Teaching Health Care Ethics: why we should teach nursing and medical students together

Stephen Hanson

Key words: collaboration; education; health care ethics; nurses; physicians

This article argues that teaching medical and nursing students health care ethics in an interdisciplinary setting is beneficial for them. Doing so produces an education that is theoretically more consistent with the goals of health care ethics, can help to reduce moral stress and burnout, and can improve patient care. Based on a literature review, theoretical arguments and individual observation, this article will show that the benefits of interdisciplinary education, specifically in ethics, outweigh the difficulties many schools may have in developing such courses.

Introduction

The idea that health care ethics should be taught jointly to medical and nursing students runs contrary to some modern thought in this field. A review of the recent literature in health care ethics revealed arguments that different disciplines do and should have rather fundamentally different ethical responsibilities and codes. Some authors discuss the difference between the practices of nursing and medicine as being that between 'caring' and 'curing', with various moral roles and responsibilities inherent in these two functions.[1–4] Others develop this concept to distinguish more fully between nursing and medical ethics on the grounds that the goods sought by nurses and physicians are fundamentally different.[5,6] Some research suggests that there is at least a perceived difference in how specific professions see and learn ethics,[7] which is often (and, one might argue, should be) reflected in how ethics is taught to them.

One consequence of this has been that courses and texts on nursing ethics and the ethics of other allied health professions are proliferating. This very likely increases the numbers of professionals who study health care ethics both before and after entering their professions. Yet the teaching of ethics in health care largely to groups comprised

Address for correspondence: Stephen Hanson, Assistant Professor of Philosophy, Department of Social Sciences, McNeese State University, PO Box 92335, Lake Charles, LA 70609, USA.
E-mail: shanson@mail.mcneese.edu

  10.1191/0969733005ne773oa

only of members (or students) of one profession can lead also to a conceptual and practical isolationism of thinking about health care ethics, where physicians concern themselves with the problems of medical ethics, nurses with nursing ethics, social workers with the ethics of social work, etc., each considering a given ethical case only as their own profession perceives it. This article will argue that schools teaching health care professions ought to strive in the opposite direction: we should teach health care ethics to students of the various professions together, as much as possible. Teaching in this fashion would theoretically be more true to the mission of health care ethics. Also, by the early development of mutual respect and collaboration on moral issues, this can help to improve the lives of health care workers, especially nurses, by aiding the prevention of burnout and providing better paths to communication. It can also help to improve patient care owing to better collaboration.

Theoretical justification

First, there are good theoretical reasons to consider and teach health care ethics as one single topic, rather than a combination of various related, but different, disciplines. Demonstrating this is important because this claim runs contrary to some current thought. There has been significant study of the various concerns of individual health care professions, particularly the differences in approach between nurses and physicians.[1–7] Among the concerns voiced by many in this debate are the distinction between caring and curing, and the related issue that nursing and medicine pursue rather different goods. (The same could be said for other disciplines – the code of ethics for genetic counselors, for example, is explicitly relationship based[8] – but nursing and medicine are the professions most commonly discussed.) If the caring relationship between patient and professional is the primary ethical concern, as this literature holds (rather than respect for autonomy or a balance of autonomy, beneficence, and/or justice concerns), then these professions actually seek different moral goods and may even employ different moral reasoning.[6,9]

Although specialized study of the specific concerns of various professions can be important for the academic study of ethics, the case is different with regard to teaching basic health care ethics to students engaging in what is, for many of them, the only structured study of ethics they will undergo. The problem with conceptualizing health care ethics separately for members of individual professions is that it implies that, fundamentally, there are different moral problems that need to be solved (more or less independently) by the different groups. On the contrary, the problems of health care ethics, as a whole, are largely the problems of how best to treat patients. A patient remains the same person, whether being treated by a nurse, a physician, or any other health care professional. Thus, the different moral issues that nurses and physicians raise are intrinsically related in a way that ethics education should highlight rather than diminish. The various issues are all aspects of the larger issue of how best to treat a given patient with the complete range of skills that modern health care has to offer. The same ethical case approached from a different professional perspective may raise different troubling issues, but it remains the same case and the same patient, with whom health care professionals need to work together to treat and cure.

