

***Conference on Learning, Teaching and Assessing Medical Ethics
BMA House, London Wednesday 29 March 2006.***

Draft Report on the Proceedings

Introductory Plenary

In his keynote address, *Sir Kenneth Calman* reviewed what had been achieved in medical ethics and medical humanities and addressed current challenges. In medical ethics there was a need for: (1) leadership with capacity and capability at all levels of an integrated curriculum; (2) clarity about the purpose and process of learning and teaching in medical ethics; and (3) methods of learning and assessment relevant to the knowledge base in both science and ethics. This should include recognition of where there is uncertainty and lack of knowledge, and an understanding and critical analysis of social, personal and professional values. While medical ethics had come a long way since the 1980s, it could now do better: the key was investment in people, and for science and the arts and humanities to work together.

Dr Karen Mattick presented some key findings of the national survey of learning, teaching and assessment of medical ethics and law, and raised a number of concerns and questions for discussion in the workshops about: (1) staffing, present and future, including training and deployment; (2) the possibility of students graduating without ethics competencies, particularly with reference to integrated curricula; (3) how to further develop integration of medical ethics in the medical curriculum; (4) whether the 12 topics in the 1998 model core curriculum remained appropriate; and (5) what was the appropriate balance between critical and normative medical ethics within undergraduate medical curricula, and how critical ethics might be learnt in a way students find interesting and relevant.

Dr Roger Worthington, speaking on behalf of the GMC, discussed its role in evolving ethical standards in risk based medicine. Risk, he emphasised, could be enabling in medicine, but clinicians needed to know how to deal with it and with uncertainty. To this end, the GMC and medical schools had complementary roles: the schools had autonomy, but were inspected by the GMC, and knowledge of medical law and ethics was increasingly emphasised as a GMC requirement, best integrated into the whole curriculum. It was worrying that the national survey showed that not every medical school had *at least one* dedicated subject specialist. The chair of the Shipman enquiry had stated that “professional conduct and ethics must be taught from day one”: this could not be achieved by means of sessional support alone.

Workshop Reports

Designing the Curriculum

The **AIMS** of medical ethics teaching were characterised by one workshop as imparting a language and developing skills in reflecting on behaviour, making difficult clinical decisions, and critically evaluating laws and guidelines... [and helping students] to understand cultural and viewpoint differences and get research ethics approval for projects.

In another workshop there was general agreement that the aims of ethics education should be both to ensure that students know and understand key aspects of the law and guidelines (especially the GMC); and critical and thinking skills in ethics. The balance between these, however, was seen differently by different members of the group. Some emphasised the vocational training aspects whilst others emphasised medical education as a university education, preparing students for lifelong learning and reflective practice.

In subsequent plenary discussion it was acknowledged that tension existed in the curriculum between 'education' and 'formation', or between what Dr Mattick, reflecting on the survey findings, had characterised as critical medical ethics (e.g. ethical theory, analysis, argument) and normative medical ethics (e.g. expected behaviour in given situations, including professional and legal obligations). It was generally agreed however that this tension was an unavoidable aspect of ethics teaching and learning in the practice-oriented context of medical schools, where all students had to gain a basic competency in a great variety of scientific disciplines, in not all of which they were expected to become specialist.

The **CORE CURRICULUM** proposed in the 1998 Consensus Statement, it was generally agreed, had served its purpose well, but now was 'ripe for reconsideration'. This was, one workshop considered, only in part because it might be dated with regard to topics and emphasis. It was also thought that there were issues that could now be addressed and were not considered in the original document in sufficient detail.

Examples suggested by this group were:

- 'what are the 'critical skills' and methods of medical ethics and what teaching methods are appropriate in order to help students learn them?
- how is the progression of the student's learning through the years of medical education to be thought about, and what are the implications of this for teaching and assessing?
- what is needed from those who are facilitating ethics discussion (mindful that many people who are doing small group facilitation are not expert in medical ethics)?'

Another workshop made a number of comments on 'Content' with reference to the core curriculum. It felt that it is important to develop ethical competency/capability/capacity as a set of overarching/underpinning themes; these could be worked through in relation to some (not necessarily all?) of the specific areas in the core curriculum consensus document (it was acknowledged that the original paper did mention most of these themes in the introduction). This thematic approach would be seen as providing the ethical skills to underpin the core knowledge and the professional attitudes in learning, teaching and assessment, enabling students to process their experiences.

