The Roman Catholic Church and embryonic stem cells

Skene and Parker raise a number of concerns about religious doctrine unduly influencing law and public policy through amicus curiae contributions to civil litigation or direct lobbying of politicians. Oakley picks this up in a way with an emphasis on the Roman Catholic Church’s interest in preventing the destruction of embryos for embryonic stem cell research. Skene, Parker, and Oakley seem to be concerned mostly with religious views having undue influence on public policy. My concern is the negative effect that such Church influenced public policy may have on the progress of the biomedical research that is itself foundational to the debate. Oakley seems to be particularly incensed that, as he puts it: “Those who support a total ban on embryonic stem cell research sometimes talk as if theirs are the only views based on moral principle”. What seems to be at issue here though are not the moral principles of the sanctity and dignity of human life, but the application of those moral principles to biomedical research.

The Roman Catholic Church has historically defended the sanctity and dignity of human life to varying degrees at different times. Human life for much of the past 2000 years was defined by the Church as the presence of the soul, which was thought at different times to appear at various different stages during development. Only recently, with the advent of modern biology, has the Roman Catholic Church shifted its position to claim that the fertilised egg also qualifies as the right sort of human life. It should be noted that this doctrinal change was fundamentally driven by developments in our understanding of embryology and not the process of ensoulment. The Church’s current position on the embryo is thus based not solely on Church doctrine but also on a specific interpretation of our empirical observations of human development. It is the Church’s interpretation of the biology of early human development that is foundational to their current stand against experimentation on early embryos. However one of the reasons we may wish to experiment on early embryos is that we know surprisingly little about them. In fact any position that claims to be based on a solid, empirical understanding of the embryo is essentially misleading, as we simply do not have the data available. The reply to this will inevitably be that we know enough about embryos to make certain claims. For example the Roman Catholic Church likes to point out that the early embryo is obviously the earliest stage of a human life, and thus attributes to it many of the characteristics associated with actual people. Many would disagree with this on the grounds that the Church has confused being merely human with being a person. I am concerned by the claim that the early embryo is obviously the early stages of a human life.

My concern is not that the claim isn’t obvious to some people but that obviousness is a dangerous thing when it comes to science. It is, for example, quite obvious to me that I am currently sitting at my desk. Empirically my senses seem to confirm that I am more or less stationary. I may well believe that I am stationary. For much of human history we believed the earth to be stationary at the centre of the universe. This assumption was confirmed in the western world by the Church itself. Church doctrine confirmed that the earth was the centre of the universe with the heavens above and hell below. When Galileo challenged this view by promoting the sun centred Copernican system of cosmology the Roman Catholic Church attempted to silence him. The Church’s attack on Galileo and Copernicanism was tripartite. Firstly, the Copernican system appeared to contradict some scriptures. Secondly, the Copernican system contradicted the Church sanctioned science of the day represented by Aristotelian physics. Thirdly, the appeal to obviousness or the immediate evidence of the senses. Of the three, only the scriptural objections were undamaged in nature. The appeals to science and obviousness were able to be settled by empirical evidence. We now know that we are not stationary at the centre of the universe although this is still far from obvious to many people.

Any position that claims to be based on a solid, empirical understanding of the embryo is misleading: we simply do not have the data.

The situation 400 years ago regarding Copernicanism thus seems to be very similar to that today regarding the status of the early embryo. The Roman Catholic Church tried to prevent Galileo from collecting empirical evidence using his telescope and disseminating his empirical evidence by banning his books. Similarly the Church today has attempted to prevent the gathering of empirical data on the basic properties of stem cells that might show unexpectedly properties of stem cells the basic lack of empirical evidence regarding the embryo as such developments as the unexpected properties of stem cells the Roman Catholic Church’s input into the embryonic stem cell debate has not been simply moral or ethical as one might assume but has openly defended a particular claim about the biology of the early embryo. Given the basic lack of empirical evidence regarding the embryo and such developments as the unexpected properties of stem cells the Roman Catholic Church’s choice of position on the biology of the embryo seems to be chosen solely as a prop for its doctrinal position. This prop has then been introduced into the secular debate on the status of the embryo as a somehow obvious empirical claim.

