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The teaching of medical ethics

THE Pond Report,[1] a recently published report of a working party on the teaching of medical ethics, was commissioned by the Institute of Medical Ethics and prepared by a formidable committee of clinicians, philosophers, nursing teachers, a professor of law and a professor of theology. Their brief was to address the question to what extent, and in what manner, should the teaching of medical ethics become part of the curriculum for medical undergraduates.

The report distinguishes two meanings of 'medical ethics'. The first concerns standards of professional competence and conduct, and embraces formal codes of practice which doctors are advised to follow. The second refers to the study of ethical or moral problems raised by the practice of medicine. These problems may take the form of 'ethical dilemmas' but are just as likely to arise from everyday actions of doctors.

It is appropriate that the recommendations of the report address the second meaning of medical ethics, thus eschewing the idea of ethics as 'rule-following'. The essence of morality lies in individuals evaluating and assessing moral issues for themselves. The idea that it is possible to arrive at a perfect code of practice is a myth that has been repeatedly exposed as such by generations of moral philosophers. Ethics is not a science but a personal activity. Sheep and monkeys can follow rules, but moral reasoning is a higher art. Sometimes it happens that the same conclusion is reached whether rules are followed blindly or a painful personal analysis is undertaken. But, as Jonathan Glover writes in an appendix to the report,

> '... I would prefer the decision about whether or not to keep me alive to be taken by someone who had thought systematically and clearly about the kinds of reasons that could be given, rather than by someone who went by what the consultant told him when he was a student. They might come to the same decision, but the difference in the quality of thinking behind it is not trivial.'

The report's 12 recommendations urge that the art of moral reasoning, an essential medical skill, should be encouraged in all medical undergraduates. The following recommendations are among the most significant.

- 'Medical ethics teaching should recur at regular intervals throughout medical training, and time should be set aside within existing teaching for ethical reflection relevant to each stage of the student's experience.'
- 'Clinical teaching of ethics should normally begin from clinical examples. Such teaching should be exploratory and analytic rather than hortatory...'
- 'Interested medical teachers should be encouraged and assisted to undertake further study of medical ethics in the context of courses already available.'
- 'Care should be taken to avoid leaving ethics teaching in the hands of a teacher whose tendency is to promote a single political, religious or philosophical viewpoint.'

The Institute of Medical Ethics is to undertake a reassessment of teaching options and the working party's present recommendations in five year's time.

These recommendations have placed the teaching of ethics, for so long regarded as a peripheral activity, firmly on the agenda for medical education. Within the next five years the necessary facilities and teachers to educate medical students in this ancient discipline will have to be found. Philosophers may become involved and clinical teachers with experience of teaching ethics will find themselves with additional responsibilities. It is also likely that general practitioners, particularly those in teaching practices, will have an increased opportunity to teach medical ethics.

This is indeed a challenge. If ethics were a question of learning formulae and adhering strictly to authoritarian codes of practice, then teachers of general practice could simply train students in the technique. But this is not the nature of ethics. Many ethical dilemmas have at least two solutions, each of which can be justified by reason. How are general practitioners to begin to cater for such complexity and uncertainty?

Although ethics permits a variety of opinion it is not the case that any solution to an ethical dilemma will be as good as any other. There are five key features on which teachers of general practice should concentrate.

1. Clarification. It is essential that students become proficient in separating the key elements of a case in order to have an uncluttered picture of the problem.

2. Alternative perspectives. There is a classic distinction in moral philosophy between those who advocate obedience to principles or duties, and those who believe that ethical deliberation should focus on the calculation of the most beneficial consequences. As students become aware of these alternatives the complexity of apparently simple problems becomes obvious. But this distinction can help to provide solutions. Most moral philosophers argue that ideal moral reasoning lies somewhere between these two extremes.

3. Analysis. Students must be able to weigh up the key considerations, balancing one against another.

4. Justification. Students must become adept at justifying their analysis, and the conclusions derived from this analysis. Once doctors realize that the onus of moral choice rests on their shoulders rather than on vague codes of practice it becomes vital that they can answer certain questions to their own satisfaction: why did I do this and not something else? can I be sure that I genuinely did the best I could as I understood the situation?

5. Integrity. None of the four key features listed above carry any weight unless the teacher can convince the student that personal integrity, intellectual stamina and honesty are essential to the process of moral reasoning.