These themes would include:

- Acquiring basic ethical language and concepts
- Understanding professional obligations
- Identifying one's own assumptions
- Awareness of the perspectives of others, leading to discourse
- Thorough ethical analysis defining parameters, even solutions
- Using various cases, situations and contexts (individual & community)

In subsequent plenary discussion, questions were raised about whether some subjects in the core list might be more appropriate for postgraduate rather than undergraduate study.

Related matters raised in plenary discussion included the core curriculum might be more usefully characterised in terms not of a list of topics but of

- exemplars of what help a student understand medical ethics
- an outcomes-based approach
- skills in analysing any of the topics.

The skill of dealing with complex situations, it was suggested, was generic in medicine, and ethical analysis was not essentially different in this respect to, e.g., differential diagnosis.

Delivering the Curriculum

HOW and WHEN? There was broad agreement with the observation of one workshop that the ethics and law curriculum should be delivered by a ‘**variety of learning methods, integrated as far as possible with the students’ current learning and with “everyday practice”**’. A block of teaching on was very much less desirable than a ‘thread of ethics and law throughout the curriculum with perhaps concentrated teaching at some points’: ethics and law ‘should be represented in each year of the curriculum and should form a continuum with learning in Foundation years 1 and 2’.

Three recommendations of this workshop were

- We are often unaware of where learning and teaching is taking place and the E & L content of the curriculum should be *mapped* by consulting students and key clinical and basic science teachers.
- The ‘*hidden curriculum*’ needs to be considered. Ethics ward rounds were seen as important in the later years of the course – depending on the availability of suitably qualified staff.
- Links with *other disciplines* (e.g. medical humanities) should be encouraged.

In another workshop

Individuals in the group identified examples of good practice in ethics teaching and learning at their schools, including theatre workshops, debates, small group discussion and distance learning initiatives. They also identified constraints, including large group sizes, pressure on time, financial limitations, optional status, timing of sessions to ensure relevance, difficulties of integration with other topics. Financial constraints had led to creative initiatives, including the use of retired clinicians and drama students.

On the specific question of **small group** work, one workshop emphasised that the optimal mode of delivery is through small group work, whether in problem- or enquiry-based learning, in groups reflecting on clinical learning experiences, in workshops, in “firms” or groupings of “firms”, or linked to clinical and/or communications skills work. Some small group settings will allow students to work through ethical analysis between sessions or in a series on the same case.

Despite the difficulties of such work in large institutions, this workshop stated, It is possible to use interactive, or even “small group”, processes effectively in large lecture groups, e.g. promoting specific mini-discussions with neighbours, voting formats. Trained facilitation is essential to ensuring depth of discussion and the development of skills in ethical analysis and reflection, and to avoid simplistic “airing” of views and “common-sense-only” solutions... Depth in learning would be secured by training of facilitators, breadth in learning by the experiences and questions of students.

Two of the workshops made special mention of **student portfolios**

- Portfolio mentors, or equivalent roles, can document and encourage reflection on ethical issues, and act as a tool for raising awareness.
- Many schools are now asking students to keep learning portfolios and this was seen as an important means of encouraging students to reflect in the ethics dimensions of clinical practice. Students should be encouraged to examine their own values early in the course and develop the skills of logical argument.

WHO? Staffing was discussed in all three ‘delivering the curriculum’ workshops, which made the following recommendations.

1. *Who should deliver it?* Experts and non-experts will need to be involved. There must be a senior person in each medical school to lead curriculum development and training of tutors. They must be appropriately resourced.
2. Perhaps the worst-case scenario for the teaching, learning and assessing of medical ethics is the combination of: absence of senior support; an isolated and embattled ‘lone arranger’; and teaching arrangements comprising an easily avoidable slot (or slots) in the curriculum. The antithesis of this – the golden scenario? – might be a combination of a champion and an enforcer, and a pan-curricular student exposure to medical ethical issues in a series of clinical contexts that are integral to clinical teaching, unavoidable, and thus recognised by students as of current importance.

Some schools may be there already, others may have far - or very far - to go. From anecdotal evidence available on the day, it appears that in a number of centres the teaching, learning and assessing of medical ethics had drifted somewhat, sometimes to the extent of being totally marginalised.

