The need for education on a moral debate

Roland Derk Thijs

sEthics and medical students

Starting an ethical disussion proves to be a difficult task. At the University of Utrecht, the Netherland students are introduced to medical ethics during the second year of medical studies. The objectives of this course are to define moral problems, to formulate precise arguments and to analyse these arguments.

The introductory course consists of three work group sessions and four lectures. As a student instructor at these sessions I wish to discuss, in this essay, some common difficulties encountered at the start of a discussion.

In order to extract a clear view from a variety of opinions. I am forced to generalise this summary.

1. Responsibility

When posed with a moral dilemma students tend to withdraw. They basically don't feel responsible to deal with this problem. Moreover, some students think their task is only restricted to the medical treatment, so they won't respond. Other students will say: 'I am a doctor and it's my duty to treat patients but not to argue with them'. In the work group sessions the students are shown their responsibility and are motivated to face it. A distinction is made between pure professional responsibility which covers your knowledge of the medical skill, and moral responsibility, which is related to your own personal view, in which the physician is 'equal' to the patient. Students are challenged to act the actual doctor and to formulate decisions without fear or favour.

2. ***Relativism***

In any discussion the diversity of opinions is evident. Mostly there is strong opposition between deontological and utilitarian argumentation. At an almost predictable point some students respond by saying: 'It's no use discussing this matter, for we will never agree', thereby actually killing the discussion, or (another sledge-hammer argument): 'I don't mind that he doesn't agree, he may say so'. This relativistic approach to moral pluralism is opposed in the sessions by emphasising certain aspects of the dilemma which they can't possibly tolerate. In addition, students are encouraged to convince each other of their own opinion. Motivating proves to be a powerful drug, though it unfortunately doesn't always succeed.

3. ***Authorities***

In argumentation, students tend to refer to authorities such as lawyers and doctors. For example. 'In the Netherlands abortion is accepted by law (if several conditions are met), this makes it morally correct to abort a child'. Or: 'In Vitro Fertilisation (IVF) is a common treatment in medical practice so it's ethically correct'. However, authorities can be ignored by posing a counterexample like: 'Slavery has also been a practice but do you approve of this?' Physicians and lawyers, students are taught, may be authorities in the social context, but from the moral point of view they are all equal to other people, they only express their personal views.

4. ***Abstraction***

Often students try to escape a moral decision by claiming lack of information. Throughout medical studies, students are taught to approach a dilemma scientifically. A general difference between a moral debate and scientific debate is that a scientific debate is ruled by facts, whereas a moral debate is ruled by arguments. Therefore a moral dilemma requires a different approach. It's difficult for them to argue on abstract information. The problem of abstraction is very instructive. If you ask students which information they lack, they mostly answer medical information. They ask for precise percentages of success of medical treatment, the risks etc. But when offered exact information such as, for example, 'The rate of success is 30% and the risk of operation is lung emboli', they still don't know what to do. This is a very essential point. Students are clearly shown that a practical situation does not clarify an ethical problem. Moreover, practice often troubles the doctor's vision. Doctors may think they decide on medical grounds but actually it is a moral decision.

5. ***Misconceptions***

Students usually think ethics have to do with some imperatives stating right from wrong. Therefore they often give answers which, they think, are ethically correct rather than their own opinion' Throughout the course misconceptions about ethics are removed. In a debate students are reminded that they have to express their personal view and they shouldn't adhere to standards or rules.

Reluctance to exercise moral faculties

All these factors have, more or less, one thing in common, which one could call a flight reaction. Moral dilemmas are difficult personal dilemmas. Participation requires some courage for no one likes to take a vulnerable position by expressing one's personal views. This may be a common psychological phenomenon. In spite of the fact that these factors may paralyse the discussion and create a blockade in

Roland Derk Thijs, Bleyenburgstraat 8, 3572 JN Utrecht, the Netherlands. .E-mail:R.D.Thijs@med.ruu.nl

the student by alleviating these difficulties, they may create important learning points. I hope I've demonstrated sufficiently that even in a society as liberal as the Dutch, education on medical ethics is an essential element of medical education. In defending ethical standards of the medical profession one can not solely trust the conscience of the physician. This physician must be challenged as well, to defend his or her decision. I refer to twofold interpretation of the principle of respect for autonomy: a decision must not only be respected but challenged too. A moral attitude is often thought to be an inborn consciousness which some people have and other people have not. I do not agree. Communication is, in my belief, the basis for the development of your moral attitude. Discussion broadens and, even more, sharpens your personal opmion.

One could ask: 'Why do you need education for this attitude?'. My answer is because of the flight reaction I experienced. In the sessions I observed that students tend to tolerate all too soon each others' arguments, just because they don't want to offend each other. Moreover in my opinion it's very essential that in the preparation for the medical profession, students are taught to acknowledge both their professional and moral responsibility.

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The art of medicine...

The practice of medicine combines both science and art, The role of science in medicine is clear. Technology based on science is the foundation for the solution to many clinical problems; the dazzling advances in biochemical methodology and in biophysical imaging techniques that allow access to the remotest recesses of the body are the products of science. So too are the therapeutic manoeuvres which increasingly are a major part of medical practice. Yet skill in the most sophisticated application of laboratory technology or the use of the latest therapeutic modality alone does not make a good physician. The ability to extract from a mass of contradictory physical signs and from the crowded computer printouts of laboratory data those items which are of crucial significance, to know in a difficult case whether to 'treat' or to 'watch,' to determine when a clinical clue is worth pursuing or when to dismiss it as a 'red herring,' and to estimate in any given patient whether a proposed treatment entails a greater risk than the disease are all involved in the decisions which the clinician, skilled in the practice of medicine, must make many times each day. This combination of medical knowledge, intuition, and judgement is the art of medicine. It is as necessary to the practice of medicine as is a sound scientific base.

To be a physician...

No greater opportunity, responsibility, or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering he needs technical skill, scientific knowledge, and human understanding. He who uses these with courage, with humility, and with wisdom will provide a unique service for his fellow man, and will build an enduring edifice of character within himself. The physician should ask of his destiny no more than this; he should be content with no less.

Tact, sympathy and understanding are expected of the physician, for the patient is no mere collection of symptoms, signs, disordered functions, damaged organs, and disturbed emotions. He is human, fearful, and hopeful, seeking relief, help and reassurance. To the physician, as to the anthropologist, nothing human is strange or repulsive. The misanthrope may become a smart diagnostician of organic disease, but he can scarcely hope to succeed as a physician. The true physician has a Shakespearean breadth of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people.

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