Once a month, or the secret to raising the status of medical ethics

We need to send a strong message that ethics is relevant and important and belongs to the clinic rather than the classroom

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Ethics was a key theme at the Royal Australasian College of Surgeons’ Scientific Congress in Perth this May. The topics ranged from the ethics of innovative surgery to the ethics of medicolegal work. In my speech to the delegates, I applauded the selection of the theme and gently criticised the situation “up north.” I referred to the lack of an ethics course on the vast menu of courses offered by the Royal College of Surgeons of England and recounted a failed attempt to publish an article on neurosurgical ethics in a leading surgical journal for lack of a category allowing articles on ethics. I argued that the 21st century surgeon is a clinician who is both technically proficient and ethically astute, shedding the old reputation as a “doer” with little time for reflection.

Between sessions, I asked delegates from several countries if ethics formed part of their national medical school curriculum. It did, but all my interviewees added that the subject had a poor reputation among students. It seems, sadly, that this is a widespread view.

The possible explanations for this apparent distaste ranged from poor teaching to wrong content, premature delivery in the preclinical years, incompatibility with the scientific temperament, and institutional indifference to the subject. Whatever the reasons, it is a shame. Ethics should be both interesting and useful. This low esteem raises an obvious question: what can be done to raise the status of medical ethics?

A simple solution

There is one measure that is so effective, so simple, and so cheap that all medical schools should insist on it. Its implementation, even if imperfect, could transform the perception of medical ethics among students and trainees. It is this.

Every doctor should, at least once a month, highlight an ethical issue within earshot of a more junior clinician or medical student. This could be in ward rounds, morbidity and mortality meetings, departmental meetings, conferences, clinics, or corridor conversations. It can be about any aspect of ethics, from consent to resource allocation, from the most minor to the most serious of matters. This need not take more than a few seconds, but it must include the word “ethics” or “ethical.” For example:

- A consultant anaesthetist: “I’ve become aware of several trainees playing computer games on their phones during operations. Does that raise any ethical issues?”
- A general practitioner: “A medical student has told me that he’s lied to the medical school about a medical condition in order to get an extension for his essay. Are there any ethical issues here?”
- A consultant surgeon: “It looks like one of our colleagues could have done a better job with the first operation. We need to go back in there to fix the problem. Any ethical issues here?”
- A consultant paediatrician: “The parents don’t want us to inform this 8 year old patient of her true prognosis. What are the ethics of this?”
- A consultant intensivist: “This patient is deteriorating quickly. The relatives are at his bedside. We need to think about a do not attempt resuscitation notice (DNAR). Any ethical issues?”

Even a comment as brief as those above sends a strong message that ethics is relevant and important and belongs to the clinic rather than the classroom. Why else would a consultant mention
it? It bridges, in the space of a few words, the theoretical and the concrete, the technical and the ethical. The more eminent and respected the messenger, the more effective the method. Similarly, a single dismissive comment by a consultant can undo the good work, forged over years, of a lecturer in the classroom.

Now, not every case conceals a notable ethical issue. Ethical hypochondriasis is a tedious condition for those exposed to it. Most cases are ethically so obvious that no discussion is necessary, but a busy clinician will come across ethically noteworthy cases at least every month.

When they arise, flag them up at the next opportunity. Invite a trainee or medical student to prepare a brief presentation on the topic, or ask the local medical school’s bioethicist to talk on the subject at a departmental meeting. With luck, he or she will be so flattered by the invitation to the “front line” that there will be no charge. Publications, posters, and talks at conferences can follow, with glory for all.

Aside from raising the status of medical ethics, this habit would lead to a greater awareness and understanding of ethical issues, and perhaps—who knows—better care for patients.

At the end of an address to the Society of Internal Medicine in Chicago on 15 May 1901, William Osler recounted how an early mentor, Dr Bovell, handed him a copy of Latham’s Clinical Medicine. In the book, Osler said, Bovell had “marked a passage which contains the alpha and omega of clinical teaching, and with it I will conclude: ‘In entering this place,’ speaking of the wards of St Bartholomew’s Hospital, ‘even this vast hospital, where there is many a significant and many a wonderful thing, you shall take me along with you, and I will be your guide. But it is by your own eyes, and your ears and your own minds and (I may add) your own hearts that you must observe and learn and profit. I can only point to the objects and say little else than see here and see there.”

In the domain of ethics, as in medicine, there is great value in saying, simply, “see here and see there.”

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1 Osler W. The natural method of teaching the subject of medicine. JAMA 1901;36:1673-9.

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