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Re-thinking degrees in Clinical Ethics (and Law) - a contextual experience

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Author Comments:	Please note hat as instructed I have ticked the conflict of interest box. Trying to access file to make a note that I am the Coordinator of the Masters in Clinical Ethics and Law being discussed. I would not know whether this actually constitutes a conflict of interest in this case.

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Introduction

The teaching of 'Bioethics', 'Clinical Ethics and Law' and similar degrees have for some time now been introduced in many universities. These degrees are directed to various professions including doctors, lawyers, philosophers, theologians and sociologists. Although some of these degrees carry the title of 'Clinical Ethics' they are by and large offering instruction in applied ethics and law. The University of Malta has a similar degree in bioethics being offered through the Faculty of Theology. This degree is directed mostly towards health care ethics. It was felt however that a degree directed to providing skills and training as ethicists was necessary in order to better prepare professionals intending to practice within the hospital/health care setting. This paper is about the introduction of a Masters (MSc) degree in Clinical Ethics and Law by the Bioethics Research Programme (BRP) of the Faculty of Medicine & Surgery of the University of Malta (2013). The Faculty of Theology of the same University had already introduced a Masters (MA) in Bioethics five years early and mostly it addresses health care issues. The reasoning behind the introduction of this new Masters is discussed and in the process the aims and objectives, and indeed the discussion which ensured.

It was asserted that a Masters in Clinical Ethics was needed to:

a. To address the needs of the Medical School and the Hospital (Mater Dei Hospital) which is the main hospital of the island
b. Take a facilitative-learning approach to the teaching of Ethics rather than didactic teaching.
c. To introduce skills necessary for a Clinical Ethics Consultant, or to do Clinical Ethics as a health care profession in one's own work, which include communication skills, conflict resolution, appreciation of local and international law, workings of research ethics committee, clinical governance and medical leadership.
d. To introduce a novel hands-on module of Ethics Wards Rounds which takes place in the hospital wards.
e. To include study of relevant medical subspecialties such as Public Health for those coming from health care fields other than the medical course.

f. Provide training of research methods and training in order to be able to conduct research, both qualitative and quantitative, in the local health care setting.
g. To have the teaching of clinical ethics inclusive within the epistemological practice of medicine, which can therefore be included as part of the history taking and physical examination.

The course therefore had to cater for both training of clinical ethics praxis for a health care professional and for those who wish to pursue a carrier as a Clinical Ethics Consultant (CEC).

This paper explains the rationale behind these points, describes briefly the limitation of the MA in Bioethics of the faculty of Theology, and addresses briefly, without making it the subject and scope of this article, the concept of Clinical Ethics and how it cannot be solely a philosophical discussion, which is addressed by the broader subject of Bioethics itself. The two degrees therefore are complimentary. Whilst in time this was accepted, the problems faced, which temporarily took the form of 'turf battles' at Senate subcommittee level of the University are discussed. The paper also gives a full description of the modules and what changes are planned for the future.

Background

There are two backdrops against all this. The first is that the local general (and main) Hospital does not have a formal Ethics committee and neither does it employ a Clinical Ethicist. Rather there is a Clinical Ethicist at the Medical School who does work within the hospital as an encouragement on how clinical ethics consultation should evolve. However some consultants call other ethicists, which in the context of the Maltese Islands are mostly priests. This is acceptable in a country which has normative values which traditionally have been Catholic. However this raised a second issue: the University of Malta is a Secular University and with time more and more foreign students come from different cultures and denominations. Moreover there are many academics that have reservations that a Faculty of Theology ought to be dominated by a normative approach which is largely Catholic. Many European countries have Catholic Universities; and up to recent times it was still assumed that although secular the University of Malta ought to have a Faculty of theology. In the seventies and eighties a Socialist government removed the faculty, which subsequently was re-introduced by the Christian Democratic nationalist Party when re-elected in 1986. The Faculty of Theology was given spcial privileges and is funded of course by taxes, as is the rest of the University.

The MA degree in Bioethics offered by the Faculty of Theology was conceived as a degree in philosophical thought on ethical issues. It was developed at a time when Bioethics had become important and was indeed timely. However no effort to construe this degree with the Faculty of Medicine & Surgery was made and this of course did create some tension. Nevertheless the BRP collaborated as much as it was allowed to. The MA was open to people from health care, law, philosophy, psychology and other areas. Whilst the degree provides a very good framework for ethical teaching in health care (as it indeed concentrates solely on health care and omits other bioethical topics such as environment ethics, new technologies, etc), the Faculty of Medicine and their resident academic felt that specific needs of the Faculty were not being met. The Resident Academic (at the time an Associate Professor) only contributed to one module on Ethics in Genetics in the MA. Whilst it is not understood whether there were any political connotations to this one understand the efforts of every faculty to impart teaching of fields which are relevant to its area and bioethics has traditionally not only fitted into theological arguments but one can also argue that theology has been a motive force behind the development of the field itself. As we shall see the Faculty of Theology strongly feels that within the University the Faculty of Medicine does not have the remit to teach ethics. This was strongly expressed by the Dean of Theology on a number of occasions and communications, notwithstanding that the Faculty of Medicine had been offering undergraduate courses in the MD course for several years and that it also serviced the teaching of Bioethics and Law in the Faculty of Laws, Ethics and Critical Thinking in the Faculty of Health Sciences, and Ethics in Society and Science in the Faculty of Science, besides other courses in several departments within the university.

