Teaching medical ethics symposium

The Oxford Practice Skills Project: teaching ethics, law and communication skills to clinical medical students

Tony Hope and K W M Fulford  Oxford Practice Skills Project

Abstract
We describe the teaching programme in ethics, law and communication skills for clinical medical students which is being developed as part of the Oxford Practice Skills Project. These three elements of practice are approached in an integrated teaching programme which aims to address everyday clinical practice. The role of a central value of patient-centred health care in guiding the teaching is described. Although the final aim of the teaching is to improve actual practice, we have found three ‘sub-aims’ helpful in the development of the programme. These sub-aims are: increasing students’ awareness of ethical issues; enhancing their analytical thinking skills, and teaching specific knowledge.

Introduction
Here are some recent headlines from the British press: When can a doctor kill? Doctors who play God’s role; Death wins its debate with life; Jehovah’s witness died after refusing blood transfusion; Nineteen arrested in abortion protests; Doctors back right to choose sex of child.

Medical ethics is certainly getting a high profile and seems to be becoming more prominent every year. However, if one were to judge medical ethics from the press it would be of relevance only to somewhat esoteric medicine, high-profile, but pretty specialised.

Ethical issues, however, permeate everyday ordinary medicine and in teaching ethics to medical students, or to nursing staff, we should be aiming to improve students’ everyday clinical practice. It is the centrality of this practical clinical aim which has affected the particular form which the teaching has taken in the Oxford Practice Skills Project. However, although this practical aim has helped to shape much of the project, we have found that, by itself, it is not enough. We have needed to identify other aims in order to help guide the details of the teaching; and we have needed to clarify our own perspectives and values. In doing this we have found the value of ‘patient-centred medicine’ particularly helpful.

We have described elsewhere the origins and theoretical basis of the practice skills approach to medical education (1,2,3). In this paper we outline the background to the project and to the concept of practice skills. Then we discuss some of the aims which we have found it helpful to articulate. Finally we indicate some of the ways in which the idea of the ‘patient-centred’ perspective has influenced our teaching.

Background to the practice skills project
The Oxford Practice Skills Project has been running for three years. Its central purpose is to develop and evaluate a teaching programme for clinical medical students in ethics, law, and communication skills (‘practice skills’). The remit of the project is the teaching of clinical medical students. However, our approach is, we think, of relevance also to other health care students and to postgraduates.

The concept of practice skills
When one considers the everyday practice of medicine, ethics is not readily separated from law and communication skills. All three aspects make up the ‘practice skills’ needed for the successful application of medical knowledge; successful, that is, from the patient’s point of view.

Consider the following case examples:

Case 1: A 22-year-old woman has taken an overdose of paracetamol tablets. On arrival in the emergency room she is fully conscious. However, the blood level of paracetamol indicates that she is at some risk of liver damage unless she receives specific treatment involving intravenous infusion. She refuses treatment and wishes to go home.

The problematic clinical questions in this situation are ethical and legal; should the woman be forced to have treatment, or be allowed to go home; what guidance or constraints does the law place on what can or should be done? Moreover, these questions, in the practical setting, cannot be divorced from the
communication aspects of the case: listening to the patient and seeking to understand her reluctance to accept treatment; involving her relatives where appropriate in a sensitive and responsive way, and supporting other members of the clinical team in whatever management plan is finally agreed.

This close relationship between ethics, law and communication skills is true throughout medicine – it is not a peculiarity of the psychiatric end of the spectrum.

Case 2: A 55-year-old man has valvular heart disease causing breathlessness on mild exertion. He might benefit from surgery, but the surgery has risks, and the results are not certain. Should he consent to surgery?

This case illustrates the importance of practice skills even at what might be thought to be the technical end of the spectrum of medicine. In coming to a decision with the patient about how to proceed, the patient must be properly informed. It is therefore necessary for the doctor to give information about the advantages and disadvantages, risks and benefits of treatment. But different patients will want different amounts of information. The best way of informing patients of, for example, the risks of treatment is a complex communication issue.

There is no one right way to deal with the kind of clinical situations illustrated by these two cases. There are many wrong ways, however, ranging from insensitivity through to gross negligence. The practice skills project aims to improve clinical care by developing students’ competence in the ethical, legal and communication aspects of medical practice through case-based, practically oriented teaching.

