

A CURRICULUM IN MEDICAL ETHICS AND MEDICAL HUMANITIES

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SUMMARY

The code of ethics derived from the Hippocratic Oath needs to be supplemented by a formal curriculum in Medical Ethics and Medical Humanities in our medical schools. The need and justification for it, a review of the medical ethics curricula in American, European, British and Australian Universities, together with an outline of the proposed curriculum is described.

INTRODUCTION

MEDICINE has evolved over the centuries moving from sorcerer to priest and ultimately to the physician. During this time it has gradually developed its own code of conduct. However, it was Hippocrates of Cos, who in the fifth century B.C., apparently recognizing that greater guidance was necessary, proceeded to develop our first code of ethics (Nordlicht, 1977). Physicians are, in this tradition, represented as learned and noble men, members of a select brotherhood, which is largely self-regulating and autonomous. Hippocratic physicians assume responsibility as set forth in the Oath - "not to harm patients, not to induce abortion, not to practise euthanasia, to preserve confidentiality, and to take a paternal interest in their students as the future members of a select group" (Pellegrino, 1977).

This code of ethics is still with us today but no longer fulfills out present needs. The technical advances, together with the accompanying changes in the social structure, confront us with a variety of problems which continue to challenge our former and accustomed ways of thinking.

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The Oath of Hippocrates does not have much application to specific 20th century problems. It has significance, but the relevance is rather vague. We are in the midst of a biomedical revolution which has created a critical need for serious and systematic attention to the social and ethical aspects of medicine (Veatch and Gaylin, 1972). The ability to transplant organs, or to inhibit conception, involves factors that had no counterpart in the 5th century B.C..

Yesterday's training and teaching of the future physicians cannot today be viewed as acceptable unless it also includes education in medical ethics and humanism. Our students can then learn that the solution to many problems may not be as simple as they once may have thought; but involve a more profound understanding and analysis of complex personal, familial, moral, religious and societal factors.

DEFINITION

It is important at this point to define what we mean by ethics, medical ethics and humanism.

a. Ethics

We are constantly called upon to choose between two or more courses of conduct. Some decisions we make simply from habit, others from desire or impulse or perhaps whim, still others from motives of prudence. However, some choices involve the quite special concepts that we call right and wrong. Decisions of this type, the situations that give rise to them, and the principles on which the choice is made, comprise the realm of ethics (King, 1970). Ethics, also referred to as moral philosophy, is "that study or discipline which concerns itself with judgements of approval or disapproval, rightness or wrongness, goodness or badness and virtue or vice" (Nordlicht, 1977).

Jonsen commented, "Ethical principles announce the limits of morally acceptable decisions" (Sieglar, 1978).

b. Medical Ethics

Medical ethics, which is a part of general ethics, adheres to the very same moral principles but is solely concerned with man's medical experiences. "Medical ethics" may be properly used to cover all problems of right or wrong that physicians face in their professional relationships with their patients, or colleagues, or society as a whole (King, 1970). Clinical ethics is a component of medical ethics and has relevance for the practising physician, health professional and clinical investigator.

c. Humanism

This has been defined in various ways but, in the medical context, it encompasses a spirit of sincere concern for the centrality of human values in every aspect of professional activity. This concern focuses on respect for the freedom, dignity, worth and belief systems of the individual and it implies a sensitive, non-humiliating, and empathetic way of helping another person with some problem or need (Pellegrino, 1977).

JUSTIFICATION FOR THE CURRICULUM

The curriculum of a large number of medical schools is based on the traditional concept of the pre-, para- and clinical disciplines.

When medicine was in its infancy, doctors learnt their art through an apprenticeship system, whereby following the precepts and examples of their teachers over a period of time, they in due course grew to be physicians in their own right. At the beginning of the century, reforms in medical education were being instituted, but it was the Flexner report that ushered in a new era of medicine. Today we may be witnessing just as dramatic a reform but focussing also on the ethical, moral and social issues (Nordlicht, 1977). This must mean that the training of a doctor is not a matter of transmitting knowledge and skills

in diagnosis and therapeutics alone, but somewhere, somehow the doctor-aspirant must learn the basic tenets of medical ethics and humanism (Editorial, 1969).