In a report to the Faculty of Medicine & Surgery, the Bioethics Research Programme explained why the MA in Bioethics being offered by the Faculty of theology was not addressing the needs of the Medical School or the needs of the Hospital to which it was attached. One needed to address a proper training of Clinical Ethics Consultants which will be able to involve themselves directly in the context of a case and with health care teams, collaborate in developing protocols, encourage and do research into perceptions and what was needed to implement changes in protocol, and indeed have the medical leadership skills in order to manage and motivate political change and shifts in practice. When ethical problems arose consultant physicians would often call an ethicist (either from the faculty of Medicine & Surgery, or he Faculty of Theology – as there was no coherent system) whom they knew and discussed the case with him. As already

mentioned this was considered much of an armchair approach as the consultation was often done by phone and there was no effort to discuss this within the health care team and with the patient and his or her relatives. This of course has its limitations and the consultation remains very theoretical and makes many assumptions (for example it relies on the consultant to know what the patient (or others in the team) thinks and does not address other stakeholders in person). Conversely a clinical ethicist (CE) ought to be able to organise meetings in which the whole team can discuss a case. The CE would need to have skills to consult with stakeholders and patients or relatives, depending on whether policy or cases are being discussed.

In the local context the report states that CECs needed skills beyond an in-depth philosophical discussion of biomedical ethics issues. It was recognised that even internationally HCECs were developing into a profession - the American Society for Bioethics and Humanities' (Clinical Ethics Consultation Affairs Committee, 2010; Tarzian, 2013)) had produced important documents in this regard. The BRP therefore made a recommendation that a degree in Biomedical Ethics should concentrate also on certain core competencies with a thorough understanding of legal issues. These did not necessarily parallel the recommendations of the ASBH due to certain local needs An example is the ability to perform and supervise research and training in medical leadership in order to motivate change at various political levels – such is the local case with improving and harmonising and of life care (EndCare 2016, Abela, Mallia 2016) and in this regard the Ethics Chair of the Royal College of Physicians of London was invited to discuss what went wrong with the Liverpool Care Pathway in the UK (Saunders 2013) in a seminar organised by the BRP. The report noted however that generally there seems to be agreement that CECs need skills beyond a degree in applied philosophy. (This is elaborated in the paragraph on the description of the modules). CECs were also required to teach CE in the medical course and therefore a 'clinical' approach to a consultation rather than a profound discussion of a moral dilemma needed to be imparted in order to help doctors in their training of how to apply ethics.

The Dean recommended that a parallel degree in Clinical Ethics & Law be introduced . The Coordinator of the BRP recommended that first the faculty seeks to ask the Faculty of Theology whether it be ready to tweak its degree to the needs of the Faculty of Medicine & Surgery, or perhaps have two degrees with a common core. As will be seen in the next paragraph this was not successful.

Why 'Clinical Ethics' and not Bioethics?

This paragraph is not intended to argue exhaustively the difference between clinical ethics and bioethics. This would be the scope of another paper. They are certainly not mutually exclusive. However the thought behind the degree is important in imparting the extra skills needed for doing clinical ethics, both as an individual doctor who decides to add to her bag of knowledge and clinical practice and more importantly for those who would wish to work within a health care setting with health professionals, be they health professionals themselves or not. We have seen that the ASBH has produced much work in this regard which was closely studied in the formulation of this degree whilst including also contextual needs. There seems to be an agreement that clinical ethics is not merely bioethics and that there is a method of consultation and praxis (Agich, 2001, 2005).

Three scenarios which helped to prompt the thinking of changing tack in the teaching of clinical ethics are briefly presented. Again, the intention is not to be but to help set the scenario to distinguish the broad term of applied ethics into at least two categories – that of discussing broad ethical issues and that of discussing and practicing in specific clinical case scenarios.

<u>Case 1 – organ donation</u>

This case come from the local ICU in which a husband whose wife has just died agrees to donate her organs. Sometime later he finds out that his two young girls, aged twelve and fourteen do not want this donation to happen. The nurses feel that they are too young to understand. The husband does not know what to decide. He knows his wife would have wished to be an organ donor, and yet he can identify with his children who are perhaps not old enough to understand the importance and altruism of donating organs. This has not remained a bioethical issue. It is about pedagogy, communication, immediate counselling, conflict resolution between any decision the husband makes and the children or hospital team. A decision that may seem objective and obvious to some has suddenly become very subjective and difficult. Bioethics alone cannot help in deciding what ought to be done and perhaps any bioethicist who has never dealt with patients is being presumptuous in assuming he or she can offer a solution. If he or she has no consultation skills as a minimum one cannot presume to discuss this issue with the father or the children. Something more is needed.

Case 2 – Hydration

A second more general scenario found in Malta is understanding why there is a perception that a hydration drip ought to remain attached to a dying patient even if it is thought that it is not accomplishing anything (Mallia 2011). Why is there fear with increasing doses of pain relief or removing other futile treatment? Is this fear to do with non-existing legal frameworks, or with fear of litigation, or indeed of not following (or knowing) ones moral teaching well? A more specific recent scenario was of a consultant Oncologist who sent a dying patient home because of lack of hospital beds. His predicament was an issue of allocation of resources trumping over fidelity to a patient. When doing theory, the answer to these questions may be quite straight forward; in reality clinical decision making brings in many factors which go beyond the law and morality but have to deal with psychological issues of relatives to pressures consultants may have. These doctors are good and compassionate doctors and yet the decision seems cruel.