I believe the Church’s religious fervour for its preferred doctrinal and scientific position of the day is fundamentally at odds with the process and progress of science. Science is an exploration of the physical world that is characterised by ever accumulating facts and, historically at least, major shifts in understanding. Over the last 400 years the Roman Catholic Church has been slow to accept that science progresses at all and has protected to maintain its doctrinal position as a matter of faith even when it has been shown to be empirically unsound. My concern here is I think similar to that of Skene...
and Parker. The Roman Catholic Church's contributions to public policy are based not only on their moral or ethical principles, but on any effectively arbitrary and dogmatic application of those principles that is backed by the full force of what is effectively a very powerful lobby group in many countries. Like Skene and Parker, I have no answer to the problem I have raised. Historically one thing is certain, in the future the Roman Catholic Church's current position on the embryo will be judged to have been right or wrong with the wisdom of hindsight. Just as we judge the Church's persecution of Galileo almost 400 years ago now.

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Non-compliance: a side effect of
drug information leaflets
The problem of non-compliance with treat-
mant and its repercussions on the clinical
evolution of different conditions has been
widely investigated.1 Non-compliance has
also been shown to have significant economic
implications, not only as a result of product
loss but also indirectly through the complica-
tion of disease management and its subse-
tuent healthcare and social costs.

Non-compliance as a health problem
The term “non-compliance” might be taken to
refer both to the failure to follow a drug
regimen and to the failure to adopt other
measures that contribute to improvement in
health—for example, changes in lifestyle or
diet. This letter focuses on the former.

Non-compliance with a drug regimen can
be the result of a number of different factors10 and a
variety of techniques have been
developed in an attempt to control it.11 12 Discussing
this, the few techniques that have been shown to be effective have only managed to
solve the problem in specific situations over
short periods of time. The use of such
techniques to control non-compliance, parti-
cularly where these are effective, raises
interesting ethical questions about the extent
to which their application constitutes an
infringement of the patient's right to
decide on how to manage their own health.13 Here we
suggest that in some cases one factor that
leads to non-compliance is the tendency to
provide extensive and exhaustive information
on side effects in patient information leaflets. Consider the following case.

A true story
One morning Dr Smith woke up with a slight
cold—muscular aches, headache, chills, and
nasal congestion. He decided to take some
medicine to counteract its effects. His initial
thought was to find something to combat his
runny nose, so he chose a product specially
indicated for congestion: “StopSnorting”. After
reading the product information leaflet, how-
ever, Dr Smith felt another kind of chill
run down his spine. He was struck cold by
the contraindications, warnings, interactions,
precautions, and contraindications listed in
the leaflet. If he had used this drug, it said, he
would run the risk of suffering nausea,
headache, chills, and jaundice, kidney disease,
peptic ulceration, mouth ulceration, visual abnormality. . . . So in the end, armed with his clinical and
pharmacological knowledge, Dr Smith simply
opted to continue blowing his nose and suffer
a few muscular aches. He had no desire to
play Russian roulette with his health.

The principle of autonomy and the
right to information
The principle of autonomy in medical ethics places the patient at the centre of medical
decision making about his or her care. It
places particular emphasis on the importance
of informed consent, and suggests that, except in rare situations,14 no patient should
undergo medical treatment or surgical inter-
vention without his or her fully informed
authorisation. This is the basis of patient-
centred medicine.

