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Ethics in the clinic: a comparison of two Dutch teaching programmes

H A M J ten Have
Department of Ethics, Philosophy and History of Medicine, Catholic University of Nijmegen, Nijmegen, The Netherlands

SUMMARY
This paper compares ethics programmes in clinical education in two medical schools in the Netherlands. Ethics education in the University of Maastricht is case oriented, whereas the emphasis in ethics teaching in the Catholic University of Nijmegen is focused on the methods of ethics and moral reasoning. The general objectives, format and evaluation are discussed. Both programmes assume that in clinical decision-making normative and technical issues are intertwined; if a normative dimension is intrinsic to medical practice itself, students should learn during clinical training how to explicate and evaluate the moral quandaries of their profession. The positive characteristics of the Maastricht programme (student-centred approach, relevant cases, team-teaching of ethicist and clinician), if combined with those of the Nijmegen programme (a coherent theoretical framework and method for case analysis and interpretation), would create a new, powerful model for clinical ethics teaching. In a recent report such a model is advocated for all Dutch medical schools.

Keywords
*education, medical, undergraduate; clinical medicine/*educ; ethics, medical/*educ; *teaching; curriculum; Netherlands

INTRODUCTION
Five of eight medical faculties in the Netherlands have ethics courses in their curriculum. Six of these faculties have departments or centres of (medical) ethics. Most of the medical ethics programmes have only recently been introduced into the curricula, starting as optional but rapidly evolving into integrated and mandatory parts of medical education. All of these programmes offer introductory courses during the preclinical years (years 1–4). The number of ethics teachers involved in medical education is small. Although some have more than a decade's teaching experience, data on programmes are scarce (ten Have & Kimsma 1987; van der Ploeg et al. 1991).

Several departments have recently introduced ethics teaching into the clinical education of medical students (years 5–6). However, clinical ethics education may differ as to format and objectives. This paper compares and evaluates ethics teaching in clinical education in Maastricht and Nijmegen, and suggests an ideal programme, taking into account the strengths and weaknesses of both programmes.

THE MAASTRICHT MODEL: CASE-ORIENTED
In major clinical clerkships (obstetrics and gynaecology, internal medicine, neurology, paediatrics) ethical conferences for clinical students in the University Hospital take place every 2, 3 or 4 weeks (dependent on the duration of the clerkship). During lunchtime all students (7–12 students) in the clinical department come together to discuss a particular case for one hour with a clinician (in most conferences, the Director of the Department) and a moral philosopher. The design of the conference is identical to other clinical conferences in which the students usually participate. One of the students selects and presents the case; ideally the case should concern a patient who has been examined by the student him- or herself. A few days before the conference, relevant data are communicated to both commentators (a clinician and a medical philosopher). Each conference then follows the same procedure:

1. Presentation of the case by one of the students; relevant data and clinical findings are presented with the help of the overhead projector or a concise paper handed out at the start of the conference. Since only the main issues of the case need to be emphasized, this part of the conference takes only a few minutes. The presentation ends with the students' clarifying the reasons for their choice of this particular case. They do so by offering a preliminary answer to three questions:
Teaching ethics in the clinic

(a) What is, in your opinion, the moral problem in this case?
(b) How would you deal with this problem (and how has it been resolved in practice)?
(c) Why do you propose to resolve it in this way?

(2) Clinical comments: The most important medical aspects of the case are expounded by the attending clinician, who can explain the empirical evidence for the clinical judgement and explain the benefits and risks to be expected in such cases. The clinician is also familiar with the diagnostic and therapeutic policies of the department.

(3) Ethical comments: The moral dimension of the case is clarified by the philosopher, who points out which moral values and principles may be involved in the case, and which are the crucial components of the moral dilemma(s), thus offering a first outline of the ‘moral structure’ of the case.

(4) Discussion: This is the most important part of the conference and takes the greater part of the available time. Students are invited (if necessary) to express their opinion on the case. In order to apply some structure to the discussion, a pattern of moral reasoning is followed. This Ethical Work-up (Thomasma 1978) proceeds from facts to values and from weighing alternative decisions to justifying an actual decision. The first steps do not usually take much time since they have already been outlined in the comments. The discussion therefore focuses on the choice of a particular course of action (or criticism of the decisions made in practice) and on justification of this course of action with moral arguments. It motivates students to explore their own attitudes to moral problems and to pay attention to the relationship between professional morality and their personal value system.