Case 3 – request for abortion

This third scenario we consider a relatively common occurrence in General Practice in which a young lady comes to the doctor to request an abortion. This case has relevance not so much as to the practice of CEC but in the teaching of applying clinical ethics and in showing that the discussion goes beyond a reflection of abortion and how it is inserted in the epistemological framework of history-taking. Irrespective therefore of whether abortion is legal or not in the country concerned, clinical ethics does not involve discussing the concept of abortion, but rather deals with a case of abortion within an existing legal framework (Stannett 2013). In teaching about approaching the management of such a case, which obviously is value laden with a strong ethical issue, the discussion is not merely about the right to objection of conscience and what to do about it. One does not simply accede or object on moral grounds to a case at hand. Rather, irrespective of one's moral position the doctor must learn to go through a required praxis which are the same irrelevant of the moral position of health care provider or patient. In teaching the clinical ethics approach for an abortion request, morality and praxis require communication and consulting skill that goes beyond mere bioethics. One must still enquire, for example, about the sexual history, whether the patient used contraception, whether she has told anyone else, why she feels that abortion is the right choice and what it is that motivates her, has she considered options, what is her religious background and does she feel that this may affect her future well-

being – can she live with her decision. These are non-directive questions and the woman may be asked to reflect and come back with a decision which has to be respected.

One enters into a true relational clinical encounter that is patient centres, even if abortion is illegal in that country. A consideration of seeing abortion as a right or conversely not wanting to participate is purely doctor-centred and has nothing to do with helping a patient reach a moral choice which is right for her. The moral objection comes at the very end and one may have to follow rules such as referring a patient to a colleague. Helping the patient come to a reflective stage is important as the health care professional may be the first person she has come into contact with.

This 'clinical ethic' approach may indeed be painful to the health professional especially if the encounter brought about a choice with which they are in disagreement. But if the goal is caring for the patient, then we need to accept autonomous choices, finding solace that we have guided into reflection. This also means respecting the law. But one cannot simply dismiss a patient if there is a law prohibiting abortion as the patient may always opt to go abroad. The clinical encounter must provide for the ethical/communicative component; it is facilitative rather than didactic or prescriptive. Clinical ethics therefore departs with existing laws, practices, and normative values. It enters a dialogue through appropriate skills to see that all concerned are clear about the goals, objectives of care (whether cure or care, for example), and make conscious choices guided by a clear understand of moral principles, which hose concerned may not have had occasion to reflect about before that time and indeed in this emotionally charged situation.

Some differences

Whilst at first the difference between Bioethics and Clinical Ethics may seem to have reflected itself only in the titles of degrees (to show that the course is solely about biomedical ethics, for example), certainly the introduction of the word 'clinical', has to do with medical practice of day to day problems. The teaching of 'Bioethics', 'Clinical Ethics and Law' and similar degrees have for some time now been introduced in many universities. These degrees are directed to various professions including doctors, lawyers, philosophers, theologians and sociologists. Although some of these degrees carry the title of 'Clinical Ethics' they are by and large offering instruction

in applied ethics and law. The University of Malta has a similar degree in bioethics being offered through the Faculty of Theology. This degree is directed mostly towards health care ethics. It was felt however that a degree directed to providing skills and training as ethicists was necessary in order to better prepare professionals intending to practice within the hospital/health care setting. This was developed at the Medical School of the same university. This paper describes the reasoning behind this process and indeed gives a short description of each module.

Authors Jonsen, Siegler & Winslade (1982) have come up with the clinical models of CURE, CARE and ACURE, for example, and clinical decision making has come to recognise an ethical component in each and every encounter. The problem therefore is one which requires a scope of imparting skills to the practitioner of clinical ethics. The Mayo Clinic Proceedings examined the case for clinical ethics consultation as a clinical service which is integral to the medical case of patients (Geppert, Shelton 2012). Certainly health professionals and patients may come from the same moral and socio-cultural background and agree on principles and perhaps even religious beliefs, but there is a dimension which ranges from the biological to the psychological and social background of the clinical scenario. Philosophy has not dealt too much with this clinical biopsychosocial model approach which has become very relevant in practice (White 2005) other than merely pointing out its importance.

There have been others who have voiced a concern that the terms 'bioethics' and 'clinical ethics' are used interchangeably. There is a basic difference between the two and those who engage in one field or the other usually come from different backgrounds (Bartlett 2015). Whilst a philosopher not working in hospital but occasionally being consulted on a case or serving on a health ethics committee may feel he or she is doing clinical ethics, in reality he is being analytical and not orientated to cases at hand (Zaner 1996); the ethics consultant should approach the consultation as a form of dialogue and not with an answer ready to a moral problem. To do clinical ethics one needs to *be-with* the patient as well and indeed enter the realm of the biopsychosocial (social including cultural/religious/legal) aspect of the situation. A clinical ethicist does not 'prescribe' what needs to be done, but rather not only tries to discover what ought to be done (as part of a team) but to go beyond and consider options, taking into account other people's values. Whilst it is appreciated that the distinction was very hazy in the few

decades that bioethics has been around, one now notices that the work of bioethicists is often of a prescriptive nature and deals mostly with broad issues.

