Teaching medical ethics symposium

CABGs and KINGS: Relevance and realism in the teaching of clinical ethics in Camberwell

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When in the late 1970s a student group declared that it wanted to discuss 'a cabbage', the jargon was arresting. For those not involved in the details of cardiology, a Coronary Artery Bypass Graft operation (CABG) sounded too alarming for this name. That on this occasion the operation had gone wrong and the patient was severely ill caused more than a double-take. The concern, even repugnance, which some of the students felt about the procedure fuelled a lively debate about the ethics of a high-technology response to a degenerative disease of life-style. Today, a decade later, the operative techniques are more assured and the clinical subject is hardly raised by students. The medicine has changed but what of the medical ethics? The issues are still important, and the students still challenged by them, but the focus of concern and debate has altered. This is but one example of the problems which the teaching of clinical ethics faces if it is to remain responsive to educational needs. While there is evidence that British medical students are now much more aware of and interested in medical ethics, as are their clinical teachers, details of curriculum, teaching methods and timetabling are still experimental and remain unassessed. The experience of two methods used over ten years in one medical school are in contrast and present important lessons for curriculum planners and teachers.

A course of instruction

The formal course was created to cover a broad curriculum by using several different types of presentation, and was given perforce to all of one annual student intake, usually more than one hundred students. The topics were covered in three main ways. Initial didactic lectures, using videotape material, covered an introduction to the main principles involved, and were followed by two different types of debate. One was based around a moral issue, and conducted between speakers of opposing views, in the method familiar to those attending Medical Group lectures. The other was a 'medico-moral case conference' conducted by a small but multidisciplinary group of clinicians, nurses, philosophers or lay speakers on a specific case, often previously submitted by a student as being of special interest or concern. The timing of the course, at the end of the first clinical year, was intended to round off the year's course of medical lectures by offering a broad 'coda' section to participating students now well initiated into other areas of clinical medicine.

The curriculum was developed from a fusion of ideas from a number of sources. In the initial years, all those in the school interested in the area of medical ethics met to discuss the subjects to be covered, and conducted a post-mortem on the previous course. Students were asked to rate the individual items of the course, and to offer suggestions. Current cases were used as a basis for presentation, and the course was finally shaped by the department. The content of the course was thus under regular review, and changed considerably over the first five years. It somehow had, within six to eight sessions of one hour each to cover, an impossible range of objectives: to present coherently the concept of medical ethics as a discipline, to identify its range of thinking and contribution to clinical medicine, to examine the principles and methods used in debating them and to apply them to important issues currently facing the students.

Background

When the King's College Hospital Medical School, as it was, received a suggestion from the university in 1978 that medical ethics should be taught to students, the embryonic Department of General Practice Studies was asked to take on the task. It responded in two ways: by setting up an eight-part course as part of the regular 'Topic Teaching' lecture series to new clinical (third-year) medical students, and by enlarging the scope of discussion groups related to ward work on medical firms conducted by sessional general practice teachers. The successes and failures of these two approaches should now be reviewed.

Key words
Medical ethics teaching.
Background reading, often a good supplement to cramped courses, was offered but seems to have been little used. Although lectures in ethics had been given to some students in preclinical sociology teaching, the work in the course had to stand largely on its own feet.

The method of planning, the content and the style of the course, all contain elements of success and failure. The initial approach to interested teachers recruited several important participants within and without the school, and this has had good effects for the course, the school and, on more than one occasion, for clinical medicine and patient care. Unusual topics have been debated by enthusiastic teachers and have engaged student participation. Canvassing students' views, though never a recipe for a good night's sleep, has produced a regular stream of clinical cases, several of which have been subsequently published in this journal. The course has become multi-disciplinary, being open to and patronised by clinical nurses and physiotherapists for several years. This is now part of a joint King's College (KQC) course for BSc nurses and for medical students, bringing together the preclinical and clinical teachers. When attendance at all the Topic Teaching lectures was threatened by students spending time in distant hospitals, the ethics series was one of the few courses considered vital enough to be made compulsory, although assessment (that two-edged accolade) has yet to be achieved. However, the creation of a new course each year on this dynamic principle, responding both to student needs and ideas and teachers' interest and availability, is a difficult and demanding task for a small department, and the regular meeting of teachers in an expanded school has more recently had to be abandoned. This has allowed the course to settle down, but has reduced its responsiveness and removed the contact between participating teachers which had created a minor ethics forum in its own right. The development of a real forum within the school is an urgent challenge.

