Workshop

"Integration of Medical Humanities into the Education of Health Care Professionals"

Vilnius, 28 and 29 June 2002

organized by

the Lithuanian Bioethics Committee and Department of Medical History and Ethics of the Medical Faculty of Vilnius University

sponsored by
Open Society Fund Lithuania

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Introduction

The word combination “medical humanities” sounds quite unusual in Lithuanian. However, this concept is very precise in characterizing humanitarian subjects that either traditionally or quite recently have been linked to medicine itself and to educating and training health care professionals. It is usual to class medical ethics and medical law as medical humanities. Nowadays, the concept has acquired a much broader meaning. Professor S. Holm, one of the co-authors of this publication, claims that “medical humanities” is an umbrella term that encompasses a number of sciences, such as the philosophy of medicine, medical ethics, the history of medicine, medicine and literature, medicine and cinema, and medicine and the arts.

The articles in this publication describe the concept of medical humanities and the subjects inherent in it. In addition, it describes the experience of integrating medical humanities into curricula for educating medical professionals and upgrading their proficiency, in Lithuania and in other Central and East European countries, as well as in countries of Western Europe.

This publication on medical humanities is one of the first such publications in Lithuanian. The articles have been prepared based on presentations given on 28 and 29 June 2002 at a workshop entitled “Integration of Medical Humanities into the Education of Health Care Professionals” organized at Vilnius University. The seminar was one of the numerous events dedicated to issues of medical ethics. It was organized by the Lithuanian Bioethics Committee and supported by the Department of Medical History and Ethics of the Medical Faculty of Vilnius University, within the framework of a project sponsored by the Open Society Fund Lithuania.

The great interest shown in the issues analyzed in the course of the workshop provided the impetus to have this publication produced. We believe it will be beneficial both to lecturers and to students teaching or studying medical humanities.

We extend our sincere thanks to Professor Z. Szawarski and Professor S. Holm, to Dr H. Fangerau and his colleagues, to Vilnius University, and especially to the Open Society Fund Lithuania for sponsoring and encouraging the development of medical ethics in Lithuania and in other Central and East European countries. If it were not for the support of these people and the above-mentioned institutions, this publication would never have been made available to our specialists and students.

Asta Čekanauskaitė

Eugenijus Gefenas
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The Importance of Medical Humanities in Lithuania

First I would like to express my hope that the restructured Department of Medical History and Ethics will facilitate the teaching of Medical Faculty students in medical humanities. In this presentation, I will give an overview of the history and the current status of the teaching of medical humanities in the Faculty of Medicine at Vilnius University.

I believe it is easy to see that there is a common trend in many post-communist countries. In various different universities in these countries, medical ethics was introduced under quite different circumstances when Marxism stopped being taught after the collapse of the Soviet Union in the last decade of the 20th century. At that time, I believe, medical history was the only subject that experienced any continuity. Before the fall of the Eastern Bloc, the teaching of Marxism was given a lot of class hours, at least in the Faculty of Medicine at Vilnius University. After independence, these classes were replaced by other subjects. Therefore, the current course in medical ethics, which we can also call bioethics, was first offered to pediatricians only, in 1993. In 1994 it was introduced to public health and nursing students, and only a few years ago to students of curative medicine. In fact, the subject is very new at Vilnius University. The situation at Kaunas is somewhat different. Kaunas Medical University managed to use some of the class hours given to ideological subjects to teach medical humanities instead. We have to admit that most East European universities have failed to follow this "positive scenario". I believe our colleague from Poland, Professor Szawarski, will comment on this issue.

Why do we speak about medical humanities? Why do we discuss its significance and its place in medical studies? It seems to me that one of the main arguments is that health care is not only applied biomedicine. Unfortunately, a number of medical specialists believe that it is possible to master medicine by studying the natural sciences or other clinical subjects. However, every decision made by a medical doctor regarding a patient is a decision based on values. We could give many examples to help us think what in fact goes on when a transplant surgeon has to decide to whom to give a donated organ when there are several possible recipients, and their condition from an immunological point of view is the same. What are the exact criteria for selection? In fact, medical doctors face daily challenges, such as whether to stop treatment that could extend the life of a terminally ill patient or not. And here I am not talking about a decision on euthanasia, which in itself is an extremely controversial one. I am talking about daily decisions, such as overdoses of painkillers. A biomedical background is not sufficient to make one decision or another. We could also mention those day-to-day situations when medical doctors have to withhold a diagnosis. We can find relevant articles in the new Civil Code which stipulate that under certain circumstances it is allowed not to reveal a diagnosis to the patient. But, in fact, it is always the doctor who decides what should be done, and how. Research into embryo stem cells calls for decisions to be made based on values intrinsic in medical practice as well. This subject might seem bizarre in a Lithuanian context, but we have to remember that it is a very important global issue that has been

brought about by the progress made in biomedicine, and it entitles us to ask whether medical knowledge is sufficient to decide on the continuation or the prohibition of such research.

What are the "hottest" bioethical issues in Lithuania today? First, the Law on Artificial Insemination is being widely debated, bringing out some very controversial opinions. There is also strong opposition to a clause in the Civil Code which says that a single adult individual has the right to change his or her sex. A third issue that I want to point out is related to the Additional Protocol to the Convention on Human Rights and Biomedicine on the Prohibition of Cloning Human Beings. Lithuania is in the process of ratifying the protocol. The question arises as to how much Lithuanian citizens know about cloning. Do they know that a distinction has been made between reproductive cloning and therapeutic cloning? Even if the question is somewhat rhetorical, it is worthwhile asking if medical professionals are ready to discuss the issue. Why medical professionals? Because, I believe, they should be, or could be, the group in society that ought to lead the discussion, because doctors know the technicalities best, and can understand the essence of the matter better than those in other professions. If they are good at grasping the ethical and cultural aspects of the problem that give rise to the arguments, they find it easier to moderate the discussion on this sensitive issue. Therefore, I think that in our country it is the medical community that can best demonstrate how to go about discussions on this delicate issue.

Now I'd like to go back to the Additional Protocol to the Convention on Human Rights and Biomedicine on the Prohibition of Cloning Human Beings. Lithuania signed this important document in 1997. In September 2002 it is going to ratify the Convention on Human Rights and Biomedicine and the Additional Protocol. But what does this mean for Lithuania? In my opinion, it means that the country as a whole must accept the convention. However, the acceptance of such important documents must follow a comprehensive public debate. Can we really say that the discussion in Lithuania has been sufficient and that the public at large is aware of what is going on?

I started my introductory note with the normative issues, because the significance of a knowledge of humanities is best seen when talking about patients' rights, professional codes of conduct, and other rules. On one hand, humanities can be considered as being important per se, because we want our medical doctors to have a good educational background. I think that humanities can be very practical as well, due to the reasons that I have already mentioned. For example, when carrying out biomedical research, a doctor always comes across ethical aspects of decisions to be made. Therefore, we must ask again if there is a better time to train our medical students to recognize and differentiate between ethical issues than in the course of their studies. The importance of medical humanities is even more evident when we take into account the fact that nowadays the doctor-patient relationship is based on the values and principles of a pluralist society. For example, the new Civil Code and the Law on the Rights of Patients and Compensation for Damage to their Health contradict the normative statements that are inherent in the Hippocratic oath. However, all ethical questions have a philosophical conceptual dimension. If we talk about artificial insemination, we must face the issue of the concept of the person: what is the distinction between a person and a human being? Moreover, it is important that people with different world-views interpret these concepts differently. However, this discussion is not only a purely philosophical one; it is equally important to the medical profession as well, such as when we face

moral dilemmas related to the beginnings of human life. If we talk about the transplantation of organs, we will inevitably face another conceptual philosophical issue, namely the concept of death. What is defined as the death of a human being? What are the criteria and why have they changed? Is the current legal concept of death (i.e. death of the whole brain) understood and accepted? Has the understanding of death changed only due to the progress made in the field of transplantations, because the conventional understanding of death (the stopping of the heart and respiration) would make it impossible to obtain organs for transplantation?

Finally, if we talk about artificial insemination or about sex change, the question arises as to what is the status of infertility or transsexuality, and whether they can be treated as diseases. The concepts of health and disease are not easy to define. Is the state of an individual who wants to change his or her sex a disorder? If it is not a disorder but just a strange desire related to moral views, the decision taken will differ from that when such a wish is a consequence of disease (transsexuality is on the list of international classifiers of mental disorders). I believe that questions such as: what is a person? what is human life and death? what is health? and what is disease? must constitute a composite part of medical studies and professional upgrading. What is the situation today? Do we teach subjects that would enable students to go deeper into these important issues in the philosophy of medicine?