A clinical ethicist may not waste time dealing with the problem of abortion if that is not legal in the country of concern. Rather she brings her philosophical and skills training in dealing with a situation (Geppert, Shelton 2012); such as arose in Ireland where a woman who was aborting a fetus in a Catholic Hospital was not induced because there was still a fetal heart beat being registered on the cardiotocogram. The lack of a clinical ethicist in this situation led to the wrong clinical judgement on the part of the medical team. It is not that a bioethicist may not have arrived to the same conclusion; rather it is a matter of thinking like a clinician and recognizing the dilemmas and responsibilities they face both legally and morally and helping (them in this case) come to terms with what ought to be done. A simple prescription, even by a professional, may not be enough to alleviate the legal and moral responsibilities involved – at the end of the day the practitioner has to 'dance to the music' and carry the moral and legal responsibility. This element of 'not knowing' was recognised in the training of a clinical ethicist programme done at Cedar-Sinai Medical Centre in Los Angeles (Bartlett 2015).

It takes a considerable amount of understanding, communication, and reaching compromises and resolutions of conflicts and disputes (Zaner 1996); something which neither nurses nor doctors may have the time or training to do. We tend to take this for granted. Therefore, with the increase in clinical ethicists, one should have a training programme which goes beyond simply the biological discussions of controversies. One can say that clinical ethics ought to start where bioethics ends.

The reasoning behind the skills oriented modules

Clinical Ethics consultants have special clinical skills which include the ability to identify and analyse ethical issues, effective communication, facilitation and negotiation skills and the ability to teach others reach ethical conclusions in medical decision making (La Puma, Schiedemayer 1991). In 2007 a study in the US showed that only 41% of those doing ethics consultation had formal supervised training in the area; a number which is preoccupying (Fox, Myers & Pearlman 2007). Ausilio et al report that ethics facilitation requires certain core competencies (Aulisio, Arnold & Youngner 2000), and Agich questions what ethics consultation actually involves (Agich 2001); it is certainly not an armchair business but involves being on the ward and with the team and patient. The Bioethics Research Programme of the Faculty of Medicine and Surgery, whilst appreciating the validity of the degree offered through the Faculty of Theology, felt that a degree must be offered to professionals coming only from the health care professions or at least for those who intend to work in health care. The reasoning was that the phenomenon of dealing with patients is not only a philosophical or legal endeavour. One must deal with human nature and hence clinical ethics requires certain skills which theory alone cannot provide. Students in the degree are also encouraged to move beyond philosophical analysis in their dissertations and study phenomena as described below which show that applied ethics is not straight forward such as the fears of applying morally approved guidelines at end of life.

The task force of the ASBH give a list of the scope of questions arising in Health Care Ethics. These vary from shared decision making with patients to how to deal with 'verbally abusive surgeons'. It also advocates a facilitative approach which explains that the two core tasks of skills are to identify and analyse the nature of the value uncertainty and to facilitate the building of a 'principled ethical resolution'. It clearly states that all parties must be listened to and therefore admits that an 'armchair' approach cannot always resolve questions. Indeed their definition of a Clinical Ethics consultation is 'A set of services provided by an individual or a group in response to questions from patients, families, surrogates, health care professionals, ot other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in patient care'. To this it was felt that local needs had to be addressed. Confronting recurring problems, such as management at the end of life required more than institutional decisions but applying for structural funds (through European Union Projects, for example) in order to study what issues external to the hospital may be producing the problems and how these can be addressed through political pathways.

As discussed above there was no agreement about a common core, although this is now again on the table, and therefore the first intake had intensive modules also on bioethics itself. Clearly the distinction between bioethics and clinical ethics had to be defined in these modules to set the scene for the skills modules. The Clinical Ethics degree was restricted because of the limited targeted audience it was given, the cost (an MSc costs twice the amount of an MA under the Universities' regulations), and the competition that ensued – the theology degree was also promoted in Church services.

During the presentation of the BRP to the FB, it was expressed that it was not enough to know about ordinary or extraordinary treatment, but how to discuss these with patients and relatives and develop an advance care plan is also important in management; again, it was not enough to have a right to a moral objection for abortion, but how ought one to manage a request for an abortion and what questions can or should be asked in order to have a standard of competence of not abandoning a patient. These questions can universal in principle but can be quite contextual in local scenarios.

The description, aims and outcomes of the first intake are described later. In this paragraph a brief rationale is given to follow the thought processes behind the needs assessment. It is appreciated that this is very contextual and that in larger countries, or indeed larger hospital, there may not be a need for some of the modules as experts in the field may be available, such as clinical governance. However it was considered that these modules equip a CE with the necessary skills to manoeuvre beyond a case within the structure of the system. Some recommended changes for the next intake are also discussed.

The first modules therefore had to focus on bioethical issues but had to be imparted in a way to make sense in a clinical situation. It focused on Patient Rights, Reproductive Ethics, Organ transplantation, genomic medicine, and an introduction to end of life issue. Therefore this module was to be less concerned about the moral argument over abortion than about how to manage a request for an abortion within the context of the law. The health professional may be the first person the patient is talking to and one had to have a facilitative patient-centred approach, rather than a directive one imposing values, to help the patient think through the problem: who has she talked to?, what were the circumstances?, why she wished for an abortion?, has she considered alternatives?, what is her social background, including religious? - as these can have future impacts on her decisions, etc.

