National Consultative Ethics Committee for Health and Life Sciences

Opinion n° 84

Opinion on education in medical ethics

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Introduction

On July 9, 2003, Monsieur Jean François Mattei, Minister for Health, Families and Disabled Persons, referred to the National Consultative Ethics Committee (CCNE) regarding proposals set out in the report « Ethics and the health care professions » which had been officially submitted to him on May 19, 2003. This document[1] was the work of a commission chaired by Monsieur Alain Cordier who – as former Director General of AP-HP (Public Hospitals) – was the founder within the French public hospital system of the first Hospital Ethics Forum. This eleven-member commission, including the director of a hospital, a State Councillor, seven physicians, one mid-wife and one senior nurse, was created on November 26, 2002. Its task was to submit a report on the needs of the medical professions as regards ethics, with a view to suggesting educational and research goals in medical ethics. The document submitted to the Minister recommended that links between hospitals and universities should be strengthened, through the creation of medical ethics training courses in the form of Ethics Forums to be integrated in CHUs (*Centre hospitaliers universitaire* s– university teaching hospitals).

The two parts of the Report to be examined by the Committee covered:

- Recommendations concerning a reform of the university educational system,
- Proposals for cooperation between hospital and universities for the purpose of enhancing the humane aspects of health care.

CCNE is further concerned by a proposal made in the second part of the document that it should examine existing structures concerned with ethics in hospitals and establish the guiding principles of a charter which could serve to regulate some of their activities. In the present Opinion, CCNE will refer to those parts of the Report which need to be particularly highlighted, and will examine proposals to associate CCNE to plans for extending training provided for medical students and other medical professions.

However, points in the following pages will not be overly restricted to a literal reading of the text submitted to it for examination. After referring to the four points in the Cordier report which it considers to be essential, in the form of a preliminary summary, the Committee will then broach the subject of implementing medical ethics training projects which the document does not consider. Among other things, on the basis of an examination of the Cordier commission's proposals, it will consider the difficulty raised by the very principle of « teaching » ethics, since it is recognised that medical ethics cannot be the subject of normative knowledge after the fashion of deontology.

On this second level of analysis, this Opinion will seek to underscore the sensitive side of institutionalising the teaching of ethics as part of the general training of medical students in France. Sharing the general attitude of the Cordier report as expressed in feelings of disquiet and a desire for change, the Committee wishes to contribute to the debate on education in medical ethics by drawing attention to some of the concrete problems raised by the nomination of ethical referees, and to uncertainties both in form and substance of the proposed courses. The third part will devote more attention to permanent education and the involvement of members of the medical professions within hospital ethical structures.

[1] Available at *http://www.sante.gouv.fr/htm/actu/cordier*

I. The main points of the Cordier report

I.1. Four legitimate reasons for disquiet

The Cordier report explains why there should be more ethical reflection both in health care institutions and in the education of health carers. The Report broaches four main themes:

a) **The depersonalising effects of specialisation**: In just a few decades, the dispersal of care in hospitals has profoundly changed the bond between the health caring community on the one hand, and patients and their families on the other. The range of medical science is now spread over a mosaic of qualifications so that each new facet can only contribute partial[2] enlightenment. On the occasion of a medical work up, patients sometimes follow such a multidirectional route that it destroys any chance of a personal relationship with the various members of the medical profession that they encounter. This splintering of the practice of hospital care into a growing host of specialised domains is paralleled by the emergence of new communication circuits which broaden the dialogue to include colleagues, para-medical practitioners, administrative staff, and test laboratories. When there is no longer accountability by a single individual, but coordination of a whole group, the care relationship becomes more effective, more technical, but also more anonymous. ("you are in good hands" but whose hands are those?). Piece workers with their eyes constantly on the clock, obsessed by a micro-analysis of the specific body function which their medical speciality deals with, each player of the healthcare company examines the bodies brought successively for inspection, but there is not necessarily sufficient awareness of the full psychic and affective whole that the person in question represents. For this reason, health care requires that carers adopt a more collective approach to the problem of establishing good communication among themselves so as to better avoid the effects of dehumanisation generated by the drive to specialise.

b) **Eclipse of the clinical side of medicine:** Progress in the field of medical imagery is the most characteristic illustration of an insidious move in the direction of "mechanising" the body. Doctors are gradually turning into "image makers" and patients disappear entirely behind a technological array of instruments in the shape of a screen, both literally and metaphorically. The increasing technical level of medical procedures reduces the body to what the imagery revealed by ultra-sound, radiography, MRI and CT scans. This technological invasiveness which reduces patients to the iconographic and digital perception of a body, customised, measured and immobilised by practical necessities, tends to dissolve the clinical relationship to the body's existence[3]. The therapeutic and preventive advantages provided by these techniques for the exploration of the body's intimacy are so

[2] The Committee has already had occasion to emphasise that the body of medical data has grown to such proportions that it seems quite impossible, unless titanic and ceaseless efforts are made, to adjust the daily practice of care to the sum of available knowledge. "no doctor can claim to know everything: acquired knowledge becomes obsolete so quickly that a practitioner needs to up-date it constantly". (Opinion 58, *Les cahiers du CCNE* n°17, « Informed Consent of and Information provided to persons accepting care or research procedures », oct. 1998, p.10.)

[3] Cordier A., *Rapport*, http://www.sante.gouv.fr/htm/actu/cordier, p. 16 : « The weight of technology in medicine is increasing. The hand of the clinician on the patient's body is gradually giving way to clear the ground for remote technicality. Objective, but fragmentary, medical data accumulates so that each individual becomes an almost inexhaustible source of signals of various kinds".

obvious that one almost forgets that medicine is an art and that hospitality must be represented by the warmth and proximity. Now that medicine has entered an era of techno-science, to ausculate, palpate, touch, and stroke the skin of an injured body are gestures that are giving way to contact through increasingly sophisticated machinery. By encouraging in this way an objectification of the sick, the increasingly technical nature of medicine is insidiously converting the art of healing into a process of expertise, so that there is a risk of forgetting that technology is no substitute for hospitality.

c) **The limits of « excessive legalism»** : Legislation designed to protect patients has helped to attenuate the lack of symmetry which prevailed until a short time ago between those who know and those who suffer. Respect for patients is no longer dependent on the individual virtues of the doctor; it is commanded by the need to observe the law. However, there is general agreement that it is not possible to regulate all the problems that alter the relationship between carers and users by charters and laws. The intersubjective bonds that govern life in a hospital are frequently beyond the reach of law. There is a risk of forgetting that doctors are not confronted with citizens defending their rights, but with human beings whose sufferings need to be heard instead of being made remote by formal recognition of rights. In certain cases, the juridicisation(*) of the relationship between doctor and patient can even create an undesirable distancing effect between them. This is because emphasis has been placed on "risk" in the information provided to the patient in recent years, so that the effect on the psyche of receiving a message of information is equated to acceptance of a risk. This situation is not foreign to the "rise of a form of procedural mania"[4] which is symptomatic of juridicisation gradually becoming "judiciarisation" (**). The law has reinforced the obligation for a physician to obtain proof that his duty of information has been discharged, and the best way of proving that information has been supplied is proof in writing. In this way, patients may find that increasingly their doctors are on the defensive. It is then hardly surprising that despite doctors' words of reassurance, anxious patients may not be entirely comforted in a climate that smacks hazily of suspicion. Judiciarisation which is a symptom of poor quality communication, is also an aporia in that complaints expressed on a regular basis against practitioners carry the threat of turning what is meant to be the art of creating a trusting relationship into a strategy of prudence. This growing climate of mistrust is all the more regrettable because it is often the fruit of confusion between what would appear to be a simple and legitimate request for further information, sometimes a complaint, and the start of criminal proceedings, although this is still a rare occurrence.

d) **The side effects of apportioning health care**: There is increasing tension between individuals and the community because of the cost of new medications and contemporary medical techniques. Faced with the danger in the long term of a collapse of the system of universal coverage of health care expenditure, ethical reflection should lead to public understanding of the need for collective

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* *Excessive intrusion of law into medical activity*

[4] *Ibid*., p. 13. Although this statement may seem forceful, it is not without justification if one considers the increasing number of lawsuits against hospitals particularly. (Cf. on this point *Le Quotidien du Médecin* dated 27/02/04).