A local Champion – senior, credible and influential – might fulfil an essentially political role: promoting awareness of the importance of the work; encouraging participation throughout the curriculum; recognising and rewarding participation. Clearly the politics of the various medical schools varies enormously, but in many centres such a person might greatly assist progress in the teaching, learning and assessing of medical ethics. Political ‘top cover’ of this nature might empower a more junior functionary to get on with the details and much of the work – the roles being separate, individually insufficient, but mutually reinforcing.

3. a) The key staff member(s) were the *specialist(s)* in Medical Ethics and Law, of whom there should be at least 1.0 WTE even in the smallest medical school. This person would be fully trained in Medical Ethics, and would preferably also be active in research and/or scholarship in the field. They would be the Champion for the topic area, with strong connectivity: to senior staff within the school (especially in education) for advocacy and support to the topic area; to other medical ethicists at similar institutions for cross-fertilisation, professional support and to avoid narrowness or insularity; and also to clinical and non-clinical teaching staff with an interest or involvement in the field. They would have a pivotal role in securing and providing staff development for clinical and other medical ethics teachers/facilitators, so that they could provide appropriate depth and support for the students’ ethical analysis and reflection.
3. b) Since much of the teaching will be provided by, and the learning facilitated by, *generalists* with an interest, mainly clinicians, this network needs to be appropriately identified, supported and developed, by the specialist(s). Initially, on a pragmatic basis, they would be keen and interested people, mostly trained at some level in medical ethics and/or law. These could serve as positive role models, and may help students to identify other role models (positive and negative). They should be comfortable with uncertainty, capable of doubt, and informed on ethical analysis. We felt it was appropriate to aspire in due course to appoint such staff against specific selection criteria, and then for the institution to support and develop them, though the specialist(s), to maintain and develop appropriate skills for their curricular role(s).

Another workshop (on ‘designing the curriculum’) considered that the ‘perceived role of an academic medical ethicist was to provide a framework for analysis, an authoritative source, a more objective approach and a toolkit for practice. This group recommended

That, as a minimum, every school should have an ethics ‘champion’, with identified resources to support their activities. The grade of this person (e.g. relative merits of a full time lecturer or a part time professor)... seemed to depend on the local context, particularly how curricular decisions were made, and the likely research expectations. Joint posts spanning topics or institutions could potentially promote integration.

National Resources. The workshops on ‘delivering the curriculum’ also identified a need for national collaboration on teaching and learning issues.

- The development of ‘*learning packages*’ for students and tutors was suggested. These would be available in electronic and hard copy formats and include scenarios with commentaries. It was suggested that the IME could play a role in identifying where these already exist and producing packages to fill the gaps.
- A systematic *web-based* effort directed at disseminating and thus perhaps generalising good ideas and good routines was now an urgent but probably achievable goal. Case material, course outlines, assessment documents etc could all be made available for perusal and replication and use elsewhere – tailored, of course, to local circumstances. Some central support, some technological expertise, some funding and – perhaps most crucially – some sustained organisational competence would be required. [These matters were again referred to the IME.]

Assessing the Curriculum

Assessment was discussed in some detail by four workshops, whose observations and recommendations are as follows.

Workshop 3

[It was reported that a] number of formats were used to assess medical ethics. Individuals noted that ethics assessment was often hard to fail and the topic doesn't lend itself to MCQ and MEQ format. OSCE stations were useful, using either a paper or video-based scenario followed by questions. Group members recognised a need to assess practice rather than just knowledge, and observed that students tended to favour the 'big' ethical issues rather than the everyday ones. The group noted the difficulty of ensuring parity of feedback to students from small group facilitators and also potential for peer and patient facilitation.

This workshop recommended:

that assessment should be longitudinal and take account of students' prior learning, ethical maturity and increasing levels of responsibility. Knowledge, skills and attitudes should be assessed separately, for example by essay, OSCE and portfolio respectively.

Workshop 7

Group members shared their experiences of a wide number of assessment methods that they had used. The range was from standard essays, ethical reflection following patient contact, presentations with assessment grids, extended matching and single best answer computer marked questions and OSCE stations. There were concerns about poor performance in ethics assessments being compensated by good performance in other areas especially in qualifying exams but this was considered inevitable with maximum integration. It was suggested that the generalisability tendency in assessments is likely to make this less uncommon and that it is possible to stratify marks for the ethics elements of integrated assessments and decide on a "cut-off" for progression.

