Correspondence

Teaching medical ethics

SIR,

Jack Arbuthnot's reply to the criticisms of his paper *Teaching medical ethics: the cognitive-developmental approach*[1] by Raanan Gillon,[2] cannot be allowed to pass without comment.

As one of the research fellows in the Edinburgh Medical Group Research Project in Medical Ethics and Education,[3] I was very interested in Goldman's and Arbuthnot's paper and had hoped for some clarification of the philosophical and methodological bases of their approach in response to Gillon's criticisms. Instead Arbuthnot appears simply to re-state their position and to offer rhetorical rather than logical or factual arguments in defence of it. He completely fails to see, or ignores, the fact that there are implied value-judgements built into their programme of moral education that require independent philosophical justification.

Arbuthnot misses the point and misrepresents Gillon when he attributes to him the view that 'the cognitive-developmental approach to moral education is philosophically irrelevant'. Gillon is concerned to make the point that it is not possible to argue legitimately from the 'is' of Dr Kohlberg's findings to the 'ought' of a moral education programme that seeks to promote skill and sophistication in moral reasoning as a value to be pursued for its own sake. 'The fact, if it is a fact, that humans' moral reasoning develops through a maximum of six invariant and invariantly consecutive stages does not help us to decide which of these stages represents the most valuable, important or true of the various ethical theories or stances which they incorporate'.

The fact is that several unexamined value-assumptions are built into Goldman's and Arbuthnot's educational programme: the assumption that it is good to promote the development of the individual through these six 'invariant and universal' stages, the assumption that development in logical sophistication equates with moral development, the assumption that e.g. egocentric hedonism is self-evidently inferior to a Kantian type ethic, and finally, the assumption that this method is the best for making up the deficiencies described in medical education.

Arbuthnot also caricatures Gillon's suggestion that medical students, unlike other students, may be 'predisposed to find practical and clinical solutions' to medico-moral problems, and that their approach may be 'more intuitive and emotionally involved'. For it does not follow from this, as Arbuthnot suggests, that this implies that medical students are 'less rational in their judgements'.

The point is rather that other things besides logical sophistication enter into the exercise of moral responsibility in clinical situations, and that these need to be given their proper place in any programme of moral education designed to meet the needs of medical students – things such as: capacity to empathise with the patient, ability to tolerate moral complexity and different moral beliefs from their own, ability to cope with the conflicting moral responsibilities demanded by different roles, and skill in assessing the specific needs of the individual patient in his unique situation. (Our own experience of teaching medical ethics to several hundred medical, nursing, social work and divinity students in Edinburgh over the past five years is that, because of the responsibility that they have to carry, medical students in their clinical years are less inclined to treat moral dilemmas abstractly and do not find that training in moral theory or argument necessarily helps them to make better decisions in clinical practice.)

Arbuthnot's claim to have 'empirically demonstrated the effectiveness' of their method as a means of teaching medical ethics to medical students strains credulity for the reasons Gillon mentions – the size of the sample, the fact that it does not include medical students, and the inadequate criteria given for assessing the quality or sophistication of moral reasoning at the various stages. It will not do to say that 'most moral education projects do not employ large samples because they are not statistically necessary (as in the case of survey research)' because that is precisely what is at issue in the credibility of research in this area, and the fact that 'the research is extremely demanding of the time and energies of both researchers and participants' does not excuse the use of dubious research procedures.

Goldman's and Arbuthnot's paper fails to demonstrate the relevance of their course to the kinds of moral dilemmas mentioned in their introduction. How for example is skill in moral reasoning illuminating of the 'real meaning of death and dying?' There is an even more tenuous connection between the evidence that they marshall to show the inadequacies of present medical curricula and student disillusionment on the one hand and the implied relevance of their course given to twelve non-medical students on the other. What is an interesting and modest little experiment in one form of medical ethics teaching is spoilt by the overblown and philosophically naive claims that are made for the method.

IAN E THOMPSON
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References

[1] Goldman, S A and Arbuthnot, J (1979) Teaching medical ethics: the cognitive developmental approach. *Journal of Medical Ethics*, 5, 170–181.
[2] Gillon R (1979) Commentary. *Journal of Medical Ethics*, 5, 180–81.
[3] Boyd K *et al* (1978). Teaching medical ethics: University of Edinburgh, *Journal of Medical Ethics*, 4, 141–5.