** *Using criminal law to settle medical disputes*

> accountability[5]. Resources allocated to the health sector cannot increase indefinitely, so that the present growth of expenditure requires that practitioners should give more thought to an equitable distribution of health supplies and services[6]. To speak of diseases in terms of cost must cease to be taboo. In view of the exorbitant price of molecules now arriving onto the market, ritual and trite expressions such as "health has no price", or "a doctor is not an accountant" cease to be readily acceptable. Progress in the sophistication of techniques for diagnosis, prognosis, and prevention will lead to making ever more obvious the dimension of *equity* in decisions, in view of the fact that what has been given to the one cannot be given again to another, although everyone must have equal access to the health system[7]. Of course, equitable distribution of health resources is not entirely in the hands of the medical profession. It is also a matter for societal choices and for policy makers. However, it seems difficult to imagine that health professionals would be excluded from procedures for choice and evaluation.[8]

The four reasons for disquiet that we have summarised above are justification enough for the appeal in the Cordier report in favour of integrating ethics into the programme of initial and permanent education. The education of health professionals must undeniably pay more attention to the ethical component in hospital activities. Authorities must therefore take what steps are required to develop structures permitting practising physicians to consult each other and examine the moral dilemmas they encounter in their daily round. Just as sound is the general proposal in the Report that the problem should be entirely revisited through a reorganisation of the higher education curriculum. It is true that it is in an early phase, at the time when training is provided to future health professionals, that new habits of action and thought must be acquired.

I.2. Ethical training in tune with clinical care

As regards training for medical students, the Cordier report recommends efforts to increase awareness of ethical issues that students will encounter in later life when they become practising physicians. Teaching at present focuses on technical responses, with a mountain of examinations for the purpose of an apparent rationalisation of approaching

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[5] *Ibid.*: « The survival of collective acceptance of financial responsibility is dependent, however microscopically, on each individual medical act". The Report points out "the devastating and multiplying effect of microscopic useless expenditure".

[6] In its Opinion n° 57 of March 20, 1998, "Technical progress, health and societal models: the ethical dimension of collective choices, the Committee has already had occasion to emphasise this point, by remarking that "there is a profound ethical dimension to this demand for optimal use of the health care effort since it is alone able to guarantee the highest compliance with principles of justice and solidarity. In fact, any partial rerouting of this effort outside the bounds of maximum efficiency in the short, medium, or longer term, would lead to feasible improvements in health care not being achieved (p. 2).

[7] A decision can lead to a wasteful use of budgetary resources and therefore indirectly be prejudicial to other patients. Anne Fagot-Largeaut already commented twenty years ago that "billions are expended to save a few days of human life (advanced therapeutic technology in terminal cases) and yet there is a refusal to make a much smaller financial effort to save much more (prevention of accidents of malnutrition)". - *L'homme bioéthique. Pour une déontologie de la recherche sur le vivant.* Maloine, Paris, 1985, p. 23.

[8] Cf. on this subject Opinion n° 57 of March 20, 1998, chapter VI "Evaluation - a commanding necessity": « A grasp of health needs, of the effectiveness of procedures, of the existence and importance of risk, which is essential to be able to implement effective and wise health policies, must rest primarily on the quality of evaluation. (…)It will be necessary to take this a step further by promoting the creation of a sufficiently tight network of qualifications so that debate can become a possibility. Professional associations and bodies must take part and universities must develop this type of research. ».

patients. For information to be heard, it must fit into parameters and standards, enter into categories, and be identified by imagery and figures. There is every reason to fear that this scienticised standardisation of medical intelligence will lead to a withering of the original Hippocratic inspiration. For that reason, it does seem essential to alert students to a perception of difficult situations and provide much needed advice at a time when new investigative techniques contribute to the multiplication of moral dilemmas, and judiciarisation creates tense relationships between health carers and patients. A number of court cases could probably be avoided at this time if doctors could benefit, when they are being trained, from courses focusing on ethical reflection regarding information to be given to patients. Complaints are often due to patients feeling that they were not properly informed. Experience has shown that they are less inclined to prosecute doctor who recognise, after the event, that they did not choose the best therapeutic option, compared to those who seek to cover up a mistake or do not provide enough information. Generally speaking, it would be useful to broach the subject of judiciarisation with students, since it is abundantly clear that nowadays the fear it generates on the part of a certain number of practitioners is such that it influences their decisions, and thereby dangerously subordinates concern for the patient's welfare to concern for the doctor's protection.

As regards the general content of education, CCNE shares the concern of the writers of the Report to avoid falling into the trap of over theoretical ethics. The prominent role given to practice shows that, in the document produced by the Cordier commission, the word "ethics" is used to mean *medical ethics*, i.e. ethics focusing on the act of caring, more than what is central to *bioethics*, a more recent discipline which covers the whole category of problems connected to health and research and considered in their socio-political, biotechnological, economic and scientific dimensions. These are in fact two meanings of ethics which are all too frequently merged into one in the usual acceptance of the word. Although bioethics are in no way secondary, for a doctor they nevertheless take second place behind ethics, and can only be considered after the event and be part of an extension of ethical reflection where priority is given to issues debating clinical values and practices in close correlation with deontology.

When it situates medical ethics as the centre of gravity of ethics, the Report clearly points out that ethical reflection – which it invites chancellors of universities, deans, hospital consultants, departmental heads and hospital managers to inject with new impetus – cannot be an echo chamber for newsworthy debates drawing attention to spectacular feats of derring-do or exceptional cases beyond the scope of everyday practice. The ethics which this document wishes to promote are "caring ethics", active ethics which are reflected in the health carer's tiniest gesture, or spoken word or attitude to others.

As a result, the object of initiation to ethics will not be to impart a didactic lesson composed of pre-established knowledge to be slotted in next to other theoretical teachings to be absorbed by medical students. In fact, it will not be lectures from the podium, but on the contrary in-hospital training that will be the best "learning vectors for ethical reflection".[9]

The essential issue is not so much whether one can "teach" ethics (in so far as it is possible to "teach" the subject at all) but to impart and share an ethical reflection on the meaning of care. Thoughts on how to inspire a patient's trust, on the choice of words to communicate with patients, on whether they are receptive to the discussion and to the emotional tone of the voice that speaks to them, are all worthy of ethical reflection. What in fact makes reflection on ethics useful is precisely the capacity not to disconnect it entirely

[9] Cordier A., *Rapport*, *op. cit.,* p. 28.

from any empirical and empathic substrate, the capacity to dwell on routine details so as to measure the importance they have in the eyes of patients. By enriching reflection through direct contact with concrete clinical practices, ethics can become daily attention imbedded in the act of caring, of concern and questioning in the service of excellence.

