Teaching Medical Ethics in the Future

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I. The Need for Medical Ethics

As a discipline studied in major universities and colleges throughout the world, medical ethics is no more than twenty-five years old. Of course it has a history that goes back to the ancients, but it was not until recently that medical ethics became accepted as a legitimate academic subject. Being such a new discipline, its roots in the medical school and the general university curriculum do not run deep. Indeed, one might still think of medical ethics as a fad, and as something nice to have in the curriculum, but not as something essential to it. After all, on the undergraduate level there are heavy demands on the pre-medical and the pre-nursing students to learn about biology, chemistry, physics and mathematics. In medical school the demands are even heavier. Given these demands, it might be thought that medical ethics could find a place in the curriculum within some other course so that before new young doctors and nurses go out to into the world to deal with sickness and injury, they would have at least heard a few lectures in medical ethics. It might also be thought that these lectures not only would do no harm to the curriculum, but they would actually do the students a little good.

But the curriculum aside, another reason might come to mind as to why medical ethics should be taught only when a small space in the curriculum can be found for it. Medicine, it could be argued, is a field where the vast majority of practitioners are sincerely trying to do their best to serve the community. Like any field, there are always a few unscrupulous individuals to be found within it. Nevertheless, so long as the majority in the field control the unscrupulous ones, ethical problems within medicine should not be so serious as to demand that large segments of the curriculum be devoted to the study of these problems. Again, a little bit of medical ethics may be acceptable, but to devote too much time to such a peripheral study when the real need is not present is a waste of valuable curriculum time.

In this paper I want to oppose as strongly as I can those who agree with the views just expressed that medical ethics at best should be only a peripheral study within the curricula of the health-care fields. Actually I want to strongly oppose two groups of people. First, there are those who think that medical ethics is simply not an important subject matter. Second, there are those who think that it is important, but that there are more important things to study. What I want to argue is that medical ethics is important enough to deserve a central place in health-care curricula now and in the future. In this paper, I will not only argue for the centrality of medical ethics, but will attempt to outline where it fits into health-care curricula. What I will say by way of finding its place in these curricula will be such as to apply not just to universities in the United States or the Republic of Korea, but to all curricula wherever they are found. To be sure,

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the suggestions I make will need to be adapted to some extent to the particular society where they might be applied. Still, the fundamental points will be general enough, so that no one will be able to say of them that they may very well be appropriate for the United States, but they have nothing to do with “my country.”

Now why is medical ethics important enough to deserve a central place in all kinds of health-care curricula? There are at least three reasons. Perhaps the most important is the rapid advance in technology. There have always been ethical problems in medicine such as those concerned with the doctor-patient relationship. Abortion has also always been an issue for almost every society in the world. But whatever problems existed before the advent of high-technology in medicine, their numbers now are multiplied many times over. What technology has done is make medicine a profession with far greater power to control health than it had before. With that power has come choice. It is technology that keeps a badly deformed infant alive, where in the past it would have died immediately or soon after birth. In the past the infant’s death would have perhaps been thought of as an act of mercy, but certainly as an event over which medicine had very little control. Today medicine gives us a choice as to whether we should let that infant live or die. Choice is what ethics is all about. But with more choices there are more problems. Science creates moral problems for us along with its cures in the form of people whom it keeps alive, but cannot fully make well. So as the result of technology, ethics has become more important to medicine than it was twenty, thirty and forty years ago.

Indeed, technology promises to create still more problems for us in the future along with the cures. If anything, technology seems to be accelerating rather than reaching some plateau. New drugs, surgical procedures and equipment in a wide variety of areas are arriving on the medical scene. With each level of development in a wide variety of areas are arriving on the medical scene. With each level of development, new questions never faced before arise. For example, concerning an embryo transplant procedure where the fertilized egg has been planted into the womb of a “third party,” who determines the fate of the embryo? Should the woman who contributed the egg decide when and if the embryo is to be aborted? Can the “host” make that kind of decision? These are new questions. They could never have been faced with a technology on the level of herbal medicine in the East and the “black bag” medicine of the old country doctor in the West. Who decides, to raise another question, whether a “brain dead” person is dead? Also is it wrong to implant a baboon’s heart into the body of a human infant? Is it proper to experiment with humans by implanting artificial hearts into their bodies? Since there is a large demand for organ transplants, should the needed organs be sold on the open market like any other commodity in great demand or should these parts be donated? Once we learn how to do it, will it be proper to conduct genetic surgery so that humans are made more intelligent, more industrious, stronger, taller, more compliant, etc.? Or should some be made more intelligent while others are made less so? However, this technology is used, who should make these decisions? We should not delude ourselves into thinking that technology is not going to continue to create new moral problems that we only dreamed of just a few decades ago.

