

Teaching medical ethics

Teaching ethics in psychiatry: a one-day workshop for clinical students

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Abstract

In this paper we describe the objectives of teaching medical ethics to undergraduates and the teaching methods used. We describe a workshop used in the University of Liverpool Department of Psychiatry, designed to enhance ethical sensitivity in psychiatry. The workshop reviews significant historical and current errors in the ethical practice of psychiatry and doctors' defence mechanisms against accepting responsibility for deficiencies in ethical practice. The workshop explores the student doctors' own group ethos in response to ethical dilemmas, and demonstrates how the individual contributes to and is responsible for the group ethos through participation and also through non-participation.

*The student feedback about the workshop is reviewed. The Toronto Ethical Sensitivity Instrument was used to assess whether or not the workshop altered sensitivity. Compared to a control group the attenders' sensitivity was significantly increased (on Student's *t*-test *p* equals or is less than 0.002).*

Introduction

In 1986 the British Medical Association called for all medical schools to include medical ethics in undergraduate courses (1). A report of a working party chaired by Pond suggested guidelines to medical schools concerning the teaching, design and objectives of medical ethics (2). Assumptions that 'higher moral reasoning' is a desirable quality in doctors have been underlined by work such as that of Sheehan and colleagues, which demonstrated a positive association between moral reasoning ability and good clinical performance as a clinician (3).

Reasoning can only begin as a cognitive process once a problem has been identified. There must be a sensitivity to ethical issues before moral reasoning or reflection can occur. It is a matter of concern that there is evidence that ethical sensitivity may actually diminish over the course of medical training (4).

Key words

Ethics; course; psychiatry; medical students.

Fourth-year medical students were found to identify fewer ethical issues in case vignettes than students entering medical school. Authors describe how student doctors enter medical school with high ideals, and how their idealised picture of life fails to survive. Reconstruction of this picture must occur, to allow absorption of large amounts of factual information in limited time and also to protect themselves from psychological pain and distress (5). Any attempt to affect ethical reasoning must address the issues of reduced sensitivity, time constraints and the psychological defence mechanisms often used by students and doctors to minimise their own discomfort.

In deciding their behaviour doctors automatically or unconsciously heed their own needs or best interests. The part that these interests play should be recognised. To deny self-interest is, possibly, to lose control of its effects in determining behaviour. We include this aspect in our teaching, asking students to be aware of *direct* self-interests, for example financial or sexual interests and also *indirect* self-interests such as the reduction of *their own anxiety as doctors*, associated with one course of management rather than another.

Teaching methods traditionally used for promoting ethical thinking and 'moral reasoning' for undergraduates and postgraduates have included lectures, ethics case conferences, discussions of films and other techniques (6,7). Ethics is sometimes incorrectly seen as a 'soft' subject by students, since it is qualitatively different from fact-filled subjects and perceived by them as initially unfitted to objective examination techniques. However, some medical schools incorporate ethics examinations in Objective Structured Clinical Exam (OSCE) type settings (8) and other teaching methods challenge the notion that ethics is in any way a 'soft' subject (9). Since we felt that ethics did not lend itself well to the lecture format and since we were hoping to place some emphasis on the exploration of attitudes and perhaps even change those attitudes, we chose to use an interactive format rather than a didactic lecture. Such relatively innovative techniques often help to engage interest (10).

We designed the teaching around the ethical

domains of autonomy, beneficence, justice and non-maleficence (11). Traditionally, other objectives have involved improving understanding of the language and concepts used in ethics; increasing awareness of alternative views concerning ethical issues; promoting exploration of personal values; providing doctors with legal, psychosocial or other information pertinent to making ethical decisions; improving communication skills and ultimately promoting ethical practice (6).

These were our aims in constructing a workshop in psychiatric ethics for final-year students at Liverpool University Medical School. Our primary aim was to increase sensitivity to ethical issues in psychiatry, to promote discussion and demonstrate the breadth of beliefs on ethical dilemmas even in such a highly selected group and also to demonstrate personal responsibility in determining group *ethos*.

This paper describes the resulting workshop, course evaluation in terms of qualitative feedback and efficacy in terms of ethical sensitivity using the Toronto Ethical Sensitivity Instrument (4).