(5) Summary and conclusion: One of the commentators closes the conference with a summary of the moral problem(s), the lines of argumentation during the discussion and the preferable options in decision-making. Recommendations for further reading are made, and usually one or two appropriate and short publications (e.g. on confidentiality, autonomy or beneficence) are handed out to the students.

(6) Evaluation: Directly after the conference students anonymously fill out an evaluation form which consists of a number of statements. The students are invited to express the extent of their (dis)agreement with each particular statement (on a 5-point scale). A few statements concern their actual knowledge in the field of medical ethics. The others are evaluative statements on different aspects of the case and the conference. The responses to some of these items indicate to what extent the objectives of the clinical ethics conference are realized, in the perception of the students.

THE NIJMEGEN MODEL: METHOD-ORIENTED

Clinical ethics teaching in Nijmegen is not part of specific clerkships but incorporated in a general programme for all clinical students during four periods of several weeks distributed over the 2-year clinical teaching period. In the introductory stage of this general programme, preceding the specific clerkships, two sessions (2 hours each) are available for ethics teaching. In two later periods, two more sessions (4 hours each) are focused on medical ethics. In this programme, clinical students participate in small groups (10 students); thus, during clinical training each group has 12 hours ethics teaching. The teacher is an ethicist; clinicians are not involved.

The format of the sessions is as follows:

Session 1 (introductory period): A video introduces a moral debate on the use of placebos in medical practice. In a short period of time (10 minutes), various arguments are used by the discussants. Having seen the video, the students are invited to give their point of view on the use of placebos, and to give reasons for their position. The objective here is that they learn to recognize and distinguish the types of arguments used on the video, and compare these with their own point of view and reasoning. The second part of this session starts with a short explanation of teleological and deontological arguments in moral philosophy. A second video (10 minutes) then shows a debate concerning a child refusing surgery. Students are invited to identify and discuss the types of arguments used on the video.

Session 2 (introductory period): In the earlier session, moral arguments have been used by the video-debaters; students learn to identify, analyse and weigh these arguments. In this session, a structured case is used to invite students to formulate arguments pro or con a particular point of view. The case concerns an older woman, hospitalized in a coma after a severe stroke; her daughters then request euthanasia but the attending physician refuses. The problem is who should decide in this case: the daughters or the physician? The students are given 20 minutes to study the one-page case description, to choose the primary decision-maker and write down arguments defending their choice. Next, a second page is distributed adducing arguments in favour of the other party than the
one chose by each individual student. The students are invited to write down counterarguments (if they do not change their opinion).

Finally, the various arguments pro and con the two decision-making parties are catalogued and schematized using a flip-chart. Usually the group is split in two parts favouring either the physician or the daughters as the primary decision-makers. The arguments are examined and further explained. On many occasions a hierarchy can be constructed between the various arguments, and in discussing the ethical positions it is sometimes possible to reach consensus on what is the best defensible and most plausible position.

**Session 3 (after 3 months of clerkships):** The objectives of this session are to explicate and test the moral intuitions of the students and to clarify these intuitions with the help of the moral principles of autonomy, non-maleficence, beneficence and justice. A simulation game is used to specify moral intuitions. The game introduces the case of an older cancer patient who has had various treatments without significant effect. After several weeks of hospitalization, and before dismissal, the patient and his wife have a conversation with the attending oncologist; however, a research specialist is also present who wants to persuade the patient to participate in a new trial. Thus, students are invited to play each of four roles (patient, wife, physician, researcher); they have to prepare for this role by studying the role-description, provided by the teacher (without knowledge of the other descriptions). The game itself takes 30 minutes. The other students are observers. Having finished the game, the values pursued by the role-players are identified. Then, moral conflicts between the various actors are examined and analysed. The second part of the session starts with a theoretical exposition of moral principles. This is exemplified by reference to the value conflicts identified in the game. Individual experiences of the students with similar value conflicts are then discussed.