Technology creates problems for us in a different way. Technology is not cheap, and even the richest of nations must choose whether to invest in one kind of technology rather than another. No one can afford to purchase all the technology that has been created or is promised for us in the near future. These choices, however, are not just about which kind of equipment and skills need to be purchased. Certain purchases help certain kinds of unwell patients, but not others. So by purchasing one kind of technology, we are deciding to help one kind of patient. If our budget is limited so that no other technology can be purchased, then patients not helped by the purchased technology will suffer from neglect. There is even the choice
that we must make between buying high or low technology; that is, whether it is best to spend much money on CT scanners and the like or on primary care medicine.

The cost of medical care creates other problems. In the past when medicine was fairly simple, both the rich and the poor could purchase its limited benefits almost on an equal basis. Today the more expensive medical care becomes, the more it becomes possible to create a discrepancy between the medicine that the rich and the poor receive. Now the differences between a heart transplant surgery that a wealthy person receives and the palliative treatment for the same condition a poor person receives is real and great.

The lesson here is that as medical technology expands, so does medical ethics. This point is difficult for some people to grasp. They suppose that ethics is something constant and unchanging since they think of the basic rules of ethics as always being the same. We are not supposed to tell lies, cheat or steal, and we certainly are not supposed to kill our fellow humans. But because the rules are seemingly unchanging for all societies, people suppose that the problems we face must be unchanging. It may be that even the modern problems posed by medical technology are still ones of truth-telling, cheating, stealing and of life and death. But these problems are more complex today than in the past, and most certainly they occur with far greater frequency.

But technology is not the only reason medical ethics should play a central place in the curricula of future doctors, nurses and other health-care professionals. A second reason is really a cluster of reasons but, for the sake of simplicity, I will call it the fairness reason. We noted already that a few health-care professionals are unscrupulous. They need to be controlled by someone since they think of serving themselves before they think of serving others. I will have more to say about how they should be controlled shortly. However, it is not these that pose the major problem of fairness for us. The majority of health-care professionals, we noted already, are well-intentioned. They want to do all they can to help their patients. Because they do, critics of medical ethics say that there is no real need for extensive study of this field. It is said that those who intend to act well, by and large manage to act well. But I think that if medical ethics and other applied ethics fields have taught us anything in the last two or three decades it is that this apparent truth is not a truth at all. Think for a moment of some of the experiences of the medical community in the United States two or three decades ago. Many well-intentioned researchers in medicine were routinely experimenting on humans without their consent. In some cases this meant that patients’ lives were threatened and even lost without the patients or their relatives knowing what was happening. The doctor-researcher with his good intentions to gain knowledge to help mankind felt that he had the right to sacrifice other peoples’ lives if need be. In some cases, those that were sacrificed turned out to be members of groups that could not effectively speak up for themselves. Among the groups taken advantage of were Blacks, retarded children and criminals in prison.

Other doctors, again meaning well, felt that as professionals with many years of training behind them, they were in the best position to know what kind of surgery or medication suited the patient best — without consulting with him or her. ‘Doctor knows best’ is an old saying in the U.S. that reflects the kind of paternalism that was and is quite common in that medical community. It was as if when you put your body into the hands of your physicians, he not only took it, but he also took all the rights you had to make any decisions about your health and your life. If you were a woman with breast cancer and he thought that radical surgery was the best thing for you, you were not to question his wisdom. It was not surprising that doctors were for a while thought of as gods. In a way they were gods. In the U.S. and in many other countries, they had great power to control life and death. But in another way they turned out not to be
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gods. They were not always so fair as they should have been. Being paid on a fee-for-service basis, it seemed that many doctors favored extensive surgical procedures whether they benefited the patient or not. "More service, more fee" seemed to be policy that even honest physicians followed. They believed they were doing the right thing but, unlike gods, it seemed that their beliefs were affected by the condition of their pocket books. They were trying to be fair, but they were not succeeding very well since they confused their own interest with the best interest of their patients. Some of them had lost a sense of perspective.