Let us now discuss the relationship between medical ethics and the other humanities. The importance of this relationship is evident when we are talking about the shift from paternalism towards autonomy. The history of medicine could indeed show the preconditions of this shift, by explaining how it developed, and why and when the changes took place. Moreover, the historical aspect is extremely significant when we speak about biomedical research and the experience of the Nazis. In fact, we are inclined to forget the historical facts very quickly, while even now they could give us some important insights into what the ethical requirements should be. The issues inherent in biomedical research are good material for a medical historian to prove to a young doctor that sometimes mistakes are made in the development of biomedical science. Thus, I am trying to list the subjects which should be integrated into the medical studies curriculum. Medical history, ethics, philosophy, law and sociology come to mind first. The magazine *Medical Humanities* gives a much broader view of medical humanities, which includes literature and fine arts; in other words, an understanding of medicine which comes with the help of pieces of art, books and films. A long list of films and books recommended to medical students might be suggested.

I believe all the above-mentioned concepts and subjects might be covered by the term “bioethics”. This concept, when it is understood in a broad sense as the ethics of life sciences, can easily replace the long list of subjects that are considered important in training medical students in medical humanities. The integration of medical humanities into an overall curriculum of medical studies may be analyzed as an external and internal one. Its integration means that it is important that humanities are included in the official medical studies curriculum. The internal one is a challenge to the representatives of humanities themselves, in respect of the coordination of subjects covered by different lecturers. Nowadays, medical history and medical philosophy are taught in the first and the second year, while bioethics and modern medical ethics are taught only in the sixth year.

I am convinced that this seminar will give us the impetus to reconsider the subjects to be discussed with students in the Medical Faculty, so that we can touch upon historical aspects, on the one hand, and cultural and ethical aspects, on the other, when talking about issues of biomedical research, to mention just one example. I believe that sociological knowledge is very important as well for the analysis and interpretation of ethical problems.

I would like to finish my presentation by quoting a well-known psychiatrist from the last century. When talking about the relationship between psychiatry and philosophy, he claimed that there were many good and pleasant things in life, like chocolate and garlic. But if you put them together you wouldn't necessarily get a nice meal. Sceptics might use this analogy to describe the "alliance" between philosophy and medicine. However, I do not believe that the idea is entirely relevant to our discussion. I think that within the rapid progress of biomedical science, medicine requires philosophy in a broad sense. Therefore, the integration of medical humanities into the curriculum is an absolute necessity in the training of health care professionals.

Prof. Søren Holm
(Institute of Medicine, Law and Bioethics, University of Manchester)

The Trends of Integrating Medical Humanities into Curriculum of Medical Schools in Europe

I started my training to be a medical doctor at the University at Copenhagen and I sincerely believed for at least three months that I should become an orthopedic surgeon. Later I realized that the orthopedic sector was not my thing and that I was much more interested in other things. Later I also trained as a philosopher. I started out with having an interest in medical ethics, but when I started to work in this field, I realized that were are so many things I didn't know about philosophy and which could be very useful to know. So I trained as a philosopher as well. I worked for seven years in Copenhagen in the department of Medical Philosophy and Medical Theory, and then moved to Manchester where I hold the chair of clinical bioethics and I also have a part time appointment as professor of medical ethics at the university of Oslo in Norway. My main interest in this field is medical ethics, but I have also worked on issues of philosophy of medicine and a little with history of medicine. So I have some qualifications to talk about medical humanities, although I think it's a field that attracts people from so many different contexts that is very difficult for any one person to represent the whole field.

What it is medical humanities? This is a very difficult question, because "medical humanities" is really an umbrella term, which covers a number of areas. It encompasses philosophy of medicine, medical ethics, history of medicine, medicine and literature, and medicine and film, and medicine and many others things, but also things like art and medicine. The question there is not what can literature does for medicine, but how you can use arts for medical purposes, for instance, what kind of art you should have in hospitals, which is actually a question, which can and is being researched.

The use of the term medical humanities and the introduction of the topic as one topic is relatively new in Europe, but older in the United States. If you go back and look at the history of medical education in the US you will find that the introduction of medical humanities in the medical curriculum, (things like medicine and literature), actually predates the introduction of medical ethics. Already in the early 1960's and 1970's many American medical schools had

courses in medicine and literature. Now one thing that worries some people in the US and also in Europe is that medical ethics or bioethics is becoming such a large part of the field, that there is a risk that it is crowding out other parts. You can see this in the USA, where there was a number of national bioethics and medical humanities associations, which merged 4 years ago, and there was a long discussion about whether this new organization should just be the American Society for Bioethics or whether it should be, what it eventually became, the American Society for Bioethics and Humanities. Because there were a number of people in history of medicine and in medicine and literature, who were worried about their subject simply disappearing because bioethics, medical ethics was so successful.

Why would we want to introduce medical humanities? Why would we have it on the curriculum in a medical school? Well, first of all, it has a number of broad aims. We know that being a medical student, while it teaches you a lot of things, it does not develop your personality. There are number of studies from the USA and from Europe, which shows that medical school retards the personal and ethical development of students. If you compare them with other university students or the people of the similar age not going to university - the personal development of medical students simply seems to stop and the ethical development also seems to stop. And there are number of explanations which have been given for this. Medical studies are very time consuming and the pressures on medical students to conform to a specific model of study is very great. Last year in Manchester we did a study of what medical students did in their spare time, whatever spare time they have. And that showed that the large majority of medical students at the Manchester medical school do not read books, they do not go to concerts, they do not visit theaters, their only cultural experience is basically going to the movies. That is the only thing that a large proportion of medical students do. Only five percent had been reading books, going to a concert or going to the theater during the last year. So the broad aims of introducing the medical humanities is to do something about this, making sure that medical student also develop personality. Secondly, it is an attempt to influence what is now called the hidden curriculum. That the hidden curriculum is the socializing forces, that you are exposed to through medical school. The things that you learn although they are not on the official curriculum. It is quite clear from the analysis of the hidden curriculum, that medical school reinforces and emphasizes the focus on technical competence and on the attainment of sometimes super human knowledge. And how does it reinforce it. Well, it rewards it. It rewards it by making it what counts for success at exams, what counts for success when you get praise from your professors. Being a nice person or being able to speak to patients or to other healthcare staff is not rewarded in the same way. The introduction of medical humanities in the curriculum is also attempt to influence this hidden curriculum. But medical humanities is not only about sort of some woolly ideas about making medical students better human beings, they also have some very concrete, specific aims. People who are to work as doctors in modern societies have to know and understand some things about ethics, some things about philosophy or science. One example is for instance the reasons behind the move towards evidence-based medicine. Evidence based medicine is believed to be a very good thing, something that we should all have. But it is obviously important for medical students and doctors to know what counts as evidence and why it counts as evidence. Because it is not immediately clear what should count as evidence. And it is

important to have a philosophy of science understanding, to know what the problems are in the way that we generate evidence. For instance, randomized controlled trials, why do we believe those to create good evidence; and are there other questions where you have to have other kinds of evidence. So this specific aim of introducing medical humanities is to give to students the necessary knowledge base and understanding in a range of topics which are important for their further career.

I have been asked to talk about the trends in Europe. I have to paint with a very broad brush, because what happens is different from country to country and it differs even within the same country from medical school to medical school. What are the trends, at this very macro level? The first, and I think strongest trend is that medical ethics teaching, bioethics teaching is being introduced in many, many medical curricula in Europe. It is a development which started in Europe in the 80's and which is still going on. If I look at the country, where I now work, UK, it is now a requirement, that there is teaching in medical ethics and you can see various medical schools recruiting people to teach, establishing centers and this is still an ongoing process. The other trends, I think we can discern is that there is now more careful distinction between medical ethics and what you could call medical deontology. In many medical schools there have been for many years teaching about the rules and etiquette of the good medical doctor, teaching about how you should treat your colleagues without requiring a fee, how you should never tell the patient that your colleague have made a mistake and many other kinds of internal rules of the medical profession. And what we are seeing now is that the kind of teaching which is focused on the relationship between doctors within the profession, is being replaced by a broader conception of medical ethics, where you do not only teach the rules but also teach the justification for the rules, teach the underlying theoretical structure and probably most importantly try to teach the students to think for themselves, because the old medical deontology courses were not based on the idea that it was important for students to think for themselves, what was important for them was to know what to do and keep the rules of the profession. But we have come to realize that that is not enough, we also need to know why you should keep the rules. And one of the reasons is that our societies are changing at the much faster pace than they did previously, and if you are not able to think for yourself you are not able to adapt to the changes in society. Across Europe, across the medical schools, you will also see, that many medical schools introduce some other component of medical humanities. But it differs widely between the different medical schools exactly what component. At the university of Copenhagen when philosophy of medicine and clinical decision-making was introduced, what was introduced was basically a course in medical ethics, in philosophy of medicine and in decision theory. At the university of Manchester what is being introduced is medical ethics, medical law and medical history. At the university of Oslo medical ethics is being introduced and there is also a course in medicine and art, which covers medical literature and medical painting basically. So it differs between medical schools what sort of other things you take in along with medical ethics. I think that in Europe we can also see in a number of places history of medicine now being seen as less important than it was previously. So either compulsory courses are made optional or they totally disappear. Personally I think that is a worrying trend, because if you are to be a reflective medical practitioner, you need to know something about history of medicine, you need to know what the profession has done previously in order to be able to see and analyze

what we are doing today. So from my point of view I think that history of medicine is important as a part of medical humanities, because if we do not understand our past, it's very difficult to understand our present and our future.