Recommendations were made using the structure of considering the assessment methods using "what", "how" and "by whom" sections.

"What" learning outcome was summarised: students must show that they have and can apply an ethical framework to judge their own professionalism and how this will develop over their careers. *The group recommended encouraging the GMC to insist on evidence from medical schools that this was being tested.*

"How" was the use of a wide variety of assessment tools that are available and can be developed. It was debated whether the demonstrated reliability and feasibility of computer marked assessment methods could match the validity of essays, presentations and reflective diaries even with detailed marking schedules.

The group recommended setting up nation-wide questions groups that could review existing computer marked questions, OSCE mark sheets and essay structured marking schedules as well as writing new ones and sharing relevant material across medical schools and with other health professional groups.

"By whom" was answered by the brief but difficult to implement – "trained assessors". These assessors would need to deal with the problem of compensation in integrated exams and look particularly at how the ethics assessment material contributed to pass marks and rules of student progression through the course.

The group recommended setting up joint IME and HEA assessor training course that could lead to a diploma or be part of the training scheme for medical teachers interested in expanding their knowledge and skill in medical ethics that was previously considered as one of the functions for the proposed Faculty of Medical Education.

Workshop 8

[This workshop noted that one] of the problems facing medical ethics teaching is the need to encompass “professionalism”, a somewhat nebulous entity, as well as teaching the nuts and bolts of medical ethics. Although much of “professionalism” IS about ethics, it also encompasses communication skills, insight, accountability and a willingness to learn. Because of the subjective nature of many of these skills, it is difficult to teach and even more difficult to assess. Currently, therefore, the role of assessing “professionalism” is falling under the umbrella of medical ethics teaching. While this is not an ideal state of affairs, it is everyone’s responsibility that we train young doctors to be professional and ethical in their behaviour and it may be simplest to assess “professionalism” alongside traditional medical ethics.

The workshop *recommended* that the assessment should fall into three categories: **Knowledge, Habituation, and Action.**

To assess **Knowledge** (GMC guidelines, Legal precedent, etc) we suggest a summative assessment to be completed by the third year, but with the possibility of feedback early. This assessment should take the form of a mixture of *MCQs, MEQs, essays, and significant event analysis.*

To assess **Habituation** we suggest three components, making up a *portfolio*, which would have the potential to be built upon post qualification. First *self criticism*, second documenting *critical incidents* observed and *scenarios experienced*, based around medical ethics and professional practice. Thirdly we suggest examples of *assessing seniors* – both good and bad practice – in order to alert students to the different role models that we have around us.

We think this should be formative assessment from year three, but with an accumulative effect. We suggest that the *portfolio* could continue post qualification.

To assess the **Actions** of the students we suggest first *OSCEs* with issues such as consent, capacity and resuscitation, and secondly a *360 degree feedback* (with assessment coming from everyone that the individual works with, e.g. nurses, senior doctors, ward clerks, etc) with a mentor to coordinate this assessment. We anticipate some difficulties in deciding what the criteria for exit would be in this, but think that nevertheless it would be a valuable experience to hear colleague’s views on ones professional and ethical behaviour. It could potentially be added to the portfolio.

Workshop 9

The main points arising from discussion in this workshop were as follows.

Primary Purpose of Assessment

- To demonstrate the students’ understanding of the professional, ethical and legal framework in which they will practice medicine.
- Governance and ‘fitness to practice’, while informed by ethical behaviour, should be separate from the Ethics course. While those who have responsibility for the organisation and delivery of the course in Ethics in Medicine should play a role in that aspect of governance, overseeing it should not be part of their primary remit. One cogent reason for this is they should be one step removed from ‘policing’ the ethical behaviour of students.
- Assessment should primarily be formative though a summative component is important for several reasons, e.g.
- Ethical awareness and consistent moral reasoning are fundamental to the practice of medicine and all students must demonstrate at least a minimum required competence in them. It is important that all students translate knowledge of ethics into ethical behaviour.
- Having ethics as part of the examined curriculum encourages the otherwise reluctant student to take it seriously.
- It was agreed that progress through the curriculum should require demonstration of ‘competence’ in Ethics. This cannot be adequately achieved without summative assessment in the subject.