The Liverpool workshop

PART ONE

The aim of the first part of the workshop is to stimulate the audience by presenting examples of historical and current abuses in psychiatry. Four short videotape segments are shown, followed by an account of the interaction between state and medicine in Nazi Germany based on an account by Meyer-Lindenburg (12).

The four videotape sequences used are:

1) A sequence from Jonathan Miller's 1992 programme, *Madness*, describing the theories of cerebral localisation that arose out of observations of personality change in the unfortunate Phineas Gage. Gage suffered frontal lobe damage in an explosion in which a tamping iron was blown through his skull. The excerpt describes the Nobel-prize-winning work of Egaz Moniz, and the subsequent application of these ideas in the widespread use of pre-frontal lobotomy in the 1950s and 1960s. Miller interviews an exponent of the technique and reviews archive film of the technique and its results (included in the excerpt) and concludes with the long-term outcome of these patients and the current opinion and practice regarding psychosurgery.

2) A sequence derived from a 1992 programme by the American television interviewer Oprah Winfrey in which she conducts a group interview with victims of sexual abuse by psychiatrists and psychotherapists. An interview with a perpetrator is included.

3) A Granada television 1992 programme, *First*

Tuesday, on the United States' private psychiatric hospital system, worth an annual 30 billion dollars.

4) An excerpt from *Titicut Follies*, a film by Frederick Wiseman, of an asylum for the criminally insane in Bridgewater, Massachusetts, made in 1966. The monochrome film accurately depicts a harsh regime with little personal dignity. The state banned the showing of the film for twenty-five years.

The account derived from *The Holocaust and German Psychiatry* (12), demonstrates how the state can influence medical practice, and the conflict between some individual psychiatrists' beliefs and the legal requirements placed upon them. The forced sterilisation of the mentally ill under the 1933 law of 'Erb-Gesundheitsgesetz' is an example. The actions taken by only some psychiatrists to oppose sterilisation and euthanasia programmes are explored.

This brief and uncompromising introduction therefore places a variety of issues on the agenda for discussion: personal ambition obscuring individual clinical decisions (the widespread use of lobotomy – tape 1); personal desires conflicting with considerations for the long-term benefit of the patient (tape 2); personal monetary gain prolonging treatment of the mentally disordered (tape 3); insufficient recognition of human rights of patients (tape 4), and conflict between acting according to the state's requirements and the individual needs of the patient (the law in Nazi Germany, treatment decisions based on cost to society rather than individual benefit).

The group is given the opportunity to discuss the tapes and situations presented to them. Sometimes members of the group are shocked by the images and need to discuss their feelings of anger or disbelief. All agree that these are good examples of the special relevance of ethics to psychiatry. The group initially tend to distance themselves from the 'abusing' doctors as they are perceived. By way of defence students place a variable emphasis on the events being either in another country (Germany, United States) or having taken place many years ago (the Holocaust), or on the problems being confined to psychiatry. Some time is then spent on talking about the individuals shown in the tape sequences. Some members of the group point out that even the perpetrators of abuse distance themselves from their acts. The surgeon in tape 1 has forgotten that he took part in the archive film shown, the abusing psychiatrists in tape 2 rationalise their sexual behaviour. The concept of psychological defence mechanisms is explored with the group, and their own 'distancing' behaviour gently pointed out. The group is questioned: 'Are such ethical abuses really only confined to other countries, other times and psychiatry in particular? If not, why do some doctors have a tendency to behave unethically in some instances now? How can ethically abusive behaviour be minimised in the future?'

Part Two

In the second part of the workshop we aim to explore the unique *ethos* of each particular group. The group is split into groups of three or four student-doctors. Each sub-group is then given a different dilemma printed on a card and given a room in which to discuss the dilemma. The ten existing dilemmas cover aspects of patient confidentiality; issues of consent and refusal of treatment; autonomy and the loss of insight; protection of third parties; the interaction of society and psychiatry; following orders that conflict with personal belief systems; genetic counselling; sick doctors and the medical hierarchy, and potential conflicts that arise over budgets and treatment decisions. Examples of these dilemmas are given in appendix one.

The subgroups are given 20 minutes to discuss their dilemma and choose a spokesperson who will present their solution. The solution must be an agreed policy of what they would actually do in that circumstance. The spokesperson must then justify the policy, having pointed out the advantages and disadvantages of that action for 1. the patient, 2. the doctor, and 3. society at large.