This fact motivates the interdisciplinary understanding of health care ethics. Teaching health care ethics as a course shared by multiple disciplines can emphasize

this important point without eliminating the differing values that the various professions maintain. The way that we teach ethics will affect how those we teach interpret the ethical cases they encounter, and teaching students together can, if done correctly, lead to improved collaborative efforts to address the whole of patients' concerns. Students (and current members) of these professions could bring their differing values to the table and present them in a shared course as a way to address cases and issues under discussion; this would assist others in understanding this position and the values it promotes. Consider the following as an example of how this could occur.

Recognizing different values

As a graduate student, I assisted with a required ethics course at the medical school of Georgetown University.[10] The one-semester course was required of all medical students as well as highly recommended for nurses who were returning for advanced degrees in nursing. The course consisted of a medical-school-style lecture component, using a variety of lecturers and formats, immediately followed by a small-group component where about 10 students would discuss the readings, lecture and relevant ethical cases with a moderator. For several years I was a moderator for this course, responsible for one of the small groups. Each year, the small groups had an approximately 70/30 split between medical students (who were nearly all only a few years out of college and yet to have much clinical experience) and graduate nursing students (all of whom had been practicing nurses, some for as many as 20 years, before returning for a higher degree). Each semester, some of the medical students would begin the course dismissive of the nurses and their opinions. Inevitably, though, as the semester progressed, these students would stop blocking out what the nurses were saying and start listening, as the relevance of the nurses' views became so obvious that they could not be ignored. This had two clear benefits. The first was that medical students and future physicians became more willing to listen to other voices that could have something to say, and, specifically, these were the voices of nurses who might know something about the ethical case at hand that the physicians did not. As some of these nurses had nearly as much health care experience as the medical students had years of life, the opening of these future physicians' eyes to more experienced voices, before they encountered actual patients presenting difficult ethical problems, can only have brought more attentive and better care to their future patients.

Clearly, only experienced nurses could provide this kind of input, but most teaching environments do not have the advantage of such an opportunity. Moreover, to their credit, most of the medical students entered the classroom willing to listen and learn from others with experience, regardless of their profession, so, in this fashion, the class was a boon only to some. However, there was a second benefit of the interaction between nurses and medical students that would be beneficial to them all, possibly as early as in-class conversations between undergraduate nursing students and premedical students. Medical students and nurses were able to interact in small groups where they could share and try to appreciate each other's ideas and values. More than once, a medical student's resolution to a moral problem earned the response from a nurse: 'But who's going to care for the patient after you've done that?' An

example of this occurred when a medical student suggested that we can avoid all the concerns of assisted suicide and active euthanasia, if necessary, by terminal sedation and (perhaps) withdrawal of nutrition and hydration. With this, the student held, any terminally ill patients can choose the end of their lives without our having to embrace anything more than adequate pain control and the withdrawal of therapy that we already accept.[11] One of the nurses pointed out that the patient would not vanish after that order was written, but would still need care for the remaining days of his or her life, which could well be very burdensome on those family members and caregivers who would be watching the patient die slowly of dehydration. She was dubious that this method of 'resolving' the issue was really a very good idea, given the serious impact it would have on those whose job it was to care for the patient's daily needs. Perkin *et al.*[12] give a more rigorous report of comparable concerns in a similar case.

The value of this interaction could be seen in the response of the medical student: she was initially surprised, and then thoughtful. She had clearly never before considered the problem from that angle. The dissimilar approaches that the different professions brought to the problem raised an issue that one of them had not thought about, and, because we had a mix of nurses and medical students, each received the benefit of the other's approach.