Two modules were considered of importance to impart a broader philosophical discussion besides the applied situation of a CE. This was mainly due to the importance of the subjects and the lack of an agreed upon common core of the two degrees. Thus a module on Beginning of life and Paediatrics, and another on End of Life, Palliative Care and the Elderly, were considered important contextually as they presented the bulk of ethical issues arising within the local context. This may be revised in the future.

In a Masters in Clinical Ethics and law it is obvious that modules addressing Local, European and International Health legislation is important. This is perhaps self-explanatory. However another module on Human Rights and Medical Ethics was considered more specific to the knowledge of a CE and the aims of this are described below. Moreover it was felt that Anthropological Perspectives on medical practices were an important discussion both in the understanding of the development of ethics and more importantly perhaps in the understanding of development of law. Thus a 'reasonable person standard' can and has anthropologically developed rather differently in different countries (Mallia, 2016; Donovan, 2008).

A number of skills-oriented modules were considered important. It was considered that a knowledge of Clinical Governance is important for CECs in order to assure continuous quality improvement and an understanding of what social, professional and political factors drive governance. A module on Research Methods and Ethics (other than solely research ethics) is an important skill for CECs in order to learn how to gather information and publish papers to produce understanding and hence having an evidence-based tool, besides moral principles, to implementing policy and change. Therefore it as seen that there is no qualm about the theoretical moral approaches to end of life but somehow these were not implemented all the time. Studies showed (Abela, Mallia, 2016) that there is a lack of social understanding of moral issues and health professional moreover felt a lack of a legal framework within which they can work safely. These kind of questions help develop improvement in creating frameworks and pathways for ethical decision making. The module is therefore complementary to the Clinical Governance module.

Another complementary module is Medical Leadership. Leadership is directly related to health outcomes. To implement change one must develop leadership skills. Moreover leadership is also necessary to drive a healthy Ethics Consultation and to participate effectively in a board discussion.

A module on communication skills, conflict resolution was considered important for CECs since they had to learn to listen to all parties, understand the issues, evaluate whether one has a conflict of values or a dispute of management without significant differences in ethical principles etc. In this module Ethics Committees were introduced as often these committees require the same skills for an CEC lest he or she is to take a paternalist role. The CECs participate both at consultation level with particular cases with the patient, and also in committee in which policies are discussed.

A module on Public Health was considered important not only from the perspective of ethical issues such as allocation of resources, but in actually understanding the principles and practice of public health. Professionals not coming from the medical course may not have had proper training in public health and the theory underpinning the topic was considered important for someone who has to negotiate and work with medical, nursing, administrative and policy staff.

The module on ethics ward rounds is an experimental module to give the students hands-on experience. They are required to observe, reflect and perhaps discuss and observe how ethical issues arise and if, when and how they are discussed. The module then has space for reflective feedback and discussion and how what was learnt from other modules such as Clinical governance, Medical Leadership etc could have helped.

The rationale behind the degree is therefore not only to help health professionals have a qualification in CEC in order to improve their own personal skills, but also to develop a method of teaching in medical school which goes beyond ethical reflection.

Aims and objectives of modules

From a glance at the list of modules one immediately notices the lack of focus on philosophy and a strong effort to bring in modules which are relevant to someone practicing within a clinical setting. Conversely certain modules on ethical issues which are deemed to be more relevant on a day to day basis in a hospital setting were given the weight of a whole module. In particular these have to do with the beginning and end of life. The first module on principles and practice deals indeed with other ethical issues and such as organ transplantation. Less relevance is given to topics which may have little impact on the 'life' of a clinical ethicist, such as genetics, and indeed neuroethics, which tend to be more broad in concept other than perhaps

understanding the biology of things like Persistent Vegetative States, as a lot of research is going into this typical field. This module is based on case discussion and people bring cases they typically see on the ward.

It is important to note in this regard that the degree is aimed mostly to health care professionals therefore and is not open to people who do not have a degree in science or a health-related field. Whilst bioethics can accept people from all areas, a key to this degree is to see it as a pathway of specialized training for health care professionals, not only imparting a knowledge-based foundation, but training in a practical setting.

The following are the Modules for each semester:

YEAR 1

Semester 1

Principles and Practice of Clinical Ethics	5 ECTS[1]
Clinical governance in Ethics and leadership	5 ECTS
Introduction to Local, European and International Health Legislation	5 ECTS

Semester 2

Research Methods and Research Ethics	5 ECTS
Medical Leadership	5 ECTS
Public Health: Policy and Allocation of Resources	5 ECTS

YEAR 2

Semester 1

[1] An ECTS is a European Credit Transfer System which follows the Bologna Process for transfer of credits between EU member states universities. A Masters degree will have 90 ECTS credits in Malta.