Resource for Assessment

The form and quality of assessment are currently greatly constrained by resources (particularly staff). [We express some concern at the lack of ambition expressed by the meeting at the level and number of staff being aimed for in many Medical Schools]. We considered that there were worrying trends for Ethics being assessed using tools that are not wholly appropriate but require less resource for marking (e.g. MCQ, EMQ). We were also concerned at the unthinking and uncritical enforcement of marking procedures in some Schools: e.g. one member of our group faced demands that the marks for SSMs be normalised (e.g. they had to follow a normal distribution curve) even among those who had chosen to carry out a SSM in ethics when those students who made that choice were not normally distributed within the whole class.

Further development of an array of tools should be encouraged: e.g.

- Self and peer assessment
- Essays
- Case presentations
- Timed assignments (These are already used in the University of the West of England, Bristol where students, under exam conditions, have access to relevant texts and their workbooks to answer questions they have not seen before within a set time. UWE suggest that this reduces the risk of plagiarism).
- OSCEs
- Portfolios

The formation of a national bank of assessment tools should be considered.

Integration

Ethics must be integrated into the whole curriculum both vertically and horizontally. It is vital that clinical colleagues across the professions and in every discipline be involved in that. To do this it is imperative that a greater number of them have much better grounding in ethical theory. This is one argument for CPD courses in Ethics such has been developed in Bristol (web based) and other places. It was noted that this is to be discussed by the IME.

Plenary Discussion of Workshop Reports

One the questions raised in plenary discussion of reports from the workshops concerned the relationship between ethics teaching and **fitness to practice**. This is specifically mentioned in the report above from Workshop 9 (under the heading ‘Primary Purpose of Assessment’), and might be implied from the observations above of Workshop 7 (on “professionalism and under ‘Actions’). After some discussion it was agreed that while medical ethics curricula involved assessing students’ understanding of what was expected of them in terms of professional development and fitness to practice (as one participant remarked, ‘ethics explains why “you must not do that”’), assessment of students’ fitness to practice was the responsibility of the medical school as a whole and not specifically of medical ethics teachers. It was also agreed however that the relationship between medical ethics teaching and learning, professionalism and professional development, reflective practice, and fitness to practice was complex and **called for further examination**.

Among the other areas of broad agreement arising from discussion of the workshop reports, the following general summary points were made.

- Medical ethics needs ‘friends in high places’
- Medical ethics ‘champions’ are needed, but need to be *resourced* champions
- The skills of reflective practice and critical thinking should be encouraged
- Learning, teaching and assessment should be embedded, mapped, staged and longitudinal
- The consensus core curriculum should be revised
- National medical ethics networks and a website should be developed
- Research is needed into (*inter alia*) what constitutes success in medical ethics teaching and learning and how it is best achieved
- Further conferences of this kind are required to discuss outstanding and emerging questions

Summing Up

Professor Raanan Gillon drew the conference to a close with the following observations and recommendations, which attracted general approval.

1. Every medical school in the UK ought now to employ: (a) *at least one* full-time medical ethics academic to champion, co-ordinate and bring intellectual rigor to medical ethics learning, teaching and assessment; and (b) a recognised supporting team of clinicians and scientists committed to integrating medical ethics teaching and learning throughout the curriculum.
2. The core curriculum in medical ethics and law should be reassessed and an updated consensus statement developed. This process should involve both professional and lay input.
3. Meanwhile a variety of methods of learning, teaching and assessment, should continue to be explored and evaluated.
4. Learning packages and a data base of assessment tools should be developed
5. A national network, web-based and involving further conferences, should be created for those involved in medical ethics teaching, learning and assessment.
6. The Institute of Medical Ethics, in consultation with the co-sponsors of the conference, the BMA, the HEA and the MDU, should convene a working party of stakeholders – teachers, students, medical school heads, GMC and others, including members of the public – to enquire into medical ethics and law learning, teaching and assessment in the medical curriculum, and to investigate how the above and other relevant recommendations might be implemented.
7. The Institute of Medical Ethics, again in consultation with its co-sponsors, should also take steps to fund or seek funding for those recommendations which could be implemented in advance of the findings of a working party, e.g., creating a national web-based network, arranging further conferences, and supporting further research.