This medical student had had this valuable perspective pointed out to her gently, but memorably, in a way that taught her the truth of it far better than simply being told in a lecture could ever do. This allowed her to realize, rather than merely memorize or be told, that concern for the ongoing care of patients is part of the practice of medicine and a relevant part of any case discussion. The student simultaneously recognized the ability of another health care professional to show her something about her own profession, and also that she needed to evaluate more carefully the ethical cases before her to ensure that she addressed everything that was important, hopefully in part by discussing it with other involved professionals. The insights given here were broader than just the case under discussion; the interaction of medical students and nursing students gave each side an opportunity to present, and recognize, the importance of the other profession's way of perceiving ethical dilemmas.

Helping to prevent moral burnout

Teaching different professional students together can have a third, more direct, benefit, particularly for nursing students. As a professor at a university with a nursing program that includes a required course in ethics, I see many potential nurses who, though very clearly possessed of moral views that they understand to be valuable, nevertheless want to refuse to voice an opinion in a case where a physician must eventually make a treatment decision. This refusal seems to be due to a combination of factors, including a perception that nurses are obligated to show deference to physicians' opinions, a desire to avoid making difficult ethical decisions, and an unfortunately apparently accurate belief that nurses who challenge physicians' claims, even correctly, tend to get treated less well than those who accede meekly. The problem is not that these students cannot make moral decisions, but rather that they are resistant to voicing them in the (even hypothetical) presence of a physician. Many of these nursing students already perceive, even at the preclinical stage of their studies,

that at least some physicians wish them to care for patients but stay out of the way when important decisions are being made.

This produces stress in nurses, particularly those in positions where they feel they cannot express their views on troubling cases. It has been shown that nurses who feel unable to express their views and make an impact on the decisions that guide their actions, particularly in morally difficult cases, are affected by moral stress and may burn out sooner.[12–16] When people feel obligated by their job to perform actions they believe are immoral, this leads to stress and self-doubt.[13,15,17] This is hardly surprising: even if someone else has written the order, we all must take responsibility for our own actions; this responsibility can be great if people believe the actions are either wrong or required by their job.

Three factors that lead to this stress have been identified as: (1) the moral sensitivity of nurses to their patients' vulnerability; (2) the experience of external factors preventing nurses from doing what is best for patients; and (3) nurses feeling that they have no control over a specific situation.[13,17] The first factor is worth preserving, but, to the extent that we can prevent the latter two, we can avert or alleviate some of the moral stress that nurses experience. Much of the cause of the last two factors can come from an inability, whether real or perceived, of nurses to voice their opinions and make an impact on the decisions being made in a given morally challenging case.[13,14,17]

In teaching a mix of medical or premedical students and nursing students together in an ethics class, this difficulty can be addressed in a significant way before it becomes a problem. Students would be able to discuss their views in the class and educators could explain why they should continue to do so when they enter practice. Although there could well still be an initial reluctance from nursing students to speak against medical students, this could be far more easily dealt with in a classroom environment where the major power interaction is between professor and student. In this context, the students are on an 'even playing field' that will allow them to discuss ethical cases without concern for the eventual power issues involved in practice. The benefits of this development could be long lasting. In a multidisciplinary ethics class, nursing students could develop their abilities to voice and defend their positions, even when a (future) physician thought they were wrong, and medical students can see the value of (future) nurses' input. This could go a long way towards alleviating some of the strain in interactions between physicians and nurses (which appears so significant that students already feel it), and, in so doing, could diminish an important source of moral stress in nurses.

Development of collaboration

The value of this development of professional interaction at an early stage could go beyond relieving stress to providing even greater benefits through developing interprofessional collaborative behavior. It is clear that collaboration between health care workers, particularly physicians and nurses, is valuable and perhaps even necessary for adequate patient care and a better working environment.[10,16–20] There is a body of research devoted to the improvement of collaboration between health care workers; a significant portion of this suggests shared learning as one important means of increasing collaboration.[10,19–23] The thinking behind this is, at least in part, that disciplines can learn to work together by learning together. Additionally, it is hoped

that members of different professions learning together can help to break down stereotypes and mistrust between professions and to promote better interprofessional communication.[20,21,24]

Health care ethics training is well suited as a course to be taught interprofessionally for at least four reasons. It is a subject that all health care professionals must appreciate and most already study at some point. It should place minimal additional strain on students' courseloads to teach ethics interprofessionally instead of to each profession separately.

