Medical Education

Teaching medical ethics

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At Southampton Medical School students in the third year of the course (the first clinical year) spend one morning a week in general practice. Discussion of patients' problems with students often encompasses ethical issues, and for some time we have been aware of our inability to provide any clear framework for an informed debate. Our students get some formal teaching in ethics, but not until the second clinical year, and we thought that this arrangement missed the opportunity of tackling the problems when they have most relevance. As in other medical schools, the students already have a full timetable so that inserting extra sessions presents problems. Nevertheless, the third year general practice programme incorporates seven sessions in seminars in the department of primary medical care, when there are eight to 12 students in a group. We thought that part of this time could be devoted to a discussion of ethical matters, intending that students should consider the implications of clinical decisions—and it is considerably easier to encourage critical thinking in an interacting group than in a set lecture.

Against that background, a chance meeting between the head of our department and Ian Kennedy, professor of medical law and ethics at King's College, London, led to a plan for five experimental sessions during the academic year 1982-3. Each student was asked to read some preliminary material. One article enumerated the fundamental principles of medical ethics, showing how they are identical both to those in general ethics and to principles identified by philosophers in antiquity.1 The second was a short extract from a book on medical ethics which discussed the nature of moral argument, showing how moral statements may be rationally defended or questioned with reference to ultimate beliefs.2 Finally, there was a published case presentation concerning a 76 year old woman admitted to hospital after a stroke. She suffered from maturity onset diabetes, controlled by tablets, and mitral valve disease and atrial fibrillation, for which she took anticoagulants. The article was in the form of a students' teaching session, where the discussion dealt with which treatments should or might be withheld, and how such questions should be answered for an individual.3

We aimed at using the first seminar to discuss general principles as they exist in all social life as well as in medicine, in terms both of their application and of their exceptions. The second seminar would then be devoted to discussing clinical cases brought by students, analysing them with reference to general principles and ensuring that the conclusions could be applied generally. As this was planned as an experiment, and as another development was being planned for assessment of the third year general practice course as a whole, we undertook no formal assessment of these seminars. What follows is the collective opinion of the teachers who took part, supported by videotapes of two sessions.

Reactions

Initially all groups expressed some antagonism, expressed as an unwillingness to admit to living by commonly accepted moral rules (as opposed to laws). For instance, some students refused to make value judgments on cheating at cards or bigamy. Some of the antagonism may have come from the common reaction of medical audiences to any "outsider" trying to teach doctors their job. Nevertheless, there was also a genuine reluctance to express any moral judgment on the behaviour of others, apparently from a fear of taking up a moral position which the students might then be called on to defend. This same denial was illustrated in the medical context by concentrating on the particular circumstances of any case rather than on the ethical principles. This was a disappointing aspect of the seminars. Southampton students are, we think, no different from those in the rest of Britain and we know that by the end of their training many of them will have adopted the traditional attitudes of their clinical teachers, whose discomfort with principles is illustrated by the frequently stated opinion that "every patient is different," or that "every case is decided on its own merits." One reason for attempting the exercise at this stage of their course was that we hoped that students would be more receptive to the concept of working within commonly accepted rules than they might be later on.

There are several possible reasons why these ideas were harder to accept than we had expected. Firstly, students may be modelling themselves on their clinical teachers even at this early stage, and in particular they may find it intolerable to be led into expressing adverse moral judgments on their teachers' behaviour towards patients. A second possible reason results from the remarkably stereotyped and authoritarian views some students hold about the relationships between patients and doctors, so that the principle of patients' autonomy is especially hard to handle. Thirdly, the pressing need to learn clinical facts does not enable or encourage students to consider the wider implications of clinical problems. Certainly they showed how much less happy and competent they were at handling abstract ideas than concrete ones; we should have been less surprised by this attitude than we were, but it did hamper intelligent debate.

After this disappointing start there was a lively discussion in which the groups were shown that what they believed ought to happen in certain hypothetical circumstances obeyed principles which could be generally accepted. Principles which were identified included: doing good and not doing harm; respect for patients' autonomy and dignity; telling the truth and keeping promises; respect for confidentiality; and acting with

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justice and integrity. The students' ability to learn quickly was shown by the fact that by the end of the first session they were prepared to discuss the relative weight of different principles when these came into conflict. They were shown, by reference to the care of demented old people, that we do not regard saving life with much absolute value as might be expected, and that when handling children there might be merit in paternalism which overrode the patient's autonomy. It was useful to see how individuals differed in the relative importance they gave to different principles—for instance, some students apparently put telling the truth above all others.