The spokespersons for each small group present their dilemma and their solution to the larger group. The lecturers who are present act purely as facilitators, to help explore the group's reaction to the subgroup's dilemma and solution. Discussions can become quite heated and the teachers must be aware of their own emotional reactions to dilemmas and the solutions proposed. It is important that the facilitating teacher appears to remain neutral throughout the discussion, or else the opinions expressed by the group will be 'edited' accordingly. The lecturers seek to try and tease out all opinions that exist within the group. Groups may be asked to vote on a course of action to determine what the prevalent *ethos* of that group is. Serial groups often reach very different conclusions from each other.

Facilitators may, towards the end of the discussion, make suggestions as to what the currently accepted solution to the dilemma might be, but they take care not to say whether they consider this solution ethically right or wrong. So, in the instance of the sick doctor dilemma, we give information regarding the UK sick doctor scheme, and the General Medical Council Health Committee. In the dilemma concerning a suicidal depressed patient's refusal to enter hospital we discuss the relevant current mental health legislation. In a dilemma concerning confidentiality and child abuse, we give information concerning the regional policy on the disclosure of child sexual abuse and the protection of third parties. We point out an inherent tendency of doctors to equate a legally correct solution with an ethically sound solution. The group is often intrigued to try and learn what the teachers consider to be the ethically correct solution, but we resist the temptation to comment since the exercise is

designed to make the group aware of its own *ethos* and how the individual beliefs of its members, expressed and unexpressed, may affect the *ethos*, and therefore the actions, of themselves and their colleagues.

DISCUSSION

The workshop is a busy one, discussions are never forced and facilitators have to limit spontaneous discussion to keep within the time-limits of the afternoon. Facilitators may also need to limit, within reason, individuals who take up more time in the discussion than others, although usually the large group self-regulates. Since the format is stimulating and discussion is broken down into small groups who each 'own' a dilemma, few, if any, individuals remain silent throughout the afternoon. We do not allow the afternoon to overrun, because despite the temptation to continue the discussion, we believe that set-limits contain anxiety and allow time for reflection after the workshop.

The images and issues raised in the workshop are often re-visited by students with their supervising consultants throughout their clinical attachment in psychiatry and in small-group tutorials with lecturers in the academic department. We suspect that there is a lasting effect, but this is not systematically tested yet.

EVALUATION

Routine evaluation has been by feedback questionnaire. We ask students to provide us with qualitative feedback, stating what they like best about the workshop, what they learnt from it that was new to them and what might be done to improve the workshop.

Students appreciate the historical references, the video clips and the discussions. It is clear that they welcome being listened to by their peers and debating their own viewpoints. One feedback form stated: 'The uncritical style of the presenters is good, because in the end the group can come up with a solution that most people are happy with', and 'the lecturers seemed genuinely interested in our ideas'.

The most important things that they learn are given as 'the complexity of ethics'; 'the many possible responses that you could make in difficult situations'; 'how much people's solutions differ'; 'the importance of checking things with your colleagues'; 'that we must consider ethical matters all the time'; and 'the dangers of private medicine and putting doctors' financial interests before the interests of patients'.

Improvements that are suggested include a refreshment break, requests to see all of the video programmes in their entirety and requests for precise definitions of terms like ethics, autonomy, consent, negligence and duty.

We have begun a systematic assessment of the

course by assessing students' ethical sensitivity before and immediately after the course. The Toronto Ethical Sensitivity Instrument was given to 33 students at the very beginning of their psychiatry lecture block and again four days later at the end of the ethics workshop. A control group of 33 final-year students from the next series of students taking the same course six weeks later was also given the instrument at the beginning and end of their psychiatry lecture block. Instead of the ethics workshop a 'neutral' workshop on stress management was given to the control group. Thus we were able to assess the immediate impact of the workshop since both groups had similar medical student experience, had both sat through the same lecture series on psychiatry and differed only in terms of participation in the ethics workshop.

The Ethical Sensitivity Instrument presents students with four vignettes and asks them to identify the ethical issues present in each. The written information from each student can be marked according to a 'gold standard' as to whether certain key issues have been picked up. The instrument was rated independently by the three authors who were blind to the identity of the students, their sex, whether the instruments being rated were pre- or post-course, and which course (with or without the ethical workshop) the instrument came from. Ratings were logged on special forms and only later decoded as to identity.

