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SPECIAL ARTICLE
The Virtues of Medical Ethics Education

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ABSTRACT
The teaching of medical ethics in UK Medical Schools has come a long way over the last 40 years, though there remains wide variation in the quantity and content of material delivered across medical schools.[1] Attempts to improve and standardize medical ethics teaching has come from the Institute of Medical Ethics in the form of a Consensus Statement, which details a core content of learning consistent with GMC guidance on undergraduate education.[2] All graduating medical students must be aware of and understand the main ethical and legal issues they will face in clinical practice.[3,4] However, as recent events at the Mid Staffordshire NHS Trust and Vale of Leven Hospital illustrate, medical ethics education still has a long way to go and medical educators must strive to understand what underpins moral decision making in reality. A recent appointment to develop medical ethics education locally has led me to question what an effective medical ethics education should deliver to our students. This requires rethinking what "medical ethics" means to students and, in doing so, move away from the notion of ethics as a separate discipline characterized by "dilemmas". Whilst such cases are useful for illuminating the role of ethical theories or principles, good ethics teaching must deal with everyday ethics and all the factors that affect decision-making in reality. To do so we must find a role for a virtue-based ethics theory and the space for moral learning.

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Introduction

The teaching of medical ethics in UK Medical Schools has come a long way over the last 40 years, though there remains wide variation in the quantity and content of material delivered across medical schools.[1] Attempts to improve and standardize medical ethics teaching has come from the Institute of Medical Ethics in the form of a Consensus Statement, which details a core content of learning consistent with GMC guidance on undergraduate education.[2] All graduating medical students must be aware of and understand the main ethical and legal issues they will face in clinical practice.[3,4] However, as recent events at the Mid Staffordshire NHS Trust and Vale of Leven Hospital illustrate, medical ethics education still has a long way to go and medical educators must strive to understand what underpins moral decision making in reality. A recent appointment to develop medical ethics education locally has led me to question what an effective medical ethics education should deliver to our students. This requires rethinking what "medical ethics" means to students and, in doing so, move away from the notion of ethics as a separate discipline characterized by "dilemmas". Whilst such cases are useful for illuminating the role of ethical theories or principles, good ethics teaching must deal with everyday ethics and all the factors that affect decision-making in reality. To do so we must find a role for a virtue-based ethics theory and the space for moral learning.

The perception problem

Discourse about what effective medical ethics teaching should deliver assumes there is a universally accepted definition of "medical ethics" per se. However, amongst students, it is far from clear this is the case. A study by Johnston *et al.*[5] provides interesting insights into how medical students at King's College, London perceive medical ethics:

"I find it quite frustrating... Discussing questions in endless circles and never coming out with a firm resolution. I am a scientist and I like hard facts."

"The impression I get from many of my peers is that ethics is vaguely interesting but not relevant to their lives. This is clearly wrong."

"It's interesting once you turn up to it."
"Discussion is, after all, what it's all about."

Another recent study conducted amongst medical students in their clinical years at the University of Edinburgh[6] to ascertain preparedness for clinical practice reveals similar views:

"[Ethics education is...] not practical enough. We need to be taught with more examples and what actually happened. There were lots of open discussions with no conclusions."

"Teaching was all very academic, taught by academics."

The perception that ethics education is focused on classroom discussions of difficult cases is arguably an "own goal" for medical educators. These dilemmas, often framed as paradigm cases, e.g. a patient who is a Jehovah's witness declining a potentially life-saving blood transfusion,[7,i] are undeniably important and an attractive way of discussing ethical issues in a vivid way.[8] However, this approach risks missing the fundamental point that ethics is not a separate discipline with occasional, albeit challenging, cases, but at the core of medical practice.

Further, the familiarity of difficult paradigm cases reflects the development of medical ethics according to "the convention of scholarly enquiry".[9] Many of the discussions around these cases have taken place within academic literature characterized by robust philosophical arguments. While I am not advocating "dumbing down" ethics discourse, educators need to be aware that this approach risks alienating students (and clinicians) who may not feel able to articulate their views using an "academic model".[9] It may also serve to reinforce the perception among students that medical ethics is simply a "matter of opinion".[10]

Unfortunately, unlike cases framed for classroom discussions, ethical issues in reality are not pre-labelled[11] and are rarely purely theoretical.[12] I recently asked medical students and junior doctors to identify ethical issues encountered during a ward round. Whilst I believe every patient has a unique

i The scenario of advance refusals of blood products by patients who are Jehovah's Witness for themselves or their children, assuming those lives are in danger. These cases are often cited to discuss the limits of autonomous choice and the conflict between respect for autonomy and other ethical principles.

and important narrative, I shall mention only three encounters:

1. An elderly man with dementia admitted with a fall. A routine chest X-ray revealed an incidental lesion, most likely to be a lung tumour. A CT scan was booked to investigate further. His family do not want him be told about the suspected diagnosis.

