Teach Ethics

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Ethics and morality are often treated synonymously. We all have moral beliefs and values that express our views about character and conduct, what is the right sort of person to be and what is the right thing to do. However, ethics implies taking issues further by analysing the meaning and justification of moral beliefs. 'Abortion is wrong' is a moral belief, but consideration of the ethics of abortion may take us into arguments such as: is termination of a foetus morally equivalent to killing a person; at what point does a foetus become a person; indeed, what is a person? Such issues are the stuff of ethics because they require reasoning and reflection on the deeper principles, assumptions and emotions that underpin our moral dispositions.

Why teach ethics

Formerly, in medical education, doctors learned ethics on the job (as they did communication and leadership). When confronting problems in clinical practice, they would find their moral beliefs challenged by unexpected circumstances or by values conflicts with others, causing them to engage in new ethical reasoning and to re-align their emotive responses.

Implicit learning of this kind will always be an essential component of professional development, but nowadays there is a trend towards the formal teaching of ethics and curriculum designs that include learning around ethics. This is because:

◗ Ethical awareness is part of being a critical and reflective medical professional and of engaging in inter-professional working with colleagues for clients' benefit.

◗ External pressures on medicine from government and regulatory bodies have created a need for doctors to demonstrate accountability for ethical reasoning and decision-taking just as for other aspects of clinical practice.

◗ Learning ethics is part of a general education: the capability to go beyond mere opinion, prejudice and 'gut reaction' and support ethical positions with reasoning informed by ethical theory.

The 'four principles' approach

Healthcare professionals are stereotypically introduced to four principles as a framework for their ethical decision-taking: autonomy, justice, beneficence and non-maleficence (Beauchamp and Childress, 2001). While these may act as a useful organiser, it not clear what should be done when these principles collide: should respect for confidentiality, for example, be allowed to over-ride the potential harm of withholding information about a patient's violent mental state? Equally questionable is the assumption that ethical reasoning is simply the application of principles to conduct. The tradition of virtue ethics, recently re-cast as relational ethics, emphasises holistic deliberation and situational knowing in opposition to the four principles (see Tschudin, 2003).

The content of ethics teaching

The above justifications for teaching ethics may be called intrinsic, prudential and intellectual, respectively. They imply different ways of seeing ethics and how the subject is taught. Teaching ethics as an intrinsic aspect of professionalism involves supporting learners in creative exploration of their professional identities. Teaching in this constructivist vein is inseparable from the flow of clinical practice or

some approximation to it. In that sense, the content of ethics teaching is unlimited: it may include specific dilemmas such as whether or not to prescribe the contraceptive pill to a 14 year old girl whose family out rightly oppose the idea; or it may refer to the underlying ethics of everyday practice such as how GPs allocate their time in surgery. Since healthcare practice is values-laden, it is hard to imagine a decision or action of a doctor that could not give rise to ethical implications in certain circumstances.

Ethics teaching that is prudential assumes that ethics is a system of quasi-legal rules that doctors must know and be proficient in applying to their clinical practice. Under new governance regulations for healthcare research and practice, penalties and sanctions may follow for those who fail to do so. As noted above, it may be unduly restrictive to see ethical behaviour as the result of applying of rules to cases. As with 'defensive medicine', creative approaches to ethics are discouraged and replaced by self-censorship driven by fear of the consequences.

The intellectual discipline of ethics introduces a stronger emphasis on theory (drawn from philosophy, social psychology/ anthropology, etc.). Theory does not have to consist of intellectual abstractions. It can be made relevant to clinical practice by the introduction of selected cases as practical illustrations. Alternatively, ethical theories and their potential insights may be extrapolated from critical reflection and dialogue on the tacit values (theories-in-practice) that doctors engage in everyday practice.

Some strategies for the teaching of ethics

Prescriptive approaches

Various teaching strategies may be linked to these views of the content of ethics teaching. Clearly, prudential teaching will tend to be prescriptive: 'delivering' the required knowledge and comprehension of procedures, their typical applications and perhaps means of auditing against pre-defined standards (usually set out in a code of ethics). The transmission of 'must-knows' such as guidelines on health and safety to trainees can be achieved by didactic methods such as lectures. Allied to this, there may be opportunities for individuals or small groups to identify, analyse and reflect on health and safety principles and procedures using carefully selected and structured cases. A more open approach might comprise a brainstorm of health and safety needs in training posts. Other small group techniques (see Jaques, 2000) may be applied in which the teacher's role is to facilitate learners in collating, extending and consolidating the learning outcomes.