II. Remarks on recommendations for a reform of university education

II.1. Transmit standards or the inclination to ask questions?

Resisting the pernicious temptation of "ethicising" medical matters across the board, the Cordier report is careful to remind us that " there is no call to consider that all of the problems raised are the sole concern of ethical reflection"[10]. Perhaps even, taking this a step further, it should be made clear that usually medical decisions do not raise ethical issues. In many cases, outlooks nourished by experience acquired over the course of a career, through a diversity of clinical situations, are quite sufficient for a carer to be able to take decisions appropriate to a particular context. Most decisions are guided by the yardstick of scientific or pragmatic considerations and would not seem to need the stamp of ethical reflection to find justification. This is true not only for decisions relating to minor ailments since even crucial decisions do not give rise necessarily to any ethical debate because they are so obvious. However, besides decisions for which justification is immediate and unequivocal, some medical decisions remain for which intuitive conscience is not sufficiently enlightening and the code of deontology cannot fill the gap. Deontology is not a body of ready-to-use justifications; it can only be a reference framework. It does provide rules of behaviour which every student must we aware of, but does not aim to justify why this article and not the other must be applied in a given set of circumstances. In many cases, ethical debate alone can justify why one rule and not another should be followed. At the time, the doctor can only choose between options which in some cases could be justified in the light of deontological recommendations with an equal degree of pertinence, even though the options may be contradictory. Such is the case for instance when, after emergency care has been provided, a practitioner acts repeatedly to cure a patient who has become tetraplegic following an attempt to commit suicide. Do these interventions comply with deontology? According to article 37 of the code of deontology which now applies "in all circumstances, a physician must seek to relieve the suffering of patients, give him moral assistance and avoid any unreasonable obstinacy in the process of investigative or therapeutic action"[11]. However, article 38 states that "a physician must support his patient to the very end, ensure by appropriate action and care, the quality of a life about to end, protect the patient's dignity and provide consolation to his loved ones"[12]. These standards are doubtless essential, but they cannot aspire to more than being a source of inspiration for reflection. Clearly, they cannot define in a given situation where "unreasonable obstinacy" begins. This type of concept is not designed to describe a threshold or practice that can be objectively determined; it only seeks to trigger thought about the patient's quality of life and what is "best" for that patient as regards the duration of his life.

The scope for ethics in fact, is to be found through the emergence of a process of questioning based on cardinal deontological notions. There are dilemmas which are on the borderline between respect for life and taking into account the quality of that life. In its Opinion n° 63, CCNE has had occasion to recall that « the dilemma itself raises ethical issues ; ethics are born and thrive less through categorical certainties than through tension and refusals to settle once and for all questions which are recurrent and irksome and thereby express one of the fundamental aspects of the human condition »[13].

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[10] *Ibid*., p. 64.
[11] Cf. *http://ordmed.org/CODESept95.html.*
[12] *Ibid.*
[13] Cf. *http://www.ccne-ethique.fr/francais*; «End of life, ending life, euthanasia », n°63, January 27, 2000, p.12.

The conflict of values at the end of a life illustrates – apart from the inescapable limits of medical ability[14] – the difference between ethics and deontology. ***Deontology sets a course, but cannot replace ethical reflection.*** It is "a set of rules expressed formally and explicitly, the transgression of which may be sanctioned"[15]. These rules, which transmit values appropriate to medical activity (respecting the rule of medical confidentiality, for example) "tend more to impose an ***answer*** when the carer concerned is caught up in a problem situation in the course of his professional practice, than to state and arbitrate the moral dilemmas that such situations may generate" [16]. Medical ethics fill the gaps in the code of deontology, in order to deal with moral dilemmas by means of ***questioning*** established convictions, and providing alternative angles and perspectives from which to view the issue. Ethics teach humility through uncertainty by opposing moral disquiet and a sense of the contingency of decisions to categorical positions of the type: "I am in favour of this and oppose the other".

Thus, ethical training, regardless of who is addressed, must include not just the simple information that standards exist (e.g. the code of deontology or the hospitalised patient's charter) but also a range of courses focused on awakening the ***inclination***[17] to ask questions in situations and contexts that are infinitely varied. Is not training for ethics closer to "lighting fires" than "filling vases", to paraphrase Montaigne?

II.2. Initiation to medical ethics in universities

a) The difficulty of teaching ethics in the first year of medical school

Although it is clear that a place must be found, apart from learning about standards, for ethical education in training courses that prepare medical students for their calling, there are issues regarding its practical organisation that must be resolved. Should preparatory training courses for future practitioners be organised well before the first year of medical school, as is suggested by the Cordier report? To follow proposals as they stand, ideally *future* students should be given from the start a taste of the "real thing", so that contact with the clinical world gives them the opportunity of testing their own motivation. Those who want to be doctors could in this way verify that in the long term they still wish to invest in the intensive process of learning the various medical disciplines. The essential point would be that no one should enter into this long educational voyage light-heartedly and that all should be entirely aware that the career they aspire to is defined as a true "vocation".

To become a physician there is a particularly demanding need for the capacity to put oneself at the service of others. However, can one really learn a "vocation", even with no religious connotation being attached to the word. The concept of "vocation" is dependent on intimate, subjective and contingent inclinations. It is probably impossible for any teacher to instil a "vocation" into the heart of a future doctor, however hard he may try, and even less possible to be sure that the student in question intends to practise in the spirit of a

[14] In an admittedly paradoxical style, the Cordier Report does express this point: "Students will therefore be made to understand by their teachers more about the impotence than of the power of medicine" (p. 30).
[15] Siroux D., article « Déontologie » in *Dictionnaire d'éthique et de philosophie morale*, PUF, 3° éd., 2001, p. 401.
[16] *Ibid*.
[17] It is significant on this point that when he starts the chapter on justice in his Nicomachean Ethics, Aristotle does not refer immediately to a system of established standards, but to an « inclination » (*Ethique à Nicomaque*, GF., Flammarion, Paris, 1992, p.135). The definition of justice as conformity with existing law only comes later in the essay and it is defined with great subtlety: "It is clear that all acts which comply with the law are in some degree rightful" (*Ibid*., p. 137).

"vocation"[18]. Motivation can appear gradually over time, and become firmer as students progresses through their studies.

Even during the first year, training in ethics is not an easy matter. The Report considers that "PCEM 1" (*) could be an ideal time to provide a minimum amount of material, a kind of awareness "tool box", which can be of use to both those who successfully go on to a second year and those who fail their examinations but can find ethical reflection just as helpful in their lives as non medical citizens" [19]. It would seem however that in view of the number of new students registering for medical school every year, the volume of knowledge and the way in which that knowledge is imparted in the first year does not really lend itself to initiation concerning the moral dilemmas that are part of the clinical scene. Teaching ethics (as the Report states itself) requires a specific pedagogical approach. The courses need to be less directive and more interactive than for other disciplines so that relations between students can inhabit another dimension besides the usual merciless competition that is the rule in PCEM 1. Let us suppose that the teaching of ethics is programmed for first year students. Because of the climate in which it would be immersed, there is a danger that initiation to ethics reverts very quickly to mindless and soon forgotten rote learning, or that later on it produces the artificial impression of "déjà vu". To be convinced of that possibility one only has to think of the rigid pedagogical constraints applied to the few hours devoted to ethics at present in the "human sciences" section of the competitive examination. The way in which these courses are organised at present shows that training in ethics is steeped in the spirit of selection which presides over all of the subjects included in the competitive examination. For this reason, realistic proposals for this phase of university training cannot be more ambitious than a few suggestions regarding their content. For example, there would be case for suggesting that the time spent on this subject in the first year of medical school reserve a little more time for a few examples presented with all their contradictions. Rather than insist on the assimilation of a set of key concepts, such courses could be arranged to include the study of clinical cases, with a section bearing on exemplary cases (cases in point), and another section on empirical cases. The first section would seek to explain the meaning of ethical principles and rules, and the second would demonstrate the difficulties of their practical implementation.