The philosophic foundations of the profession are no longer taught but are left to a primitive form of intellectual osmosis, thus allowing for the development of situational ethical behaviour patterns without formal precedent or perspective (Butler, 1974). Ethical problems receive little consideration, other than when they crop up in the course of routine teaching; for example, abortion in obstetrics and gynaecology and terminal care in cancer patients.

The concepts of ethics and humanism is educationally relevant yet there is no formal attempt to teach these to our medical students. Medical students are sometimes treated as if they were merely rote learners of specialized technical information. But in fact they are also human beings - distinctively motivated young men and women who have chosen to undergo the often arduous initiation into the vocational hazards of medicine. This fact should be more openly recognised by medical schools and the effort to teach competence should be supplemented with an effort to strengthen the students' sensitivity and openness to themselves and others. Then, future physicians might be better supported in their desire to treat patients not merely competently, but wisely, responsibly and humanely; for there is much evidence that we come to treat others as we have been treated ourselves (Burra and Bryans, 1979).

It is evident from public opinion, press statements and from professional publications that there is a specific need for the teaching of medical ethics and humanism in Malaysia.

REVIEW OF THE LITERATURE

While reviewing the development of medical ethics curricula of the past decade, one is struck by the innovative, creative, and essentially heterogeneous approaches that have emerged from the many universities and medical schools that have

entered this new field. The diversity of approaches and the critical scrutiny these new programmes are receiving suggest that no single model has been found that is universally applicable. The design of medical ethics curricula remains in an experimental phase.

a. The United States of America

Veatch and Sollito (1976) surveyed teaching of medical ethics in 97 American medical schools. From this survey it appeared that the teaching of medical ethics could be classified into five broad categories.

The first was the teaching of medical ethics in the form of informal transmission of values that occurs through the intimate relationship between clinician and student during the clinical care of patients. "The emphasis will be upon the teaching of ethical issues as they arise in relationship to the presentation of clinical issues in various teaching formats. Probably the most important teaching of ethics take place between preceptors and students when students are actually involved with patient care and ethical issues arise".

The second method of teaching consisted of monthly conferences, special workshops, a monthly clinical case conference series and single lectures or a lecture series.

The third method was the teaching of formally structured elective courses in medical ethics. Typically, these were survey courses offered in normal curricular elective time and included senior-year electives, intermission courses, and one year electives throughout the four years. For example, the Humanities Department at the State University of Pennsylvania offers 15 elective courses; students are required to take two some time during their medical education. Other electives focused on the ethics of various aspects of medicine, such as human experimentation, death and dying, or behaviour control.

The fourth type of medical ethics teaching is the formal course required of all students. The

medical schools offer such courses, usually as part of the first year core curriculum or as a teaching module.

The fifth major type of teaching is the clinical clerkship. This was generally for at least one month but sometimes lasted eight weeks.

In some schools the first point of entry into medical ethics teaching is related courses, such as legal medicine, the history of medicine, community medicine, family practice, psychiatry, and "introduction to the patient".

This survey also showed that several schools now have departments or interdepartmental teaching programmes with formal structure and permanent staff.

The Medical Ethics Programme at Columbia University adopts a different approach (Veatch and Gaylin, 1972).

Fall semester lecture course - This consists of 10 lectures to the second year class by physicians, ethicists, a sociologist and a hospital administrator. The lecturers discuss both specific issues (e.g. the ethics of experimenting with human subjects), and general ones such as "The values of Medical Students and Physicians". After each lecture students have an hour to discuss the topic with the speaker.

Third-year class dinner-discussion series - A series of dinner-discussions in which students (who were in their clinical year) and clinical faculty members present cases they had personally encountered which raised ethical dilemmas.

Clinical case conference series - it was realized that ethics education had to be brought as close as possible to the clinical experience of the students - hence the case-conference series.

Intensive Workshops - Here a more intensive encounter with a larger issue of health care delivery was debated in an all-day meeting.

Internship in medical ethics - During the elective

(fourth) year an intensive intership for a few students with special interest in the field of medical ethics is offered.