Practice skills course
The main teaching consists of two principal strands:

1) firm-based seminars, combining all three aspects of practice skills; and
2) small-group tutorials which focus on basic communication skills.

The firm-based practice skills seminars are two hours long, with 15–20 students in each seminar. Each student takes part in three seminars in each of the three clinical years. Since there are about 100 students in each year, every seminar is repeated six times a year with different groups of students. The seminars have been enhanced by the use of both ‘internal experts’ (doctors and nurses working on the firms) and of ‘external experts’ (lawyers and philosophers). In addition to these seminars a few lectures are given to all 100 students in a year. Table 1 outlines this teaching programme.

The small group tutorials have been developed in collaboration between the practice skills project, Dr Theo Schofield of the Department of Community Medicine and General Practice, and Dr William Rosenberg, the medical tutor. Thirty-six tutors have been trained (two-thirds are hospital doctors and one-third are general practitioners). The students are divided into 14 groups (about 7 students in each group) based on their clinical firm placement, and two tutors are allocated to each group. Each group meets five times during the first clinical attachment (once a fortnight) for one and a half hours. The same arrangement is made during the second clinical attachment. Each student therefore takes part in ten tutorials altogether during his or her first clinical year.

The goals of teaching ethics
We were originally brought to consider the question of the goals of teaching in the context of evaluation. Part of the project is to evaluate what we are doing and this naturally led us to consider the question: how would we know whether we had been successful? What would count as success? In order to help us to think about this question we started with the following simple model:

```
  Teaching → Intermediate Aims → Final Aims
```

We originally distinguished, in this model, between intermediate and final aims; this distinction may not be as clear, however, as it at first seemed.

We started with the idea that since we were setting up a course which should form part of a core curriculum for all the clinical students the final aim should be to improve the clinical practice of the students in preparation for their becoming doctors. It was clear that we needed to identify ‘sub-aims’ in order to guide us both in the teaching and evaluation. These sub-aims we saw as intermediate, resulting more directly from the teaching than the final aim, but valid ultimately because they help to achieve that final aim. This scheme immediately raises the question of the nature of the relationship between the intermediate aims and the final aim.

**WHAT IS THE RELATIONSHIP BETWEEN INTERMEDIATE AND FINAL AIMS?**

There are two broad types of possible relationship between intermediate and final aims: firstly the relationship might be one of cause and effect; secondly it might be a logical one.

When we first used the schema illustrated above we had in mind that the relationship was one of cause and effect. For example, we thought that in order to improve practice in the relevant ways it was likely to be the case that one must improve the ability of practitioners to think about ethical matters with
We have found three sub-aims in petrol. These three intermediate aims might otherwise have been ignored and this has been a particularly true awareness. And, thirdly, they have helped in developing methods of evaluation of the teaching.

**Awareness**

However well developed a student’s ‘thinking skills’ are, they are useless unless the student is aware that there is an ethical issue which needs thinking about. We believe that the single most important task in teaching medical ethics, at least if that teaching is aimed at all students, is to increase awareness of ethical issues. The problem with the apprenticeship model of education, which is central to medicine, is that a particular way of practising becomes routine, and students fail to see that assumptions are being uncritically accepted. To take an example from palliative care: it is common practice to discuss the diagnosis and prognosis of elderly, but fully competent, patients with their families. However, this goes against the view that diagnosis and prognosis are confidential to the patient – to be discussed with others, normally, only with explicit permission from the patient. In first talking with relatives an ethically laden decision has been taken, and one which is problematic at that. But many practitioners are unaware that the issue of whom to talk to first has a major ethical component. The central problem in the ethics of medical practice is not so much poor thinking about an ethical problem but lack of awareness of ethical issues raised in everyday medical practice.