b) Realisation of the need for epistemological precision

Without a doubt, the mode of recruitment of future practitioners in the French system of higher education is disputable. Is it not paradoxical to call for a more scrupulous ethical outlook on the part of physicians at the same time as they are taught to function intellectually in a way which encourages behavioural individuality? [20] However, it does seem difficult to conceive of a system of selection that would be radically different from the one prevailing at this time for entry into French medical schools. Clearly, there is serious reason to doubt that today's selection process is fully consistent with its stated didactic objective i.e. to provide future doctors with very thorough scientific knowledge of the human body. As those who are in charge or organising this recruitment competition are ready to admit, the frontier between assimilation of medical knowledge and exhaustion is sometimes difficult to define. ***Education prefers accumulation to the detriment of reflection and critical scrutiny.***

[18] The Cordier report uses the word "vocation" no less than 8 times.

[*] *First cycle of medical training*

[19] Cordier A., *Rapport… op. cit*., p. 27.

[20] The Report mentions this paradox on page 27: "PCEM 1 is a competition. This climate of competition which sometimes encourages non ethical behaviours, is very influential."

This is not however reason enough to question the need for selection based on a corpus of scientific knowledge. To the question put by the Report: "What kind of preferred profile does the existing selection process for admission to medical and paramedical studies seek to recruit?" [21], one might well reply that although a scientific turn of mind does not particularly encourage ethical reflection, but nor does it particularly encourage indifference to those issues. It is true that the history of science is tarnished by numerous cases of plagiarism, of misrepresentation of the results of experiments, of public expressions of opinion strangely contemptuous of humanity which are sufficient testimony to the fact that scientists are no less exposed to human failing than any other mortal. Although the obviousness of such facts is no reason to ignore them, it should not lead us to forget that scientific endeavour integrates – by its intrinsic demand for scrupulous, cautious, and transparent behaviour – virtues that converge towards ethics by encouraging researchers to work in a spirit of intellectual honesty. It is for that reason that we feel that the proposal of "ethical initiation" in the first year would be more purposeful if the epistemological bias was adopted[22]. The aim would then be to establish a system for the selection of candidates that would not be based exclusively on their capacity to memorise information, but would also take into consideration their capacity to gauge the honesty of a method or of the instruments of analysis used by the authors of scientific publications. Developing a critical turn of mind, without which the word "ethics" becomes rather meaningless, is at the core of the epistemological approach which seeks to evaluate data found in the literature from the point of view of its pertinence and usefulness for the case under examination. In a nutshell, it will not be possible in practical terms to arouse awareness of ethical reflection in the PCEM1 year if it does not lead to a new way of teaching medicine.

c) A training course in the second year based on an ethical dimension of practising medicine.

As regards initiation to ethics (viewed independently of the wish to achieve epistemological clarity), it could be done in the following phases of the programme of university education as recommended by the authors of the Cordier report. Observing situations *in concreto*, followed by interviews for the purpose of evaluation as suggested in the document would certainly enable students (starting in the second year of study) to reflect in passing on the meaning of practices. However, for the pragmatic purpose of not having a whole assortment of training courses, it would perhaps be better to inject into what is usually called "the nursing training course", a section focusing on the ethical dimensions of medical practice. Along those lines – and as part of the hospital on-site training course whose primary purpose is to absorb clinical experience – students would have the possibility of expressing quite freely the intensity of feeling they experienced and of discussing the ethical questions that this encounter with the "real world" has made them conscious of. The ensuing discussion would be just as enriching for those in charge of the course. One way of organising this opportunity for self expression could be to have students participate in a two-day workshop session at the end of the training course. Students could then draft a 10 page report on the subject of a scene that they had found particularly distressing, a moral dilemma, a conflict observed between carers, a patient's complaint, or some other empirical episode which they had personally witnessed during their training course. Based on the case singled out as being of particular interest, they would be required to construct a methodological reflection on its ethical aspects.

[21] Cordier A., *Rapport*, *op. cit.,* p. 26.

[22] This suggestion does not contradict the general tenor of the Report since its authors highlight that "the first ethical demand is the competence expected of each physician and health carer". (*Ibid*., p. 25)

It is worth noting that this kind of training course report – which would be submitted and evaluated during an oral session at the end of the PCEM 2 year – would also be useful to evaluate the quality of a student's written and verbal communication skills. It does seem essential that future practitioners should have the advantage of some time spent during their training on testing their skills at public speaking and educate them in the use of the French language. Mastering their mother tongue is implicitly required by the criteria set out in deontological rules regarding information owed to patients.

II.3. Initiation to ethics in training for other health caring professions

When it referred to training in ethics for medical students, the Cordier report suggested that "solutions adopted for nursing staff training"[23], could be a source of inspiration, which implies that initiation to ethical issues is already institutionally organised and generalised in such training. In the present state of affairs, could training in ethics as provided for nursing staff be a guide for training future doctors? The Report quotes two documents on the subject, one of which puts emphasis on "providing nursing care taking into consideration problems arising out of functional disorders and the physical or psychological distress that may be present in a patient". The other document emphasises the need to "include cultural aspects and a person's character when inviting an individual or a group to participate"[24]. However, neither of these texts refers in any way to the word "ethics". They are closer to deontology than to ethics. It therefore remains entirely the decision of the trainers to evaluate to what degree the above texts recommend running course centred specifically on the ethical dimensions of care.

In view of the disparity that can be observed *in situ* from one medical school to another, one can not always be certain that the nursing staff training programme is in fact "closest to those expectations in that it integrates ethics in each educational module and devotes a considerable amount of time to working in restricted groups" [25].

Generally speaking, it is essential to avoid prejudging whether within a training programme for health care professions, some need more ethics than others. It would probably be closer to the facts to say that, at this point, initiation to ethics remains to be encouraged in all branches training health carers, be it odontology or pharmacy, physiotherapists or clinical psychologists. Some parts of the Report actually argue for that to be done, by mentioning the initial training to be given to all actors in the world of health, including all paramedical and administrative professions. It is noteworthy also that mention is made of students preparing for the task of hospital managers, and one can only subscribe to the recommendation regarding this section of the student body that "a definite intensification as compared to the present situation, of initiation to ethical issues, both during internships and appropriate academic teaching, as well as by the organisation of seminars on ethical reflection" [26].

II.4. Organisational arrangements for setting up an ethics training programme.

a) Difficulties as regards the contents of courses

The humanist aim inherent to all the health caring professions can only become clear to those who intend to practise them if institutes of higher education concerned are serious about

[23] *Ibid*., p. 31.
[24] *Ibid*.
[25] *Ibid*. p. 65, Annex 2.
[26] *Ibid*., p. 31.

training in ethics. The Cordier report rightly underlined the need to give ethics a new pedagogical status so that the subject ceases to be just an option in university courses[27]. The fact that at present it is organised on a voluntary basis downgrades and discredits it and this introduces a spurious distinction between ethics and therapy. On this point, the idea of a seminar on casuistry for interns (this would be three-day seminar and mandatory for validation of internship) is a very welcome project[28]. In this way, all participants would have time to test the validity of their own opinions in the light of a contradictory discussion with other students.