Three different types of seminars are held

- Elective seminars for students
- Inter-faculty seminar. Here students from other faculties such as Law and Theology take part together with medical students in discussing topics such as genetic engineering capabilities or possible new definitions of death.
- Faculty and clinical staff seminars - This gives opportunities for faculty and clinical staff to explore the social and ethical dimensions of their work.

b. The Netherlands

In the Faculty of Medicine of the University of Nijmegen (The Netherlands) the programme of Medical Ethics forms an integral part of medical education throughout the undergraduate course of 6 years (De Wachter, 1978). In the first year Micro-symposia on "Human Sciences and Philosophy" are undertaken. These are presented by all members of one integrated block. It usually fills four morning hours, the last of which is reserved for plenary discussion. In the second year there is classroom teaching on the basic notions of ethics (9 hours), 3 seminars and Microsymposia on Ethics and Sexuality and Microsymposia on Sex.

In the 5th year there is more classroom teaching on Medical Ethics and Microsymposia on Medicine and Society.

During the final year, Medical Ethics is called "professional experience and ethics". These monthly discussions of one to one and a half hours help the student to focus on the moral implications of their first practical experience within the profession. This programme is offered in six departments - internal medicine, paediatrics, neurology, psychiatry, surgery and obstetrics-gynaecology.

c. The Federal Republic of Germany

In the Federal Republic of Germany, there is no

systematic instruction in medical ethics, in either undergraduate or postgraduate education. This was reported by Seidler (1979) after he collected information from various medical schools as to how subjects referring to medical ethics were treated during medical training. He reports - "In the universities and university hospitals some individual personalities are developing activities and committing themselves to a scientific approach to these problems within their own field of interest. These activities are particularly noticeable in the intensive care units; but specialists in forensic medicine, psychiatrists, pathologists, medical sociologists and particularly medical historians are likewise committing themselves to this task. They are joined by some competent experts in moral theology, law and philosophy. But once again we would like to point out that so far only individual approaches to integrated systematic investigations are being made". Dr. Seidler concludes by stating that basic curricula related to the problems of medical ethics would have to be developed and would be carried on continuously within the training programme.

d. The United Kingdom

In a survey carried out on 11 medical schools in the United Kingdom, Dennis and Hall (1977) report that the teaching of medical ethics varied from none to an extensive course of 30 lectures. To take one example, at the Southampton University Medical School, there is an introductory course in medical ethics called "Man, Medicine and Society" in the first year. The bulk of the medical ethics course takes place in the fourth year. Here seven sessions of approximately two to two and a half hours are devoted to the course. These are divided between the theoretical aspects of legal medicine and the more philosophical aspects of medical ethics, three sessions being allocated to each and the seventh session being used to hold a debate on an ethical topic such as "the cancer patient has the right to be told the truth".

Teaching methods used are lectures, films and seminars. The teaching staff consisted not only of members of the medical faculty but also members of the faculties of Law and the Arts.

At the Edinburgh Medical School (Boyd, Currie and Thompson, 1978) medical ethics was taught in the traditional way in six hours of lectures and discussions, in the Forensic Medicine course, and in a number of informal seminars in the Department of Therapeutics. However, since 1976 this teaching has been supplemented by attempts to integrate medical ethics into ordinary academic and clinical teaching within the Medical School. The reasons given for this change are that:-

insufficient time is devoted to the examination of social, moral and legal issues raised by the practice of medicine;
as far as possible medical ethics teaching should be integrated into ordinary academic and clinical teaching (i.e. that opportunity should be given for the discussion of the issues as and when they arise);

didactic teaching of the subject has limited value and that more emphasis should be placed on experientially based and participatory learning;
as far as possible opportunities should be created for multi-disciplinary and inter-professional discussion of the issues and dilemmas in medical ethics.

This innovative programme in medical ethics was initiated by the setting up of the Edinburgh Medical Group Research Project in Medical Ethics and Education. Staff from this group were invited to participate and arrange teaching of Ethics in the departments of Clinical Surgery, Community Medicine, General Practice, Geriatric Medicine, Obstetrics-Gynaecology, Psychiatry and Therapeutics.