To obtain valid informed consent, it is
argued that the patient must receive suffi-
cient understandable information to make
a fully informed choice. In practice this
means that someone undergoing a specific treat-
mant receives information from at least two
sources. Firstly, they must be given direct
information from their doctor or another
health professional about the drug to be
taken, recommended lifestyle changes, and
perhaps a warning of the hazards related to
non-compliance. They should also be told how
they will also be provided with information on
some of the side effects attributed to the drug being
prescribed. Individual patients will tend to
understand this information in a range of
different ways, and it is well recognised that
they will respond with a variety of known
behaviour patterns.15,16

Secondly, the patient will also receive
additional information on side effects from
the information leaflet included with the
drug itself. These leaflets tend to cite each
every one of the undesirable effects related—note “related”—to the principle
active ingredient used in the drug. The information can in some cases be so complete
or detailed that even any extremely unusual
syndrome described in relation to the use
of the drug will inevitably be listed in the leaflet as a possible “side effect”.

This information can sometimes have a
significant effect on the likelihood that a
patient will take the drug in question and
may lead to significant “non-compliance”. When patients with minor ailments read
about all the problems that may occur from
using the prescribed medication, they may
start worrying, to say the least. Some people
read the leaflet again and again. They may
then consult another source of medical
information such as a website and perhaps
decide to take only half the dose for half the
amount of time prescribed, or simply decide
not to take the medicine at all.

In addition to the problem of non-compli-
ance, the so called nocebo effect17 needs to be
considered, whereby the patient’s mindset
is often a key element in the appearance of either
physical or imaginary side effects, as has been
shown in various studies.18 19 Such an effect
may be caused by information leaflets.

Complete information versus suffi-
cient information
Practically any city dweller would refuse to
use transport services, work tools, or recrea-
tional facilities if they were supplied with
complete, absolute, and extensive informa-
tion on the hazards using these might entail.
Precautions and warnings are usually good
things, but they should be kept within
reasonable limits to avoid creating outright
alarm. Too much information can sometimes
undermine autonomy and also lead to sig-
nificant harms through non-compliance.
It was shown some years ago20 that
information supplied by doctors can generate
side effects that cannot subsequently be
corroborated by physical examination. As
it happens all too often, the information was
not as exhaustive or complete as it might be.
In view of this, we believe that the kind of
information given in drug descriptions should
be reassessed. The information should
be true, accurate, and easy to understand in
as complete a way as possible, but it should
not generate alarm that can lead to deleter-
ioues consequences in the healthcare sector or
in the economic sphere.

So what did the patient decide?
The patient, shocked and dismayed at the
drug’s side effects, finally decides not to follow
the doctor’s recommendation. He (or she) will
try to relax, perhaps by smoking a cigarette
laced with nicotine, tar, and a number of other
substances. True enough, doctors recommend
giving up smoking. But who will listen to what
a doctor says about smoking when they appear to
be prescribing drugs truly hazardous to
health? After all, a pack of cigarettes only says
that cigarette smoking seriously damages your
health. There is certainly no leaflet listing each
and every one of its possible side effects.
Tobacco kills, but it sometimes looks as if
medication is worse.

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We read with interest the papers on informed consent published in a recent issue of the Journal of Medical Ethics.1 Whatever their differences, and however much they questioned some aspects of the duty to respect autonomy through attempting to obtain informed consent for therapeutic interventions, there was general agreement that competent adult patients are entitled to a core of basic information about their treatment options. There was also consensus that training in the process of obtaining consent is important. In this experience, two dimensions of such training are of particular interest. On the one hand, students require good theoretical understanding of the ethical and legal background to the professional emphasis now placed on informed consent. On the other hand, they need practical training in the relevant communication skills and how to apply them to obtain consent for specific clinical procedures. To do so, doctors must obviously also have a good understanding of these procedures. We recently encountered serious problems of this kind such understanding in a study among junior doctors in England (Schildmann J, Cushing A, Doyal L, Vollmann J). The ethics and law of informed consent: knowledge, views and practice of pre-registration house officers (PRHOs), submitted (elsevier publication). No matter how good their philosophical and legal knowledge, preregistration house officers (PRHOs) will not be able to deliver the minimal standards of informed consent outlined by O’Neill unless, suffice it to say, they know what—practically speaking—they are talking about.