---

**Table 1**

**Core seminars**

<table>
<thead>
<tr>
<th>Title</th>
<th>Group</th>
<th>Time</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) An introduction to the consultation and basic communication skills</td>
<td>LG</td>
<td>3 hours</td>
<td>Introductory course</td>
</tr>
<tr>
<td>(ii) Introduction to practice skills</td>
<td>LG</td>
<td>45 min</td>
<td>Introductory course</td>
</tr>
<tr>
<td>(iii) Introduction to English and Welsh law</td>
<td>LG</td>
<td>45 min</td>
<td>Introductory course</td>
</tr>
<tr>
<td>1 'Do not resuscitate' allowing patients to die</td>
<td>SG</td>
<td>2 hours</td>
<td>General medicine</td>
</tr>
<tr>
<td>2 Confidentiality</td>
<td>SG</td>
<td>2 hours</td>
<td>General medicine</td>
</tr>
<tr>
<td>3 'Have we got a consent form?'</td>
<td>SG</td>
<td>2 hours</td>
<td>General surgery</td>
</tr>
<tr>
<td>4 Treating patients without their consent</td>
<td>SG</td>
<td>2 hours</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>5 'We're desperate for a baby' (some ethical issues of assisted reproduction)</td>
<td>SG</td>
<td>2 hours</td>
<td>O &amp; G</td>
</tr>
<tr>
<td>6 The aggressive patient</td>
<td>SG</td>
<td>2 hours</td>
<td>Accident services</td>
</tr>
<tr>
<td>7 The Children Act, consent and child abuse</td>
<td>SG</td>
<td>2 hours</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>8 Allocation of resources</td>
<td>SG</td>
<td>2 hours</td>
<td>Medicine</td>
</tr>
</tbody>
</table>

---

Some philosophical sophistication. In order for a car to go it must be filled with petrol. Filling it with petrol is an intermediate aim. We do it in order to achieve our final aim, which is for the car to go.

However, further analysis of our final aim suggested that the relationship might instead, or in addition, be a logical one. When we try to define exactly what good practice is, the ability to think in a philosophical fashion about ethical matters may turn out to be a part of that good practice. Briefly, the point is that we may decide that in order to recognise the relevant good practice it is not enough simply to define it in terms of how the doctor behaves; it is also relevant to ask what thinking process the doctor has used in coming to a decision as to how to act. Thinking in a philosophical fashion about the ethical issues might be seen to be a necessary feature of good practice.

Whatever the relationship between intermediate and final aims, we have found it useful in developing the project to elaborate further on these intermediate or sub-aims.

**Examples of sub-aims which have proved useful**

We have found three sub-aims particularly helpful in developing the project. These are:

1) Awareness
2) Thinking skills
3) Knowledge

These three intermediate goals have been valuable in a number of ways. Firstly, in the development of our syllabus and teaching methods. For example, in designing the individual seminars we have found it useful to think in terms of which of the various goals we are aiming for at any one part of the seminar. Secondly, they have helped us to clarify aims which we might otherwise have ignored and this has been particularly true of awareness. And, thirdly, they have helped in developing methods of evaluation of the teaching.

**Awareness**

However well developed a student’s ‘thinking skills’ are, they are useless unless the student is aware that there is an ethical issue which needs thinking about. We believe that the single most important task in teaching medical ethics, at least if that teaching is aimed at all students, is to increase awareness of ethical issues. The problem with the apprenticeship model of education, which is central to medicine, is that a particular way of practising becomes routine, and students fail to see that assumptions are being uncritically accepted. To take an example from palliative care: it is common practice to discuss the diagnosis and prognosis of elderly, but fully competent, patients with their families. However, this goes against the view that diagnosis and prognosis are confidential to the patient – to be discussed with others, normally, only with explicit permission from the patient. In first talking with relatives an ethically laden decision has been taken, and one which is problematic at that. But many practitioners are unaware that the issue of whom to talk to first has a major ethical component. The central problem in the ethics of medical practice is not so much poor thinking about an ethical problem but lack of awareness of ethical issues raised in everyday medical practice.
Thinking skills

Teachers of medical ethics include the development of thinking skills as an important aim. The idea is that the ways in which, say, a philosopher thinks about ethical issues is different from, and more sophisticated, than the ways a doctor, unskilled in philosophy, thinks. In teaching medical ethics we should aim to enable doctors to think in these ways.