The form and extent of participation in these teaching experiments have naturally varied considerably from one department to another, depending on the needs and requirements of the subject and the time available.

The methods of teaching varies from introductory lectures on medical ethics to multi-disciplinary case-conferences. The latter takes the form of a

'grand round'. The seminars in Obstetrics and Gynaecology are of a voluntary nature and held during the lunch-hour so that midwives, social workers and divinity students could attend. The cases presented and dilemmas discussed cover a wide range of moral issues in reproductive medicine, including contraception, sterilization, abortion, sexual therapy, artificial insemination, counselling, consent, communication and the role of institutions and professions.

e. Australia

In the University of Western Australia an experimental course in Medical Ethics has been developed and offered in 1977 to fourth year students. This followed recommendations to teach segments dealing with different aspects of medical ethics throughout the course.

The main emphasis is a study of actual case histories illustrating moral and ethical dilemmas commonly encountered, and taken from the practice of the family and specialist practitioners associated with the Faculty of Medicine. As it was non-departmental in basis the course is administered from the Faculty Dean's Office.

Teaching sessions commence with a 10-15 minute didactic presentation dealing with aspects of the theoretical basis of decision-making. Tutors act as discussion leaders, or resource individuals, to groups of 8-10 students, and are members of the full-time clinical staff who have volunteered their services.

At the Flinders Medical School in Adelaide, Ethics and Medico-Legal Matters are dealt with together. Two lectures are in Forensic Pathology, 3 sessions in Medical Jurisprudence and 4, small group tutorials on Hospital Administration and Ethics. Here topics include abortion, ante-natal genetic screening, severe congenital malformation, cost-effectiveness of medical care, human experimentation, organ transplantation, pain relief and euthanasia.

The students' formal medical training at the University of Melbourne does not include any

discussion of the human or philosophical side of medical care. To redress this imbalance, Dr. Anthony Moore (1978) created an original medical humanities course which focussed on the non-scientific aspects of being a doctor. He has designed a short course which is structured around a consideration of extracts from novels, poems and short-stories, for "many perceptive and sensitive writers in literature have captured several of the most delicate and difficult tasks of doctorship. I believe there are lessons in their works - lessons which we cannot learn anywhere else with ease - which all members of the medical profession need to consider".

He selects short extracts from the pages of literature, philosophy and history, all of which are relevant to medicine. Groups of students in their first clinical year read the passages in silence and this is followed by discussions with the Chairman asking questions such as "What does the passage say?", "Is the passage true to human experience?" and "What message is there in the extract for us to take back to the ward or clinic?" Each session last about 2 hours. Topics considered during the six-week course are:-

- The patient's experience of illness
- The relatives' experience of illness
- Portraits of Doctors in Literature: The demands of Doctorship
- The Ethical Landscape
- Hindrances to communication: The patient's expectations
- Public regard for professional performance - past and present

The students who took part in the course felt that the course stimulated them to consider previously neglected medical topics and that it contributed to their understanding of the traditions of the medical profession. The majority of the students also felt that the course contributed to their human understanding in the ward.

OBJECTIVES

At the end of the course in Medical Ethics and Humanities the student should be able to:-

- a. Have clear insight and skill at finding

guidelines to ethical decision-making using his theoretical knowledge as well as his patients' and with others in the medical profession.

- b. Solve ethical problems in a methodical fashion
- c. Have the capacity to evaluate and modify his own role and function in the broad context of community needs and social change (Mann,1979)
- d. Realize that, in ethical discourse, an answer is not a good or bad answer on its face, but is discovered to be one or the other through an unfolding process of dialogue and justification (Brody, 1974).
- e. Practise humane patient care, have a sense of idealism and personal integrity.

THE PROPOSED CURRICULUM

In most medical schools, the medical curriculum follows the traditional four stages. In the first stage or preclinical year(s), the subjects of anatomy, physiology and biochemistry are taught. In the second stage or paraclinical year(s), pathology, parasitology, microbiology and social and preventive medicine are taught. In stage three, the student is introduced to the clinical aspects of medicine and the rest of the undergraduate time (i.e. stage four) is taken up with clinical clerkship.