In contrast to Bravo et al’s results (in the same issue of the journal), almost all the PRHOs who took part in our survey had good legal understanding of the differences between competent and incompetent patients. This may be interpreted as a positive result of the change in the curriculum of their medical school, which includes extensive sessions about informed consent. These embrace ethics, law, and communication skills. However, despite their understanding, the junior doctors in our study still experienced problems about their role in the consent process. The problems pertained to pressure of time and lack of support by senior doctors, as well as pressure on them at times to obtain consent in circumstances where they had been taught that they should not. This gap between the standards of informed consent currently taught to medical students and the clinical realities they face, and into which they are thrust, is an ongoing problem.2

If informed consent is to fulfill the purpose of respecting the autonomy and dignity of patients, sufficient resources are required to train young doctors to do the job properly, especially as regards their understanding of procedures for which they are providing information and their competence as communicators. One thing is clear: if they cannot complete the task in accordance with the guidance issued by the General Medical Council and the Department of Health, they should not be doing it at all.1 Trusts and colleges should ensure that all supervisory staff are aware of their responsibilities in this regard.

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Response to ‘Patient organisations should also establish databanks on medical complications’

Gebhardt in his brief report1 pleads for patient organisations to establish databanks on medical complications. Given the references (for example, an article by Paans, a journalist, entitled ‘Medical errors to be kept secret’,2 and an implication that an error has been made. This is why the term “adverse outcomes” is used rather than the term “complications”, since the latter term is often confused with an error being made. The registration of medical complications that Gebhardt refers to is a registry of so-called adverse outcomes guided by an unambiguous definition of the term “adverse outcome”, of which only a small percentage is related to errors.3,4 Some errors will be missed in this registration—that is, errors which have not led to adverse outcomes.5

Secondly, with respect to confidentiality, this is relevant in particular for the initial years of such a registry during which it is thoroughly tested and accuracy of the registry may vary widely between participants. Nothing is gained by false positive signals with respect to the high incidence of adverse outcomes in some hospitals, except perhaps by flashing headlines in newspapers. In this respect one may compare the development of such a national registry to the development of a new drug, in which case no one argues about confidentiality during thorough testing until proved safe. Moreover, a pharmaceutical company will probably be sued if it markets a new drug without proper research. It is intended that after this initial period, national adverse outcome databases will be available to the public with respect to probability of an adverse outcome given certain types of surgery.
Box 1: Patients need information to make a well-informed choice

Who is a good doctor and what is a good hospital? This simple question is not easy to answer as it involves personal, cultural, moral, and situational factors. Patients are interested in the experience of doctors and hospitals to treat certain diseases or to perform certain operations; however, the question they are most interested in is “What is the best place to go to for this type of problem?” Therefore, it is important to know the underlying principles in this response.

The NPCF (Dutch Federation of Patients and Consumer Organisations) and its member organisations have published several consumer guides for specific diseases, which are in line with the principles of patient autonomy and respect for patients’ decisions. These consumer guides provide patients with information to help them make an informed choice about treatment and hospital care. The NPCF has chosen to work together with organisations of healthcare providers and insurance companies to use parts of their databases as a basis for consumer information. One task of the NPCF is to translate the data into consumer information that meets the needs of the patients, based on research and experiences of patients. Joint efforts are needed to make this important information accessible for doctors and patients.