Physicians and the medical community acted somewhat unfairly to the people they served in another way. This community is truly a community. It is composed of people who have been trained to perform certain tasks; and that training in most countries at least takes a long time and is extremely rigorous. Once a physician is granted his degree he serves the people who need him from within the framework of the high standards established by the community. And that is good, especially since within the community there is often a variety of views expressed about what should be done in this or that problem. Still, there is a difficulty about serving others well when the physician, the nurse and the other health care professionals talk mainly to each other about how to deal with some medical or moral issue. There is a tendency in any community to develop uniform views and to fail to listen to outsiders. Some of this tendency is related to professional pride and not just to professional isolation. But whatever the cause, it is as if one part of our society comes to think in a certain way and thus can no longer appreciate the thinking of another part of the society. The military profession probably suffers from this same isolation. So does business. These people meet, talk to, debate and compete with their own kind, and, after a while, they think like their own kind. This isolationism or provincialism is, of course, not even unique to the professions. Ethnic groups, because they too talk to their own kind by and large, tend to see only their own point of view. Health-care professionals, like other human beings, then, do not always act fairly because their perspective is not always in tune with the needs of others. Having learned to think like professionals, at times they are unable to think like and have the feelings of those with different backgrounds from their own.

The reason it is important to appreciate this point is that a crucial function of the study of ethics, no matter what kind (i.e., medical, military, business, legal, educational, etc.), is to help people overcome their provincialism. One of the ways this is done is through the application of what is called the Universalizability Principle (UP) in ethics. Roughly stated this principle says that if people, situations, conditions, actions etc. are alike, they should be evaluated or treated alike. The UP is a requirement of fairness. That sounds simple enough. But in applying the UP what one must do is learn to think as others do. Thus if a person you know has an intense rational preference, the UP requires that he be given the same consideration that you give yourself if you have an equally intense and rational preference. Coming to know about other peoples' preferences is not such an easy thing to do. The study of ethics not only emphasizes the importance of this knowledge of other peoples' preferences, but it gives us clues about how this knowledge might be gained.

The medical community's provincialism causes a related problem, one that I have alluded to already. Members of the community have a tendency to protect one another. This is natural. This happens in all communities. But the result is that the unscrupulous physician is not always exposed the way he should be. So, in a somewhat different way, well-intentioned medical professionals again can be seen as not acting fairly in part because they think that exposing the bad doctors and nurses will somehow reflect upon the whole community.

There is a third reason why the study of medical ethics is important enough to deserve a central place
in the curricula of medical and nursing schools. This reason is so obvious that we tend to overlook it. It is simply that medical care is important to people. People prize such care because by its very nature it promises to provide them better health, and in some cases life rather than death. Not being able to have access to medical care is not like not being able to buy a house or a car. It is far more fundamental. If the medical profession or the society prevents people from gaining access to such care, or if once they gain access to it they are mistreated by the medical community, then for them the moral crime committed against them is very serious.

II. The Nature of Ethics

So the study of ethics in a medical setting is important not only because of the pervasive influence of technology and because it helps those who want to be fair, but also because it provides a service that is very important to people. Yet it is one thing to say that medical ethics deserves a central place in curricula for health-care professionals, it is quite another thing to specify just what that central place is. A clue about what that place is can be gained by looking briefly into the nature of ethics.

Whatever else ethics is, it is a prescriptive study. Unlike science which is concerned to describe things (i.e., to tell us how things are), ethics helps us to decide what to do (i.e., tells us what we ought to do). As a part of the prescriptive role ethics plays, it teaches us good habits of behavior. This is just as well, since in the vast majority of situations in which we have to make moral decisions, we have time only to decide quickly what we ought to do. In these situations, we just do what seems right to us automatically or intuitively. It should be noted, however, that although this intuitive level of thinking is quick-acting, it comes to be that way because of the conditioning and training we have undergone over long periods of time. It is somewhat like playing a musical instrument. It may be that a musician today can play the right notes without thinking, but in the past he had to train many years to gain this ability.

There is another level of thinking that is also needed in ethics. This is called by Professor R.M. Hare the critical level of thinking. On this level we think carefully about what it is we are to do in a particular situation and about what rules should be found on the intuitive level. Engaging in critical thinking is very complicated and requires great discipline to be done well. In effect, if teaching medical ethics is to have any impact upon those who will be professionals in the health-care fields in the future, it has these two jobs to do. It must teach both intuitive and critical thinking. Now given the nature of these tasks, it is not likely that they will get taught quickly and easily in a few lectures during the second or third year of medical school. Nor is it likely that medical ethics can be taught informally by professors of medicine in conversations with their students. Nor is it even likely that students can be given books or articles to read about medical ethics in their spare time and on their own—assuming that medical, nursing, etc. students have time to spare to do such reading, and assuming also that they had the interest to do such reading. Rather, what will be required is a program of study that extends over the whole of the student's medical career preferably from near the beginning in undergraduate school through the end of medical school and perhaps beyond. It is as if medical ethics requires time to be gradually absorbed into the system of those who will be doctors, nurses, etc. once their schooling is over.