There is no single model that is universally applicable in the design of a medical ethics curriculum. In the tradition formalized by William Osler, clinical medicine is taught at the bedside. So it is suggested that clinical ethics should also be taught at the patient's bedside.

But during the first and second stages, the students do not see any patients and therefore bedside teaching is not possible. Yet I feel that we should not wait till the third stage before introducing the subject of medical ethics and humanism.

The subject of ethics(not medical ethics) or moral philosophy i.e. judgements of approval or disapproval, etc. concerns everyone, both inside and outside the medical profession. Hence the first and second stages should be the best time to introduce the basic principles of ethics in general. Topics should include

Basic notions of Ethics

- Human Sciences and Philosophy
- Philosophy of Medicine
- Man, Medicine and Society

These topics should be introduced in the form of short talks - not more than 30 minutes each. Six talks per year would probably be sufficient to cover the basic concepts of ethics. If the students show interest and enthusiasm, perhaps more time could be found.

I feel that students at this stage are very curious about the medical profession and are also very susceptible to high idealism and integrity. We as teachers should encourage and inculcate such feelings. As the student progresses through the later stages, he becomes somewhat hardened and cynical. In the third stage the students are introduced to patients and clinical aspect of medicine. Here, the students in general undergo a sort of metamorphosis. They feel that having surmounted the arduous basic sciences, they are at last into the nitty-gritty of clinical medicine. But the student is at his or her most vulnerable stage of the undergraduate period. This is so due not only to lack of cognitive skills in clinical "medicine" but also of the "know how" to deal with patients as human beings. Therefore, I believe this is the best time to introduce the subject of Medical Humanities to the student.

Illness is a special time in the life of patients and the experiences of illness are protean. Most people in our society do not view illness as something refined or worthy of reverence, but rather as a degrader of mankind - a degrader which is painful and offensive. All human beings are slaves to hope and fear, and most concede that in the arithmetic of illness, one adds and multiplies human woes, one does not subtract or divide (Moore. 1978).

Those who are ill, suffer an insult to their whole being. They experience a series of intimate insults to those aspects of their existence which are most integral to being human. By virtue of the event of illness, these patients lose their freedom to act; they lack the knowledge on which to make rational choices and the ability to regain their

freedom to act; they must place themselves in the power of another human being to regain their humanity; their integrity, that is, self image, is shattered or least threatened. They are in a state of wounded humanity which results in an unequal relationship between physician and patient. It is the need to repair the specific damage done to a patient's humanity by illness which imposes obligations on physicians (Pellegrino, 1977).

That is the message that we have to get across to the student that he must not only cure the wounded patient (i.e. clinical illness) but also look after the patient's wounded humanity! Hence the teaching of humanistic ethics should precede that of bioethics which deals with specific biologic or clinical procedures.

How should this subject be taught? I am attracted to Dr. Anthony Moore's method of exploring the Medical Humanities through literature (which has been described earlier). But here one must explore Asian literary works for appropriate passages, for otherwise the students may not be able to relate meaningfully to the passages.

There are abundant examples of wounded humanity to be found in the wards of the hospitals and these examples can be used as starters for a discussion in a tutorial group. Topics for discussion could follow closely those of Dr. Moore's, but in the context of Malaysia certain modifications are necessary. The racial diversity, cultural background, religious beliefs and social development of the people require adaptations and sensitivity to the local scene. Importance must be given to this, for the value systems and beliefs of the East and West differ!

About 6-8 tutorial discussions should be sufficient to cover the basic ground and stimulate those students who are interested to explore the subject further.

Having been introduced to the patient and the clinical aspect of medicine in the third stage, the student continues his clinical clerkship in the 4th stage. During these latter years, I feel that

didactic teaching of medical ethics should be kept to the minimum or preferably none at all, for we already know that teaching at the bedside is more meaningful to the students than the formal lectures held in the classroom. At the same time the programme must be flexible enough to cater to the needs of the students.

