

ETHICS MAN **Daniel K Sokol**

Seven ways to hone your ethics skills

In developing clinical technique, don't neglect the "softer" skills such as ethics

As an amateur magician, whenever I find the time to practise I focus on technical sleights. In front of the mirror I repeat the same move again and again. I transfer a coin from one hand to the next, blow on the fist, and—boom—it vanishes. I wipe my hands together to show that the coin is gone. I repeat the process until it becomes second nature, or until boredom kicks in.

The problem is that, in my zeal to master the technique, I neglect the "softer" skills. I spend barely any time on words and gestures that should accompany the effect. As a result of my skewed emphasis, I am a technically proficient but average magician.

In medicine the temptation is also to focus on technique in the quest for self improvement. Junior doctors seek to add to their portfolio of procedures, and the "softer" ethical skills are given short shrift. Here are seven ways for doctors to hone their ethical skills.

1. Read about medical ethics

The basic text for all doctors is the ethical guidance of the General Medical Council. After that, the choice is yours. An old but excellent introduction is Raanan Gillon's *Philosophical Medical Ethics*,¹ written by a doctor for doctors. There are many books devoted to specific specialties, from the comically named *Ethics and the Kidney* to *Neonatal Bioethics*.^{2,3} I shall abstain from referring to my own volume, *Doing Clinical Ethics: a Hands-on Guide for Clinician and Others*.⁴ Reading a single book on medical ethics will, in itself, set you apart from most of your colleagues.

2. Attend a course on medical ethics

Several masters courses in medical ethics are available in the United Kingdom; some are one year full time and some two years part time. Before enrolling, check whether the course has a practical, philosophical, or legal slant. If you are unsure

whether you can commit for one or two years, look for one of the shorter courses in medical ethics, such as Imperial College London's annual five day intensive course in medical ethics. A number of one day courses are also available throughout the year. The website of the *Institute of Medical Ethics* has a helpful list of events and courses (www.instituteofmedicaethics.org/ website).

3. Reflect on ethical issues in your own practice

Clinical ethics is a practical discipline. Armed with your newfound knowledge of ethics, you should apply it to your own practice. Just as in clinical procedures, the more cases you reflect on and analyse, the better and quicker your analysis will become. When I first encountered the "four quadrants" approach,⁵ a framework for examining an ethical problem, I took every opportunity to use it on real and hypothetical cases. I immersed myself in the method.

4. Join a clinical or research ethics committee

Joining a committee will present you with a range of ethical problems from which to develop your analytic skills and give you opportunities to articulate your views and assess those of colleagues. A list of clinical ethics committees appears on the UK Clinical Ethics Network website (www.ukcen.net/index.php/committees). There are currently 69 research ethics committees in England. Consult the National Research Ethics Service for more details on these committees (www.nres.nhs.uk/about-the-national-research-ethics-service/about-nres/who-we-are/).

5. Give a presentation or develop a poster on medical ethics

It will take courage to deviate from your usual comfort zone but will pay dividends later as you become known as an authority on the subject and,



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with luck, start receiving invitations to speak at study days, departmental seminars, grand rounds, and conferences. As with articles, have a clear structure, such as "facts," "identification of issues," "analytic framework and analysis," and "conclusions."

6. Write an article on an ethical problem

Every doctor with more than a few months' experience of the job has at least one case or anecdote that could form the basis of an ethics article. Or, once you have given the presentation in the previous section, consider transposing the talk into an article. It could be for a general medical journal such as the *BMJ* or your specialty journal or even a newsletter or magazine. Dozens of medical ethics journals, such as the *Journal of Medical Ethics* and *Clinical Ethics*, welcome good articles from clinicians. One idea when starting is to get an ethicist on board. He or she will know about suitable journals, will identify any gaps in the literature, and will ensure that the language is appropriate. Ethicists, like clinicians, have jargon. Approach your local medical school to obtain the name of an ethicist.

7. Teach ethics to medical students

It is well known that teaching a subject is a great way to learn it. A good lecture is informative, relevant, clear, non-threatening, and entertaining. Use photos, videos, and any other props, as well as anecdotes, to maintain interest. Again, contact the ethics lead of the medical school and express your desire to teach the occasional session. At first you may wish to teach alongside an ethicist.

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Competing interest: Raanan Gillon was my PhD supervisor. I am the author of *Doing Clinical Ethics*. I co-direct a short course in clinical ethics. References are in the version on bmj.com.

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BMJ BLOG Richard Smith

The irrationality of the REF

The Saturday before last I was rung up by a fellow of the Royal Society who was having trouble with the *New England Journal of Medicine*, and our conversation soon moved to the irrationality of “the REF” [research excellence framework].

We made the move because I asked why the results of a major trial undertaken in Britain were being submitted to an American journal.

“You know why,” he answered, “because of the REF.”

The REF is the latest version of the vast exercise that is undertaken every few years to rate the research performance of departments within British universities. It has huge consequences because money is allocated on the basis of how departments perform. Research universities and the academics within them are thus obsessed with the REF.

There is an underlying logic to the REF in that it used to be that funds were wasted on low quality research. I myself argued for something like the REF in a series of articles I wrote on research policy in the ‘80s, but I fear that the process may have become so elaborate and complex that it has become counterproductive. What I am sure about is that using where people publish as the main measure of the quality of their work is unscientific and a block to improvements in scientific publishing.

My colleague who rang on Saturday told me how publishing in the *New England Journal of Medicine* will give you a high rating, more so than publishing in the *Lancet* and much more so than publishing in the *BMJ*; and when it comes to many journals “forget it”—you might as well have published in the *Daily Sport*. (Mind you, it gave him some perverse pleasure when repeatedly congratulated for having published a paper in the *New England Journal of Medicine* to say that it had been rejected by both the *Lancet* and the *BMJ*.)

We have long known that it is wholly unscientific to use the impact factor of the journal as a surrogate for the impact of the article because there is little correlation between the number of citations of articles and the impact factor of the journals in which they are published—because the impact factor of journals is driven by a few highly cited articles. I and others pointed this out to the Higher Education Funding Council, which runs the REF, after the first round of assessing research some 20 years ago, and HEFC told assessors not to do it.

The problem is that the assessors are presented with hundreds of articles. It isn’t possible for them to read them all, and so they do pay a lot of attention to where articles are published.

What this means is that universities have effectively outsourced to journals and publishers the function of assessing academic quality, an activity that many would consider core to academia.

Then recent studies have underlined the illogicality of giving such emphasis to top journals because studies published in them are more likely to be wrong than those published in lesser journals. On reflection this is not surprising because big journals are attracted by the new and sexy, both markers of wrongness.

Another problem with big journals, particularly the *New England Journal of Medicine*, is that its high impact factor is driven by the many drug company sponsored studies they publish, studies that we know are full of bias rarely find results unfavourable to their sponsors.

My biggest objection to the craziness of the REF is, however, that it’s the main barrier to all studies being open access—because the big journals are mostly not open access.

I’d like to see a simplified REF that depends much less on where academics publish. So, I believe, would many academics.

Richard Smith was the editor of the *BMJ* until 2004 and is director of the United Health Group’s chronic disease initiative

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