So teaching medical ethics even in a full semester course at any one point in the student's training will probably not be enough. Certainly doing it that way is far more satisfactory than teaching it in any of the lesser ways we have mentioned already. At least a required course devoted exclusively to medical ethics would ensure that the student has been exposed to a systematic look at the ethical problems facing medical
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practitioners. But the problem with a single course, even if it is well-taught, is that the effect it has on students will soon wane. If, as I said, part of what any educative process of ethics should do is to affect peoples' habits of behavior, it is just not good educational theory to suppose that their habits (i.e., intuitions) can be changed simply by exposing them to a course that begins on one day on a particular semester, and ends four months later. What is needed is a program that keeps the ethical issues with which we are concerned in the front of our students' minds throughout the whole of their training regimen. What they need is a regimen of training in ethics, not a shot in the arm.

III. Recommendations for the Curricula

But what kind of regimen is required? And what will its cost be to the medical school and nursing curricula? Well, it need not be an impossibly difficult regimen to carry out, and it need not even take so much time away from these curricula that those faculty members who want their students to have more time to learn chemistry, anatomy, physiology, pathology, etc. need complain too much. Ideally medical (and other forms of) ethics should be taught first in high school. Perhaps it is asking too much to have such a course on that level, but some course having to do with ethical issues of medicine, business, law, military matters, etc. ought to be in place in high school if we think that the moral issues raised within these institutions are important. But our concern here is not to reform high school programs. We are interested in structuring a program for medical ethics for a university that trains students who go into medical or nursing school, and that itself actually trains medical and nursing students. Ideally for the kind of school, the students should have available to them a course in medical ethics on the undergraduate level.

The course could be required for all pre-medical and pre-nursing students, but it would be enough if they were encouraged to take it. Probably, for best results, it should be taken a year or so before the students formally enter their professional school. There need not be anything special about how the course is taught. Being realistics, the large number of students who would likely take it would preclude having many small discussions on the various ethical issues included in it. However, the class size should not be permitted to get so large as to make some discussion impossible. As to the content of the course, it would not deal with a few specialized issues. Rather, it would serve to introduce the student to the whole range of ethical issues found in the field of medicine. The instructor would have wide discretion as to how he structured the course, but certainly all of the following issues would be included. Under the general heading of death and dying would be found such topics as abortion, infanticide, brain death, active and passive euthanasia, and the right to die. Under a second general heading that might be labelled provider/patient relationships, such issues as confidentiality, truth telling, informed consent and experimenting with humans would be included. There would also be a health-care distribution section in the course. Here the students would learn about medical costs, various systems for paying medical bills, the role of technology in medicine, and about such problems as delivering health care to the poor and to those who live in remote regions of a country.

If my and my colleagues experiences in teaching such a course are any indication, the material itself would be taught by placing heavy emphasis on case studies. It must not be forgotten that undergraduates do not yet have a personal sense of what the problems of medicine are. Most of them have had little contact with hospitals, and many of them have not have seen death up close. If the issues of death and dying are thus presented to them abstractly, they will have very little sense of what is being discussed. Thus the questions posed to them should not, at least initially, be presented abstractly in terms of whether patients
ought to be allowed to choose to die when they are very ill. Rather, it should be in terms of whether this patient, in a particular condition with a particular family situation, ought to be allowed to die. Similarly in discussing abortion the question should not be posed in terms of whether abortions should be permitted in general, but whether this poor woman with four children should be encouraged or forbidden to get an abortion. Once the case studies have been used to introduce the problem and to make that problem real to the students, only then is it appropriate to talk about the issue more abstractly.

One other thing needs to be said about the content of this undergraduate course. It is not enough that the course’s content speak to death and dying and the rest of the ethical issues met in medicine. Material pertaining to ethical theory needs to be presented as well. This material probably should not be presented at the beginning of the course since, even more so than the ethical issues themselves, such a presentation would be next to meaningless to the students. Rather such ethical concepts as utility, rights, duty, obligation, justice, equality, fairness, tolerance and the universalizability principle will be best introduced as the students become familiar with first one and then another basic kind of moral problem. But the theoretical materials do need to be presented since, otherwise, the students would never be able to learn to think critically about moral issues themselves, and never be able to do anything but develop disconnected views about the major moral issues that will face them as future health-care providers.

The fact that a good deal of ethical theory needs to be presented in such a course strongly suggests what sort of training is required of medical-ethics teachers. Primarily they should be ethicists (either from religion or philosophy departments). It would be well if these teachers had some experience working in hospital settings but, lacking that, they should have good liaison with those in the medical profession so that they receive assistance in dealing with medical questions they pertain to ethics.