Various methods can be used to impart knowledge on medical ethics to students:

i. Bedside teaching - This is the most important method and priority must be given to this. Every opportunity should be given for the discussion of the ethical issues as and when they arise at the bedside in the context of clinical medicine. "Moral discourse in the context of clinical medicine will not become a legitimate enterprise for medical students until it is used by their clinical mentors at the bedside and until attention to these moral-ethical issues can be shown to improve patient care and physician satisfaction" (Siegler, 1978). The intensity of the clinical situation requires that moral-technical decisions be made at the bedside. Therefore the keen pressure of personal accountability for an action with consequences for the patient is found at the bedside and not in the classroom. "The bedside teaching of medical ethics emphasizes and reinforces the Oslerian concept of the patient as teacher because the patient's values, aspirations, and wishes must be understood and acknowledged before the clinician reaches a technical decision" (Seigler, 1978).

Another form of bedside teaching would be ethical "grand-rounds". This would give students, nurses, interns, registrars and consultants the opportunity to be present together and discuss ethical issues. This is different from that described earlier where only the tutor and his students will be present. There are of course advantages to be gained by the ethical grand rounds, for this will permit the entire health care team - physicians, medical students, nurses, social workers, chaplains, dieticians, administrators and the patient to participate actively in the total educational experience, including the making of clinical decisions. Hence the entire health care team becomes trained in medical ethics and human values.

ii. Case conferences. Bedside teaching and clinical grand rounds have certain constraints. The presence of the patient may not allow the participants to express their views very freely in case they are misunderstood by the patient. Also, time would not allow the discussion of the ethical issues in great depth. Hence, cases that offer the opportunity to discuss certain topics in detail and depth can be discussed by students and clinicians in the form of a tutorial group away from the patients. If this is done systematically, a wide range of topics can be covered depending on the discipline - abortion, sterilization and prevention of conception can be discussed during block teaching of obstetrics-gynaecology. Other topics relevant to internal medicine, psychiatry and clinical surgery can be covered in a similar manner.

iii. Electives. The purpose of an elective programme is to offer a particular area of subject matter (e.g. medical ethics and humanities) to the student who has a special interest in this field and would like to explore it further and in greater depth than covered by the normal programme. The time required would vary but a minimum of 2 months should be adequate.

iv. Other methods which can be used are "role-playing" by students and the use of video-taped material as starting points for discussion.

v. Conferences and workshops both within the faculty for students and staff and on a national level should be encouraged. This would provide an intensive exposure to those interested in the subject and wish to continue their medical education in this field.

vi. Lastly it must be emphasised that it is important for Faculty (i.e. clinicians etc.) to set the example in their attitudes and behaviour towards not only their patients but also their students, colleagues, nurses, and others.

EPILOGUE

The first problem that a developer of a medical

STAGE	SUBJECT	ETHICS AND HUMANITIES
I	Antomy Physiology Biochemistry	Basic notions of Ethics Human Sciences and Philosophy Philosophy of Medicine Man, Medicine and Society
II	Pathology Pharmacology Parasitology Microbiology Social and Preventive Medicine	As in stage I
III	Introduction to patient and clinical medicine	Medical Humanities
IV	Clinical clerkship in: Internal Medicine Surgery Paediatrics Obstetrics-Gynaecology Orthopaedics Psychiatry Others	Beside teaching Grand rounds Seminars Electives Conferences and Workshops "role-play" etc.

Table 1. Summary of the medical curriculum and the proposed curriculum in medical ethics.

ethics curriculum will encounter is the argument that ethics cannot be taught, that it must be learnt by osmosis while sitting at the feet of other physicians!

It is true that sensitivity and humaneness cannot be taught the way one teaches genetics or biochemistry. Anyone beginning a medical ethics programme with the promise that the physicians produced would have all the characteristics set out in the objectives, would probably be in for a major defeat.

If a medical ethics course can teach these

kinds of personal character traits at all, it will be indirectly, through the gradual increase in awareness of different kinds of value perspectives and moral convictions that may lead to greater understanding of the apparently bizarre behaviour of patients or fellow physicians. "To this end, a number of specific skills and kinds of information seem to be both relevant and teachable: ability to identify value in-puts in decision-making and to recognize the differences between moral and other kinds of value components, and an increasing awareness of the elements of ethical controversy in a medical issue" (Veatch and Sollitto, 1976).

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