evaluation itself poses a series of problems. As a contribution to this debate we describe here some of the practical problems associated with such curriculum developments.

Planning

The planning of the course began with a six-week voluntary course for 20 fourth-year medical students. The purpose of this was to field-test some of the ideas, methods and material. In retrospect this proved a most valuable exercise and allowed experimentation without the constraints of a formal curriculum. During this period the material subsequently used was refined, and an opportunity taken to obtain informal evaluation and a great deal of student comment. From this evolved the five-week course given to third-year medical students.

There are approximately 200 medical students in the year and a third of the year attended each term. This allowed for revision of the course content during the year, an example of action research. During the five-week course the whole section of the class (maximum 65 students) met each week for 1.5 hours. There was a second teaching session attended by half of the class, again for a period of 1.5 hours. The total contact time per student per week was three hours, and for the course, 15 hours. These teaching periods were dictated by curricular constraints.

Content

The content was a mixture of moral philosophy and practical medical problems. Case studies and problem-solving exercises were used to amplify and extend the more formal discussion periods. Topics included the management of uncertainty, the role of the doctor, consent and confidentiality, truth-telling, ethics of research, medical negligence, and economics and high-technology medicine. Other issues were discussed depending on the class itself and the topics raised by students.

Objectives

It would be fair to say that these developed as the experience of the course grew. Over-enthusiastic and optimistic objectives which were considered feasible at the start of the course were modified by experience. We considered that this was an important part of the authors' learning experience during the course. In summary, the objectives which were used for the course were:

1. To make the students aware that decision-making in medicine is not value-free;
2. To assist the students in learning to deal with moral decision-making in a more rational way, by logic and argument, and to enable them to justify their own views and explore their own attitudes to moral problems, especially the relationship between personal and professional morality;
3. To help the students to come to terms with conflict in ethical problems. This includes a consideration of

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the role of the doctor and the relationship with other members of the health team.

The students

One observation, though not an unexpected one, was the variation between groups of students. This related not only to the views of the students on particular topics, but on the subjects raised by them. By inviting the kind of discussion described below, the range of individual opinion within each group was quite marked. This gave an important opportunity to raise the question of conflict on ethical issues within the class and to make the students aware that such differences of opinion are real and have to be dealt with. The students took an active part in the sessions and discussed issues amongst themselves and with the teachers. There was discussion of ethical problems outwith the class.

Timing of the course

There is considerable debate as to where such a course should be placed within the curriculum. In this case the students were introduced to ethical and moral issues in the second year, and the theme was taken up in the 4th and 5th years in the course on medical jurisprudence and the clinical specialties. This course was seen, therefore, as part of an integrated view of ethics in medicine.

Inter-professional teaching

In the pilot study, nursing students were part of the class. It was noted by the medical students that this was one of the most valuable parts of the course. For the main study reported here it was not possible, because of time-tabling problems. However, there is little doubt that such interdisciplinary teaching sessions are of real value, and should be encouraged. The practical problems of doing this, however, should not be underestimated.

The teachers

There has always been a debate as to who should teach ethics to medical students. The formula adopted here has been to mix philosophers with clinicians. For some of the topics members of the nursing staff were invited to take part. This adds an important dimension to the teaching. This mix has been well received, though it is certainly capable of further refinement. One important feature of this has been the learning of the teachers during the class, as the differences in emphasis and expertise have been discussed. This has been a most valuable feature for those involved in teaching, as it encouraged a much greater awareness of the range of problems in different aspects of the subject. One outcome of this has been the collaboration of the teachers in a book for medical students and other health care professionals (5).

Small-group teaching

Because of the physical constraints, and the availability of teachers, it was not possible to arrange small-group teaching in separate rooms. Previous experience of asking questions in a large class showed that although this was possible, and discussion could be generated, the actual speaking was usually confined to a few members of the class. To overcome this the class was divided into groups of four–seven students within the lecture theatre. Without moving, students could then discuss the problem or case in a small group. Once the rationale has been explained there has been no difficulty in getting active discussion. All students now have a chance to take part and experience suggests that this actually occurs. Using this method a single teacher can supervise up to seventy students with little difficulty. As a refinement, the teacher or, in the present case, both teachers can circulate round the groups during the period of discussion, interpreting, questioning and pointing out difficulties. In addition, if the class subsequently discusses a particular question, the teacher can use examples which have been noted and bring these to the general attention of the class. The use of such 'buzz' groups is not new (6,7) but we have found it particularly useful in the teaching of ethics, given the physical constraints described.

Case studies

Most would agree that problem-solving exercises, case studies and discussion points are useful methods for providing students with experience in dealing with ethical problems. Our experience with this, using a variety of materials, indicated that the students recognised three types of problems with this approach.

1. The 'it depends' response. The student is unable to discuss the problem because the response is perceived as depending on a whole range of factors. Because the information given is limited, or the time for discussion too short, the student finds it impossible to respond.
2. The 'individual' nature of the response. The student takes the view that answers to, or comments on, particular issues are so personal that he or she sees little point in discussing them. To some students ethical problems are seen as being directly related to individual values.
3. The student has insufficient 'knowledge' to answer the question or take part in the discussion. The view is that more experience or knowledge is required before a conclusion can be drawn. 'Once I am a consultant the answers will be clearer' is a typical kind of response.

