

Ethics briefings

How should students learn? Some continuing difficulties with consent

The availability of skilled doctors is both a necessary and an incontrovertible public good. How they should develop their skills, however, and what doctors and patients can reasonably expect in a teaching context, may raise ethical concerns. At some point, medical teaching must leave the classroom. Patients understandably expect doctors to be expert in any procedure they undertake, yet every doctor must have a "first time". This conflict between the need to learn and the desire for the best available treatment is not easily resolved. Without appropriate supervised practice, doctors are likely to be clumsy or inexperienced when carrying out procedures that should be routine, and harms would inevitably result. In contrast, what constitutes a legitimate intrusion when a person is ill and vulnerable? Perhaps all members of society have a duty to participate in the teaching of doctors as all individuals are likely to need their skills in the future? Medical procedures need both technical expertise and communication skills. So, much can be done with mannequins and, with appropriate permission, cadavers, but at some point the transition to live patients is needed.

Sometimes teaching medical techniques causes conflict between the need for students to learn and the need to protect patient autonomy. The utilitarian justifications that once governed teaching practice, holding that the net social benefit outweighed any harm to individual patients, are beginning to give way to a more rights based or deontological approach that sees individual autonomy as an almost inviolable good. Practice in the past may have failed to recognise or to heed the significance of patient choice and the importance of recognising, in Kant's phrase, that patients are "ends

in themselves". It follows of course that patients are not being exploited as a "means" if they voluntarily consent. In turn however, this raises the issue of the extent to which doctors should inform their patients if they are inexperienced in a particular procedure. Would this add unnecessarily to the burden of a patient's anxiety? Although not advocating a return to the "bad old days", it is worth pointing out that a rights based approach may have a significant cost measured in terms of the public good.

One particularly controversial practice in this area is the teaching of pelvic examination techniques on unconscious patients. In 1993 the BMA published guidelines¹ on this issue, suggesting that consent was essential. With the subsequent publication of guidance by the Royal College of Obstetricians and Gynaecologists² there was a general feeling that the issue had been laid to rest, although occasional anecdotal reports of bad practice were still heard. In January of this year, these indications were confirmed by a paper indicating that in a study undertaken in 2000, up to a quarter of examinations on anaesthetised or sedated patients were apparently undertaken without consent.³ As well as raising questions about consent, communication, and respect for patient autonomy, the study also highlighted the difficulties students face when they believe they may be witnessing unethical practice. The perceived violation of patient autonomy and the intimate nature of the interventions inevitably raised questions about medicine's reputation. It must also be a source of acute anxiety that apparently typical practice in an English medical school regularly exposed students to legal charges of assault⁴ and of disciplinary action by the General Medical Council which says doctors must respect the right of patients "to decide whether or not to undergo any medical intervention".⁵

Both the ethical aspects of teaching medicine, and the teaching of ethics within the medical curriculum have been on the BMA's agenda in recent months. These issues are not easily resolved; identifying the problem is only half the battle, with the challenge of finding an effective solution remaining. There is considerable sympathy for the view that patients have

duties, although these cannot be enforced. A potential way of ameliorating the conflict is to provide ethical guidelines for doctors and information sheets for patients, outlining what they could legitimately expect. Given, however, the findings that despite published guidelines unethical practice continued, arguably the value of guidelines lies not in the skill with which they were drafted but in the effect they have on practice. The need for reviewing doctors' ethical skills throughout their careers is widely acknowledged, but it appears this recognition may still have to be translated into practice.

The crux of the problem lies in the conflict between the rights to, or the legitimate expectations of patients that they will receive, the highest possible standard of treatment, and the public interest in the benefit they can expect from future doctors receiving the best education possible. It also raises the question of how students should respond. Students need ways to make any genuine concerns heard. Such mechanisms need to both offer them appropriate protection but must also be seen as legitimate within the hierarchy. Producing guidelines is one thing, but if students feel that by invoking them they will only bring disadvantage to themselves they are unlikely to do so. In the end, responsibility for resolving the problem lies with the senior doctors and administrators who maintain the structures and set the examples. Unless changes take place at this level, with appropriate guidance and reporting procedures built in, formal guidelines will be ineffective.