In addition, ethical issues are also topics on which there is often interprofessional conflict.[21] Unlike some other areas of conflict, in ethical debate no one health care profession is or should be recognized as having superior understanding. Different viewpoints are and should be valued in ethical debate, and no one viewpoint is always correct.[23] The interprofessional ethics class environment offers a unique opportunity to encourage students to work together on issues where none of them has a *prima facie* claim to the superior approach or position, thus fostering an atmosphere of co-operation between professions that can extend well beyond the bounds of that single class. This attitude of collaboration can be exercised and developed by studying tough ethical dilemmas, which can be some of the most difficult problems encountered in health care. This collaboration could and should extend beyond the boundaries of the classroom, and could and should continue even to situations occurring years later.

Thirdly, ethics is a subject that lends itself well to developing collaborative skills. Among the factors that promote collaboration are communication skills, mutual respect, and shared planning and decision making.[25] Ethics courses can promote all of these valuable features.

- *Communication* Approaching and understanding an ethical dilemma requires careful communication and discussion of the case and its details; sloppy presentation or communication of a case will often leave out critical information. A good ethics class makes this clear. To study ethics actively, one must have or learn good communication skills; if professions that must communicate with each other to collaborate on the job learn to communicate better in their ethics class, so much the better for them in practice. This also provides an outlet that is outside of the clinical setting for students of different professions to begin to talk about patient care.[21]
- *Mutual respect* One factor in improving collaboration between nurses and physicians is a recognition of knowledge and/or experience in members of the other profession.[17] In an ethics class, each participant can see the ability of others to appreciate aspects of a particular issue that he or she does not. Respect is developed in a number of ways and over the course of time, but the growth of respect for different and important views in an ethics course is a valuable step towards that.
- *Shared planning and decision making* In order to resolve properly an ethical case, one cannot simply make a decision and move on to the next one. One must develop a plan to address the results of that action, including treatments, caring for the patient after treatment, and sometimes even after discharge. To that end, an ethics course can and should involve group efforts and discussion in which a complete plan of action is developed by a group of students working together. Having small

groups of students work through a complex case, considering the roles of various health care professions, is an extremely effective way of devising a complete plan. To do this well, however, those in the different roles must work together to develop the plan, and the individual disciplines can and do advocate well for their positions. An ethics course allows one to develop shared decision making in a way that does not challenge students' or professionals' actual roles, yet allows them to appreciate the importance of other positions.

Finally, and perhaps most importantly, interprofessional ethics education can be better ethics education. Future professionals working and debating together about difficult cases in the classroom will consider more approaches, issues and values. When they do this, they will inevitably address those cases more carefully, more completely and more appropriately. Studies of nursing and medical students collaborating on how to break bad news to a (simulated) patient (a regular issue in an ethics class) showed that a collaborative approach greatly increased the confidence of both medical and nursing students in their ability to perform this difficult task.[22] Thus, students can and do learn more about cases and ethics through collaborative learning together than they could have done in a single-profession course.

Instructors must make an effort in the ethics class environment to develop collaborative and listening skills in students, but this effort is consistent with good ethics education. Some students may need extra encouragement to share their views and particular approaches to the problems discussed. Cases may need to be chosen and discussed in part with an eye to developing collaborative and listening skills, but, as the above examples suggest, many classic cases and important issues in health care ethics easily lend themselves to this analysis.[11,12,22]

Problems in bringing disciplines together to teach ethics

There are still several difficulties to be overcome in making this sort of interdisciplinary education possible. Perhaps the first is indicated by the increasing number of texts, which are often written to be specific to particular disciplines. This makes them less well suited for use in another discipline. Few books, and fewer textbooks, are specifically written for interdisciplinary study. (A search on amazon.com for books with 'nursing' and 'ethics' in the title produced 81 hits, while a search for 'interdisciplinary or multidisciplinary' and 'ethics' in the title produced four or five appropriate results.) A significant difficulty is finding an appropriate book to use in such a setting. One reason for this may be that nursing ethics and the ethics of other professions were developed precisely to explore the different values that non-physicians bring to the health care table. Integrating these courses without providing a suitable interdisciplinary text could well be perceived as (and, if those developing the course are not careful, could turn into) incorporating other disciplines under the control of medicine and physicians. This problem may be ameliorated by the fact that many classic issues and cases can be analyzed from multiple perspectives regardless of how the text presents them, but, even so, this remains a difficulty.