There is, of course, more than one way of thinking about ethical issues; there are a number of different and overlapping ways. Elsewhere (4) we have suggested that there is a heuristic value in considering thinking skills, or ethical analysis, under three headings: perspectives, principles and paradigms. Perspectives emphasise the point that ethical considerations are often usefully looked at from different points of view. For example, the ethical issues surrounding the use of modern reproductive techniques are often analysed in terms of the interests of the potential child, the potential parent, and society (5). The value of principles in ethical analysis has received a great deal of attention (6) ever since the ‘four principles’ were first comprehensively enunciated by Beauchamp and Childress (7). Seedhouse (8) has proposed an analytic tool which he calls the ‘ethical grid’, which makes use of a number of principles and perspectives. The idea of ‘paradigms’ is to stress the value of comparing the problematic situation with other situations (paradigms) where it is clearer what we ought to do. Such comparison can help us to come to a decision about the problematic situations. This way of proceeding is generally known as ‘casuistry’ and there has been a great deal of interest in this method of analysis since the publication of *The Abuse of Casuistry* (9).

Knowledge

The importance of knowledge in ethics teaching has sometimes been underestimated. In addition to becoming aware of ethical issues, and being able to think sensibly about them, students need to learn about which kinds of ethical issues are likely to be important to patients and their relatives in different situations; how people from different cultural backgrounds are likely to think about these issues, and the kinds of solutions to ethical issues which people have come up with, their strengths and weaknesses. Students need also to be aware of the main codes of ethics, and professional guidelines.

Patient-centred values and the teaching of practice skills

All teachers of medical ethics have to face the question of what values, if any, it is right to teach. Most would not, we suspect, see it as their role to try and persuade students that, for example, abortion is either right, or wrong. The task for teachers is to help students to become aware of the issues, to think through the arguments and to make up their own minds. But values are bound to affect the choice of syllabus and of clinical examples, and affect the way in which the teacher challenges the students. The central value in the practice skills teaching is probably best described as a ‘patient-centred’. We have found, as have the developers of the Auckland programme (10), that this has helped to guide and give cohesion to the teaching programme in a number of ways. We will give some examples.

SYLLABUS AND COURSE CONTENT

Much of what is written in medical ethics concerns rare situations, chosen not because they are typical of commonly occurring situations but because they are philosophically interesting. One might call this ‘philosophy-centred’ medical ethics. In choosing the syllabus of the practice skills project we specifically wished to address everyday medicine. This wish was related to our desire to try and improve the clinical practice of the students. It is our belief that problematic ethical issues as well as legal and communication issues are a common part of everyday medicine. This by itself is a move away from ‘philosophy-centred’ ethics but it is as equally ‘doctor-centred’ as ‘patient-centred’.

What is the difference between doctor-centred and patient-centred ethics in terms of syllabus? We suggest that a doctor-centred syllabus focuses on dilemmas. A dilemma, in this sense, arises when a doctor becomes aware of an ethical problem raised by his or her practice. The key thing is that the doctor feels stuck and uncertain. We will give an example. In choosing the content of a seminar on confidentiality we asked students to consider a case history which posed a dilemma. The vignette concerned a man who did not want his wife to know that he was HIV-positive. The central issue for discussion was whether the doctor should breach confidentiality and tell the wife. Most doctors placed in this position would recognise that here is an ethical dilemma, although many doctors might feel quite certain about the right course of action. The seminar consisted of much more than just a discussion of this situation but this was its central focus. At the end of the seminar a thoughtful student said: ‘This was very interesting but you failed to address what is the most important aspect of confidentiality: the innumerable breaches in confidentiality which routinely occur throughout this hospital’. This remark led us to re-think the seminar. It led us to ask not only what situations doctors found ethically problematic in their day-to-day practice, but also what situations and practices raised ethical issues which would be important to patients but which doctors did not notice? The result has been that now the first half of the seminar on confidentiality is a discussion of the kind of breaches of confidentiality which occur all the time and which health care staff rarely notice. The next step,
perhaps, should be to try to generate a syllabus directly from patients.

TEACHING METHODS
The patient-centred perspective has also affected teaching methods. This perspective has encouraged us to use methods within our seminar teaching designed to help students understand, and in a controlled way to experience, the patients’ position. One method which we have used occasionally and which we would like to develop further is for patients to join seminars. We will give two further examples.

