

that age must never be considered has arisen.

Otherwise he attacks the paper by extrapolating it. Few 'ageists' are so extreme as to impose arbitrary age-limits on treatment. Everyone accepts old people want to live. We are discussing enforced choice. Nobody thinks cost-effectiveness should be the sole criterion for treatment.

When I ask people if they would save a thirty-year-old or an eighty-year-old, if forced to choose, all give the same answer. Perhaps Mr Rivlin would toss a coin? Perhaps that is a cop-out? Would he toss a coin if it were his own family?

The moral arguments for the 'ageist' approach are threefold, a fair innings, cost benefit, and public approval. The last is the grandmother argument I cited. Most eighty-year-olds would accept that the life of a twenty-year-old grandchild was more important than their own. Therefore it is reasonable for society to make the same general choice. It is not relevant to say that we older people might not sacrifice ourselves for another's grandchild.

References

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Teaching medical ethics

SIR

I enjoyed Shimon M Glick's article on 'The teaching of medical ethics to medical students' (1). I was amazed to see that there are many similarities in ethical thinking and behaving between Israel and Hungary. In fact, there seem to be more similarities than dissimilarities in the whole world, and not only between these two countries. For instance, isn't it a global phenomenon that there are, indeed, some individuals, mostly physicians, who question the entire enterprise of

teaching medical ethics to medical students? For those who doubt its value, it is enough to copy the behaviour of a professor, or perhaps to teach a few common-places as, for example, the physician is like the captain of a ship who has to make life-and-death decisions, therefore he/she has to assume a great responsibility. By glorifying and mystifying the medical profession and appealing to the vanity of future medical doctors, the holders of such views reveal they think that that is all ethics could and should offer. Nevertheless, sometimes this approach seems to work well, provided that the teacher can really serve as a model for respecting patients, both their dignity and uniqueness. Although this leads to paternalism, it is still better than any kind of nihilism that denies the moral components of medicine.

I could not understand – and certainly cannot share, even if it is a general belief – the idea that the basic moral character of medical students has been formed by the time they enter medical school. If that were true then how could one explain another general phenomenon, stated by Professor Glick himself too, that there is such a thing as pre-cynical and cynical years during medical training? Shouldn't that rather be viewed as a change in the basic character of the students? Teaching of medical ethics should, indeed, help to develop ethical reasoning and develop moral sensitivity but why ought we to make such efforts if we believe that basically we cannot change the students' character? Only 'to prevent the erosion that almost invariably occurs in those qualities during the medical school years'? This would only be a minor compensation compared with the goals we set out to achieve.

It is certainly an appealing and useful idea to involve talented people of various fields in ethics teaching of medical undergraduates. We have been doing it in our university for more than a decade now, and feel that such people can be very valuable in leading seminars, especially if – besides being interested in bioethics – they are highly committed to the work of teaching ethics. Indeed, they can be very refreshing and supportive. I do envy, however, Shimon Glick's university for being willing to have, and being capable of having, the students enjoy an early clinical

exposure. It would be interesting to know how much any dehumanisation of the physician/patient encounter might be blamed for the lack of such an early exposure. The strictly somatic approach most likely has some of its roots in the perfect isolation of basic scientific subjects, with no clinical input at all, which occurs in the first two years of medical school. This separation surely hinders the development of 'appropriate compassion or sensitivity', and the lack of this, I, too, would call an unethical practice of medicine. Bioethics should be an integrated part of medical training but it can be done only where university leaders believe that the moral issues of medicine and health care amount to much more than assuming the responsibilities of a ship's captain.

Finally, while agreeing with the writer's questioning of absolute truth-telling, I must express my reservations concerning his belief in the demand for the concealment of bad news, supposed to be characteristic of Eastern Europeans. My experience, and various surveys carried out in regard to truth-telling, indicate that a health institute is not run as a prison and the atmosphere is open and humanistic, then about 80 per cent of the people want to know the truth, even if it is devastating (2). It is well known that there are many ways to tell the truth. If the actual truth-telling is to be brutal, untimely, unprepared and disgraceful then certainly not many individuals will want to know the truth. In my view then, it is rather the circumstances surrounding the actual giving of information rather than a particular culture which determine the acceptance or refusal of such a principle of truth-telling.

References

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