**Session 4 (after 1 year of clerkships):** This session begins with an exposition of ‘the anatomy of clinical judgement’, summarizing the debate on the nature of medicine (art vs science). It is shown how and when the object of medicine may differ (individual patient care vs acquisition of knowledge and testing of theories). The standard medical model proceeds from abstract, general knowledge to diagnosis to treatment. These steps in medical intervention imply uncertainty and ambiguity, not only because they require the application of general knowledge to particular cases, but also because applying knowledge requires normative evaluation. Having identified the normative dimension of clinical medicine, the students are required to explicate the theoretical instruments to clarify this dimension. Various moral principles (respect for autonomy, beneficence, non-maleficence, justice, sanctity of life) are discussed. In the second part of the session a video (‘Right to know’) is shown (25 minutes). An older man consults the general practitioner; he is told that he has a malignant disease, which could be cured by surgical intervention. We then see the patient consulting the surgeon before and after operation. It appears that he has liver metastases, but that information is not given to the patient. Finally, the patient is persuaded (with inaccurate information) to participate in a clinical trial with new cytotoxic drugs, first by the surgeon, later by the general practitioner. The students are invited to analyse this video, distinguishing the various phases of doctor–patient interaction: general practitioner (first consultation), surgeon (before operation), surgeon (after operation), surgeon (follow-up consultation), general practitioner (second consultation). In each phase, giving and receiving medical information is different. The students make notes in order to identify the moral principles at stake in each phase, to comment on the use of these principles by doctor and patient, and to identify the conception of medicine prevailing in each phase. During the last part of this session, the moral dimension of the phases of the doctor–patient interaction are systematically discussed with the students.

**COMPARISON OF MODELS: TOWARDS A NEW MODEL**

**Students' evaluation**

Although the Maastricht conferences were not obligatory, they were attended by almost all students. The average number of participants was 7 (minimum 5; maximum 12). Students had the opportunity to participate in 12 conferences during the clerkships in the University Hospital (neurology 2, obstetrics and gynaecology 2, paediatrics 2, internal medicine 6). The evaluation of these conferences was excellent. The students acknowledge the relevance of the cases and the instructiveness of the conferences. They strongly agree with the statement that this kind of ethics teaching helps them to deal with moral problems. They also agree (though less strongly) that the conferences teach them to understand and justify their personal approach to moral problems. The design of the conferences was also appreciated: according to most students the duration of each conference (1 hour) was perfect. All participants preferred the cooperation of clinician and philosopher (ten Have & Essed 1989).

Students' attendance in the Nijmegen sessions was mandatory. Ethics teaching was part of a few weeks small-group teaching preceding or between clerkship periods. Usually groups of 10 students participate.
Although systematic evaluation was not very extensive, students were dissatisfied with this type of ethics teaching. They indicate that teaching was too theoretical, leaving almost no room for students' real-life experiences in clinical work.

**Objectives**

It is remarkable that the objectives of both programmes are more or less identical. The objectives are threefold:

1. to make students aware of the normative dimensions of clinical decisions, so that
   a. they are able to identify which aspects of decisions are technical in nature and which are ethical;
   b. they are able to assess how technical and ethical aspects are related to each other.
2. to develop skills in analysing the normative dimension of clinical decisions (identifying moral principles and rules; critically analysing moral arguments)
3. to develop skills of exploring and justifying personal decisions regarding ethical issues as they arise in specific clinical contexts.

These objectives arise from the basic idea of clinical ethics teaching itself, *viz.* from the philosophical conception of clinical medicine as essentially a moral profession (ten Have & Kimsma 1988). It is argued that medicine is a moral activity since it has a unique character as a healing relationship between doctor and patient. Value judgements are pervasive in clinical decisions. Moral concerns are therefore inseparable from the technical concerns both in correct diagnosis and in the best choice of treatment.

Thus a moral–technical duality is fictitious: many clinical decisions do have ethical components. The logical consequence of these ideas is that ethics is primarily an inherent, second-order reflective function of medicine itself (ten Have & Kimsma 1990). If a normative dimension is intrinsic to medical practice itself, physicians have the duty to reflect on the moral quandaries of medicine. It is of course true that a transfer of clinicians' moral commitments to their students in fact takes place in clinics every day, but so far this transfer has been implicit and unreflective. Just as the technical dimensions of decisions are articulated and evaluated by means of, for example, clinical-pathological conferences or pre-operative case conferences, the normative dimensions also need to be explicatized and evaluated. Common sense should adopt the view that the education process concerning most clinical decisions is not sound as long as their normative dimension is not explicatized and discussed (Seedhouse 1991).

**Lessons**

Frequent clinical ethical conferences in the particular clerkships are apparently better received by the students than sessions programmed in special teaching periods in the clinical programme but unrelated to specific clerkships. Several lessons may be learned from both programmes.