Armed with information and insights gained in an undergraduate course, the student entering professional school will at least have been introduced to medical ethics. There will, of course, be students in these schools who have not had such a course. For them, the professional school should arrange an elective course as soon as they arrive to help fill the void. But even for those with a good background in medical ethics, it will be important that they find some forum to continue thinking about ethics. When they first arrive in their professional schools it will not be necessary for them to take a second course that repeats much of the material they learned about as undergraduates. It would be enough in the first years of medical or nursing school that ethics be discussed within the context of the other courses they are taking. There might also be special lectures that the students could hear from time to time. In the beginning, the important thing is for them not to forget what they have learned, rather than spend much time learning new material. As I mentioned above, everyone is aware of the pressures of the professional schools and how professors of medicine feel about spending time on subjects that do not directly bear on the practice of medicine. Given these pressures, then, not much need be done upon entry into the professional school. As we will see now, there is a better time available in the health-care schools for learning about medical ethics.

The best time for them to receive their second dose of medical ethics is when the emphasis of their program shifts from the classroom to settings where the students come into regular contact with patients. In the United States this means the third and fourth years of medical school. In nursing school it comes earlier. But whenever it comes, it is at this time that medical ethics will be more meaningful for the students. At this time, it is no longer a matter of talking about other peoples’ patients, but of their own. In this context of problems that are real for them, the study of medical ethics will yield the best results.

The format for this second serious exposure to medical ethics should now be quite different from the
first one. Instead of a standard classroom setting, the primary contact with medical ethics should be in small gatherings of students, residents, nurses, hospital administrators and, of course, at least one ethicist. Instead of hearing lectures in medical ethics as they did when they first heard about this subject, the emphasis now will be on discussion. And in this discussion the case-study approach will be even more prominent than before. The students themselves, the medical faculty or the ethicist will bring case studies to the sessions for discussion. If the group represents a particular department such as pediatrics, then the case studies will come from that field.

As the students rotate from radiology, to OBGYN, to psychiatry, to surgery, the ethicist will intercept them to carry on discussions in each of these service areas. This means that this second major contact of students with medical ethics will not be in the nature of a formal course, the way it was before. Rather, if planned properly, students would meet with the medical ethicists something like once every other week over the length of the medical program. That might mean that these students would be meeting regularly with a medical ethicist over a period of two years. More than that, contacts could be continued during residency training. So the medical student-resident might be in constant contact with discussions concerning problems in medical ethics for a total of four to six years depending on the length of his overall training program.

Over that time period, there ought to be enough opportunities for meeting with the ethicist, so that all the major issues as they pertain to direct patient contact will have been discussed. It is true that as I have so far outlined the second phase of a student’s meetings with medical ethics, he might not hear many discussions about ethical issues pertaining to health-care distribution. I will speak to that question shortly.

But first I need to say something about the person who teaches medical ethics in a medical or a nursing school. There has always been a problem about his training. Some feel that he should be a medical person with a background in ethics, while others feel that he should be an ethicist with a background in medicine and the biological sciences. The argument could be settled by finding someone with an MD degree and a Ph.D. in ethics. Such people exist I suppose although I have never met one. Realistically since it is next to impossible to find someone trained well in both areas, the choice must be between having ethics taught by a medical person or a non-medical person. I opt strongly for the latter. There are three reasons for my choice. First ethics is a highly technical field with intellectual pitfalls waiting for those who take a course or two in medical ethics and then try to teach it to their students. The subject matter of medical ethics is ethics after all, and it is in that area that the teacher of medical ethics should be a specialist. Second, even if the ethicist is not trained in medicine, if he is teaching in a medical school, he has easy access to people who can help him. So when medical questions arise, such as whether an abortion is more dangerous to the life of a woman at six months pregnancy than a normal nine month delivery, the ethicist can consult with the OBGYN department for the best available answer. The point is that it is easier for an ethicist teaching in the medical or nursing school to tap the medical resources needed for him to deal with difficult moral problems, than it is for a medical person to tap the resources of an ethicist who is not even near by. Third, there is an advantage in having an outsider teach medical ethics. Earlier I remarked about the problem of perspective. I said that the medical community, like all communities, tends to isolate itself from the rest of society. Doctors talk mainly to doctors. If those in the community develop certain attitudes or prejudices, it becomes difficult for them to understand other ways of thinking given that they are isolated. Having an outside critic, one who comes from a different background, with different prejudices and attitudes, often helps those in the community to appreciate other peoples’ points-of-view.
So my suggestion is that medical schools should not depend exclusively upon their own medical staff to teach medical ethics. These people can help to some extent, especially if they have received some training in medical ethics. But the nature of the subject matter and the need for an objective critic of the medical community dictate that the main job here be done by an outsider. Whether he be a philosopher, theologian or whatever, he needs to have access to the medical community, if for no other reason than that he must be able to intercept medical, nursing, etc. students as they rotate through the various service areas of their medical program. He must, that is, be guaranteed the cooperation of the various departments so that he can arrange his small meetings with the students and residents to discuss the various medical ethical issues. In order to get this cooperation, he will likely need to have an official appointment within the medical school and be given adjunct status within one of the standard medical departments (e.g., community health).