What are the future trends? One further trend, I think we can discern is that medical humanities is being recognized as a field where there is a separate competence, that it is actually a field in which you can train, in the UK, for instance, there are number of centers which teach medical ethics at postgraduate level. In Manchester, where I work, we have been running a masters degree in health care ethics and law for at last 15 years. King's College in London has been doing the same. And there are number of other centers running courses in medical ethics, and also broader - in medial humanities. In the US this has been going on for a much longer period. Now people also get doctorates, which are medical humanities doctorates. So we are moving away from an older system where this field was primary taught by doctors, who had a hobby interest in medical humanities, had read some books about it and then taught it. I think the move away from that is a good thing. Primarily it is a good thing, because you will get people teaching it, who has a much broader knowledge of the field and the risk of getting a very narrow approach to the teaching will reduce. People who have this as hobby interest often do not have to time to read broadly in the field and may have a very narrow approach. Finally, I think that it is becoming realized that there is a very large component of hidden curriculum in medicine, that going to medical school is an intensely socializing experience that there are many things you learn, which are not on the curriculum and at least some of these need to be counteracted.

What do you need to have successful integration of medical humanities in the curriculum? I think most important thing is that you have real support from both formal and informal leaders in the medical school. If medical humanities are introduced just because everybody else does it, and we need such a courses, or because it is formally required, then you do not have much of a chance. You obviously also need sufficient time on the curriculum. Someone is likely to ask me, well what is sufficient time, how much is that? And I do not think that we can give a specific number of hours, because it depends very much on the next item on my list, that is, it's not enough to have your own number of hours, you also need integration with other teaching, you need students to see that the surgeons, the psychiatrists, the people who teach research methodology, also take these aspects seriously. And the way to do that is to have teaching, which is integrated as part of the teaching of the actual medical topics, especially in the clinical years.

I think that you probably also need either your own exam or some significant input into a joint exam. And these have to be exams that matter, it has to be possible to fail medical humanities. Why is this? Well, firstly it is because medical students are rational, at least some of the time, and because they are rational, they will prioritize their time. And if you cannot fail medical humanities, they will decide that it is not as important as those topics that you can fail in, and that is perfectly rational. The other thing is that the fact that a topic is examined is also a symbolic mark of it being important. If it is important, it must be examined. And the harder the exam, the longer it is, the more difficult it is, that more important it is. So medical humanities, I think, need to be examined in the same way as any other important topics in the medical school. So if we really believe that it is

important that the doctor knows something about medical ethics or something about the philosophy of science, then these topics should be examined. All of this adds up to medical humanities not being an add on, something you have in some small corners of the curriculum which is detached from the rest. It has to be a part of the medical curriculum at the same level as all other important parts of the curriculum.

When we have introduced it there is also a question of long-term sustainability, what do you need for this to be a success over the long term? When the initial enthusiasm has disappeared and it is just the routine of teaching new students every year. Firstly, as with any other topic we need to have sufficient courses to develop a nucleus or a group of people within your medical school, who has this as a main interest. One thing, which can go wrong, is that there are a number of medical schools in the UK, who have appointed one medical ethicist, who has been placed in various departments (in the department of general practice or in the department of public health), and he is supposed to be responsible for all medical ethics teaching in the whole school. And that usually goes wrong. It goes wrong because that person becomes isolated. First of all, isolated from the field, because there is no one to discuss the research with, and secondly, he may also become isolated within the university. He becomes simple a token ethicist, because you have to have one. So you need a group of people, just like in any other academic fields.

I also think that long-term sustainability is more likely if you have broad based approach, which is not just ethics. At the moment we all think that ethics is terribly important and this is the most important thing in medical humanities for students to learn, but that might not always be the case. Then, again as in all other fields, you also need research to be developed what we are calling the growth layer, you need resources to develop the young medical doctors, young philosophers, the young historians, who are interested in this field in order that there will be people to take over in the next generation.

Finally I think, that for long term sustainability it is also important that the people who are interested have access to the whole community in the field, it is necessary to have access to the journals, it is necessary to be able to go to the European conferences. This is necessary both to be able to build up a network of contacts, but also, I think, to be inspired in your own research work. And I think it is important to realize that medical humanities is not only about teaching, it is also about research, it is about analyzing important issues. And most of us have experienced that being able to go to conferences, to speak to colleagues is very important for your own ideas.

What can go wrong? I have mentioned some things already but I will briefly mention some more. These are not sorted in order of importance, but in the order they came to my mind. First of all, I think what can go wrong, is if you have a too theoretical approach, if you try, for instance, in your ethics teaching to turn your students in to moral philosophers, and if you require them to know the history of moral philosophy in great detail and read Kant in original German or Plato in Greek, I think that is a mistake. You have to engage medical students at the level at which their interest is, and that is the practical level. We do not primarily want them to change profession and become moral philosophers, what we want them to do, is to become reflective medical practitioners. On the

other hand, there is also a problem, if you take a too practical approach. A large part what we want to do is to enable the students to go on to think for themselves and that requires some theory, it requires some explication of, well, how to approach a totally new problem.

Another thing, which can go wrong, is that your approach is to narrow. If you only follow one approach, for instance, to medical ethics and say to the students "this is the only way to do medical ethics". If for instance, as has happened in some UK settings, you only try to teach utilitarianism, you see that as the way to solve all ethical problems, then I think you will also fail in the long term, and you will do your students a great disservice. They need to be thought, that there is more than one way of approaching medical ethics and that people who approach it in another way, than they do, might not all be bad. They might just have another approach.

There are also external problems. First of all, there may be passive or in some cases active resistance from other teachers, who tell the students, that this is not really important, that this is not something they should concentrate on. There may be insufficient support from medical school. And finally I think, one problem that we have seen in a number of places in Europe is that there is insufficient attention to differences between cultures. In some medical schools people are trying to import an approach from somewhere else, from the US for instance. Arguing that this is the way to do medical ethics, because this is the approach they have at some famous place in the US, therefore we should teach in the same way. It is important to realize that our healthcare systems in Europe are very different from the US healthcare system, the way we organize our societies is very different from the way the Americans organize their society. And our values, social values, might also be different. So we cannot necessarily import medical ethics from somewhere else. And that of course is not only true for America; you would have the same problem; if you would try to import our course from Manchester, because there are also large differences between our countries.

What is the best model? Unfortunately, I think nobody knows. Nobody has the perfect model. And one of the reasons is of course that the model you choose have to fit in with the rest of the medical curriculum in your medical school. The model you choose is influenced by simple things like how many students you have to teach to, how many resources you have. One model, which seems to work, is to have some early introductory course, which lays the foundation. The reason that it should be early is that the students can then use what they have learned through the later years. Then you need integration all through the curriculum; you need some medical humanities input ideally in all later years. And it has to be in significant amounts. Giving one lecture, here and there, in the clinical years is not enough. And then I think you also need opportunity for special study, some kind of study for interested students. If your curriculum for instance has a requirement for special study at some point or a research project, there has to be opportunity to do that in medical humanities. So for instance, in Manchester, there are special study modules, and every year we offer topics in the medical humanities for interested students. They have to do a research project option in the fourth year and we offer some research projects every year. So this is a possible model.

One thing you might ask is "can't we just have sort pure integration". We could just integrate this over the whole curriculum, we do not need a special medical humanities course. But that really does not work; the reason why it does not work is that it is difficult for students to see this as a specific area of knowledge. It is the same reason that anatomists are not happy about pure integrations of anatomy or sociologists are not happy about integrating sociology course, because it simply makes the course disappear as an individual topic. So pure integration does not work. Is it then enough if we do have all these wonderful medical humanities courses in our medical schools? The simple answer is no, because when you come out as a young doctor from medical school and have to really work, you experience that there are differences between being a medical student and being a medical doctor. You have different experiences, so we also need medical humanities introduced in specialist training, but that is a topic for another day.

Prof. Zbigniew Szawarski
(Department of Ethics, Warsaw University)

Medical Humanities in Central and Eastern Europe. The Example of Poland

I think I should start from a short introduction about myself. I am a philosopher, professional philosopher, and all my life I teach philosophy and ethics. And the fact that I became a sort of expert in medical ethics and bioethics is quite accidental. During the first part of my life, I was particularly interested in theory of ethics, or – as it is sometimes called – pure, abstract metaethics, almost completely without any contact with reality; sometimes it is called logic of moral thinking or logic of ethics. Then I happened to apply for and receive a British Council fellowship and I found myself in Oxford. It was a very important visit that changed my philosophical orientation dramatically. That was the first time when I saw moral philosophers in action. I mean by that, that I saw how moral philosophers were trying to discuss and solve out particular moral problems. It was my supervisor, professor Richard M. Hare, who turned my interests towards practical ethics, and particularly bioethics. Since then, (1975-76) I have been more and more involved in studying and teaching medical ethics. I had a brief period of teaching medical students philosophy of medicine and medical ethics in Warsaw. It was in the late 80-s. Then I had a longer period of teaching medical ethics and philosophy of medicine to postgraduate students in Britain.