For ethics teaching in particular a student-centred approach has many advantages. It is very gratifying for students to play an active role in the educational process. Since they can select and present the case, and because there is ample time for discussion, students are motivated to clarify and rethink their ideas and preconceptions about moral issues. This motivation to student initiative is in our opinion an important factor contributing to the success of the Maastricht conferences. Now that they are working in the clinical setting, students do not like theoretical expositions or structured cases without clear reference to practical experience. But starting from their own, often confusing impressions and recently acquired, often ambiguous experiences, they appreciate clarification and theoretical models to structure their practical experiences and idiosyncratic case histories. A disadvantage of the Maastricht ethics teaching is that it is exclusively case-focused. A general theoretical framework for case analysis and interpretation is lacking; such framework may be constructed only exemplarily during a series of case conferences. A disadvantage of the Nijmegen teaching is that it is exclusively method-oriented. It attempts to inculcate a theoretical framework of moral principles and a method of case analysis, without leaving much room for the practical experiences of the individual students.

Second, the design of the programme is very important. The positive perception by the students of the Maastricht ethics teaching was due to the fact that it is conducted similarly to the daily patient conferences that take place as a routine and generally accepted component of clinical work. However, such conferences are interposed between practical activities which always have priority. Time is limited; information must be to the point and closely fitted to the practical aspects of patient care. The theoretical pretensions of a participating philosopher, who is not used to this kind of succinct and fragmentary presentation, must be reduced. Although this format is highly appreciated, it also more or less excludes the possibility of exemplifying a theoretical approach, a specific moral theory, an analysis of a particular concept.

Third, the cooperation of clinician and philosopher is essential. This has repeatedly been emphasized in other reports on clinical ethics teaching (Calman & Downie 1987; Arnold et al. 1988). The fact that one of the leading
clinchians is involved in the planning of the conference, that he is actually present at the conference and will even stress the importance of ethical issues in his daily practice, has a profound effect on the students' perception of the relevance and appropriateness of medical ethics. In fact, the clinician is one of the professional role models for the clinical student, and his influence on future conduct surpasses anything ethicists can possibly do. Perhaps, in the long run the principal effect of ethical conferences will arise from teaching the teachers.

Fourth, before introducing any kind of ethics teaching into the clinical years, it is a matter of good policy to start with a carefully planned, designed and evaluated pilot programme in one of the clinical settings. Case conferences should not be introduced incidentally and be dependent on local or shifting alliances with particular clinical departments. As a result of such a pilot programme more or less objective data and systematized experiences will be available to convince the Faculty Committee responsible for clinical education, as well as clinicians in other departments, of the feasibility, relevance, and usefulness of ethical conferences. This is a way to obtain widespread and official support for introducing clinical ethics teaching into most of the clerkships. This introduction will initiate a regular sequence of ethical conferences during the clinical years, making it possible to design a longitudinal programme, at the end of which every student has a basic understanding of relevant ethical concepts and positions.

A new model

Comparing the advantages and disadvantages of the Maastricht and Nijmegen models, a two-tiered approach to clinical ethics teaching suggests itself. In a recent report, instigated by the Ministry of Health and Culture, a similar programme has been advocated, following a consensus meeting of medical ethics teachers in the Netherlands (van der Ploeg et al. 1991).

In the introductory clinical teaching period preceding the clerkships, two (4-hour) sessions should aim at clarifying the most important normative positions in medical ethics, as well as teaching a method of case analysis. Such teaching should partly be a reminder and exemplification of notions, theories and literature studied during preclinical ethics teaching. It assumes, of course, that there is a substantial ethics programme in the preclinical period (which is the case in Maastricht as well as Nijmegen). The objectives of these sessions are to refresh students' basic moral knowledge (concepts, arguments and theories) and to teach students a method of interpreting and analysing the moral dimensions of particular cases. Both method and moral knowledge will be exercised, specified and elaborated during subsequent case conferences.

Following this introduction, a regular sequence of ethical case conferences should be organized. A programme could include, for example, 18 case conferences in the major clerkships: internal medicine (3), paediatrics (2), neurology (2), psychiatry (3), surgery (3), obstetrics and gynaecology (3), and family medicine (2). Cases are selected by the students. An ethicist as well as a clinician participate in the conferences. The topics discussed do not represent all moral issues encountered in the specific clinical setting, but they function as significant exemplars to clarify the moral dimension of clinical decision-making in this setting. This procedure does not offer students a synopsis of the body of ethical knowledge. However, it will develop their ability to identify, interpret and analyse ethical problems.

REFERENCES


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