He, or at least his program of teaching, will require one other thing. That program will have to be given status in the curriculum comparable to any other program in the medical or nursing school. Thus the meetings the ethicists arranges will not be ones that the students will attend only if they happen to be moved to do so. Instead, students would be formally required to attend these meetings and they would be assessed as to how well they are doing. In making assessments of the students it might be useful to have the ethicist require them to write reports on their views of each case study discussed. Forcing the students to do something other than merely attend the meetings would make them realize that their school considers medical ethics to be a serious subject matter, even though it is not strictly speaking a medical subject matter. In this connection, we have found in the United States that non-graded and non-credit medical ethics courses taught in the medical schools, are simply not taken seriously by students. They attend the sessions for these courses when then feel like it. But when they are very busy or simply too tired, they absent themselves from these classes with great regularity. All evidence indicates that medical ethics taught under these conditions is a waste of time.¹

Two final points about the status of the ethicist in the medical and nursing school are worth adding. First, depending on the size of the medical program, more than one medical ethicist may be required to get the job done. It may be too much of a task for one person to arrange enough meetings to have any real impact on the thinking of the students. As I suggested already, if the students cannot be intercepted in their work program at least once every other week, very likely they will not develop a sense of continuity and organization in their thinking about medical ethics.

There is another advantage in having more than one medical ethicist on the scene. Many moral problems are successfully resolved because different people bring different perspectives to them. Having just one medical ethicist on the scene might mean that only one perspective will be clearly articulated in his classes and meetings with students and faculty. With two there, such a narrowness of thinking is less likely to develop. If a medical school feels that it cannot afford to have two full-time medical ethicists working for it, that school might try retaining people trained in this field on a part-time basis. Such an arrangement would also encourage diversity of thought.

Second, in addition to the small group meetings with students, the medical ethicist will need to give formal lectures from time to time. These lectures could be given as guest appearances in formal classes taught by other people, or they could be specially arranged. In these lectures, the ethicist would address those issues that do not arise in the small discussion groups. Those groups, it will be recalled, will be mainly concerned with moral issues as they arise from the cases met in the hospital. In contrast, the lectures will be designed mainly to encourage the students to think about broader health-distribution
issues. Actually another set of issues can also be discussed at these lectures. Frequently the field of medical ethics is characterized not just in those terms but as bio-medical ethics. With the introduction of biology into the field of study, issues pertaining to experimenting with humans begin to come to our attention. Since in many hospitals clinically oriented research is being done, it is appropriate that these issues be discussed as well. So in the process of meeting students regularly in the hospital setting and lecturing from time to time, our medical ethicist will not be at a loss for work that needs to be done.

One of the major themes of my argument in this paper is that medical ethicists should be non-medical people. They should be outsiders with the ability to look into somebody else's community at a distance with a certain amount of objectivity. If my point has any merit to it, one of the suggestions I have made seems to go against this theme. By asking that these outsiders receive appointments within the medical community it seems that, in time, they will become insiders even though they are not doctors. Meeting and talking to doctors so often, they are likely to start thinking like doctors, and therefore lose their sense of distance and objectivity from the community. Now this is a valid criticism. The expression we use in the U.S. to characterize what might happen is that the ethicists may, in time, be coopted (i.e., by cooperating and having others cooperate with them, the person who allegedly was to be a critic of a community no longer is able to criticize it).

What can be done about the dangers of coopting? The solution to this dilemma is for the ethicist to cooperate with the medical community and thus risk being coopted, but to seek the help of others who are not part of the medical community. Thus it should be a regular part of the ethicist's job to invite scholars from other departments, not formally associated with the medical school, to help him present materials to the students. These scholars might be other medical ethicists, but they also might be medical sociologists, medical anthropologists, economists or anybody who is studying the medical community from the outside. The idea is that at least part of what medical ethics is about is criticism of the medical community and that this criticism can, at times, be best done by people who know that community from the outside.