Now I am going to talk about the Polish experience in teaching medical humanities. However I will begin with a sort of introduction to philosophical or ethical thinking in medicine. I would like to show you medical humanities in action, how we think, how we operate and why is it

so important for us to have some training in medical ethics and in philosophy of medicine in general. It is a tradition in Poland that we always try to find a good quotation for the beginning and usually the best source for quotation is antique philosophy. So my first quotation is Hippocrates' short sentence: "Physician, who is a philosopher is equal to demigod". We could argue of course about the proper meaning of that sentence. Does it mean that it is a wonderful to be a philosopher and a physician at the same time, like Søren Holm, Eugenijus Gefenas, Heiner Fangerau or some other of my colleagues? And what sort of philosophy they should know? Is it philosophical logic? Is it philosophy of science? Is it perhaps some metaphysics or theory of knowledge? Whatever it may be it does help to have some philosophical culture.

Then we have another quotation from the ancient philosopher Epicurus: "Vain is the word of a philosopher, which does not heal any suffering of man. For just as there is no profit in medicine if it does not expel the disease of the body, so there is no profit in philosophy either, if it does not expel the suffering of the mind". I accept that practical role of philosophy is a very powerful instrument in dealing with human suffering and anxieties. You might call it psychotherapeutic role of philosophy. There is a very powerful connection between healing powers of medicine and, I would say, healing powers of philosophy.

And let's have the last quotation quite modern, from the former editor of *The Lancet* dr. Theodor Fox. "The patient, - he says, may well be safer with a physician, who is naturally wise rather than one who is artificially learned". I think that is the essence of the problem. I would like to be treated by a wise physician; I would try to avoid the artificially learned. By how am I to recognize a wise physician? What is wisdom in medical profession? I think that this is the place where medical humanities come into medicine. Medicine is first of all a kind of knowledge – it describes and tries to explain what are the causes of disease; it teaches how to treat disease and what to do to avoid them. But a good doctor, as Hippocrates would say, should have not only good brain and excellent memory but also a disposition to good and clear thinking. So he not only needs some knowledge of the facts, he needs some skills of reasoning, he needs some skills of recognizing good evidence in medicine. He should be able to distinguish what information is reliable, and what is not reliable; what is trustworthy, and what is not trustworthy. And of course he needs also some general knowledge about the moral goals of medicine. He must have some idea what is good and what is wrong for the patient as a human person. And now let me try to offer you a more detailed explanation of my thoughts referring to some simple examples.

If you have a patient who complains about sleeping problems, very low activity, lack of motivation, feeling no sense of life etc, probably you will diagnose it as depression, and then you'll consult your memory or look to your books. It is quite possible that you will end with something like this: "If a patient suffers from depression, he should be treated with Prozac (fluoxentine) or lithium, or electric convulsive therapy or with combination of lithium and electric convulsive therapy or maybe some sort of psychotherapy or perhaps he should have some rest". You refer to some general abstract knowledge, which is contained in medical textbooks. For every patient, who has depression, he or she should be treated with x, z, w, d and the doctor must choose the right treatment. That general pattern of the way doctors think, I would call "clinical syllogism" ("If a

patient has a condition p, then he should be treated with q, r or t whatever combination of them. The patient has the condition p. Therefore, the patient X should be treated with q, or r, or t, or whatever combination of them".) So if it is broken bone it should be treated in such and such way; if it is breast cancer it should be treated that way etc. If we are not quite confident in our knowledge and memory, we may look through the most recent professional literature or consult specialists. So you might say, medicine is quite easy, there is no problem there is no problems with philosophy, ethics, etc., etc.

But let's take another case. We have patient who comes and asks for abortion. Well, this unplanned pregnancy was just bad luck, just an accident, so what shall we do? Shall we consider abortion a treatment or not? Of course it might be a sort of treatment, because the doctor is the only professional who has got enough skill and competence to deal with a human body in safe way, that's his specialty, that's his practical knowledge, he knows how to do this, he knows how to terminate pregnancy safely. But we have a legal problem - the abortion might be banned in particular country. So am I going to risk my career, trying to violate the law? Should I follow my conscience and help this poor woman to terminate her pregnancy (even when abortion is banned in my country), because she was raped, because she's got hard condition, because that was just emotion, passion, whatever it was, bad luck in her life and she needs my help. What shall I do? Do we have a book, which would guide your decision in this particular case? Now we have a moral problem and we can check, what is the possible solution of that problem. From the clinical point of view there is no problem, because it is enough to take a proper book in gynecology, to read the particular chapter about different kinds and methods of terminating pregnancy and if both, the doctor and the women agree, that her pregnancy should be terminated, well, that's up to the doctor to choose this or another method and terminate the pregnancy. How about the legal problem? Well, let's see what the law says. In Poland right now we have very strict law. I think that in Europe, only Ireland has a stricter law on abortion. The Polish law permits abortion in three cases only: first, when pregnancy poses a threat to life or health of the women; the second, when prenatal examination or other medical factors point to a high probability of serious and irreversible damage of the fetus or incurable illness threatening the fetus' life; and the third, when there is a justified suspicion that the pregnancy is a result of an illegal act (its usually rape, incest or sexual intercourse with a teenager). So let's assume that we have a case where our patient fulfills one of those conditions, let's say, the first condition. She's got a health problem, which might justify her asking for abortion. Let's see what happens then. It is legal. So we have fulfilled the legal condition, we have a patient with a serious threat to her health and we have to decide, shall we terminate the pregnancy or not. It is a tradition in Poland (and I guess it is in Lithuania) to argue that abortion is always wrong, morally wrong, because when you perform abortion you are killing an innocent human being and killing of an innocent human being is always wrong. Human fetus is an innocent human being so killing of a human fetus is always wrong. If a doctor is a true believer, if he is a catholic, he should refuse to carry out abortion, but it is still legal. A woman has a right to have an abortion, especially if she's got a serious health problem. Let's suppose that our doctor is not that stringent in his beliefs and that he is ready to perform abortion if woman's health is at risk. So we are back with our moral problem and we have the next syllogism:

If pregnancy poses a serious threat to health of a woman, then it is legally permissible to terminate it.

This particular pregnancy poses a serious threat to the health of the women.

Therefore it is legally permissible to terminate this pregnancy.

But what is a "serious" threat? The books are silent about what it is. It is up to the doctor to make the decision. And the decision he or she makes is a moral decision. We can seriously argue that, for example, retina *detachment* is a serious threat to her health, because she may become blind. Is blindness a good reason to terminate abortion or not? If you take two doctors, one may say, "Yes, it is", and another may say, "No, it is not". How about angina - mild angina, moderate angina, severe angina - does it justify aborting the fetus or not? How about kidney failure, or diabetes?

Whatever is your decision, it is a moral decision. And you have to understand the situation of the patient and the meaning of that decision for the patient. You have to choose between the patient's good and the fetus' good. It's a tragic decision. I'm afraid, that our medical students, in my country at least, are not taught to make moral choices. They are simply offered some rules and left alone, without being taught any skills to analyze the case, and to make a good argument and justify the moral decision.

Polish abortion law is quite liberal if we take it literally, but because most of our doctors do not have any guidelines with regard what constitutes a serious threat for health they are very careful not to make any mistake when qualifying the health status of women, and usually err on the side of life. We have about 300 legal abortions per year. If you go to England, they have about 170 000 abortions every year for legally justified reasons. What does it mean? Do they have better doctors? Do they have more ill women? Or perhaps our doctors are too careful not to violate the present law? We have incredible abortion underground. The last figure quoted by the Polish Women Federation mentions from 80 000 up to 200 000 illegal abortion every year.

So let me come back to the clinical syllogism. The major premise of the syllogism is usually value free and contains a general statement of fact about a possible method of treatment. The minor premise is a particular proposition saying that patient K has a condition p. It is the place where moral values enter. She may have a quite mild heart condition but she's got a husband, who is alcoholic, she already has 8 children, and both husband and wife are unemployed. They have particularly difficult situation. Well, in Poland, theoretically we have no right to offer her abortion, because the first clause in our abortion law does not apply to her – her health is not that bad. Yet if you are a good doctor, a wise doctor, your decision may be different. Therefore the medical humanities, as I understand them, are to help us to make a virtuous doctor. They are to teach him some moral wisdom that will help him to make the best possible decision in the interest of the patient. And of cause it's a big problem - can you teach wisdom? How is it possible at all to teach somebody to be wise? But at least you can try to develop moral empathy, moral sensitivity, moral imagination of the doctors, to make them more, I would say, compassionate and understanding; more, I would say, wise.