Beginning of Life and Paediatric Issues	5 ECTS
End of Life, Palliative Care and the Elderly	5 ECTS
History and Anthropology of Ethics and Law	5 ECTS

Semester 2

Human rights and Medical Ethics	5 ECTS
Ethics Committees, Communication and Conflict Resolution	5 ECTS
Ethics Ward Rounds	5 ECTS

YEAR 3

Semesters 1 and 2

Dissertation	30 ECTS
Total	**90 ECTS**

From a glance at the list of modules one notices less focus on philosophy and a strong effort to bring in modules which are relevant to someone practicing within a clinical setting. Conversely certain modules on ethical issues which are deemed to be more relevant on a day to day basis in a hospital setting were given the weight of a whole module. In particular these have to do with the beginning and end of life. The first module on principles and practice deals indeed with other ethical issues and such as organ transplantation. Less relevance is given to topics which may have little impact on the 'life' of a clinical ethicist, such as genetics, and indeed neuroethics, which tend to be more broad in concept other than perhaps understanding the biology of things like Persistent Vegetative States, as a lot of research is going into this typical field. This module is based on case discussion and people bring cases they typically see on the ward.

The Following is a more detailed analysis of each module describing its aims and objectives. For the purpose of this paper the Teaching and Learning Methods, Method of Assessment (usually by assignments), and the Recommended Texts, have been left out. They can be viewed on the

University of Malta Website (Bioethics Research Programme, Faculty of Medicine and Surgery, University of Malta 2013).

Principles and Practice of Clinical Ethics

Description of this Study-unit

This study unit serves as an introduction to the Masters degree giving the student a clear understanding of what is ethics and theories in ethics. It discusses in depth the four principles of biomedical ethics (respect for autonomy, beneficence, nonmaleficence and justice) as applied to clinical situations, plus other European principles such as dignity, integrity and vulnerability. The module also introduces and discusses patients' rights and virtue ethics in practice. Declarations of UNESCO, Council of Europe and others will be discussed.

It then continues to build and apply the basic theory to several fields, including genetics, reproductive medicine, organ transplantation, equity in health care and death and dying. The module also dedicates time to case discussions during each lecture.

Study-unit Aims

- An introduction to ethical theory and practice
- An in-depth analyses of principle of clinical ethics
- An exposition of patients' rights and equity in health care
- Ethical discussion of genomic and reproductive medicine, organ transplantation, and special categories of patients, with a special focus on vulnerable groups
- Death and an introduction to end of life decisions
- Case presentations

The aim of this study unit is to introduce the student to the principles and practice of moral theory in health care giving special attention to the difference and applicability of deontological and utilitarian ethics, within the scope

of the normative values of health care as practiced locally and then, more broadly, within the European Union.

In this regarding the study unit aims to provide an in-depth analysis of the Principles of Respect for Autonomy, Beneficence, Non-maleficence, and Justice and the rules of confidentiality, truth telling, privacy and fidelity. Particular attention is given to the informed consent process in daily practice and in research, with reference also to its applicability in vulnerable groups. Hence an appreciation of understanding, voluntary choices, and competence will be provided.

In addition the unit will provide an introduction to patients' rights, justice in health care, beginning and end of life issues and a discussion of death and dying. Special categories of patients will be discussed, including, but not restricted to, organ donors and recipients, infertility, genetics, etc.

The unit also aims to discuss cases which students will need to bring. Students will be asked to present cases for discussion and assigned to write a report of the group discussion and their personal reflection of the case. Electronic copies will be kept so that they are shared at the end of the unit in order for each participant to have a compendium of cases discussed.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- discuss the ethical principles underpinning clinical ethics,
- demonstrate knowledge about ethical theory.
- explain how virtue ethics can affect clinical outcomes.
- discuss what it means to respect the autonomy of patients.
- explain the nature of clinical ethics in genomic medicine, reproductive medicine, organ transplantation.

- demonstrate knowledge of patient rights
- have a vision of equity and justice in health care.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- identify the ethical issues related to their work.
- analyse ethical issues using appropriate models.
- work as a team in arriving at ethical choices.
- recognise when expert advice or consultancy with ethics committees is necessary.
- justify decisions based on valid ethical arguments.
- consider counter arguments of ethical choices.
- discuss key laws in relation to clinical ethics.

Clinical Governance in Ethics and Leadership

Description of this Study-unit

This study-unit firmly embraces the concept of clinical governance which has become an integral part of the continuous quality improvement agenda in health care. It ensures that clinical governance continues to be the central framework for:

- assuring quality
- minimising risks
- ensuring patient safety
- ensuring public and professional confidence and experiences so that organisations and individuals play a major role and shoulder responsibility to ensure that this happens.

Indicative Content:

- Societal, political and professional drivers for clinical governance
- What is Clinical Governance?
- A guide to clinical governance
- Applying clinical governance in daily practice
- Identifying and exploring the barriers to the implementation of clinical governance
- Ethical implications for clinical governance
- Identifying the impact of clinical governance

- The future implications of clinical governance

Study Unit Aims

This study-unit will be student lead using a combination of lectures, case-studies and discussions. The teaching and learning strategy will provide the students with the opportunity to explore a debate that merits and/or demerits the engagement and application of an integral governance framework to their practice. Case Studies will be used to illustrate how clinical governance fits together.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- Demonstrate a comprehensive and critical understanding of the relevant theoretical and conceptual issues associated with the clinical governance framework.
- Demonstrate a systematic and critical understanding of the different component parts and how these interrelate within the clinical governance framework as applied to practice.
- Understand and discuss clinical governance in relation to medical leadership and clinical ethics.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

Cognitive and Intellectual Skills:

- Be able to Integrate and synthesize the wider societal, political, professional, economical that may influence the utilisation of clinical governance both personally and organisationally.
- Understand the cultural issues relating to clinical goverance
- Be able to integrate clinical governance in medical

leadership and ethics to help implement necessary change.