Dr I van Bennekom, Director, NPCF

Finally, what does the patient want? (see box 1). International research has shown that patients do not use public information on performance of hospitals or doctors for making a choice of treatment or hospital because, among other reasons, they do not understand and do not trust this data. This also applies to adverse outcomes data. For interpreting the incidence of hospital specific adverse outcomes it is important to know that this is often not clear— for example, since older, sicker, and more complex patients have higher probabilities of adverse outcomes. It is therefore vital to establish a reliable registry which can be trusted and understood both by medical professionals and the public. For this reason, the Association of Surgeons of the Netherlands and the Dutch Federation of Patients and Consumer Organisations (NPCF) are collaborating with respect to the national surgical adverse outcome registry, in particular, to produce information that is relevant for patients about treatment and hospital choices. Supported by the international literature, the NPCF holds the view that patients are not primarily interested in data on adverse outcomes, since they are aware that these data need to be interpreted in the right context. Patients are more interested in the experience of doctors and hospitals to treat certain diseases or to perform certain operations, since the question they want answered is “What is the best place to go to for this type of problem?” That this question is more likely to be asked is even more the case if the patient has a high adverse outcome record, and not relevant for patients about treatment and hospital choices. Supported by the international literature, the NPCF holds the view that patients are not primarily interested in data on adverse outcomes, since they are aware that these data need to be interpreted in the right context.

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What do patients value in their hospital care? A response to Joffe et al

In the Journal of Medical Ethics, Joffe et al recently published an article titled “What do patients value in their hospital care? An empirical perspective on autonomy controlled bioethics.” This empirical study evaluates whether patients’ willingness to recommend their hospital to others is more strongly associated with their belief that they were treated with respect and dignity than with their belief that they had an adequate say in their treatment.” Joffe et al go on to suggest that confirmation of these empirical hypotheses would constitute a prescription for elevating the principle of respect for persons to the level that the principle of respect for autonomy currently enjoys in our model of the ideal patient–physician relationship (p 104). In other words, they suggest that by

“Joffe et al also evaluate whether patients’ reports that they had confidence and trust in their health care providers significantly predicted whether they would recommend the hospital to others.”

This is important because it reflects the respondents’ real moral sensibilities, and not those stemming from superfluous prejudices or their mood on the day they happen to respond. However, important questions, however, for researchers, who, like Joffe et al, are using the concept of reflective equity: (1) precisely how should considered judgements have to be if they are to count; and, more practically, (2) how can a researcher know whether he or she is collecting them—that is, what survey method, if any, is appropriate for the task?
Although it is difficult to give a positive answer to these questions (and I will not attempt to do so here), some survey methods, such as the mailed questionnaires that Joffe et al used, seem particularly inadequate. Rawls suggests that certain external conditions favour the formation of considered judgements: “the person making the [considered] judgment is presumed to have the ability, the opportunity and the desire to reach a correct decision (or at least, not the desire not to)” (p 48). Very likely, however, many of Joffe et al’s respondents lacked the necessary ability, opportunity, or desire to reflect on their moral judgements when responding to the questionnaire they received in the mail. Furthermore, even if a number of patients did offer legitimate considered judgements, there is no way to distinguish these from those made by respondents who lacked the requisite ability or desire. Although the size of Joffe et al’s study is of value for its ability more accurately to reflect a population’s response to its survey questions, because of the practical limitations that come with its size, the study falls short of capturing patients’ considered moral judgements.

Any empirical approach using reflective equilibrium, as Joffe et al, faces a second challenge: why do we want people’s considered moral judgements to influence our theories of ethics in the first place? In his influential critique of reflective equilibrium, D W Haslett writes:

... given the wide differences between people’s considered moral judgments, and given that these differences are, as we know, largely just a reflection of differences in upbringing, culture, religion, and so on, it would appear that, far from having a reason for giving people’s considered moral judgments initial credibility, we have instead a reason for initial skepticism (p 309). 4

If moral judgements are liable to reflect superficial prejudices, one could argue, considered moral judgements are liable to reflect deep seated ones. Surely this prejudice is something that would like to overcome, not codify. While I do not think this challenge is insurmountable,† it does demand that researchers justify the inclusion of considered judgements in ethical theory before using the method of reflective equilibrium. Joffe et al have failed to do this.