Because of the pattern of the timetable, the second seminar took place some weeks after the first. After the acceptance described above, which was reached by the end of the first sessions, students tended to revert to the standpoints they had held at the beginning, so that, for instance, they were unwilling to tie themselves down to defining the criteria under which they would not intervene to prevent a patient from dying. In addition, they tended to deny that patients with whom they had come into contact presented ethical problems. The major task of the second session then became to show that there is an ethical component in so many apparently straightforward consultations, and that these are frequently dealt with unconsciously. For instance, potentially patient autonomy is always an issue when new treatment is being considered, particularly when the patient is an adult. The balance between benefits and side effects, both of drugs and of operations, is very much influenced by the patients themselves, whether they are conscious or unconscious. The easy answer is “no.” Secondary bacterial infection after virus bronchiolitis is very uncommon. As long ago as 1963, Reynolds and Cook stated, “Oxygen is vitally important in bronchiolitis, and there is little convincing evidence that any other therapy is consistently, or even occasionally, useful.” A double blind control trial of the use of ampicillin in 52 infants with bronchiolitis showed that there was no significant benefit from the use of this antibiotic. It would be equally true to say that several other treatments often used in bronchiolitis infants are equally ineffective. These include mist and steroids. Essentially the infant should be given oxygen as appropriate to maintain adequate oxygenation. Hydration should be maintained, and the infant should otherwise have minimal disturbance. Should respiratory failure develop, which is a problem in 1-2% of cases, then ventilatory support may become necessary. Most bronchodilator preparations have no value. It has been shown, however, that nebulised ipratropium bromide can produce some degree of reduction in the work of breathing, but in a double blind clinical trial the treatment

What was learnt?

The students were able to display and defend their attitudes to medical care and to learn something about a framework for discussing moral and philosophical issues. The teachers were reminded in a forceful way that doctors are not automatically qualified to teach these matters. Both the timing and the format of these sessions appeared to be appropriate, as judged by the high level of interest shown, although the coincidental appearance on television of Ian Kennedy's own television series Doctors' Dilemmas at the same time as the seminars probably contributed to the good attendance. We have been encouraged enough by them to plan a similar venture for the next academic year. The law faculty of Southamton University has staff already competent in medical ethics who have agreed to participate in our seminars, so that in future we shall be able to rely on local resources. At present, with so little time devoted to ethics in the curriculum, we think that the more experience students get with this sort of thinking the better; there is no immediate danger of overloading them.

In the long run, however, such teaching is in danger of falling into a trap which besets much of the medical curriculum. Students in most medical schools are faced with a series of discrete components of the course, each of which does its own teaching, has its own staff, and sets its own examination questions. Hardly surprisingly, students subsequently find it difficult to synthesise the parts into an integral body of learning. We have found that many students have completely different approaches to questions asked by hospital physicians compared with the same ones asked by general practitioners (we ourselves may be guilty of fostering this attitude). Under the present system giving seminars specifically entitled medical ethics is openly inviting the students to develop a mental compartment to be kept well insulated from clinical subjects. The intention of teaching medical ethics is that students should apply the discipline to everyday clinical decision making. As Johnson has said, therefore, the ultimate aim is for ethical teaching to occur when decisions are being made. This is not a practical suggestion when, like our students, most clinicians are unaware of the ethical components of their decision making, do not have the theoretical framework for rational teaching, and often are frankly antagonistic to the concept. Nevertheless, the long term aim must remain: that there should be either medical teachers skilled enough to defend their own decisions or ethical experts permanently appointed to medical school staffs, free to comment on decisions being made by clinicians. In the interim we shall pursue our efforts to help students recognise and understand the moral decisions they will be called on to take when they have qualified.

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References


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In young children with bronchiolitis viruses such as respiratory syncytial virus can be rapidly and easily detected in the nasopharyngeal aspirates by immunofluorescence. When such a viral diagnosis is established shortly after hospital admission, would antibiotic treatment still be advisable?

The simple answer is “no.” Secondary bacterial infection after virus bronchiolitis is very uncommon. As long ago as 1963, Reynolds and Cook stated, “Oxygen is vitally important in bronchiolitis, and there is little convincing evidence that any other therapy is consistently, or even occasionally, useful.” A double blind control trial of the use of ampicillin in 52 infants with bronchiolitis showed that there was no significant benefit from the use of this antibiotic. It would be equally true to say that several other treatments often used in bronchiolitis infants are equally ineffective. These include mist and steroids. Essentially the infant should be given oxygen as appropriate to maintain adequate oxygenation. Hydration should be maintained, and the infant should otherwise have minimal disturbance. Should respiratory failure develop, which is a problem in 1-2% of cases, then ventilatory support may become necessary. Most bronchodilator preparations have no value. It has been shown, however, that nebulised ipratropium bromide can produce some degree of reduction in the work of breathing, but in a double blind clinical trial the treatment was of no benefit clinically. Antibiotics would only be considered necessary in the extremely sick infant, where it may be impossible to exclude the diagnosis of bacterial sepsis.—J WARNER, consultant paediatrician, London.


What might be the cause of clicking joints in a healthy athletic young woman?

This may occur spontaneously or can be performed as a nervous habit as when the patient pulls her finger joints. It is probably created by the same mechanism that occurs with removal of a rubber suction tip from a wall; the sudden opening of a fold in the synovial lining of the capsule produces a vacuum effect and the accompanying noise. It has no clinical importance if it is unaccompanied by pain, and no treatment is required.—L KLENERMAN, consultant orthopaedic surgeon, London.