The pressure is on individual doctors to arrive at the most

moral decision they can within the broad guidelines of their professional code. Such responsibility is a privilege of the profession. It now falls to the present generation of doctors to provide future doctors with the tools and skills to tackle increasingly complex issues, even though they are not able to prescribe solutions. Doctors have their own opinions but it is anathema to the nature of ethics for clinicians to foist these opinions on other thinking people. Where there is so much uncertainty it is both courageous and practical to acknowledge its existence. It is only by doing so that students will come to appreciate the great responsibilities that they are to take on.

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Diabetes and the general practitioner

DIABETES mellitus is known to be present in over 1% of the population[1,2] and there are probably nearly as many undiagnosed cases particularly among the elderly.[3] Diabetes is not a pleasant condition for the patient or his family. Hyper- or hypoglycaemia can precipitate acute illness at any time and there are the late complications of the disease, such as retinopathy, nephropathy and peripheral vascular disease. There is now good evidence that if the diabetes is well controlled, these complications may be prevented or delayed,[4,5] for example if retinopathy or foot ulceration are detected early and properly treated, blindness or amputation can usually be avoided. Renal failure can now be treated with ambulatory peritoneal dialysis or renal transplantation. In the last decade there have been important improvements in the treatment of diabetes — new and better insulins, fresh approaches to insulin administration, improved oral hypoglycaemic agents and new ideas about diets for diabetics.

Clearly, good care has a lot to offer the patient with diabetes, but what constitutes good diabetic care? First, there is early diagnosis. The general practitioner with a list of 2000 patients probably has 20 undiagnosed diabetics. How can he recognize them? The obese, those with a strong family history of diabetes and women who have had big babies, are those most at risk. When a new diabetic is diagnosed, treatment must be started. This does not necessarily mean medication. Diet features in all treatment programmes and is of great importance.[6] It is now realized that patient education is a key factor in the management of diabetes.[7] If patients are to keep their diabetes well controlled they need to know a great deal about the condition and the factors that influence the blood glucose — diet, tablets or insulin and exercise. The next stage in diabetic care is regular follow up to check on weight, blood glucose level and measurement of glycosylated haemoglobin, the latter to see what diabetic control has been like over the previous six weeks. Studies have shown that the education process is needed not just at the start of treatment, but should be repeated and updated from time to time. In the long term a regular check perhaps once a year must be made for early evidence of complications — the eyes for retinopathy, the urine for albuminuria, the blood pressure, the legs for evidence of peripheral neuritis and the feet for the risks or presence of ulcers.

A key question is who is to provide care for the diabetic patient. The average health district will probably have 2000 or more cases. The district diabetic clinic will be unable to cope satisfactorily with this number, although the consultant in charge would try to deal with the problem patients and those with complictions. Furthermore, many diabetics would prefer to be supervised by their general practitioner. There are problems, however. The general practitioner may have difficulty getting advice for his patients from a dietician, although an increasing number of health districts employ a dietician to see patients referred by their general practitioner. The education of the patient is another problem. Experience has shown that nurses can be the best diabetes educators and three quarters of the health districts now have specialist diabetes nurses.[8] In some larger practices one of the practice nurses may take a special interest in diabetics and obtain the training needed to advise these patients. The annual check on the retina may present a problem but ophthalmic opticians may be able to undertake eye screening for diabetic retinopathy that may need laser treatment.[9] Another problem is that the general practitioner cannot prescribe the blood glucose testing strips for his patients — a point that is under continuing discussion between the profession and the government.

A real difficulty is that some general practitioners are inadequately informed about the new developments in the management of patients with diabetes and a number are reluctant to learn about them. The Royal College of General Practitioners has recently produced a valuable information pack to help them. In many health districts, the consultant responsible for diabetic care has actively sought to enlist the help of general practitioners and to encourage them to take a meaningful part in the care of the diabetics in their practices.

Diabetes is a real challenge, and recent developments have the potential to improve the outlook for the diabetic patient. It is not possible for the hospital consultant to shoulder the entire burden of caring for the diabetics in any district, indeed it would be quite wrong for him to attempt to do so. The majority of diabetics can be looked after as well or better by their general practitoner and in most instances would prefer this. The challenge is for general practitioners to show that they can do at least as good a job as the hospital clinic.

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The information pack on diabetes can be obtained from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Price £5.00 to members, £6.00 to non-members.