Small-group teaching

The small-group teaching was entirely different in style and content. Students on the medical firms had eight opportunities to meet general practitioners in their first clinical (third) year, in a secure but relaxed setting, and to raise topics of immediate interest to students. The resulting curriculum was a compromise between this urgent need and the teachers' desire to establish a broader 'community' view of the medical task than would otherwise be covered in student ward teaching. The original plans were to try to introduce students to medical and moral problems in the family and environment surrounding a patient's admission, and to teach about discharge plans and resources in the community. However, the concerns of students were often much more immediate. These were related to the difficulties which the students were currently facing or to unresolved conflicts that they perceived or experienced. These latter topics were the more memorable for us all by being more dramatic, and often surrounded the dilemmas of the students' own role and shifts in their perspective. Examples have been quoted elsewhere (1,2).

Of the many dilemmas posed by this teaching, one stands out. It is hard for anyone to retain the view of a situation both from that of a patient and from that of a professional. However, this double perspective which new entrants to clinical medicine find striking but so difficult remains absolutely essential to clinical medicine, and is lost at our peril. How can doctors in training continue to be able to see things both from a professional viewpoint and from that of a patient or relative? To many students transition from one role to another and the uncomfortable almost nauseating effect of the 'diplopia' this causes, prove too much to tolerate. In the course of the academic year, it was always noticeable how much less questioning the students became, and how much less tolerant they were of any teaching whose focus was other than important factual material about the immediate narrow clinical task they were facing. The pattern was repeated year after year, and as teachers we began to accept the obvious message, that students need to take up a professional role, and are heavily influenced by what they see obsessing the majority of their models and mentors. In many this 'battening down of their hatches' is a temporary affair, as those involved in postgraduate general practice training can testify, but specific educational activities are required to reverse it at a later point in a career. It therefore remains important throughout the undergraduate course that the students see teachers offering questioning as well as certainty. This style should be given curriculum space and opportunity at a time when students are still capable of responding positively.

Small-group teaching appears to be the best method of provoking and providing this missing piece of medical education, and should be maintained. Clinical medical ethics teaching in this context must therefore beware of presenting too 'cut and dried' a response to students' ethical questioning, and should encourage questions, argument and debate even if the teacher must also show the group the required tools for handling such issues or the spectrum of reasoned responses that are considered possible, and the reasoning behind them. Teaching in small groups like this does not come easily to everyone, and in itself requires to be learned as a technique. Teachers themselves change, and though gaining experience, may become more rigid in their thinking as the curriculum is repeated year after year. Faculties therefore should actively recruit young teachers who are near enough to their own student careers to perceive the problems, but confident and organised enough to do this work. Faculties should also allow teachers regular breaks from this type of teaching for reassessment and 'refuelling'.
Issues repeatedly presented by students in small groups

The status of medical students, and their imprecise responsibilities and role in patient care.

Dilemmas of talking truthfully to patients about their condition, particularly in relation to poor role-models in teachers.

Using patients as ‘objects’ to learn on.

Students’ own experiences as patients or as relatives, and the consequent insight or bias gained.

Passing of information and confidentiality.

How to retain or develop empathy as a communication skill.

Approaching the ‘difficult’ patient — the deaf, confused, or acutely disturbed.

Developments

These two modes of teaching have developed in different ways. The medical course now includes a much larger element of general-practice instruction, and the small-group discussions have therefore been taken into the new curriculum at the same point but in a different context. It is too early yet to judge what has been lost and what gained. The formal course continues, and has been expanded to form the second part of a potential joint instruction series for nursing as well as medical students. This has highlighted the need for basic instruction in ethics to improve the clinical debate. Students continue to respond positively to clinical teachers who can present the dilemmas of real practice, but the point is approaching where the sophistication of the audience in the field of moral argument may be greater than that of their teachers. Teaching can only be relevant if it is based on real examples, and yet it is not easy to find multidisciplinary clinical teams regularly debating in an informed way about the issues facing them. The challenge is there: teaching must be based on real practice, but the practice must demonstrate the reality of our teaching.

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References