And now I will go back to Poland. I think we have had three stages in history of our medical humanities. We began to teach medical humanities quite early. The Polish philosophy of medicine had in fact begun in the second part of the XIX century. The first chair of history and philosophy of medicine was established in Krakow, in 1920, with Władysław Szumowski as its head. Practically all main medical schools in Poland before the World War II had a chair of history and philosophy of medicine. The situation changed dramatically with a new system of communism, because all universities were expected to teach Marxist philosophy and social sciences. The same happened in medical schools. Marxist philosophy was a compulsory subject and philosophy and history of medicine disappeared from the curriculum and were replaced by so called "block of ideological subjects" like political economy, political science, sociology and philosophy. Probably you had exactly the same situation here in Vilnius, because the whole idea was "imported" from Moscow. Apart from ideological subjects we had a little bit of so called medical deontology, about 15 hours, which was simply understood as a medical etiquette, professional medical code, and selected legal rules concerning medical profession. Nothing else. So when I replaced the old teacher of Marxism at the medical school of Warsaw in 1986, my first decision was to take those 240 hours allocated to ideology and use it for the philosophy of medicine and ethics. And for several years in the 1980-ties, we used to have 240 hours for teaching philosophy of medicine and ethics. That was the golden age of medical humanities in Poland, I would say. Since then, we are declining and there is almost no place for teaching medical humanities in medical schools. There are many reasons for that. The first is an incredible arrogance of my medical colleagues. They feel experts in medicine, and they transfer their expertise and authority in clinical sciences into ethics and philosophy of medicine. So the chief of the clinic will say, in my clinic you will never do this or that, e.g. "There will be no abortion in my hospital". It's an old tradition. Is it possible to change it? We have no central program of teaching medical humanities. We have no particular policy on teaching medical humanities. There are 11 medical schools in the country and each of them has it own autonomy in deciding what non-medical subject they will put in their curriculum. So there are schools that have 10 hours for medical ethics, and schools that have 15 hours for medical ethics or almost nothing. They are free to choose what they want. We have no national bioethics committee and we won't have it for a long time. The reasons are mostly political, because even medical ethics is a political subject. You may teach ethics in a catholic way, pretending that you know all the possible answers to all the possible questions. And you may teach medical ethics in a more democratic, pluralistic style, assuming that people are different, they have different moral, social, political and religious beliefs.

I am afraid that at present nobody in Poland teaches good philosophy of medicine or methodology of medicine. We have no tradition in analyzing moral cases, and it seems to be common to all Central and Eastern Europe. Our medical students and our doctors want to have simple and clear answers. Yes or no, moral or not moral, white or black. And they refuse to analyze some very difficult cases, where it is possible to argue both ways referring to opposite moral theories. They do not like to make personal decisions and take personal responsibility for their decisions. They simply prefer to follow the law. They try to be more legalistic than they are expected to be. So the situation is not very nice. We do need medical humanities in Poland and we

need it for all sorts of reasons. If we are to join EU, we need to educate people who would be able to work not only in Warsaw, Krakow or Gdansk, but also in Berlin, Copenhagen or Lisbon. They should be open to democracy, pluralism, and all traditional European ideas. We can't close ourselves and try to impose on everyone one moral perspective only. We want to educate wise doctors, because we want to be treated by competent wise doctors. We need medical humanities to forget that old paternalism, when the doctor is the moral judge, he is a semi-god, who knows better what is good for you and he will make you happy, whether you want it or not.

And then the last reason. For almost 40 years our students were exposed to two opposite systems of thought – an idealist catholic philosophy and ethics and materialist Marxist philosophy. Formally these two systems have a common feature - they assume that they know a right answer for any moral problem you could ask. Right now we realize, that there is no moral system that is absolutely true. The question of truth in ethics is very controversial, and we do not have the same sort of evidence in ethics as we have in medicine.

Therefore we have to teach people that so called moral monism (a universal and absolute moral structure) is not the only option in philosophy or in ethics. Another approach, called moral pluralism, is possible. It's a view that there are many different moral values and sometimes those values come into conflict. If you have, e.g. a conflict between life and freedom, sometimes you have to choose life and sometimes you have to choose freedom as the more fundamental value. We should learn how to make that choice. But we cannot be confident at all that it always will be the best possible choice. In life, it is impossible to avoid the risk of making a moral mistake.

Dr. Heiner Fangerau
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Developments of Teaching Medical Humanities in Germany

Dear Ladies and Gentlemen. Thank you very much for your invitation to this workshop. I feel honoured to be given the opportunity to speak to you about my experiences of teaching Medical Humanities in Germany.
While I was a student of medicine, I tried to study history and the theory of theatre as supplementary fields of interest. I realized very soon that the medical studies were very time consuming and interfered with my other interests. Thus, I can from my own experience confirm the words of the previous speaker Professor Holm: Medical students often lack the time for dealing with humanities like history, the theory of theatre, or philosophy. Finally they tend to loose interest. Fortunately, I was given the opportunity to start working at the Department of Medical History at my former university. What has started as an interesting "student's job" prevented me from loosing interest in humanities and made me do my dissertation on the history of medicine in the end. Currently, I am working at the Department of Medical Ethics and History of Medicine of Goettingen University.

Medical humanities in the license regulation

I was asked to illustrate how medical humanities are integrated into the German medical curriculum. It is an interesting moment for explaining to you the "Development of medical humanities in Germany", because the medical curriculum in Germany is currently in the process of changing and the changes include the Medical Humanities: On the 26th of April the German Federal Council ("Bundesrat") passed a new license regulation for the curriculum of medical students ("Approbationsordnung"). Although the details of the new curriculum have not been settled yet, it looks as if there is a chance to strengthen medical humanities within the curriculum. At least the field of medical humanities in the curriculum is broadened. Medical ethics will play a more important role than it is playing now and "theory of medicine" will have to be taught as well. In the following I will concentrate on the status quo before I will give a short insight into the way the new curriculum will affect teaching medical humanities.

In the present situation the only medical humanity integrated in the official curriculum of medical students is the history of medicine. Philosophy of medicine or theory of medicine are basically only being taught in the departments of philosophy at our universities. Medical Ethics can be taught on a voluntary basis but is not part of the official curriculum.

The field history of medicine has a long standing tradition in German medical faculties. The first chair was held by Professor Karl Sudhoff (1853-1938) in Leipzig from 1906 on and since that time the history of medicine used to be institutionalized in more than thirty universities in Germany. Despite of this long tradition, most of the departments of history of medicine are currently renamed into departments of medical ethics and history of medicine or just departments of medical ethics. This movement is due to the growing interest in medical ethics at German medical faculties. However, instead of allowing two different institutions – one for history and one for ethics – the universities try to join the two fields under one roof. The future will show, whether this will finally lead to the disappearance of history of medicine as an independent academic field. In the new license regulation for the medical curriculum "history of medicine" still is mentioned equally entitled with medical ethics and theory of medicine.

The medical curriculum in Germany

The medical curriculum in Germany is based on the so called "Approbationsordnung", which is a license regulation. In the present situation this license regulation foresees that students have to undergo twelve semesters of medical studies. During these twelve semesters they have to pass four centrally organized major state examinations.

- After the first four semesters the students have to undergo what is called "physicum", the preclinical exam. In this exam the students are asked about physics, biology, chemistry, biochemistry, physiology and anatomy.
- After six semesters the students have to pass the first state examination. Here the first clinical fields are involved.
- The second state examination follows after ten semesters basically as a theoretical exam about the clinical fields,
- after two more practical semesters in a hospital the final exam (third state examination) is being held after the twelfth semester.

As we have heard of Prof. Holm and Prof. Szawarski exams are necessary for a field to be taken seriously. Therefore, it is interesting to see whether and how medical humanities are integrated in which of these four exams. However, before the exam there should be some teaching.

Thus, let me explain to you firstly, where teaching medical humanities is integrated into the curriculum.

Integration of Medical Humanities into the Medical Curriculum in Germany

The four exams form the framework for the curriculum. The first experience the students have with the institute teaching medical humanities unfortunately is quite odd: They have to undergo a course in medical terminology. This compulsory course is taught by the institutes for the history of medicine. In former times the knowledge of Latin was a prerequisite for being admitted to medical studies. Since the 1970s this has changed, but according to § 39(2) of the license regulation students have to learn some basics of the Latin language during this course on medical terminology. When this course was invented it was decided that the departments of history of medicine were responsible for teaching this course. On the one hand, we now benefit from this decision in terms of receiving a budget for these courses, on the other hand, teaching this course is not one of the most interesting things one can do. We end up with somebody interested in philosophy, history or ethics talking about the meaning of the suffix "-itis" and the difference between singular and plural.

Between the forth and the sixth semester the students are offered lectures and seminars on history of medicine. Joining these lectures or seminars is not compulsory for the students. Once again I can just confirm and underline another thing professor Holm said before: A course that is not compulsory is not being taken by medical students. Because of their time consuming studies they have to safe their resources for compulsory events. We experience ourselves at the end of the semester giving this most interesting lecture on history of medicine to five or six interested students, while in the compulsory and not so interesting course on medical terminology we talked to more than 70 students. This is bad for us and for the students.