2. A middle-aged lady with chronic pain admitted for the sixth time this year. Her behaviour on previous admissions has been challenging as she demands analgesia, which the doctors "don't think she needs". She is not "clerked in" as her notes keep being pushed to the back of the admissions tray. She is in pain and refusing anything except morphine.

3. An elderly lady admitted with acute confusion. She is agitated, trying to climb over the bed rails, exposing herself to the mixed ward and sobbing. The medical staff ask the nurses to help her. However, they are busy dealing with another patient. The junior doctor asks whether she can be sedated.

The students identified the first case as a matter of ethical concern; concepts such as autonomy, non-maleficence, and truth telling were discussed. Yet, what about the other encounters? I cite them because they do not constitute packaged ethical "dilemmas" yet were undeniably distressing experiences for the patients which raised matters of ethical concern. The morally astute would identify a plethora of issues: the challenges of inexperience, uncertainty about their role as students (or junior doctors), doing something "non-medical" by leaving a ward round to comfort a patient, the possibility of causing harm, reluctance to prescribe drugs that are believed not to be in the patient's best interests, staff resources, and uncertainty about their own emotional responses to challenging patients all come to mind. This was not an unusual ward round and my job is not extraordinary.

Students' lack of ethical awareness, or what Sokol[11] describes as moral perception, may arise from a narrow or sensationalist definition of medical ethics as outlined earlier. However, this is compounded by the nature of clinical environments, which can be daunting places. Students become focused on clinical matters and the need to impress seniors. Patients become objects of learning or, in some cases, frustration and antagonism.[13] Adopting a purely biomedical model to patient encounters ignores the existential aspect of disease and human suffering,[14] exacerbating moral blindness. Good medical ethics education must raise moral perception by acknowledging that ethics is not a separate discipline external to medicine, it is at the core of what we do as clinicians.

Not just the principle of the thing

Raising students' moral perception exposes them to the challenges of *how* to deal with the ethical issues arising from clinical practice. Students need the skills to make ethical decision making orderly, systematic, and rational.[15] To this end, the role of principlism[ii] in medical ethics is well established and, for many proponents, the four principles are sufficient for good ethical decision making.[16,17] Indeed, examining medical student finals recently, it was apparent that principlism is firmly embedded within the dialogue of soon-to-be doctors. The majority were able to identify ethical issues within patient encounters and recite the four principles in rote fashion, some impressively engaging in the process of specification and balancing[17,18,iii] in order to reach a morally defensible course of action.

However, adopting the four-principle approach to ethical decision making is not without its difficulties and thus its critics.[19,20] Ethical confidence in the classroom does not necessarily translate into ethical competence[20-23]; a gap exists between "stated values and actual practice".[24] Clearly it is not enough for students to be able to reflect (however articulately) on competing ethical principles to guide action. I do not argue that principlism does not have an important role to play in ethical decision making, rather, that teaching the four principles alone is not a comprehensive approach. Clinical

ii Principlism in medical ethics refers to the four principles of medical ethics – beneficence, non-maleficence, justice and respect for autonomy – as developed by Beauchamp and Childress in 1979 (see reference 16).

iii Specification is the process of giving general norms action-guiding capacity while retaining their moral commitments. Beauchamp and Childress propose six conditions for the exercise of "balancing" to be used when conflicting moral considerations occur in practice (see reference 18). Gillon simplifies these conditions as "reflective judgement" (see reference 17).

encounters cannot be reduced to reason alone, to do so overlooks the role of other core components of the doctor–patient relationship – the character of the doctor, how emotions and reason are intertwined, and the challenges of putting desired action into practice against a backdrop of challenging institutional factors.[14,19] Even if we adopt principles alone, they are instruments whose value will depend upon "who" is using them.[20] This makes it inconceivable that the character of the clinician can be extrinsic to moral decision making.

The four principles are also vulnerable to being "dumbed down", reduced to what Kong describes as a "tick box" exercise[19] epitomized by "toolkits" and "checklists".[14] As such, good ethical practice becomes synonymous with the acquisition of skills which can be used or discarded as required.[13] In this way, ethical reasoning becomes an "entity",[13] divorced from the doctor's professional identity, serving to further detach the role of human factors in ethical decision making. Clinical work is a value-laden enterprise in which the character and emotions of the doctor are inexorably linked. Good ethics teaching must include the "development of professional virtues"[23] and, thus, find a role for virtue ethics.