This way of putting it may seem as if I am subjecting the medical community to unfair treatment. It is as if I am asking that community to cooperate in a project that might possibly lead to having it embarrassed and humiliated. We all know that there are people outside of medicine who resent the high standards of living that medical people enjoy, and resent as well the high social status accorded to medical people—especially doctors. But my proposal for allowing outside visitors to criticize the medical community is not aimed just at the medical community. I am not saying that the community deserves inspection by outside critics more than any other community. If we have learned anything in the past two decades when it became popular for philosophers and others to engage in applied ethics, it is that outside or external criticism can be of great value. So my proposal that outside critics need to be used in the process of teaching students about medical ethics would, basically, be the same one for teaching legal, business and military ethics. What the exact procedures used to expose students to the ethical discussions of their respective fields would vary with the nature of the field itself. But medicine, because the training period is so lengthy, affords an opportunity for educating students about ethics over a long period of time. That lengthy training I have argued probably will have more effect in the long run than a program exposing students to medical ethics over a short intensive period of time during a single semester.
IV. Summary

Let me review both what I have and have not said in this paper. I have not said that courses or programs in medical ethics are more important than anything else taught in medical and nursing schools. In fact, I would argue that if so many courses in medical ethics were taught in these schools that the quality of the training in medicine and nursing suffer that would be immoral. Since medicine and nursing are disciplines that provide important services to others, it is morally incumbent on those who plan such courses to make those they are training as good as possible in their areas of specialization. One way to make them less good than they might otherwise be is to over-involve them in ethical discussions. We want doctors, good ones, and nurses, good ones, caring for the sick and the injured - not medical ethicists. By the same token, we do not want unscrupulous and morally indifferent doctors and nurses caring for the sick and injured no matter how good they are in their respective professional fields. Since medicine is a service field, we need people in it who are good both professionally and morally. We want them to do their work right both medically and morally. So quite properly medical ethics deserves a central place in the medical and nursing school curricula, but it deserves a place where it will not intrude into the quality of the medical and nursing skills that also need to be taught.

What I have proposed then for the university in the future is a modest two-part program in medical ethics. This program teaches the student about medical ethics in a general way at first. Later, at a slower pace over a much longer period of time, it continues to expose them to ethical issues in medicine at a time when, being with patients, they can appreciate how important these issues are. I have also argued that it is a program that needs to be taught primarily by non-medical people. Neither ethics in general nor medical ethics in particular is a subject matter that forms part of the study of medicine. But if having its people act ethically is important to medicine, such a program should be taught by those who have been professionally trained both to know the most about it and to know most about how to teach it.

FOOTNOTES

2) RM Hare: Moral Thinking, Clarendon Press, Oxford, 1981. See especially the early chapters.
3) At Emory University where I teach, for example, the medical school offers a course in medical ethics to its second-year students. Since the students are only graded on a pass/fail basis, they do not take the course very seriously. If there is a major test in another course coming up soon, the students prefer to prepare for it rather than listen to a lecture or discussion in an allegedly peripheral subject like medical ethics. The student thinking here seems to be that since the school itself does not take the course in medical ethics seriously, they also will not take it seriously.
Teaching Medical Ethics in the Future

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Prof. Fotion's lecture gives us many important suggestions and ideas towards the desirable direction for the teaching medical ethics in the medical schools. In general, I agree with him at least in the following three points, a, his argument that medical ethics is important enough to deserve a central place in health care curricula now and in the future, b, his emphasis on the fairness and moral dimensions of medical doctors with an objective criticism from outside, c, his actual plan for teaching medical ethics in the class room and in a group. His aim is to educate a responsible medical doctor both professionally and morally through the process of training regimen.

Therefore, my discussion will be some addition or little bit of revision of his suggestions. But at the same time, I would like to point out some important aspects which, I think, are more basic and urgent in medical ethics at present in Korea.

First of all, I agree with him that medical ethics has become a crucial issue not only for the medical doctors but also for society as a whole. Dr. Fotion points out three reasons, a, the rapid advance in technology which offers more power to control and therefore, more moral responsibility to choose, b, the question of fairness and objectivity, suggesting some way of controlling bad doctors and professional provincialism by the criticism of outsiders, c, the importance of medical care to people, that is the fundamental need to provide better health for them.

My discussion is on the first reason. His emphasis on medical ethics because of the rapid advance in technology does not seem to penetrate into the more fundamental problem of medical ethics. What I am trying to say here is that the rapid advance in medical technology and life science has changed the traditional concept of morality as a whole. The concept of life has been changed as one dramatically expressed, "Man does not live by life alone." At present, the moral issue in medicine is often not how to make a patient live but how to make him die rightly. Frankly speaking, a medical doctor has to make a decision almost everyday whether he has to shorten the patient's life or prolong it for some reason in case of cancer. This is only one example. Life science has more crucial problems. Who knows within 50 years whether man can create life-cell and control all the process of human production. Furthermore, we still do not have any common agreement even on the single problem of abortion and euthanasia. What I am trying to say here is that the formation of medical ethics in the present context is still in the process.