This Opinion, however, would like to issue a word of warning regarding some lack of precision as regards the contents of the ethics training programme in the second year of medical training onwards, and would recommend a more decisive approach. It is essential that contents are not left solely to decision on a local basis and that they should be clearly set out nationally through a pre-defined programme. The authors of the Cordier Report mention on page 34, "teaching time spent on the subject of patients' dignity" which could be cancelled out by a practical counter-example. But should ethical training in higher education include "teaching time spent on dignity"? This passage in the Report supposes that the referee might be asked to lecture on what is the definition of a good doctor with the risk that students might be just as perplexed as they were before they started because of the inoperative nature of the lessons. Rather than transmit moral catechism, this teaching should be supported by the "intellectual demand for as complete an understanding as possible" that philosophers since antiquity have stated as the "foundation of ethics" [29].

On the whole, the Cordier report tends to minimise the concept of ethics as a rational deliberation based on universally recognised ethical principles in order to favour the existential and intersubjective dimension to which it grants extensive preponderance. It should be possible to teach in a voluntarily critical mode the principles commonly used in the international bioethics literature, such as autonomy, beneficence, non-maleficence and justice[30]. The concept of dignity must be the subject of dialectic teaching as should be the case also for freedom of research, informed consent, confidentiality, intellectual honesty, solidarity, etc. Otherwise, if ethics were to be out of reach of common references, and be diluted in the infinite singularity of individual cases, it could not be taught in any defined form. If that was so, it would be up to each referee-educator to teach what he or she thought was meant by the word "ethics".

On this point, the Committee recommends the creation of a common platform on the basis of which a relatively homogeneous national programme could be constructed in order to limit the risk aattached to pedagogical improvisation. The fact that a course in ethics should favour exchange and interactivity does not detract from the need to assign to it a pedagogical direction with cognitive aims. Students will only be willing to speak in public if the subject is one for reflection. Experience of already existing training courses on ethics has shown that they are not very inclined to engage in discussion spontaneously. Shyness, apathy, inhibition

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[27] Cf. *op. cit*., p. 30 : « Each transversal module should contain a mandatory section on the meaning of research, investigation, and therapy".

[28] *Ibid*., p. 32 : The authors of the Report attach to this recommendation two further pertinent suggestions. On the one hand, they believe that only assiduity should be "mandatory and required for validation of internship". They would favour the "neutrality" of this seminar in terms of evaluation, which would certainly seem the preferred solution for this type of education. Furthermore, the seminar formula could be extended to Consultants.

[29] Canto-Sperber M., *L'inquiétude morale et la vie humaine*, PUF, Paris, 2002, p.128.

[30] These values have been the subject of internationally recognised work through the publication (re-printed four times over) of the classic book by T.L Beauchamp and J. Childress, *Principles of Biomedical Ethics*, Oxford University Press, New-York/Oxford, 1999 (1st published in 1979).

because of gaps in general knowledge are obstacles that whoever is in charge of the course will have to overcome. Seminars are probably the most suitable framework for the promotion of interactive courses.

A course on ethics must therefore base discussion with students on the platform of cultural content. By mentioning the four main reasons for which ethics must be developed in a university hospital environment (the depersonalising effects of specialisation, the limits of "legalisation", the eclipse of the clinical side of medicine, the side effects of apportioning health care[31]) the Cordier report has already prepared the ground for training organised around these four main themes.

Initiation to ethical reflection in the second year of medical school could therefore be constructed along a few main outlines, such as for example: "information to the patient", "difficult situations at the beginning and at the end of life", or "the problem of equity in the allocation of health care and equipment". Regardless of which themes are chosen, it would be essential to construct a nomenclature and an index of key concepts to arrive at an orderly arrangement of university courses on ethical reflection. For ethics to become a recognised training cycle, it would be desirable that the volume of works and memoranda which are presently produced every year in various universities should fall into a carefully codified national classification in order to facilitate archiving, and that is in fact suggested by the Cordier report[32].

b) Difficulties as regards the designation of educators

One essential issue is to decided on who should be given the task of making ethics exist within the university.

The Cordier commission suggests that, rather than call on professional ethicists from the other side of the Atlantic, the adoption of a system of "referees" for medical ethics both in the world of education and in daily practice in health care institutions. It considers that "complementary training to become a "referee" for ethical reflection should be extended first of all to people who take on the management of patients and that it would be useful to provide also such training to teachers of the social sciences who want to engage in a significant dialogue with medical culture and the reality of health care".

In agreement with university presidents, deans of medical schools and directors of university life sciences departments should ask teaching staff trained in the social or legal sciences to take on ethics courses for students or practising health carers or researchers. This is already the case in some universities and CCNE considers that it is a step in the right direction.

For example, it would be quite conceivable that an historian of medicine – while making a comparative study of past and present medical practices – could contribute to highlighting aspects of health care besides those strictly related to science and technology. Or else, a professor of philosophy could teach moral philosophy and forms of ethical discussion to medical and paramedical students.

However, regardless of whether ethics courses are put into the hands of non medical professionals, clinicians, or scientific researchers, CCNE suggest that a prerequisite must be a doctorate degree based on a doctoral dissertation demonstrating dual competence and defended in the presence of a truly pluridisciplinary examining board. Similarly, should the Ministry in charge of higher education create senior lecturers' posts in universities (as suggested by the Cordier report), or professors' posts specifically to teach ethics, their recruitment should be approved by a board composed of pluridisciplinary specialists and/or a

[31] Cf. *supra* p. 2.
[32] Cordier A., *Rapport... op. cit.,* p. 35.

dual CNU(*), composed of members from two sections corresponding to separate disciplines. Furthermore, for medically trained teaching staff in ethics, a possible dissociation between university and hospital disciplines could facilitate this type of recruitment.

CCNE considers that in the near future, through the creation of several specific university teaching posts, medical ethics should receive a form of institutional consecration essential for the subject to become tangible and lead to collegial reflection.

c) Ethics and research

Research in French universities on the subject of ethics is only fleetingly represented in international publications, contrasting with the vitality of Anglo-Saxon publications on bioethics[33]. Obviously, when ethics is a university subject as is the case in many States in America and Northern Europe, biomedical research tends to thrive better than in countries where ethics have no university status. If the authorities wish to encourage ethics in universities, the possibility, as suggested, of creating pluridisciplinary departments or "axiological"[34] research projects for the improvement of practices, should certainly be explored. The concept of *axiology* is well chosen in that it suggests the possibility of the federating theme for these poles of research to be the listing and critical analysis of standards, those which preside over hospital customs and practices or over medical decisions in a given society (medical action as regards the life of the embryo, for example). Perhaps such work should be spurred on by the award of a specific master's degree for ethics[35]? Or perhaps it would be better served within existing masters' degrees in scientific or medical disciplines? It would seem that ethics would be more at home, because of specificity of the subject, if it existed in the form of modules to be integrated in training courses for the preparation of the various masters' degrees of the medical and scientific faculties.