Practical/Professional qualities and skills:

- Be able to autonomously interpret (student's) own learning requirements relating to their current level of knowledge and practice regarding clinical governance.
- Be able to apply new knowledge and critically evaluate the effectiveness of this interpretation in one's practice at an individual , team and organisational level.

Key transferable skills:

- Be able to communicate and disseminate complex clinical governance information to solve problems in practice.
- Be able to use clinical governance to enhance one's ethical and leadership skills.

Introduction to Local, European and International Health Legislation

Description of this Study-unit

This study unit comprises a series of lectures outlining local, European and International legal instruments that regulate the practice of healthcare professionals and scientific researchers in the fields of biotechnology. The emphasis is on local legislation, examined in the context of legal instruments and ethical guidelines in a global context.

There will be an introduction to the Maltese legislation regulating the health service and the practice of healthcare professions, followed by a series of lectures focused on particular issues of medico-legal importance. Lectures will explain the law with particular prominence to areas impacting on the input of medical professionals, including organ donation, reproductive technology, end of life care, data protection, clinical research, genetics and forensic aspects. There will be a synthesis of legislation that

provides protection of vulnerable groups, namely, children and the physically and mentally disabled as well as legislation to protect society.

Selected case histories will form the basis of two seminars, where students (or a group of students) will discuss cases with a reasoned analysis of the ethico-legal dilemmas and the proposed legal solutions. The case will then be written up and presented as an Assignment, as part of the formal assessment. Students will also be assessed by another Assignment, in the form of a long essay.

Study-unit Aims

This Study Unit presents local and European legislation and policy guidelines impacting directly on the delivery of healthcare by clinical professionals, with a view to highlighting:

- the duties and responsibilities of health care professionals, who aim to practice in accordance with international standards, and
- the role of the state in protecting society, especially the most vulnerable.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- name the laws of Malta applicable to health care;
- name European legislation relevant to ensuring medical practice in Malta functions in accordance with international standards;
- describe the differences between public (criminal) and private (civil) law;
- explain the concept of medical negligence and malpractice with respect to the law of contract and the law of tort;
- discuss the objectives of data protection acts in relation to medicine and medical research; and
- recognise areas of potential ethical dilemmas and the

legal solutions guiding medical practice.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- apply the provisions of local legislation to clinical scenarios;
- question and evaluate how legislation impacts on the practice of healthcare;
- evaluate the practical problems encountered in the application of local legislation to everyday healthcare practice and suggest legal solutions;
- uphold patient rights and the codes of practice of profession;
- effectively contribute advice on the application of legislative instruments, especially when serving on relevant committees;
- assess the impact of differences between local and European legislation in relation to medical practice and research; and
- discriminate between divergent legal solutions employed to maintain professional standards in medical practice.

Research Methods and Ethics

Description of this Study-unit

This study unit will describe the basic elements of research methods in the health field with special interest on those elements which elicit ethical concern.

It will delve into the essentials of epidemiology - as the qualitative form of research in this area, qualitative research, medical statistics and applied research methods to various medical areas, including health policy.

Study-unit Aims

- to provide the essential elements of epidemiology, qualitative research and medical statistics

- to teach students the ethical concerns related to medical research
- to teach students aspects about the planning and implementing of research
- to familiarise students with the process of research ethics applications
- to describe the essentials of an audit and its use of research methods
- to ensure that students are aware of the basics of and ethical concerns related when applying for research grants, including EU grants.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- discuss the importance of research in medicine today.
- describe the history of research, its ethics and its implications on the trust of society.
- distinguish between research methods including qualitative and quantitative analysis and the statistical methods used.
- explain the various phases of research.
- distinguish between a research and an audit
- identify the need to apply for research ethics approval.
- explain the role of the principal investigator.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- apply the EU and local laws relating to research ethics.
- devise a proper informed consent procedure, including the necessary measures for vulnerable / disable groups.
- identify the different needs of special categories of patients such as the quantity of blood to be taken in newborn for research purposes.
- effectively implement and/or evaluate safety

measures needed for research.

- carry out an ethics audit for research.
- write a scientific paper.

Medical Leadership

Description of this Study-unit

Medical Leadership is becoming an increasingly more important and strategic subject to understand and deliver in health care. Evidence clearly shows that leadership is directly related to health outcomes and to the performance of a health care organization and every senior official in health should demonstrate a clear understanding of the principles of medical leadership as well as possess the appropriate leadership skills and knowledge for proper decision taking. Such decisions very often have ethical, moral and legal implications and so this subject is considered integral to this course.