From practical experience we have found that unless such problems are dealt with at the start of the course, they will be raised by the students during the discussion time. Accordingly, we have taken to explaining to the students these issues at the start of the class, together with some of the ways in which they can

be dealt with. This is done by working through an example. Thus the statement: 'Patients over the age of 70 should not be resuscitated' is presented to the students. Clearly, the response to this statement WILL depend on a number of factors. The student who takes this line of response is therefore encouraged to define for himself which factors ARE important. Indeed, a satisfactory response would be to list those conditions under which the student might agree or disagree with the statement. Alternatively, the response might be to disagree entirely with the statement, as long as the student has a clear view of his reasons for this choice. It is impressed on the students that these are all acceptable responses.

To deal with the issue of the individual nature of the response several lines of argument are used. The first is that the objective of the exercise is not necessarily to reach agreement on the statements or case problems. The second is that disagreement is a normal feature of clinical decision-making. The third is that in clinical practice such disagreements can lead to conflict between doctors, or between members of the health care team. In the non-threatening atmosphere of the classroom the student can have an opportunity to find out whether or not his views are the same as others or different. It provides an opportunity for the student to explore his views against others. Open disagreement is not positively encouraged, but clearly permitted. As far as the statement given above is concerned, there is ample opportunity for this to occur. During the teaching session use is made of similar statements on a range of issues, providing triggers for discussion. Other examples of such discussion triggers are 'Doctors should set a moral example to the community', or 'I like to see my doctor nicely dressed', or 'Patients should see their medical records'.

As far as the question of insufficient experience is concerned, the point is made that ethical and moral problems will occur throughout their career, and that seniority is not synonymous with wisdom. It is essential, therefore, that they do not wait until they are fully qualified before forming views on particular medical issues.

It goes without saying that those teaching the subject should not put forward particular personal views, but encourage discussion and stimulate alternative views on subjects. For this reason we have found it prudent to state explicitly at the outset that the views given are not necessarily our own. This does give the teacher more freedom to raise issues. Finally, the point is made to the students that there will be a degree of confidentiality in the discussions and that they should not feel that they cannot raise any point, or take a particular line of argument, in case it will affect their future career.

In summary, we have found that the use of statements and case histories is a valuable teaching method. However, the students require an introduction to their use before they can benefit fully from them.

Student projects

Each group of students (6–7) was given a series of articles to review (easily obtainable from newspapers), together with a number of related questions. Students were asked to present their findings to the class. In general this was very well done, and enjoyed by the students. However, there were some problems. Preparation for these projects was often limited and it was clear that in terms of priorities this was low in the eyes of the students. One possible reason for this is discussed below.

Assessment

The course was designed to stand alone, though clearly related to other parts of the curriculum. In addition, no assessment or examination was related to the course. This was a deliberate decision, following discussion in faculty, and with the students. The purists might recognise that formal examinations are unnecessary, but in practical terms when there is competition for time, those subjects which are not examined are downgraded in the view of the students. This was most noticeable in the third term when attendances were poor at times, because of other professional examinations. It could be argued, of course, that it was the course which was poor and that its value to the students was seen to be limited, hence their non-attendance. However, discussion with them showed that the major factor, however regrettable it might be, was the fact that the course did not count in examination terms. Our plan for the future is to incorporate questions on ethics within an existing professional examination in a related subject such as community medicine or forensic medicine. The most appropriate subject remains to be discussed.

Evaluation

Evaluation of the course was carried out by questionnaires and informal interviews with students. The format of the course was appreciated, as was the opportunity for discussion. In such a short course it is impossible to detect changes in attitudes. However, it is worth noting that students found that the course made them think about their own attitudes to ethical problems in medicine. Refinements of the evaluation will depend on a clearer statement of objectives.

Conclusions

This paper has presented some of the practical issues which have resulted from the teaching of a course in ethics for medical students. From this several conclusions can be drawn.

1. The pilot course provided an opportunity for material to be tested and for those teaching the course to learn from each other.
2. The objectives of the course were modified by experience, and by observation and evaluation. These

objectives were more important than the detailed content of the course.

3. The methods used invited active participation by the students, using statements and case histories. Students, however, required some initial help in using such material. The methods were used to allow students to explore their own attitudes to moral problems. By encouraging discussion in small groups, even within a large lecture theatre, this could be achieved.

4. The teachers required a background in medicine, moral philosophy, and teaching methods to make full use of the opportunities which were presented. The learning of the teachers was as important as that of the students.

5. To achieve credibility in the eyes of the student population it is suggested that some form of assessment or examination is required.

6. Interdisciplinary teaching between different professional groups is considered to be valuable, but in a formal setting, as opposed to voluntary discussion groups, this may be difficult to achieve because of time-tabling constraints.

K C Calman is Dean of Postgraduate Medicine and Professor of Postgraduate Medical Education at the University of Glasgow. R S Downie is Professor of Moral Philosophy at the University of Glasgow.

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