A certain number of research masters' degrees could include an ethical section within which the axiological work recommended by the Report would find its place. It is to be noted in this respect that some of the institutes of higher education and universities have already included epistemology and ethics into their courses, with the assistance of philosophers, in compliance with the Lecourt[36] report. A knowledge of the moral philosophies (utilitarianism, personalism, etc.) which dominate contemporary ethical culture could serve as instruments to approach, guide and successfully implement research on ethics. For that matter, it is not unthinkable that it would be well if training in ethics were to exist throughout the world of academia and not be solely reserved for the health caring professions, particularly so because it is clear that exercising ethical reflection is an essential dimension of citizenship.

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* *Conseil National des Universités – National Council of Universities*

[33] Although some work, for instance what is done in the *Laboratoire d'éthique médicale et de droit de la santé et de santé publique de la faculté de médecine de Paris-Necker* (Medical ethics laboratory in the Paris-Necker medical school), the Catholic University of Lille, the *Espace éthique* of *AP-HP* (Health and Social Security Services and Public Hospitals), the *Espace éthique méditerranéen*, or the *Espace éthique aquitain*, demonstrate that there is ongoing activity.

[34] Cordier A. *Rapport…. op. cit.,* p. 64.

[35] *Ibid.*, p. 63 : the report suggests "developing the creation of DU, DESS, and DEA (ie masters) in medical ethics".

[36] Cf. rapport Lecourt *www.education.gouv.fr/rapport/lecourt/lettre.htm* : The Ministry of Education recommended in 1999 that the subject of philosophy should be expanded in courses preparing for scientific and health caring professions: "Such education should contribute to developing a critical and inventive mind in students of the scientific disciplines, in a world where science occupies an ever greater intellectual and social space. In the tradition of the philosophy of Enlightenment, a living philosophy must be called upon make sure that increased freedom is the fruit of scientific development". It is also to be noted that the present Ministry of Education approved this recommendation.

III Contribution of the ethical structures in hospitals

III.1. Permanent education and "Regional Ethics Forums"

Independently of the problem of insufficient initial training in ethics, the Cordier report refers to the development of ethics in existing health institutions for the benefit of practising professionals. It is probably in respect of training in ethics that the concept of an "*Espace* Ethique" (Ethics Forum) and its essential mission are most worthwhile[37]. Reflection on ethics must continue beyond initial training and be extended to private or public sector physicians and to all members of the health caring professions. Even though difficulties connected to the general climate of thought in present day France render its achievement challenging for the time being, it is still worth reminding the teaching community in the health care sector that such a project would be valuable[38].

The regional Ethics Forums, which are the focus of education and research, are distinctive in that they are open not only to health carers but also to jurists, philosophers, psychologists, scientists, representatives of associations, and many others. They are also forums for exchanging experience and knowledge. The word "espace" in the title in French is to be understood as meaning primarily the physical space indicating the presence (within some teaching hospitals) of premises available to those concerned. Secondarily and metaphorically, the notion of space refers to freedom of speech and open mindedness[39]. To move freely in an ethical "space" means that thought can expand into a horizon for reflection that is broader than the cramped spaces of the media scene, can flourish outside political, scientific, or ecclesiastical institutions into which it is only too frequently confined. Health carers can assemble according to preference, competence, concern (pain, management of the disabled, medically assisted reproduction, etc.) in discussion groups which could be designated, depending on what is most appropriate, "ethics committees" or "reflection workshops". The objective would not be hand down directives or recommendations in view of the urgency of some clinical situation or a medical decision to be taken immediately. On the contrary, they would fill the need for gaining perspective far from the emotional context in the heat of action, for rethinking the meaning and object of a particular activity.

As a meeting point, Regional Ethics Forums provide a possibility for physicians and jurists to exchange views on health issues elsewhere than on the scene of disputes to which their relationship seemed to be confined in recent years. On a general level, these Regional Centres represent an opportunity to escape the barriers erected between disciplines that have long been the bane of the French university system. There is every reason to be pleased at the

[37] When the draft bill on bioethics was adopted by French Parliament on December 11, 2003, legislators wanted the work of the Ethics Forums which had been in progress for the past ten years to gain national extension, first in Paris, later in Marseilles.

[38] Cf. Académie nationale de médecine, Rapport 179, « A propos du rapport CORDIER : Ethique et Professions de Santé. Médecine et humanisme », mars 2004, *http://www.academie-medecine.fr/upload/base/rap ports_179* : "Surely educators themselves must be convinced of this requirement, and it is to them that the possibility of appropriate training should be offered. It would be most desirable to organise for them short seminars to give them the opportunity of meeting and exchanging views fruitfully with other doctors, philosophers, psychologists, sociologists, representatives of patient support groups and of scientific associations whose work touches on ethical issues specific to their own field of activity".

[39] As the Cordier report points out the "concept of "Espace" (space) is more of an invitation to expression and debate, to sharing of experience, to gaining and acquiring ownership of knowledge, scientific knowledge in particular".

sight of health carers (doctors and nursing staff) rubbing shoulders with health economists, actors of the human and social sciences, representatives of associations, and thinkers of different philosophical or religious backgrounds. Their meetings and work in common help to achieve a multidimensional approach to ethical problems. Taking the opposite view to multisecular *habitus*, the *Espaces Ethiques* blur the traditional frontiers separating theoreticians and practitioners. These new forms of cooperation between scientists and those involved in action are extremely useful because health carers can participate in reforms concerning facilities, the organisation of hospital departments, insofar as a quest for equitable allocation of funding is "entirely a matter for ethical reflection" [40].

In view of this multiplicity of advantages, one can only agree with the proposal in the Cordier report to develop this type of joint hospital and university institution in such a way that within a few years there exists at least one "*Espace Ethique*" (Ethics Forum) per region[41]. One of the more immediate advantage of multiplying them throughout France, as pointed out by the Report, would be the dissemination of information and knowledge throughout a federative network. Experience has shown that healthcare professionals actually want this kind of training, that they are motivated and very ready to spend time on ethical reflection concerning the practice of their profession. The usefulness of a federative network would be to make available to everyone the work and publications from other Ethics Forums, and ensure that information regarding symposia, conferences, debates, reflection, taking place in each region is circulated.

Cultural dynamics are encouraged by the availability to healthcare professionals of substantive documentation on ethics and the human and social sciences, and conferences in the form of debates open and free for public participation ensure that the Regional Ethics Forums become the point of departure for renewing a collective perception of the hospital world which those whose working life is spent there feel a pressing need for. They transform hospitals into a place of cultural and human enrichment, and at the same time they contribute a great deal to dispelling feelings of isolation on every part, carers and patients alike, because they create a forum for discussion which helps to harmonise behaviour along common ethical foundations. Therefore, the National Consultative Ethics Committee is entirely ready to support and encourage regional initiatives coordinated by university hospitals containing Ethics Forums. In particular it approves the specific request that it should be associated in a partnership in the form of a report by the *Observatoire des Espaces Ethiques régionaux* (Observatory of regional ethics forums) to be presented at CCNE's annual conference (*Journées Annuelles*) [42].

However, since CCNE is not empowered to edict standards and these Forums are the responsibility of competent and institutionally recognised local authorities, it leaves organisers entirely free as regards their methods internally. It has every confidence in the organisers of these Forums, and also recognises the need to allow the network to function "flexibly and contractually in federative form" [43].

[40] Cordier A., *Rapport*, *op. cit.,* p. 64.
[41] *Ibid*., p. 45.
[42] *Ibid*., p. 63.
[43] *Ibid*.