In large part the various ethical problems raised by the teaching of medicine betray large scale shifts in social attitudes and expectations. Ultimately, responsibility for providing workable solutions that balance both patients' private interests in autonomy, and the public good in educating doctors—which in turn will safeguard the autonomy of future patients—lies with the broader society.

Future legal status of tissue blocks and slides

In the UK, the wide ranging public consultation about the retention and

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use of human tissue continued into February 2003. In November 2002, the Retained Organs Commission which had been set up in 2001 to oversee the return of improperly retained tissue and recommend how the law should be changed, issued its latest consultation document⁶ on the future legal status of blocks and slides (tissue blocks are small pieces of tissue). It noted that the public was largely unaware of blocks and slides, which are either made in connection with patients' treatment or as part of a postmortem examination. Retained blocks and slides have played a role in defining vCJD, AIDS, the causes of cot death, cerebral palsy, and epilepsy but have rarely been mentioned to patients or their relatives. The consultation raised fundamental questions about ownership of such human material and whether modifying it for scientific use would effectively change its legal status. Interestingly, in the consultation the commission made clear that its controversial decision to return to patients' relatives all previously collected blocks and slides was "not necessarily based on sound legal or ethical arguments" but was justified on the basis of humanity and compassion.

In response to this consultation, the BMA argued that patients should be made aware about the use of blocks and slides made for their treatment and that these should be treated as part of their medical records. Patients should also be asked whether they are willing to donate such material for education or research once the diagnostic value has been exhausted. At postmortem examination, the making of blocks and slides should be regarded as a normal facet of the examination and relatives need to be aware of this.

This followed on from the in depth consultation in England and Wales in autumn 2002 about potential law reform on wider aspects of tissue donation and use.^{7 8}

Equity and prison health care

A central ethical argument about the provision of health care to detainees is that it should meet the same standards as health care in the wider community. This goal clearly requires comparable

resourcing and equitable access to treatment, including psychiatric care, for prisoners. In Britain, however, there are general problems of poor health and high psychiatric morbidity in the prison population, and the prison health care system has long been seriously under-resourced. This has resulted in difficulties in recruitment of doctors and nurses.⁹ In England, Wales, and Scotland, prison health care has also traditionally come under the jurisdiction of the Home Office rather than the National Health Service. The BMA has argued that this is an unsatisfactory arrangement, not least because it blurs the distinction between the prison doctor's role as care provider and the disciplinary role of other prison staff. The BMA has long highlighted the importance of separating the role of the prison doctor from the security and disciplinary role of other staff.¹⁰ It felt that this could at least start to be achieved by the important symbolic step of bringing prison health care into the public health care system.¹¹ In 2001, the Chief Inspector for prisons in England and Wales also recommended that responsibility for prison health care be transferred to the NHS.¹² From April 2003, funding for prison health care in England passed from the Home Office to the Department of Health and a substantial funding increase was agreed but this, in turn, highlighted other potential dilemmas about the allocation and equitable distribution of funding. It is envisaged that primary care trusts will eventually be responsible for commissioning all health care services for prisoners held in their locality, as with other residents. Some argue that these commissioning bodies are best placed to ensure that good quality care is provided to prisoners. On the other hand, such commissioning bodies may perceive prisoners as only temporarily in the area and feel less concerned about spending money on their welfare since, once released, prisoners return to their homes. Some argue, therefore, that primary care trusts in the home locality of prisoners should be entrusted with commissioning since they have a longer term interest in ensuring the quality of prison health care.

Assisted suicide

On 20 January 2002, a 74 year old man from Liverpool died after travelling to Switzerland for assisted suicide, using barbiturates supplied by the organisation Dignitas. Mr Reginald Crew, who had motor neurone disease, was accompanied to Switzerland by his wife and a TV crew. The resulting programme was shown in late January: *Tonight with Trevor McDonald*, "Reg's last journey—a tonight special", ITV1, 24 Jan 2003. Merseyside police announced that they are investigating Mrs Crew and members of the TV crew for aiding and abetting suicide.

Mr Crew was not the first Briton to travel to Switzerland for euthanasia, and the Swiss authorities are reportedly alarmed at being seen as a centre for "suicide tourism".¹³ The Swiss parliament could, however, take up to 18 months to prevent this.

The events have led to renewed calls for euthanasia and assisted suicide to be legalised in the UK.

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