Virtue ethics

Virtue ethics is concerned with the character of the moral agent and traces its roots to Aristotle, Socrates, and Plato – they searched for the elements that make a person good by reference to his character.[25,26] The morally right act is that which a virtuous person would do in the circumstances. In the context of medical ethics, virtue ethics is concerned with the characteristics that make a good doctor. A commitment to virtuous behaviour is declared in the GMC codes of practice, which reference the "virtues" of a good doctor.[25,27]

The list of desirable virtues can be extensive. In the wake of recent failings in healthcare, compassion, trust, and candour[14,27] find prominence. Yet, it may not be clear what should be done when virtues conflict or what the limits of virtue should be. In order for virtue ethics to be truly action guiding, virtues must be underpinned by moral or practical wisdom.[25,28]

Notwithstanding that, it is not enough to simply follow these rules or prescriptions, being "virtuous" as required. Virtue is at the core of medicine's identity, so the virtues must become part of our individual professional identity.[13] Without this, we have no desire to behave well and virtues become disposable – in the same way principles can – and unable to withstand the challenges of moral decision making in reality.[25] A virtuous physician will act well, regardless of whether "anyone" is watching. Pellegrino reminds us that the medical profession has its own unique philosophy that unites those who are called to the vocation.[29] It is therefore imperative that ethics education explicitly acknowledges the importance of allowing medical students to "hone the virtues".[14]

Medical students embark upon their training with their moral characters shaped by the experiences of their formative years. Each individual has their own inherent morality which affects their responses to the "miracles and macabre"[13] they are exposed to throughout their training.

"Student doctors are put through a gruelling course and exposed younger than most of their non-medical friends to death, pain, sickness, and... the perplexity of the soul."[30]

Medical training must therefore demand more than just the acquisition of knowledge and skills, but the development of moral learning. Doing so requires the time and space for students' moral and self-reflection or what Glover describes as developing the "moral imagination".[31] For example, using one's own imagination to try to understand what the other persons (patients or colleagues) are "going through" and developing different, perhaps more creative ways of "framing" the situation. This should be complemented by teaching that equips them with the tools and vocabularly[12] to resolve difficult issues. There may rarely be an unequivocally "right" answer; the goal is to find a "morally acceptable"[20] one for the patient and the clinician. It is beyond the scope of this paper to propose how this should be achieved. However, learning from patient narratives and their own narratives by sharing personal experiences may be one approach.[32] This requires engaged, approachable teachers who are aware of their own virtues (and vices), operating within a climate of mutual respect.

"[A teacher should be a] helpful knower in relation to students' attempts at coming to terms with their own moral beliefs, convictions and doubts... and

deal in an artful way with the pain and distress arising from the process of moral learning." [20]

Doing so will not necessarily equate with moral action unless learning takes place within a "moral community".[13] As de Zuleta[14] argues, codes of practice with their commitment to the virtues are "incoherent" and will not engender moral responsibility unless framed within a broader context of morality. To this end, the impact of the "hidden curriculum" on the maturation of students' ethical development must be acknowledged. Negative role models and feeling unable to ask questions or raise concerns can lead to disengagement from ethics and even moral corrosion.[23] This is epitomised by the recent failings in healthcare at Mid Staffordshire, where a lack of compassion, care, and humanity were shockingly evident.[33] Perhaps one of the most important "virtues" is courage – for educators, health professionals, and students – to speak out. As doctors and role models of the future, students have a vital role to play in the promotion of ethical standards.[34]

Conclusion

Medical ethics education is firmly on the curricula in UK Medical Schools. However, there is no room for complacency and there is much work still to be done. Many students and clinicians perceive it as a separate discipline, dealing with abstract principles and complex cases. While there may be some truth in the latter, medical ethics is everyone's business as it is at the core of clinical encounters. Ethical issues in reality do not come as neatly presented dilemmas. Educators need to develop creative approaches to raise students' ethical awareness or moral perception by attending to the existential aspects of illness. Doing so will unveil a plethora of issues which cannot be addressed by recourse to ethical principles alone where the outcome will depend upon "who" is using them. Ethical principles alone do not adequately address the role played by character and emotions, which underpin moral decision making in reality. Therefore, it is incumbent upon medical educators and the profession as a whole, to ensure that as future doctors, medical students develop the virtues that are at the heart of medicine's professional identity, allowing us to connect with our patients as fellow humans. This requires more than simply adhering to rules or a code of conduct but an explicit commitment to moral learning throughout training within an institutional ethos that eschews the right moral values.

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