Dr. Fotion's introduction of U.P. (universalizability principle) in medical ethics is not practical in a sense that there are still many disagreements and conflicts in opinion. Medical ethics for me seems to be more contextual and situational. We have to draw conclusion from our own experience rather than depending upon the traditional moral principles. In other words, the method of medical ethics should be deductive rather than inductive. This means that we should start with situation and then to U.P. This is so because the traditional ethics cannot catch up with the rapid advance of medical technology and life science.

Therefore, when we speak of teaching medical ethics we have to examine what is our present situation in the academic formation of medical ethics in Korea. As far as I know there is only one study groups on
medical ethics set up by medical doctors and nurses at Han-nam Sungsim Hospital, through there have been some sporadic seminars. It seems to me that the academic formation of medical ethics is more urgent task for us at present in Korea.

In order to do so, the first task is to build up the medical ethics library, the formation of medical ethics society, and the publication of books and pamphlets on medical ethics. How many books on medical ethics does the medical school library have is a practical question. There have been only one or two books translated into Korean and published recently. I do not say that we have to wait until all these preparations are done before we start teaching medical ethics. But the basic preparation should come first before we start it.

More practical problem is where to find such a person to teach medical ethics. Our practical problem is how many are qualified to teach it at present. Because medical ethics is an interdisciplinary course one should have training in both medicine and ethics. The most desirable method is a team teaching. There should be at least four persons involved in this team teaching, a medical doctor, an ethicist, a minister, and a lawyer. The reason to have a minister is to have a person to value life in a spiritual way, a lawyer to deal with legal problems related to medical ethics, such as in case of AID, organ transplant, euthanasia etc. No one can reach to the final solution all by himself on the question of medical ethics. As Dr. Fotion advocates in his lecture, any answer to medical ethical questions should be open to the public and the decision should be shared by as many as possible.

Our attention should be paid also on the degree program in medical ethics. An interdisciplinary degree program including ethics, medicine, and law will be the most desirable one. If this is not possible, then an interdisciplinary degree program between medicine and ethics is at least neccessary.

About the fairness and objective criticism against bad medical doctors and professional provincialism, I have some different suggestions. One way of solving the cost of medical fee for the common people is the extension of medical insurance system. Korea has adopted the medical insurance system among the government officers, teachers, and buisiness people in the corporation. It should be extended to the common people as much as possible. The free medical service for the poorest is recommendable. But we have to recognize its limitation. And some good will program without any governmental support cannot solve the health care for the mass in society.

For the professional provincialism I agree with Dr. Fotion in that we should have someone evaluate medical profession from outside. In this sense an organized checking system is needed. One solution for this is to set up a medical ethics committee in the hospitals so that one may bring any criticism or protest on medical issues and related problems to the committee. The committee should have some rights to in-fluence upon medical programs and medical profession. Dr. Fotion's suggestion of having one or two medical ethicists from outside in order to check bad doctors and professional provincialism is too simple and unrealistic.

Along with the organizational checking system, more attention should be given to the personality formation of medical students in the medical schools. High skill and professional training are necessary in medicine. No one will disagree. However, just because of such onesided emphasis on skill and technics often tends to minimize the personality formation of medical doctors. As a minister and ethicist it seems to me that personality formation of medical student is more basic and the onesided skill oriented education should be corrected. This will be more true in the future of medical profession.

What I would like to suggest here is some kind of personality test or professional preference test for the incoming students. And for the enrolled students there should be a strong curricula in the field of morality not only of medical ethics but of personality formation. Dr. Fotion's idea of having somebody from outside
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to check the corruption of medical profession is meaningless unless medical doctors are willing to listen
to it. This means that moral education of medical students are more basic than organization checking system.

The final question is how to make a responsible person of medical profession through the educational
process and how to mould a responsible community of medical doctors. In other words, how to make
medical profession to serve the people rather than to use them. There are three important professions
in human society, a minister, a medical doctor, and a lawyer. A minister is to serve people for their spiritual
need in suffering, a medical doctor for the physical need of the sick, and the lawyer to serve people in
their legal difficulties. And that is the reason why these three professions need three more years of educa-
tion in a graduate level.

As a conclusion, it is noteworthy to quote the founding spirit of the Yonsei Medical School, Christian
spirit, pioneering spirit, and cooperation. Along with skills and technics in medicine, the Yonsei Medical
School has emphasized the spiritual, ethical, and personal dimensions of medical profession. The wholistic
medical education has been the goal of the Yonsei Medical School. In this tradition I would like to recom-
mend strongly to the Yonsei Medical School of the radical change in the school curriculum with much em-
phasis on medical ethics, the degree program for medical ethics, and the formation of medical ethics
committee as soon as possible.