Constructivist approaches

The intrinsic approach lends itself to learner construction of ethical issues in the course of experiential, reflective and self-directed activities conducted either by individuals or in learning sets. Its essential association with deliberation on clinical practice suggests an open, exploratory approach in teaching that is largely process-driven. Ethics discussions, for example could be woven into the mentoring of GP registrars and into portfolio-based methods, all designed to deepen their reflective capacities on practice placements. It is easy to see how ethical concerns might arise from exploration of professional, social and personal 'selves' and reflection on the compatibilities and tensions between those selves under the guidance of a skilful mentor (Freeman, 1998). The constructivist theme of postgraduate approaches to ethics teaching may be echoed in undergraduate teaching of ethics. Small problem-based learning (PBL) groups will be confronted by cases or problems that, though often paper-based, may represent something of the authenticity and complexity of ethical issues arising in clinical practice. Here is an opportunity to introduce the subtleties of ethics in professional practice without undue simplification or caricature. Clinical aspects of the problem may be developed first through the PBL cycle of problem formulation, objectives setting, research, discussion and arrival at interim outcomes before the time is ripe to inject an ethical dimension to the problem. Even then it may not be labelled 'ethics' as such, and it may be left to the group and facilitator how far they wish to follow through on issues of ethical reasoning and affect. Learners may proceed to deepen their ethical awareness and powers of justification developed in PBL using the reflective space of a learning journal or portfolio. Teachers may follow up with a formal lecture that models the arguments for a particular position in healthcare ethics.

Social and emotional context

Intrinsic approaches by definition will be committed to tackle the personal conflicts, stresses and turmoil that sometimes upset the designs of reasoning in ethics. Once again, reflective tools such as diaries provide a safe outlet for individuals to gain some perspective on the emotional 'heat' of ethical issues. Drama and role-play are commonly adopted as classroom strategies to confront and manage emotions such as difficulties of empathising with the values of some patients and their relatives. Professional actors are an excellent, if expensive, way to present ethical scenarios in medical practice that can then be discussed or debated in large or small groups of learners and the learning outcomes drawn together. The actors themselves may come out of role and assist the debate, though their interventions need to be carefully negotiated to fit with the aims of the session.

As an alternative, the students themselves may role-play an ethical dilemma. They are usually provided a description of their roles (e.g., doctor and angry patient) and/or some background information to guide their interactions with other role players. As a scenario is played out, it may take unexpected turns: even amateur actors can invest their roles with a realism that may make or upset a teaching strategy. If a role play seems to be going awry, it is important to call 'time out', take the students out of role and discuss with them what is happening. After all, the role play is only a means to set up a de-brief in which discussion of the arguments and associated emotions can take place in a supportive and reflective climate. This simulated environment is invaluable in giving learners a vicarious experience of modes of ethical reasoning and of expressing and withholding emotions that will produce a professionally defensible outcome in sometimes uncertain and fraught conditions.

Socratic questioning

Socratic questioning is a whole-class strategy derived from the teaching of Socrates, a philosopher in Athens (5th Century B.C.). Socrates was famous for challenging his interlocutors to define a controversial term such as justice. He then proceeded by critical questioning to force them to qualify their initial definition, reveal the assumptions behind it and admit inconsistent or absurd conclusions. This courtroom-type interrogation may seem daunting, and somewhat abstruse in a medical teaching context, but the Socratic procedure can be preserved by staggered introduction of hypothetical cases. In addressing the question 'What do we mean by patient consent?' learners may first venture definitions before being led to consider standard protocols and how far

they apply, for example, to organ donation by an unconscious patient. Further ramifications of the case are drip fed into the debate – e.g., whether the patient is clearly brain dead, what the likely consequences are of withdrawing life support, whether the family would support that action, etc. By being led to argue back to first principles, participants learn about themselves, in particular, the bedrock assumptions that they refer to in providing ethical justifications.

The 'neutral' moderator of the discussion has to be in full command of the implications of every line of argument and skilful in improvising spontaneously around the hypothetical case or changing the case in order to challenge the assumptions of group members. Playing one definition off against another encourages learners to question their beliefs, and perhaps to take ownership of the discussion. Lack of participation may push the moderator to act overbearingly as 'devil's advocate'. This presents a doubtful role model of a professional in command of all arguments, but committed to none. In Socratic questioning, the ethical content becomes secondary to the purpose of engaging learners in a process of formal reasoning. This classroom climate is not suitable for exploration of social and emotional aspects. However, learner participation may be improved if the content at least mirrors the multiple and sometimes conflicting factors that impinge on ethical decision-taking in practice. In the final stage, the teacher will step back from Socratic questioning and engage the learners in meta-reflection on the ethical theories underpinning their modes of reasoning – e.g., were they consequentialist or deontological in their arguments (Seedhouse, 1988)?

Conclusion

There is no right or wrong way to teach ethics. It all depends on the educational aims behind the teaching. As has been shown above, these may range from prescriptive teaching to meet a pragmatic need - trainees cannot be let loose on patients unless they have a grasp of the rudiments of ethical procedures – to facilitation of reflection on self, clinical practice and the ethical theories that underpin various modes of reasoning and affect that doctors bring to ethical issues in healthcare.

Further Reading

Beauchamp, T. and Childress, J. (2001) *Principles of Biomedical Ethics (5th ed.)*, Oxford: Oxford University Press.

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LTSN (2004) *Approaches to Ethics in Higher Education: Teaching Ethics across the Curriculum*, Leeds: Learning and Teaching Support Network.

Seedhouse, D. (1988) *Ethics: The Heart of Health Care*, Chichester: John Wiley and Sons.

Tschudin, V. (ed.) (2003) *Approaches to Ethics: Nursing Beyond Boundaries,* London: Butterworth Heinemann.

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