A related problem could be finding faculty members who can teach well in an interdisciplinary course. However, this has been less of a problem than one might

expect when interdisciplinary ethics education has been attempted.[10,21,26] The joint class I worked with in a graduate school involved medical school professors, nursing professors and practicing nurses, philosophers and sociologists, all of whom were eager to participate in a new and valuable project. Comparable responses have been seen elsewhere.[21] The interdisciplinary teaching style can be provided not by a single, very talented educator, but by teachers from the various disciplines teaching in their own styles.

This solution, however, points to a more fundamental problem seen in this sort of teaching, which is that interdisciplinary courses require multiple professions to be represented. This may initially be a problem because many schools that teach one discipline do not teach another; not all schools that teach nursing also have a medical school. The same is true for any other discipline that one would want to share the experience. Although this can be helped somewhat by separate campuses working together, this can go only so far; to require students with already full schedules to add in long commuting times could be an extreme imposition. This means that not all schools would be able to offer such an interdisciplinary program, but it places an even stronger impetus on those that do teach multiple health care professions to make the effort to do so.

A related problem of interdisciplinary courses is that it can be difficult to make these courses mesh well with the schedules of the different schools. The course I assisted with in a graduate school was a full semester course, yet it began several weeks after the medical students had begun their other classes, and there was a gap of nearly a full month in the middle because the starting dates and spring breaks of the medical school and the graduate school of nursing were different. Edward and Preece also note that inserting the course into the curricula of different schools with a minimum of disruption to other studies was a challenge, and such things normally as simple as room availability and location can become difficult in these circumstances.[21] Should the class always meet in the medical school's large lecture hall, where there is ample room, or should it alternate between medical school and nursing school, etc., in order to show the equal importance of the disciplines (and, importantly, to make getting to the class comparably easy/difficult over time for all the students)? How should the course be graded if some students in the same course are graded on an A–F scale and others are graded on a low pass, pass, high pass scale? New questions such as these, which are not even relevant in courses involving only a single profession's students, are raised by interdisciplinary education.

These problems may, however, come with a silver lining. Although it may be difficult to work within the confines of other schools' schedules, if members of the other disciplines are also working on the course, then any given person or school need not devote as much time to developing the course as they would have to do in order to develop a full course on one's own. Classrooms may be unoccupied and available for other uses during part of the semester when students are in a classroom in a different school. Economies of scale may even make shared learning less expensive. Barr and Shaw report that in some cases this has been the main rationale for providing shared learning.[27] This should not diminish the importance of the difficulties noted above, but it may make them slightly more palatable.

It is worth noting that, despite all of these difficulties, there have been a number of schools that have attempted interdisciplinary ethics education and have been at least provisionally pleased with the results.[10,21,26] These programs have produced only

preliminary, though generally positive, results. At the very least, the results demonstrate that the problems above, although real, are not insurmountable, and they tentatively provide the expectation that the hoped-for practical long-term results above may well be attainable.

Conclusion

Students of different health care professions have a lot to say to each other about health care ethics, and they can inform each other in ways that will benefit both professionals and patients by allowing ethically difficult cases to be more carefully and completely thought through. These conversations can happen only in an appropriate atmosphere. By teaching health care ethics to students of different professions together, educators can help to inspire and develop an atmosphere of co-operation, confidence and willingness to listen and learn from each other, which can make professional life, ethical decisions and health care itself, better for all.

References

[1] Baumann AO, Deber RB, Silverman BE, Mallette CM. Who cares? Who cures? The ongoing debate in the provision of health care. *J Adv Nurs* 1998; **28**: 1040–45.