Joffe et al’s study is susceptible to a second line of critique. Even if the study’s use of mailed surveys is appropriate, it fails to capture either patients’ considered judgements or principles, because, put simply, it does not ask for considered judgements or principles. Instead, it asks patients whether providers respected their person or respected their autonomy, and then tests patients’ responses against whether they report being satisfied with their care. If a provider’s acting with respect for persons is a better predictor of patient satisfaction than him or her acting with respect for autonomy, Joffe et al conclude that the principle of respect for persons should be assigned much more importance, ethically speaking, as the principle of respect for autonomy. As should be clear, this conclusion does not follow from Rawls’s conception of how one constructs a moral theory. In a Rawlsian view,4 a moral theory requires knowing which principles patients hold, not whether those principles are associated with patient satisfaction. Joffe et al seem to be operating with an underlying utilitarian assumption to the effect that what we ought to do or persuade others to do is whatever will lead to the greatest patient satisfaction. Although there may be reasons for accepting this utilitarian assumption (which Joffe et al do not provide), certainly there are others for rejecting it. For instance, although patient satisfaction may give a hospital a very good reason to change a policy, we probably do not want to say this reason is a good ethical reason. It is just good business sense. This is an especially important point given the principles that Joffe et al evaluate. Respect for autonomy and respect for persons are traditionally viewed deontologically—that is, it is duties or rights, which are valued for their own sake, and respect for the consequences (such as patient satisfaction) that they produce. In any case, these utility considerations take us far from patients’ actual moral views, the very things Joffe et al, by invoking Rawls’s reflective equilibrium, propose to capture.

Lastly, there is a question of their instrument’s validity. As I have been arguing, Joffe et al claim to assess whether patients are treated according to the principles of respect for autonomy and respect for persons. Yet, their single item assessing respect for autonomy—“do you feel you had your say?”—does not do the principle justice. The principle of autonomy not only requires that the health care provider asks the patient for his or her opinion, but also that the provider acts on the patient’s opinion. Their instruments are similarly inadequate for the principle of respect for persons, which, they suggest, includes “autonomy, fidelity, veracity, avoiding killing, and justice,” as well as “respect for the body, respect for family, respect for community, respect for culture, respect for the moral value (dignity of the individual),” and respect for the personal narrative” (p 104).7 How are we to know whether patients had all or any of these in mind when they answered the question: “Did you feel like you were treated with respect and dignity while you were in the hospital?” Joffe et al acknowledge that these ethical concepts are a bit unwieldy for a survey of manageable length. However, these practical considerations should be used not only to excuse the study but also to question its ability to clarify the ethical concepts it claims to assess. They should prod us to ask, regardless of the survey’s scale and the

† See, for instance, Delden and Theil, in which the authors argue convincingly that a reflective equilibrium-like method may be valuable for capturing the norms of health care providers and that knowledge of these norms may guide individual providers.

‡ See a Rawlsian view” rather that “Rawls’s view” because he notes, Justice, Rawls advocates balancing a single person’s considered moral judgements (for example, Rawls’s or his reader’s) with a single person’s moral principles (p 50). Although he later gestures toward reflective equilibrium as an exercise that involves the considered moral judgements of others (p 8), it is probably safer to say “Rawlsian”.

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How to be a ‘good’ medical student

The public revelation in 2003 that medical students perform intimate examinations without patient consent has engendered much debate in the press and scientific journals. Using this case as a springboard for discussion, I will argue that medical schools and journals should encourage students to raise their ethical concerns and call for a change of policy making it easier for students to do so. I will also address the question of medical students’ moral obligations towards their patients, and conclude that medical students should express their discontent when faced with unethical practices or attitudes.

In early January 2003, a study appeared in the British Medical Journal revealing that nearly a quarter of rectal and vaginal examinations on anaesthetised patients were performed by medical students without patient consent.

The study raised ethical concerns about the examinations and so cannot be harmed is, at least, questionable. Suppose a newspaper revealed tomorrow that sociology students had placed hidden cameras in the cubicles of public toilets to study urination habits. Most people would be understandably outraged by this violation of privacy, even though the victims were not harmed by it at the time. This is based on the belief that a person’s rights can be violated without that person’s knowledge.