III.2. The difference between the « *Espaces éthiques* » (Ethics Forums) and « Independent Ethics Committees »

Should one arrive at the conclusion that continuing education on ethics organised under the aegis of the regional Ethics Forums is sufficient for health carers to deal with the morally thorny problems they encounter in practice? The authors of the Report point out in passing that "certain medical teams or health care or research institutions feel the need for an Ethics Committee which can pronounce itself in response to specific issues" [44].They refer here to the Independent Ethics Committees. The Committee has already had occasion to express an opinion regarding these consultative bodies when they were in charge of drafting opinions on ethical problems arising out of research (cf. Opinion n° 13[45]). The Huriet Law and the creation of CCPPRBs (*comités consultatifs de protection des personnes se prêtant à une recherche biomédicale* – consultative committees for the protection of persons participating in biomedical research, i.e. institutional review boards) have, in the meantime contributed to limiting room for deliberation allotted to these local committees[46]. However, although the usefulness of such local ethics committees is not in dispute, there would be a need to reorganise them so that they can operate as committees to provide ethical assistance to medical decision. If they were given such a name, this would help to dispel any misunderstanding as regards their intrinsic purpose and their relationship with CCNE. In the present state of affairs, there are no laws providing any link between local or regional committees and the National Consultative Ethics Committee. This is mainly due to the fact that – as already mentioned Opinion N° 13 of November 7 1988 – it is not part of the National Consultative Ethics Committee's mission to assume a function of moral authority giving it the power to confer approval on any other body:

"However this would entail decision making as opposed to proposing opinions and would lead to legal consequences which would be at variance with the spirit of the institution. Such accreditation can only be in the hands of public authority" [47].

However, in the absence of accreditation procedures, how can self-institution of such committees be avoided? The Cordier report points out that one of the main pitfalls to avoid is to "transform such structures into ideological models" [48]. Self-proclamation of certain bodies who (like the "ethical committees" of scientific associations) pronounce opinions behind closed doors raise some misgivings which the Committee has already had occasion to deplore when in its Opinion on Functional neurosurgery for severe psychiatric disorders[49]. The scientific logic which pervades medical action is particularly dangerous when dealing with disorders whose existential repercussions are aggravated by mental or psychological[50] components, so that accreditation by some public authority is important.

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[44] *Ibid*., p. 43.

[45] CCNE's Opinion n° 13 November 7 1988, « Recommendations regarding local Ethics Committees ».

[46] Let us note in passing that the expected reform of the CCPPRBs which will become "committees for the protection of persons involved in research" (CPPR) will not bring about much change, since the ethical preoccupation of protecting participants remains one of the fundamental objectives of these supervising organisations.

[47] CCNE's Opinion n° 13 November 7 1988, « Recommendations regarding local Ethics Committees. », ch II – « Organisation. Organisation Creation and establishment ».

[48] Cordier A., *Rapport*, *op. cit.,* p. 43.

[49] Opinion n°71 April 25 2002.

[50] For severe psychosis for example, Opinion n° 71 suggested that in order to minimise the risk of unilateral opinions, a committee composed of not only attending physicians and experts, but also "pluridisciplinary medical, and non medical personnel, together with individuals capable of evaluating a handicap, and the misery

The Cordier commission adds that "in view of its terms of reference, CCNE could be put in charge of elaborating a national Charter setting out rules for the composition, representation, and mode of operation of these various Committees"[51]. As regards this request, the Committee considers that recommendations contained in its Opinion n° 13, dated November 7, 1988 – although they were more specifically addressed to committees delivering opinions on research protocols – are still pertinent as guidelines. These recommendations concerning the composition and prerogatives of local committees do provide the required safeguards. They would therefore seem to suffice for the drafting of a charter with the object of providing guidance for the type of intervention to be undertaken by such local organisations[52].

The present Opinion will confine itself to reviewing,, using vocabulary which takes into account changes that have occurred in the meantime, the main safeguards which could provide them with the "stamp of authenticity and commitment" that Opinion n° 13 alludes to, while it discourages a "proliferation of ill-formed groups"[53]:

a) Committees for ethical assistance to medical decision should not be composed exclusively of specialists. It is essential that their members come from varied horizons so that their opinions may appear justified to people who are not members of the medical[54] or nursing professions;
b) They should ensure a periodical renewal of their composition, of their nomination procedures, and the transparency of their financing processes;
c) They must be strictly consultative and cannot in any circumstances override a collective decision taken by a team of health carers, the head of a hospital department, or a general practitioner;
d) They are a link between the medical professions and civil society, a task which includes the production of documents and the dissemination of information found in scientific, medical, or ethical literature.

These structures for ethical assistance to decision-making are therefore totally unlike the "Ethical Forums" since their objective is to propose a response to a practical question[55].
In conjunction with these structures, the system of clinical ethics, which already exists on the American continent, could perhaps be useful in that its purpose would be "improving the dialogue between patients and carers in view of the growing demand on the part of patients and their families to be seen as partners to a medical decision" [56], albeit not to dictate that

endured by the patient, the family, and the entourage, would help to attenuate the pain and anxiety of taking such decisions".

[51] Cordier A., *Rapport, op. cit*., p. 43.

[52] Cf. CCNE Opinion n°13 November 7 1988*,* Ch. I « Missions of the Ethics Committees ». Recommendations set out in this document included the possibility that local or regional ethics committees could take into account opinions relating to medical activity as a whole: "Thus, over and beyond research evaluation, emerges the possibility of also advising physicians on matters of diagnosis and therapy".

[53] Introduction of CCNE's Opinion n° 13 of November 7, 1988, « Recommendations Regarding Local Ethics Committees ».

[54] On this point the enlightening distinction in Opinion n° 13 between "pluridisciplinarity" and "pluralism" is still valid. The first of these states simply the different qualifications of technicians and practitioners from diverse medical activities. The second means the presence of citizens and laymen. It is only thanks to this second formula, "pluralism", that it is possible to avoid accusations of unilaterality about an opinion. This is the condition of its credibility, for two reasons: "First of all, it is difficult for these professionals, however distinguished, to escape from their own field and evaluate all of the issues arising. A fresh eye from outside is a precious contribution. Secondly, an opinion issued by a single-sphere Committee will be less credible in the eyes of the public than one given by a pluralist Committee. In the second instance the public will recognise an expression of its own preoccupations and will feel, with some justification, that they have been represented".

[55] Cordier A., *Rapport*, *op. cit.,* p. 41.

[56] *Ibid*.

decision. The purpose, rather, would be to provide clarification of the decision parameters so as to "facilitate reflection on all sides regarding the basis for a decision, the legitimacy of the person taking the decision, the position of the various actors concerned in respect of that decision" [57]. A clinical ethics centre would therefore seem to be a variable ethical structure because of the modesty of its ambition to contribute, from the viewpoint of "an external third party", with no other aim than to incite protagonists of the clinical situation to "draw all the logical conclusions" [58]. Its action may turn out to be pedagogical, by giving carers in the broadest meaning of the word, an example of the way in which the factors that condition medical decision can be elucidated and put in order. The paradoxical risk however, is that the clinical ethics centre, despite its stated objective, i.e. assistance to ethical reflection, comes to be seen more as an ethical reference centre than as a site for ethical mobilisation. If it turns out over time that the operational line trod by this ethical structure has crystallized around rules of conduct that have stood the test of time and that the medical profession does not relinquish responsibility because of its existence, then the concept of clinical ethics could be encouraged[59] in a form suited to French ethical culture.