[2] May C, Fleming C. The professional imagination: narrative and the symbolic boundaries between medicine and nursing. *J Adv Nurs* 1997; **25**: 1094–100.

[3] Grundstein-Amado R. Differences in ethical decision-making processes among nurses and doctors. *J Adv Nurs* 1992; **17**: 129–37.

[4] Bates B. Doctor and nurse: changing roles and relations. *N Engl J Med* 1970; **28**: 129–34.

[5] Fry ST. The role of caring in a theory of nursing ethics. *Hypatia* 1989; **4**(2): 88–103.

[6] Twomey J. Analysis of the claim to distinct nursing ethics: normative and nonnormative approaches. *ANS Adv Nurs Sci* 1989; **11**(3): 25–32.

[7] Oberle K, Hughes D. Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *J Adv Nurs* 2001; **33**: 707–15.

[8] National Society of Genetic Counselors. *Code of ethics*. (n.d.) Retrieved 30 December, 2003, from: http://www.nsgc.org/newsroom/code_of_ethics.asp

[9] Parker RS. Nurses' stories: the search for a relational ethic of care. *ANS Adv Nurs Sci* 1990; **13**(1): 31–40.

[10] Cloonan PA, Davis FD, Burnett CB. Interdisciplinary education in clinical ethics: a work in progress. *Holist Nurs Pract* 1999; **13**(2): 12–19.

[11] Bernat D, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. An alternative to physician-assisted suicide or voluntary active euthanasia. *Arch Intern Med* 1993; **153**: 2723–28.

[12] Perkin RM, Young T, Freier MC, Allen J, Orr RD. Stress and distress in pediatric nurses: lessons from Baby K. *Am J Crit Care* 1997; **6**: 225–32.

[13] Lützén K, Cronqvist A, Magnusson A, Andersson L. Moral stress: synthesis of a concept. *Nurs Ethics* 2003; **10**: 312–22.

[14] Severinsson E. Moral stress and burnout: qualitative content analysis. *Nurs Health Sci* 2003; **5**(1): 59–66.

[15] Wilkinson JM. Moral distress: a labor and delivery nurse's experience. *J Obstet Gynecol Neonatal Nurs* 1989; **18**: 513–19.

[16] Almost J, Spence Laschinger HK. Workplace empowerment, collaborative work relationships, and job strain in nurse practitioners. *J Am Acad Nurs Pract* 2002; **14**: 408–20.

[17] Lockhart-Wood K. Collaboration between nurses and doctors in clinical practice. *Br J Nurs* 2000; **9**: 276–80.
[18] Fagin CM. Collaboration between nurses and physicians: no longer a choice. *Acad Med* 1992; **67**: 295–303.
[19] Glen S. Educating for interprofessional collaboration: teaching about values. *Nurs Ethics* 1999; **6**: 202–13.
[20] Kennard J. Illuminating the relationship between shared learning and the workplace. *Med Teacher* 2002; **24**: 379–84.
[21] Edward C, Preece PE. Shared teaching in health care ethics: a report on the beginning of an idea. *Nurs Ethics* 1999; **6**: 299–307.
[22] Wakefield A, Cooke S, Boggis C. Learning together: use of simulated patients with nursing and medical students for breaking bad news. *Int J Palliat Nurs* 2003; **9**: 32–38.
[23] Gallagher A. Medical and nursing ethics: never the twain? *Nurs Ethics* 1995; **2**: 95–101.
[24] Tunstall-Pedoe S, Rink E, Hilton S. Student attitudes to undergraduate interprofessional education. *J Interprof Care* 2003; **17**: 161–72.
[25] Henneman EA, Lee JL, Cohen JI. Collaboration: a concept analysis. *J Adv Nurs* 1995; **21**: 103–109.
[26] Browne A, Carpenter C, Cooledge C *et al*. Bridging the professions: an integrated and interdisciplinary approach to teaching health care ethics. *Acad Med* 1995; **70**: 1002–1005.
[27] Barr H, Shaw I. *Shared learning: examples from the literature*. London: Centre for Advancement of Interprofessional Education, 1995.