‘Empathy exercises’
During a seminar on consent we present students with the following somewhat stylised situation. Imagine that you have a disease. There are two possible treatments. With the first treatment there is a 50 per cent chance of cure (defined here as a healthy life for 50 years), and a 50 per cent chance of death within a couple of days. The second treatment offers $X$ years of healthy life. We then ask students to decide, for themselves now, what is the value of $X$ such that they are unable to choose between the two treatments. The interesting result, in most student groups, is the wide range for the value of $X$ (one student chose three months, another 49 years). In most student groups there are those who choose five years and those who choose 30 years. In asking students what factors affect their choice they talk about what is really important to them. For some, unless they are going to live long enough to complete their training they feel they may as well risk almost instant death. For others the calculation is about having children and seeing those children to a certain stage in life. The student who chose three months argued that a 50 per cent chance of death was a high risk and it would be a great pity to die without having had a really good time. He preferred a guaranteed few months in which to have ‘a whale of a time’ than to take that risk. The exercise gives students some insight into the situations which patients may face. It also provides a graphic demonstration that even amongst a group of people of similar age and background, there are fundamental differences in how they evaluate their lives. We use this exercise to emphasise how dangerous it is for the doctor to try and evaluate what ‘is in the best interests of the patient’ in the setting where the patient is faced with treatments with differing prognoses and differing effects.

Role-play
We use role-play, particularly in the setting of the small-group communication tutorials, not only for students to practise their communication skills but also as a means of enabling students to empathise with the patient. Role-play frequently involves one student playing the doctor and one student the patient. Students often remark that they learn more from playing the patient.

EVALUATION
Whilst there is considerable agreement amongst teachers of medical ethics about the goals and content of courses, there have been few attempts at evaluating the effectiveness of such teaching. Pioneering attempts (for example (11, 12, 13)), to do this have, on the whole, been encouraging, but it remains very difficult to define and measure clear and reliable outcome measures or to set up educational programmes which are also well designed for measuring effectiveness. We are attempting to develop reliable measures of awareness and thinking skills based on students’ answers to brief clinical case-histories. But the relationship between students’ answers to written questions and their performance in clinical practice remains quite unclear. This is an area of educational study which requires a great deal of further development.

Acknowledgements
We would like to acknowledge the financial support of the Leverhulme Trust which has generously provided the major funding for the project. The project has also received generous funding from Oxford and District Hospitals Improvement and Development Fund and Oxford Hospital Services Development Trust. The grant holders are Mrs Caroline Miles and Professor Sir David Weatherall. We would like to thank the Project Assistant, Mrs Anne Yates, and the many students, doctors, nurses and other experts who have helped in the development of the project.

This paper was given at the Fifth International Congress on Medical Ethics at Imperial College, London, in 1993.

Tony Hope, PhD, MRCPsych, and K W M Fulford, DPhil, MRCP, both of whom are Honorary Consultant Psychiatrists, are, respectively, Leader and Director of the Oxford Practice Skills Project.

References
(2) Fulford K W M, Hope T. Psychiatric ethics. See reference (1).
Submitting manuscripts for publication

Papers submitted for publication should be sent in quadruplicate to: The Editor, *Journal of Medical Ethics*, c/o Imperial College of Science, Technology and Medicine, 14 Prince’s Gardens, London SW7 1NA. The journal considers papers only if they are not under consideration by any other journal at the same time. Rejected manuscripts are not returned. Papers should be in double-spaced typewriting on one side of the paper only. The preferred maximum length of papers is 3,500 words – absolute maximum 5,500 (including references). A total word count (including references) is requested. On a separate sheet some brief biographical details should be supplied, including the title of the author’s present post, degrees and/or professional qualifications (if any), and any other relevant information.

Two copies of the journal will be sent to authors free of charge after their papers are published. Offprints of individual papers may be bought from *Journal of Medical Ethics*, BMA House, Tavistock Square, London WC1H 9JR.

In March 1981 the JME adopted a simplified ‘Vancouver style’ for references: details are given in various issues, including December 1990. They are also available from the editorial office. The full text of the ‘Vancouver Agreement’ was published in the *British Medical Journal* in 1988; volume 296; 401–405. As the ‘Vancouver style’ is incompatible with the long-established style of references for legal articles, lawyers should use their own standard style, but try to facilitate reference by others. The journal is multidisciplinary and papers should be in clear jargon-free English, accessible to any intelligent reader.