

Ethical dilemmas: a focus of discussion for junior doctors



EDITOR'S
CHOICE

Jeremy Levy,¹ Bob Coward²

That an essay such as the one written by Quarini¹ in this issue of the journal has been written at all, and written by a junior doctor, is cause for encouragement. We are also delighted that trainees recognise the myriad of ethical dilemmas in their routine day-to-day ward work, and the detrimental impact on patients of relatively subtle behaviours.² These observations represent important opportunities for learning, not just for the medical trainees but for all staff involved. Such dilemmas are included in the curricula for both the foundation years, core medical training and training in general practice in one form or another, and so should be the focus for repeated discussion during the early years of training. If curricula and e-portfolios worked as they should, then trainees with their trainers would be exploring such problems in some detail as they occur during the first 4 years of training.³ All curricula place the patient as a central focus of care encompassing their beliefs, concerns, expectations and needs, encouraging patients to voice their preferences and personal choices. Supporting patient self management is an important issue which has been developed in training by using expert patients and patients as educators. More widespread use of these models both at the undergraduate and postgraduate level is vital in improving medical education in the UK. What is needed are mechanisms for using these everyday events to stimulate discussion and where indicated to prompt change in practices and approach.

HOW TO SUPPORT LEARNING ABOUT ETHICS

What can training programme directors and directors of medical education do to support such learning?⁴ They can: ensure that formal teaching sessions do not just encompass the medical topics of the curricula (chest pain, pneumonia, meningitis, acute kidney injury, etc), and that communication, ethics, team working are fully integrated into all training programmes; encourage consultant trainers to get trainees to lead on ward rounds so they can learn how to handle teams, difficult discussions, the pressure of time, decision making; and get trainees to give feedback to each other, higher trainees and consultants about what was done well, done poorly, and completely forgotten on ward rounds. We should be reminded that training of junior doctors in handling ward rounds and the teamwork this entails is generally not done well and often assumed to be learned by osmosis. Much of this is already done in some hospitals and hopefully can be spread by training. Training in consent, for example, should now be uniformly provided in all Trusts, no trainee should be placed in a position to take consent for something they cannot do, and all staff (including consultants, nurses, higher trainees) should be aware that pressure on junior staff to take consent in such circumstances is unacceptable. Much of this is included in inductions where the important messages can get lost in the morass of information, but issues of risk and risk management should have a key place—for example, covering consent, ordering investigations, good quality communication, how to raise concerns, and the variety of people available for trainees to talk with.

Some of the behaviours described by Quarini would provide relevant scenarios for any number of interview questions, including wrong imaging, incident reporting, dealing with colleagues' unprofessional behaviour, etc, and are all used widely for this very purpose. But it would be so much better if this was discussed in 'real time'.

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INTERACTING WITH PATIENTS

The amalgamation of multiple incidents presented here, clearly does not indicate the actual frequency of such events. That makes the practicalities of using them for learning somewhat easier! Some of the examples suggesting poor practice may not be so when dissected and discussed—for example, the discussion of patients

and sharing of information within a multiprofessional team may not necessarily breach confidentiality if it will avoid duplication and ensure all members are informed of ongoing decisions. There is also nothing wrong with gaining verbal consent to take blood for multiple tests without explaining each in advance and in detail to a patient. In general, consultants do interact much more with patients on ward rounds than described since they are often the only single person holding continuity of care, are often gaining the key pieces of information from patients when probing the history, are the main provider of the diagnosis, having distilled the data collected by the team, and are almost always the key players in formalising discharge plans with patients. We have not come across a medical student who does not introduce himself in an almost parrot like fashion to every patient as a "medical student asked by the consultant to examine ." for several years now. But the point is not the right and wrong of each of these incidents but rather that each of them can and should be the focus of discussion. Medicine, despite advances in information technology, remains an apprenticeship with experiential learning. The consultant role model is important. For precisely this reason educational and clinical supervisors must be fully trained to meet the standards of the General Medical Council and be able to identify and use such examples every day in training.

Finally, we are surrounded by intelligent motivated trainees who should be encouraged to raise the sorts of issues described in the article by Quarini in education and training committees, governance, risk or quality committees, and should be empowered to help resolve structural or behavioural problems they have noted at the coalface, for the benefit of patients, the organisation, and themselves.

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¹Imperial College Healthcare NHS Trust, London, UK;
²School of Medical Specialties, North Western Deanery, Lancashire Teaching Hospitals NHS Trust, UK

Correspondence to Dr Jeremy Levy, Imperial College Healthcare NHS Trust, London W12 0HS UK; j.levy@imperial.ac.uk