As for the conflict between the educational need of students and the respect for patient autonomy, it would only arise if an overwhelming number of patients refused to be examined. This is an unlikely scenario. As a commentary on Dr Coldicott’s study, Brittinger Nesheim, a professor of obstetrics and gynaecology in Norway, affirms that obtaining patient consent to student examinations is not difficult as long as the patient feels comfortable with the arrangements. Yet for me the study raises a more interesting question which extends beyond the recondite sphere of intimate examinations. It concerns the moral obligations of medical students faced with ethically dubious situations. In short, what should a “good” medical student do?

In an article on the scope of medical ethics, Professor Raanan Gillon recounts two experiences from his days as a medical student. The first describes his teacher’s refusal to grant an abortion to a 14 year old girl on the grounds that she was “a slut”; the second his own refusal to examine a scrotal lump on a patient whose testicles had already been examined by five other students. Gillon’s objections were very much the exception. When these events took place in the 1960s, medical students were simply expected to follow their teachers’ orders and to absorb their evident wisdom without question. Since then, medical ethics has developed from an ill defined embryonic subject to an academic discipline in its own right, with specific journals and associations, and a place in the medical curriculum.

Judging from some of the comments students at Bristol, however, the growing emergence of medical ethics has not dispelled the awkward climate of unquestioned reverence towards teachers. Many of the students felt uneasy about the examinations, but were too intimidated to voice their concerns: “You couldn’t refuse comfortably. It would be very awkward, and you’d be made to feel inadequate and stupid”, commented a fourth year student who participated in the study. It seems clear that medical schools should strive to foster a climate more conducive to open discussion on ethical issues between students and teachers. Students should not have to perform heroic acts of courage to raise ethical concerns. In light of medical ethics’ place in the curriculum, the situation is deeply paradoxical. Students may be taught the importance of respecting the patient’s autonomy one day, but witness an obvious violation of this principle by their teachers the next. For the subject to be any use, students must not only be allowed, but positively encouraged, to put into practice their knowledge without the fear of appearing “inadequate and stupid”. If a student’s ethical concerns remain unresolved after discussion with the teacher, there should be formal mechanisms of complaint, perhaps through a committee specifically set up for that purpose, or through the school’s medical ethicist, who would then investigate the matter thoroughly. Medical ethics is, after all, an applied discipline.

It is nonetheless all too easy to blame the medical establishment and individual teachers for the unethical behaviour of students, as if the appellation “medical student” shielded individuals from moral fault. In Nick Hornby’s novel “How to be good”, the narrator, an adulterous GP and mother of two, resolves her moral conundrums by mechanically repeating “I must be good. I’m a doctor.” It is only later that she acknowledges that her justification is too facile: “it’s not enough to just be a doctor, you have to be a good doctor”. Students, however wide eyed or intimidated, are entitled to form independent thought. Their personal values should not vanish as they put on the white coat, just as a patient’s rights should not evaporate when anaesthetic. Although the reluctance of many Bristol students to perform the examinations is comforting, it seems that none acted on their qualms by declining to perform the procedure or asking that proper consent be obtained. Neither the diminished responsibility of the medical student, nor his status as an apprentice, removes the need for ethical reflection in daily proceedings. Indeed, far from absolving him from moral inquiry, these factors should encourage a process of ethical questioning. This exercise is, to my mind, crucial to a student’s flourishing as a morally responsible future doctor. To paraphrase Nick Hornby: “it’s not enough to just be a medical student”.

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Institute of Medical Ethics Student Electives

The JME wishes to award 10 bursaries of up to £500 each to support Medical Student Electives, or exceptionally Special Study Modules, on issues in medical ethics. Medical students, jointly with their supervisors, are invited to apply by 28th February 2005. Application is to be done via email, explaining the project’s relevance to medical ethics and the reasons why a bursary is requested. An outline study protocol and project budget should be included or attached. Applications should be sent to Mrs M Bannatyne, JME Bursaries Administrator, email: bannatyne@dial.pipex.com.

Successful applicants will be informed by 31st March 2005.