Exams in Medical Humanities

In the existing curriculum the course on terminology and a lecture on history of medicine are the only compulsory "opportunities" for medical students to get in touch with Medical Humanities during their studies. In addition all the students have a written exam in history of medicine during the first state examination and some of the students have oral examinations after the tenth (second state examination) or twelfth (third state examination) semester. (The second and the third state examinations have a written and an oral part. Topics for the oral parts of the examinations are assigned to the students randomly from any field that is included in the whole curriculum been taught. Thus, they may be questioned in the history of medicine).

The first state examination is a multiple choice question exam. 5 out of 290 multiple choice questions are related to the history of medicine. Multiple choice questions may be quite fair in terms of giving all the students the same questions and same chances of passing. However, for testing the knowledge in the field of history of medicine or any other Medical Humanity multiple choice questions are inappropriate. They are an example how, in my opinion, exams on medical humanities should definitely not be performed. Multiple choice questions are a way of examining medical students Lithuanian professionals in the Medical Humanities should - if possible - avoid.

Multiple choice questions

Multiple choice is a system that offers five answers to one question. The student has to find out the right answer out of the five. Even if the student does not know anything about the things

asked in the question he or she has a statistical chance of twenty percent of giving the correct answer.

Five out of 290 questions are dealing with medical history during the examination in question. So, what do you think the clever and rational students do? They do not touch a book in history of medicine. They spend their time on learning other topics that have more questions to pass the exam.

This system has brought to us this caricature of a textbook on history of medicine I hold in my hand. This is a book on the history of medicine which you can buy in Germany. It consists of 78 pages depicting the whole history of medicine from ancient past until today. These pages are followed by about one hundred pages with old multiple choice questions, that had been asked during exams in the last twenty years. The idea is to just repeat the questions until you know them by heart to increase your chance of answering further multiple choice questions on the topic dramatically. I noticed that some of you know the German language. I will hand around the book to you, so that you can have a closer look at the questions and at the textbook.

The history of medicine should have the aim of teaching the cultural and social history of medical thinking, knowledge, science and practice, change of concepts of health and disease and furthermore, ethical aspects of medical practice. The license regulation has converted this aim into a precise subject list of things the students need to know to pass their exams. The subject list can be found at the beginning of the book I just handed around. The questions are based on this subject list and thus, at least, reliable. I would like to give you an example for a multiple choice question in medical history:

The concept of the transmission of diseases by a “contagium vivum” was followed by

1) Arnald de Villanova in the 13th century

2) Girolamo Fracastoro in the 16th century

3) Max von Pettenkofer in the 19th century

4) Robert Koch in the 19th century

A) 1 is correct

B) 3 is correct

C) 1 and 3 are correct

D) 2 and 4 are correct

E) 3 and 4 are correct

Imagine you are a medical student which answer would you choose?

The right answer is D. The propositions 2) and 4) are correct. Just some basic knowledge of the life and works of Robert Koch helps you to increase your chance of finding the right answer to 50%.

An oral exam in my opinion is much more effective in examining medical humanities, but – one must admit – it is much more time consuming.

The new license regulation

In the current license regulation teaching medical ethics is not included. It is a facultative course you can offer anytime during the medical curriculum. Examinations are not foreseen and there is no need for the students to attend these courses.

The need for teaching medical ethics has been realized by the politicians and therefore, in the new curriculum the field "medical ethics" has been included. The universities will have to offer a course or lecture on "medical history, medical ethics and theory of medicine" as an elective course. The idea is that students have to undergo one elective course they can choose from about twelve different topics. "Medical history, medical ethics and theory of medicine" will be one of them.

We do not know yet, whether this is a chance for the medical humanities in the new curriculum or whether this will lead to a further decline of this field. However, the universities will have some freedom in designing their curriculum following the guidelines of the new license regulation. And we hope that many universities see teaching medical humanities as a chance of profiling. Maybe once comprehensive institutes for "Medical history, medical ethics and theory of medicine" will be founded...

We have to face the fact that this vision may remain a utopia. Professor Szawarski stressed an important point mentioning the limited financial resources of the universities: Personnel costs and person hours have to be paid. As the universities have a limited budget, hours for Medical Humanities would have to be taken from other institutes. Of course, no institute will be happy to give away their hours to Medical Humanities. Hence, a stronger standing of the Medical Humanities at our medical faculties is far from realization.

In a newspaper I once found a caricature of an old, retired doctor, sitting in his wheelchair saying: "Now that I am retired I do have time for ethics." We need to overcome this attitude and make the Medical Humanities an integral part of the medical curriculum.

The German philosopher and medical doctor Karl Jaspers warned that medical doctors loose the attitude of being a physician if they only concentrate on the biological aspects of human living. The human being has more to offer than just joints, bones and chemical processes. Medical students should have an insight in the methodology and the way of thinking of the humanities. This might help them to become better physicians from a patient's point of view and not just medical engineers. Teaching Medical Humanities during the medical curriculum will be a step forward in this direction.

The new license regulation may be a chance of improving the standing of Medical Humanities in our faculties. Thereby, we should avoid replacing medical history by medical ethics. All possible Medical Humanities are needed to attract the maximum of students and make them aware of the existence of different styles of thinking. Future physicians need both, biological knowledge and knowledge in the field of Medical Humanities.

Prof. Søren Holm
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Methods of Teaching Medical Humanities in Europe

What I want to say is primarily 3 things. First about how you can integrate medical humanities in a problem based learning curriculum, what the problems are and what the opportunities are. Then I will skip the second part, because we already discussed that, very intensively, that is what the hidden curriculum is, what medical students learn, and I will lastly talk about the my experiences with examination of medicine humanities courses.

In the university of Manchester we have a fully problem based learning curriculum, this means that there are no longer any courses in anatomy, physiology or any other subject during the first 2-3 clinical years. Everything is supposed to be integrated in PBL cases and the students are then supposed to go through the 7 step process, that has already been described by doctor Fangerau. Through this process they identify their own learning objectives and learn what they need to know about anatomy, physiology, biochemistry, medical ethics, and so. So the number of lectures is very low. There are only 4 lectures per week in the first 2 years of the medical curriculum. There are no seminars; there are only the PBL groups and practical courses. In the practical courses you for instance do dissection or learn how to use the computer for statistical analysis. But basically all of the learning is supposed to take place trough the PBL process. Where the students identify problems, based on one case per week, they identify their learning objectives, go out and seek the information they need, learn what they need to learn, come back and discuss in their PBL group. So this has caused a number of problems in trying to rethink how wee can integrate medical humanities in that structure, because all of us, who teach now in Manchester, come from more traditional medical schools, where you establish a course in medical ethics, you have a certain number of small seminar groups; and then you have an exam at the end. And in such a structure, you can discussed with the anatomists, why they should have 279 hours when you can only get 12, but in a fully PB based curriculum, there simply are no courses any longer. It is always open for discussion how many lectures you need to teach ethics and philosophy. But there is a further argument that lectures may not be the best way of teaching this subject, especially if you have many students each year. In Manchester we have 350 students in each year, and lecturing to 350 is not a very good way to teach them ethics. So in this situation, what we have to do is to write the ethical problems, to write the history of medicine into the cases and the tutor notes. If the students are for instance having a case about somebody with some kind of acute illness, you may write something about inform consent or refusal of treatment. The first problem is to identify what are the important areas, and then try to get these important areas within as triggers into the cases and draw attention to them in the notes, that the tutors have. These PBL groups in Manchester only have 8 students in each of them, and you can quickly calculate that that means, that there are more then 40 PBL groups. Each of the groups meets for six hours every week. That simply means that even if we wanted to, we cannot provide tutors for all of these groups, we cannot provide tutors who know something about medical ethics or history of medicine, or any of the other medical humanities for each group. So the second problem we have is that a lot of tutors will know nothing about medical humanities, but they have to pick up

the triggers and they have to explain to the students why they are important and this means that we have to do quite a lot of tutor training, because most of the tutors are basic scientists, they are not medical doctors, they are anatomists or molecular biologists and if they know something about ethics, it is usually because they had compulsory course in laboratory animal science, where there was some ethics component. So we have to educate the tutors, first of all, so that they can turn the student in the right direction. We have to tell them that there is such thing, as consent, how it works, we have to tell them, that the Journal of Medical Ethics, is a good journal, we have to tell them how you can find ethical literature in Medline. So we do quite a lot of tutor training. About half of the hours, that we are paid to do for the medical school, are actually tutor training courses. That is also because every year there will be between 10-20 new tutors coming in to the curriculum.