RESULTS

The correlation between the three raters' overall ratings was 0.70. Immediately after the ethical workshop there was a significant increase in the students' ethical sensitivity. The mean ethical sensitivity score before the course was 7.36 and after, 9.90; one-tailed Student *t* test ($p = \text{less than or equal to } 0.002$). There was no significant difference in ethical sensitivity ratings over the four days of the psychiatry course without the ethical workshop (mean score pre course = 7.09 and mean score post course 7.39, one-tailed Student *t* test $p = \text{less than or equal to } 0.33$). There was no significant difference in the ethical sensitivity between men and women in any of the groups.

Conclusion

It seems that the Liverpool ethics workshop in psychiatry is subjectively appreciated by our students who appreciate its use of history, video images and group discussions. Objectively it appears to raise immediate ethical sensitivity, but we do not know whether this effect persists, and if so for how long. There are very few unflawed studies of the effects of ethics teaching (7). We hope to perform further prospective studies to investigate whether such a workshop changes ethical sensitivity and reasoning in the short and long-term.

Appendix one

ETHICAL DILEMMAS

The sick doctor

You are a junior doctor in general medicine. Your consultant is consistently late for ward rounds. In the mornings he has a marked tremor and his breath continually smells of alcohol. He appears to be getting forgetful and is always mixing up his patients and their illnesses. Other more senior doctors on your team desperately try and cover for him. What do you do?

Following orders

You are a consultant psychiatrist. There is a change of government. The incoming party favours the policy of eugenics. Using the latest discovery (that major psychoses have a high genetic component) as justification they pass a law to the effect that proven sufferers of psychotic illness must submit to sterilisation. You are asked to provide the Home Office with a list of your patients. What do you do?

Consent to treatment: 1

You are an accident and emergency doctor. A 24-year-old man is brought in by his brother. Earlier that evening he had tried to hang himself after his marriage broke up. His brother cut him down and 'talked him round'. However, the patient had a change of heart later and took 24 tricyclic antidepressant tablets and 50 paracetamols to kill himself. His brother found out an hour later, by chance.

You see the patient, but before you can physically do anything the patient refuses to co-operate. You try and persuade him to co-operate, but he says he is a law student and that any treatment by you without his consent is an assault. Unfortunately, he lapses into unconsciousness as you argue your case. What do you do?

Consent to treatment: 2

You are a consultant psychiatrist. An outpatient's family doctor asks you to visit her. She is aged 40. She isn't eating and hasn't drunk anything since the day before. She says that there is nothing inside her and that she has no future. She wants to die and is lying immobile in a darkened room 'waiting for death'. You assess her and think that she has features of a severe depression and ask her whether she will come in to hospital for treatment. She refuses your offer. What should you do? Is this in the patient's best interest?

Consent to treatment: 3

An 80-year-old lady is refusing to see her family doctor for routine screening which he is paid to do. He presses the point since his contract stipulates he should screen all elderly patients. She reluctantly agrees and in the course of a physical examination

discovers she has a carcinoma of the vulva. He arranges an appointment with a gynaecologist with a view to surgical treatment. She refuses to comply. What can or should the family doctor do?

Confidentiality

You are a general practitioner. A 24-year-old man has been coming to see you 'in confidence' for puzzlingly trivial minor complaints. Now he tells you that he has been unsure of whether to tell you something he has been ashamed of all his life. Can you promise that you will treat it in absolute confidence?

You reassure him that you will treat his remarks confidentially. He tells you that he was sexually abused by his father until the age of 17. As a consequence he is worried about his own sexuality. However, whilst he is talking you realise with some discomfort that his 13-year-old brother is now being abused by the father. What do you do? Do you respect the confidentiality of the discussion or do you do something else?

A genetic disease

You are a general practitioner. A 21-year-old woman comes to see you about starting a family. Her husband is worried and has not accompanied her. His father died in his thirties of a movement disorder characterised by unintentional choreiform movements. His grandfather died in his fifties of a dementing illness and similar odd movements. Her husband is aged 23 and is asymptomatic. What would your advice be?

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