Conclusion

- The essential contribution of the Cordier report is the notion of training for ethical reflection throughout higher education, by integrating into scientific education a portion of ethical questioning rather than a set of normative ready-structured responses. It does seem that if more attention was given to training in ethics, one could hope for an improvement in practices and relationships between those involved in the health care system. The disembodiment of the one-on-one relationship – through a combination of phenomena: depersonalisation, judiciarisation and technological transfer – to which is added, on the collective front, the demand for equity in the allocation of resources, are crisis-producing factors. There is therefore good reason to reflect on the possibility of both initial and continuing training for health carers at an earlier stage. CCNE would emphasise on this score, the pertinence of several of the proposals formulated in the Cordier report, in particular those which relate to experience with the concrete aspects of clinical situations which are the subject of written or oral representation. Organising seminars at a later stage in higher education also appears to be worth considering. Opening up of the training provided to various actors of the health care system to the human and intersubjective dimensions of therapeutic activity requires the creation of new sites for discussion to facilitate interdisciplinary exchange and the provision of documentary resources. Institutionalising forums for ethical reflection within the university teaching hospitals would respond to that objective.
- Some of the passages in the document submitted to the Committee do raise some reservations. This is the case for guidance as regards educational options, some of which seem to be a little unrealistic at times. In particular, the notion of training courses before entering medical school and at the end of the first year in the form of further written and oral tests, seems rather illusory. Furthermore, such reform

[57] *Ibid*.
[58] *Ibid*. , p. 53
[59] The three year lead time suggested by the Report does seem well suited to the time needed for evaluation. Cf. Cordier A., *Rapport*, *op. cit.,* p. 53: "The rather unusual system experimented in the Hôpital Cochin ('ethical' turn of duty, mandatory training) would not necessarily be adopted in other establishments. It would therefore be possible to provide time for evaluation of this pilot structure and of this understanding of clinical ethics, which could be set at three years".

would only defer the basic problem which arises because of the existence of unavoidable (and necessary) rivalry between candidates who must, willy-nilly, be selected on the basis of a competition. It is for this reason that training in ethics at this point in higher education must remain at a modest level, at least if this training seeks to inspire an inquiring mind. What would seem to be most realistic at the PCEM 1 level, is that the existing ethical module should incline more in the direction of initiation to dialectics. Probably the best time would be at the end of the nursing training course, when an insight in critical enquiry would appropriately accompany first encounters with the reality of disease, which is a very suitable time for ethical reflection.

- There is much opposition to extending ethical reflection and it is necessary to be lucidly aware of this fact so that ambitions can be adjusted to realistic possibilities. The value of intentions does not detract from the need to question the feasibility of recommendations. For example, although the intention of integrating ethics into medical meetings is laudable, it is difficult to imagine that this could be followed effectively in practice[60]. Ethical necessity is experienced, not imposed. Undoubtedly, the amount of space in the report devoted to training as a method of modifying behaviour is witness to the fact that the authors were well aware that force of habit is a powerful obstacle and creates incompressible inertia. However, even in the earlier phases of training, there are considerable difficulties. Be it agreement on what should be the content of ethical "education", the objectivity of qualification procedures for educators who are to become "ethical referees", or on the possible cultural gaps of students, reasons abound for harbouring doubts about the possibility of "prompting a decisive 'cultural shock'" [61] in this respect. The Cordier report itself underlined quite rightly that at present the notion of "ethics" in medical circles is not given much credit. [62].
- Existing initiatives and achievements, wishes as already expressed, must be recognised and even encouraged. Nor should the initiatives in certain French universities to introduce ethical referees in the biosciences and medical faculties be disowned. If one accepts that the present statu quo is hardly favourable to solving the serious problems mentioned above [63], then any existing efforts for making some progress in France should be supported and given due recognition. Quite obviously, because there is no institutional consecration, ethics are not seen to exist and time that should be spent on the subject is still regarded as superfluous. As a result, creative medical energy is directed either to the effectiveness of diagnostic and therapeutic procedures, or to research, to the detriment of time spent listening to patients, of clinical examination, and to ethical reflection which is becoming ever less familiar to health carers.
- It is true that there is a risk of going in the wrong direction. However, there is no reason to believe that faculties are unable to assess the pedagogical qualities of their staff or to intervene should they fail to respond adequately to the tasks assigned to them. Therefore, and although it failed to mention the structural difficulties impeding their realisation, the Cordier report seems justified in proposing new avenues for exploration. For this reason, the Committee decided to offer some

[60] Cf. Cordier A., *Rapport*, *op. cit.,* p. 29 : « Staff must be allowed to have their ethical say ».
[61] *Ibid*., p. 32.
[62] *Ibid.,* p. 18 : « Ethics are seen as a kind of luxury to decorate, or even camouflage, less prestigious considerations. Ethics are going out of fashion before they have had a chance to serve! That's enough about ethics, we begin to hear… ».
[63] Cf. *supra* I.1. « Four rational motives for preoccupation ».

possibilities when they mentioned recruitment according to the intersection formula of CNU (National Council of Universities) as a modestly proportioned experiment, with the nomination of referees qualified by instructions regarding their own training and the training they would pass on to others[64]. In any event, whatever formula is chosen by competent authorities, it would appear to be essential to see to it that those in charge of training should work on the development of a collective thinking process, in close cooperation with hospital practitioners and other educators from faculties teaching life and human sciences, medicine and law. One essential point is to avoid giving students the regrettable impression that these referees have some monopoly over ethics. Should the ministry in charge of higher education wish to encourage the presence of referees in university institutions training health carers, the Committee considers that their teaching should not resemble traditional courses and be only given to students in medical schools. It should be extended to coordination and motivation in the framework of permanent education, so that it can become a federating influence between hospitals and life and health sciences faculties. By participating in the organisation of inderdisciplinary meetings and seminars, or conferences and transversal think tanks, ethics referees could bring out the essence of dialogue and the pluralist dimensions of ethics.

- Finally, although the Report rightly drew attention to the increasing unease in health care institutions, it is also important to take account of the fact that most of the physicians who are trained in medical school intend to practise medicine in the private sector. Nor should one forget the problems linked to the present state of isolation in which doctors practising in either urban or rural environments find themselves, so that frequently they are alone when they take decisions which may have dire consequences. For this reason it would be desirable that the initial training they are given in medical school should include some anticipation of the difficult situations they will be confronted with in a solitary one-to-one dialogue. Regional Ethics Forums should therefore not only respond to crisis in hospitals, but also help private practitioners to compare their decision-making experience and to meet with hospital staff so that they can reflect in common on the moral dilemmas encountered in private practice.

CCNE therefore wishes, in agreement with the Cordier report, to encourage:

- A determined policy for including ethical reflection in university courses;
- A plurality of solutions so that implementation can be gradual and progressive, and inclusive of the nursing training course;
- Taking into account and evaluation of existing initiatives, with conceptually diverse approaches for modes of student training;
- Pedagogical responsibility to be taken on by trained referees, recognised by pluridisciplinary bodies;
- A clarification of the respective missions of structures for reflection with various aims:
    - Regional Ethics Forums for the purpose of collecting the fruits of pluridisciplinary reflection;
    - Ethics Committees for assisting medical decision.

[64] We purposely used the expression “training” rather than “teaching” which conjures up the idea of a subject to be taught and therefore blurs the specificity that a course on ethics must have compared to existing disciplines.

Regardless of their institutional form of expression, medical ethics cannot belong solely to physicians. Ethics belong to all the health caring professions, united by their common participation in the adventure of contemporary medicine and committed to identical values of recognition and solidarity.

Thursday April 29, 2004