This of course also makes it very important to have exams. From my point of view, what we want to examine, is basically whether the students can think and reason about these issues. It is nice, if they know, that there has been a philosopher named Kant, who is very important for the Kantian kind of ethics, but it is more important, that they are able to reason about ethical issues. And I think it is also important that they are willing to have some kind of personal commitment to the conclusions they reach. In the department I work in at Manchester and also in Oslo, we among the teachers disagree fundamentally about many issues in medical ethics. In Manchester I work together with professor Harris who is well known as a radical consequentialist. He thinks that cloning is actually a good thing to do, it might be morally obligatory in certain circumstances, that there is nothing wrong with abortion, if you do it before the human individual becomes a person etc.. So our line, and I think it is the right line, is that we are not trying to sell solutions to ethical problems, we are trying to sell reasoning ability, and if the students can reason and then by using the reasoning ability come to a conclusion, I wouldn't come to, that is all right. If their conclusions are well argued it is quite all right, and they should have full marks for this, even if I wouldn't come to that conclusion. And this I think, has implication for what kind of exams you should have, and based on my experience both in Manchester, in Oslo and previously in Copenhagen, there are at least three kinds of exams that works. I am not going to speak about oral exams, because I have never been at a medical school, where we have had enough staff to have oral medical humanities exams with the medical students. We always have to do written exams or as in Manchester, objective structured clinical examinations (OSCE). Objective structured clinical examinations work well. In Manchester, at the end of each clinical semester, you have to go, through an OSCE exam, between 10 and 20 stages. And basically what you do in the OSCE is, that there is certain clinical task that you have to be able to perform, either on a dummy, or on somebody who is acting the patient. So it might for instance be, that you have to perform cardiopulmonary resuscitation on a dummy, or it might be the case, that you have to get the patient's informed consent to a certain intervention, or you have to discuss do not resuscitate orders with somebody acting the patient. And in this form, you can examine whether the students are actually able to perform certain ethically important clinical actions, like getting consent or discussing certain issues with patients. Another form of exam we have experience with, is basically the essay exam, where you give the students questions and ask for their reasoned answers. Or you can have paper based exam, either based on newspaper articles, or based on articles from professional journals, where you ask the students to

analyse the arguments that are put forward, and criticize them. This also works very well. What does not work is multiple-choice exams. There are so few things that you can examine within the fields of medical humanities in that way. You can mainly examine knowledge and in most of the medical humanities fields, it is not primarily knowledge which is important but understanding or ability to reason. And similarly, very short questions, like "define consequentionalism" or similar questions are also problematic. What we want to have is reflecting practitioners and reasoning abilities. Now, the great thing about OSCE is that you can easily integrate medical humanities questions in exams in a whole range of subject in OSCE form. So that you can have part of the exam, which is trying to examine some parts of medical humanities learning. An example could be in psychiatry, where there are very obvious opportunities to examine, for instance, whether students understand, what it is that makes someone have capacity to decide for them selves, or examine issues, around involuntary commitment, or treatment. So in the clinical years, I think, what can easily be done is to integrate medical humanities topics in other exams.

Now, I want to answer some of the other questions, I think I can answer. Yesterday somebody asked about the role of medical law in all of this. And I think that teaching medical law, if a reflective lawyer does it, is a very good thing. Teaching of medical law by physicians, is a bad thing, teaching of medical law by philosophers is conceivable even worse. But why should we teach medical law, why is it sometimes a good thing to teach it together with medical ethics? Well, my reason id that medical students as well as medical doctors, have an extremely naïve understanding of the law. They think that for any legal question there is one right answer. They even think that this answer is simple to find. But that is a misunderstanding. As anybody, who has thought a little bit about it, will know, law requires interpretation. And I think it is very important that the students understand that. And also understand the interrelations between law and ethics. That there are many things that are legal, that are not ethical, and there are also things that there are legally forbidden, but they are still ethical or might be in certain circumstances. So I think it is important that medical law is there and that it is taught by medical layers. Another questions, which were raised yesterday, were whether medical humanities were a basic, a general or a specialist subject. And my answer is that it is a basic subject and it is a specialist subject. It is specialist in the sense, that many of our clinical specialities raise specific medical humanities questions, the most obvious example is psychiatry, which raises a number of questions, not raised in the same form in other specialties. There I think its advantageous that when we teach issues, for instance, of competence or concerns about involuntary treatment in psychiatry, that should be done when the students are taught psychiatry. What we do in Oslo is that we have common seminars with the psychiatrists. That we have two hours seminars, for instance, on involuntary treatment, where one of the professors in psychiatry, a medical lawyer, and a medical ethicist participate. And when we teach resource allocation in our clinical years, we do it together with the nephrologists, and we discuss about allocation of organs and allocation of dialysis. And that is done with the professor of nephrology and often with the patient present as well. And I think, pedagogically, that it works very well, also because, it is symbolic of the fact that these are important issue that clinicians take seriously. So my argument would be that it's a basic subject that you need to have a basic knowledge of. But there are also specialist areas that you have to teach and examine in clinical

years. Finally the question, why should we do this asked by a student, why are we here, why should we teach medical humanities? My answer to this is that first of all, I think the students have a self interested reason because we live in a society, where the prestige of the medical profession is decreasing. It might be decreasing at different rates in different countries, but the doctor can no longer argue for a decision, just on the basis, "because I say so". Even doctors now have to justify their decisions. And one thing, which teaching in medical humanities might learn some people, is how to justify those decisions. I don't think we can expect teaching medical humanities to make all of the student wise. I am quite sure, that some of the students, even if we had hundreds of hours, would never become wise. What I do think is there are certain forms of stupidity and ignorance that can be rectified in certain people. And I think that is sufficient, to make medical humanities an important subject.

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Teaching Medical Humanities – Scope, Methods and Context at Goettingen University

In this talk, we will present aims and methods of teaching medical humanities at the Medical Faculty of the University of Goettingen. A part of the curriculum in medical humanities, particularly history of medicine and medical ethics, is taught at our Department of Medical Ethics and History of Medicine. We intend to give an overview of our teaching activities and an example of our teaching methods. We teach about 250 students every semester. Each semester has 14 weeks. All in all, courses at our department take a minimum of about five hours every week during preclinical and clinical studies.

- We offer a course on Medical Terminology (1 hour per semestrial week).
- We give a lecture on the History of Medicine (2 hours per semestrial week).
- We organize a colloquium on selected issues every semester.
- Each semester we offer a variety of seminars dealing with Medical Ethics or History of Medicine.
- We give a course in Medical Ethics (2 hours per semestrial week).
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Medical Terminology

This course provides an introduction into the "lingua medica", at the same time sensitizing medical students to the relevance of communication skills. It is organised in six blocks centred around: the theory of the medical language (1), the basics of Latin grammar (2), the degrees of Latin adjectives, Greek and Latin colours and numbers (3), regions of the body, anatomical positions and directions (4), Latin and Greek prefixes and suffixes (5), Greek and Latin synonyma (6). At the end of the course the students have to pass a written exam.

Lecture on History of Medicine

This course is designed as a classical series of lectures. In these lectures we try to cover aspects from different periods in the history of medicine. Selected topics of the whole range of periods from ancient medicine to the concepts of modern times are being taught.

Colloquium

Together with the "Academy for Ethics in Medicine" we organise a colloquium on selected issues from the fields of medical ethics and history of medicine. This colloquium is held twice a month every semester. We usually invite foreign experts as speakers. The targeted audience are doctors, patients, students and the interested public. The colloquium is being held at the university hospital to give as many lecturers, clinicians and patients as possible the opportunity to join it as an open critical forum for discussions.

Seminars

The seminars are open to students from any faculty, not just for medical students. Thus, in these seminars we find ourselves confronted with lawyers, philosophers, medical students, theologians, historians and persons from other faculties. Due to this fact the seminars are interdisciplinary by nature. Lively and controversial discussions result from different perceptions of ethical issues.

The topics of our seminars change every semester. Topics during the last semester were: "The Myth of the Medical Profession", "Medicine and Ethics – scope notes", "Euthanasia and Assisted Dying – History of Ethics" and finally "Pregnancy: Modern Metaphors and their Criticism".

Course on Medical Ethics

After the short overview of our teaching activities, we would like to explain the way we perform the course on Medical Ethics in detail. This example will illustrate our methods of teaching medical humanities.

We use a modified version of the method called "Problem Based Learning" (PBL). Problem Based Learning was developed during the 1950s, and the basic idea of this method is to avoid classical ex-cathedra teaching. Students confronted with a problem are asked to find solutions for the problem themselves guided by a teacher.

This is quite an effective method. Just think back to the times when you were at school or maybe at university learning anatomy: When you - for example - asked your tutor about a structure of the brain, what the name of the structure was, and the tutor gave the answer to you, you had forgotten the term after 20 minutes. When you had to search for the answer in an anatomy book comparing the pictures in the book with the original structure, you could remember the name of the structure much longer. It has been found out that people remember only 10% of the things they hear. Of the things they do, see and hear they remember up to 90%.

In Goettingen we have modified the classical Problem Based Learning and adjusted some elements of PBL to the particular needs of medical students.

At the beginning of a lesson small groups are formed with no more than ten students. The students are confronted with an ethical dilemma in medicine, mostly a paper case. A tutor guides the small group through the first six steps of Problem Based Learning. In a seventh step invited experts discuss the cases with the students in a plenary session.

The seven steps

There are seven steps of the classical Problem Based Learning.

1. The first step is dedicated to clarification. After having read the paper case – mostly a summary of a real case – the students have the opportunity to ask questions. Anything that is unclear or that is not understood can be clarified during this step.
2. In the second step we ask the students to define the problems involved in the respective case. The group discusses if there is a dilemma at all and if so in what it consists. For the tutor this can be a very exciting moment, when - after a short period of reflection - the students start to express their ideas and a lively discussion starts.
3. The students' ideas concerning the case are collected during a phase of "brainstorming", which is the third step. Based on their own experience the members of the group collect their knowledge, develop ideas, theories and explanations. We ask the students to write down their ideas on small sheets of paper in order to facilitate the next step.
4. During the fourth step the collected ideas are summarised and structured. This structure helps the students to formulate the goals they want to achieve through discussion and study time. The students realise the knowledge they lack and develop ideas about what would be necessary to know in order to deal with the ethical dilemma in a professional way.
5. The "goals of learning" are fixed in the fifth step. This is an important stage of the educational process because the formulated "goals of learning" are elementary for the motivation of the students to do self studies during the sixth step.
6. Usually the first part of one lesson ends with the definition of "goals of learning". Until the next meeting of the group, the students have to acquire knowledge related to the respective dilemma described in the paper case themselves. In one week's time the students individually or in small teams of two or three try to achieve the goals they have fixed in step five. As material for self studies we hand out notes and scripts. This way the students collect documents and papers during the course that form a small booklet on Medical Ethics at the end of the semester. Furthermore, the students are invited to use our library.
7. A week later, the students come together for the seventh and final step of our course. This step implements the synthesis of knowledge the students have gained in a qualified discussion about the case. The discussion is held in a plenary session. One or two students of each group summarise last week's discussions and after that a dialogue with invited experts begins. Thus, the students can apply their acquired knowledge and learn to put forward their own opinion.

At the end of each lesson the students are given the opportunity to give feedback on the course. They can tell us what they liked, what they disliked, what could be done better and so on. With the help of this instrument we are trying to improve our teaching and to adjust it to the needs of the students.

At the end of each semester the students undergo an oral examination in the form of an Objective Structured Clinical Examination (OSCE).

Our aim is to offer interesting courses on Medical Humanities to make the medical students "look over their cup of tea". There is a great chance for medical humanities not to be seen as "just another course one has to undergo" in the medical curriculum. If Medical Humanities are taught in an interesting way they can be much more: even if students will never work in this field again they may have acquired a different attitude towards their work as physicians. They may have learned how to get important information in a special area of Medical Ethics and may be advanced in the culture of medical reflection. At least they will have undergone a course they will remember.

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EURETHNET – an International Initiative to Improve the Information Infrastructure in Bioethics

One of the most interesting things about medical ethics is that it is an interdisciplinary field and that it stands for a large diversity of opinions. However, this diversity leads to some problems if you are doing research in the field of medical ethics, especially if you are looking for literature. In the international literature you do not just have to deal with a great variety of opinions but also with papers written in different languages. In Europe, this problem becomes obvious. Doing research on a European scale is often complicated by the fact that there are so many different languages.

European biotechnological research

The European Commission wants to foster research on a European scale. With their new framework programme they especially put an emphasis on the creation of a European research area in the field of biotechnology. Being aware of the fact that biotechnological sciences always implicate ethical questions, the European Commission wants to integrate bioethics in their research programmes. Furthermore, they want to encourage a qualified dialogue between researchers and the public on the ethical implications of biotechnological research. This raises two questions:

1) How can researchers, bioethical professionals, decisions makers and the public quickly gather information about the ethical implications of research in the life sciences?
2) How can these groups participate in an educated dialogue on so-called "common fundamental values and ethical principles"?

First of all, to answer the question what European "common fundamental values" in bioethics are you have to come to a dialogue about these values on a European scale. A key to this dialogue is finding international literature on bioethics.

Finding bioethical literature

Searching library catalogues, bibliographies and journals on bioethics is one possibility of finding the required information. Anybody can do that, but still searching libraries causes some

problems. The user has to face the problem that he or she finds him- or herself confronted with a vast amount of unscrutinised literature. The user has to go through every single book to see what it is actually about. Therefore, some national activities have been started to set up databases on bioethics literature in order to make this literature available and easily accessible. There are, for example, initiatives in Germany, England and other European countries, but these remain on a national level.

In order to really investigate European-wide approaches to bioethics, the different European attitudes towards biotechnological progress and the different ethical answers to challenges arising from research in the life sciences have to be taken into consideration. Therefore, searching just one national database is not enough. A researcher would have to use all databases. This can be a time-consuming and complicated process. Furthermore, such a comprehensive search would require the knowledge of many different languages.

Until the end of 2001, BIOETHICSLINE has been a useful tool for European scholars in search for bioethics literature. But in autumn 2001, BIOETHICSLINE was closed down. Luckily, the information it contained will not get lost as it will be integrated into the monographic database LOCATORplus (http://locatorplus.gov) and into PubMed (http://pubmed.gov). Although its coverage is worldwide, most records are from English-language sources, i. e. from US-American or English journals and newspapers. European cultural and philosophical diversity is thus not taken into account. However, the specific nature of European consumer needs and the diversity in European answers to bioethical questions require the pooling of European information resources from as many countries as possible. This will foster pluralism in national as well as global bioethics discourses. For achieving the necessary level of heightened understanding across nations and cultures, it is essential that the maximum number of involved and affected persons and professional organisations in Europe be awarded free and easy access to the knowledge resources in the area of ethics in medicine and biotechnology.

European Information Network Ethics in Medicine and Biotechnology

As a solution to this problem the European Community stated that Europe in large is in need of a more systematic information facility on ethical issues. This information facility should provide access in various languages to information on legislation, codes, best practices and debates taking place in the different European countries. In order to realise such an information facility the European Commission launched some calls to fund projects aiming at creating the required information system.

The result was a proposal to the European Commission by an international fully European consortium to set up an international literature database. This international literature database was to be called European Information Network Ethics in Medicine and Biotechnology (EURETHNET). In the end of 2001, the European Union agreed to fund this project for three years with more than one million €.

Currently, 18 partners from 9 European countries are participating in EURETHNET. The project is co-ordinated by the Department of Medical Ethics and History of Medicine at the University of Göttingen, the coordinator is the head of department Professor Dr. Claudia Wiesemann. The co-ordinating unit is the Academy for Ethics in Medicine. The head of the co-ordinating unit is Dr. Alfred Simon. Dr. Heiner Fangerau holds the position of an administrative officer for this project.

Our aim is to develop a European information network, in other words a knowledge base, in the field of ethics in medicine and biotechnology. EURETHNET will be an information network designed as a virtual unit of different databases, constructed along common database structures that will allow for cross searching and comparative information research.

The underlying idea is that every partner establishes a database with national literature on bioethics. Articles representing the national discourse are abstracted and indexed following controlled terms in English and national key-word lists. This procedure allows the establishment of independent and autonomous national databases. In a second step we are going to link all the databases together to EURETHNET. Via an Internet Portal the joint national databases of EURETHNET will be cross-searchable. For this purpose, the databases will have to be structured along a common framework to allow easy linkage. The aim is to harmonise documentation structures, documentation standards, and documentation procedures. The content of the information will not be affected.

In other words, every centre will have its own database, in its national language with an English translation of the bibliographic information, the abstract (if available), and controlled terms describing the content of respective articles. The common structure will allow linkage. The user will be able to search all the databases as one via the Internet.

EURETHNET is an acronym for "European Information Network Ethics **in Medicine and Biotechnology**". In order to allow users to search either for information on medical ethics (human) or for information on biotechnological ethics (concerning the non-human sector) we are establishing two sub-networks within the network of EURETHNET. The sub-network realising the databases on "human bioethics" is called EUROETHICS, the sub-network working on "non-human bioethics" is called ENDEBIT.

Our project aims at more than just offering literature databases. For this reason our Internet portal is designed to supply additional information on bioethics: We are developing a system to search for institutions and persons dealing with ethics in the life sciences. We intend to make scope notes on selected issues available via the Internet portal. We will create a conference calendar and other information products.

The products we are going to offer will be evaluated regularly to guarantee the most effective user orientation of our services.

EURETHNET's services will be available online for the first time at the end of this year.

At the moment, all of EURETHNET's existing members are from Western Europe. Thus, EURETHNET is not yet a network integrating Europe as a whole. This is why we took the chance to write an extended proposal to include participants from Central and Eastern Europe. New partners will be from Lithuania, Poland, Hungary, Slovenia, the Slovak Republic, the Czech Republic and Bulgaria. The evaluation process for our extended proposal has been finished but contracts have not been signed yet.

Once this network will be accomplished it will be of great value for researchers, journalist, teachers, schoolchildren, medical students and many others. It will be a perfect forum for exchanging information on bioethics to foster a qualified dialogue between all categories of user's. We hope that very soon Eugenijus Gefenas will represent Lithuania in this network.