Study-unit Aims

The objective of this study unit is to introduce the students to the principles of medical leadership, it's importance and relevance in health care, the various models pertaining to leadership in health and its linkages to medical ethics and legal issues.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- describe the relevance and importance of leadership in health care and the impact that leadership has on quality and outcomes of health care services
- Analyze the various leadership models as applied to health care
- Differentiate between leadership and management qualities
- discuss the impact that medical leadership has on patient outcomes and experience

2. Skills (including transferable [generic] skills): By the end of the

study-unit the student will be able to:

- Demonstrate the qualities that an effective leader should possess
- Distinguish between various leadership paradigms and it's influences on the decision making process
- Demonstrate the link between effective leadership and successful health outcomes
- Work within teams and create the right teams to achieve good outcomes

Beginning of Life and Paediatric Issues

Description of this Study-unit

This study unit will be divided into two parts, one dealing with beginning of life issues, and the other dealing with the rights of the child in medical care, both before as well as after birth. These will be seen especially in the light of the United Nations Convention on The Rights of the Child which has sanctioned a number of rights which children, defined as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier." Before discussing particular ethical issues in pediatric care, the study unit will set the context for these issues by defining the concept of childhood, evaluating children's rights from a philosophical perspective, and reviewing their psychological capacity to consent. Throughout the unit reference will be made to local and international jurisprudence with respect to the issues under examination. Students will be encouraged to share their own legal and ethical dilemmas.

Study-unit Aims

The study unit aims to explore issues related to the beginning of life, as well as ethical and legal issues related to the care for the child both before as well as after birth. It aims to present these especially with reference to the United Nations Convention on the

Rights of the Child, especially article 12 which sanctions the child's right to participate in decisions which have an effect on the child.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- discuss beginning of life issues using a number of ethical principles.
- explain the arguments which characterize the debate on abortion and embryo experimentation.
- discuss legal issues related to the unborn child (e.g. law of tort)
- describe the sociological construction of childhood
- 3. discuss the major court cases in various jurisdictions related to children's best interests and the possibility of their consent to medical treatment.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- identify the major ethical issues related to the beginning of life.
- analyse and utilize various ethical principles in dilemmas from the beginning of life to the age of majority.
- apply the UN Convention on the Rights of the Child with respect to the pediatric patient.

History and Anthropology of Ethics and Law

Description of Study Unit

T his study unit will first introduce anthropology to students and then narrow the

s ubject down to anthropology of law and include an ethical dimension as well. It will discuss the development of medical law in Malta and the EU and of ethics in general and medical ethics in

particular.

Study-Unit Aims

To introduce anthropology to students, to apply anthropology in a legal setting and to trace the development of ethics and clinical ethics within an anthropology setting.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- understand the concept of anthropology;
- study anthropology from a legal perspective;
- discuss the development of ethics and clinical ethics from an anthropological angle;
- discuss the development of Maltese Law from an anthropological angle

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- write about the study unit of anthropology in general;
- apply the general principles of anthropology to legal studies;
- communicate how ethics and clinical ethics are viewed from an anthropological perspective;
- demonstrate how Maltese law has developed from an anthropological perspective.

End of Life, Palliative Care and the Elderly

Description of this Study-unit

This study unit focusses on ethical and legal issues for the clinician as these often arise:

(a) when decisions to limit treatment have the potential to affect the manner and timing of death,
(b) when treatment decisions will deliberately hasten death, and

(c) when the potential for boundary crossings or multiple relationships exists.

There is a variety of types of law that may impact end-of-life care:

They also need to be aware of their biases and the biases of other health care professionals regarding "appropriate" decisions in various end-of-life situations. Given that there are a number of ways that cultural beliefs can affect end-of-life decision making, it is important to know how these biases may be affecting interactions with patients and loved ones. These biases may also come into play when cultural beliefs can affect end-of-life decision making.

Study-unit Aims

This study unit aims to provide the moral principles underlying end of life care and to apply the communication skills and conflict resolution in situations of disagreement between parties.

The objective of the tutors is to ensure that the candidates make a clear distinction on what is generally held to be morally correct and what is culturally relevant, being sensitive to the latter in order to help come to sound moral conclusions which are legally viable

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- discuss clinical management according to sound moral principles in dealing with end of life decisions.
- describe the moral principles involved in management of pain and the underlying principle of double effect.
- explain the relevance of team work in moral decision at the end of life.
- discuss local and EU legislation at the end of life.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- identify the difference between killing and allowing to die and an appreciation of what does not constitute euthanasia within the clinical scenario.
- analyse the importance of Advance Directives at the end of life.
- describe the importance of communicating with patients and relatives in the management of pain relief and the relevance of involving the whole team including spiritual guidance.
- distinguish between ordinary treatment and extraordinary/disproportio nate treatment, including Artificial Nutrition and Hydration.

Human Rights and Medical Ethics

Description of Study Unit

This study-unit discusses the human rights issues of medical ethics. It focuses on a number of medical subjects which have both a human rights and an ethical dimension.

The aim of the unit is to give a clear understanding and view of the broader issues in medicine which involve clinical ethics decisions. These include treatment of prisoners and their use in research, asylum seekers and how they obtain their health rights, reproductive health especially in ethnic communities whose values may differ from that of the host country, vulnerable groups such as the elderly, children, orphanages, mental institutions, and the doctor's role in places where capital or corporal punishment occurs.

Study Unit-Aims

This study unit aims to teach how medical subjects have a legal implication thereto and how the law plays a vital role in medicine. The topics which will be discussed in this study-unit relate to matters such as the law on torture, cruelty and degrading treatment, trade in human organs, research and experimentation on human beings, capital and corporal punishment; the role of a prison doctor and a

forensic doctor; doctors and asylum seekers, etc.

The aims is to discuss at length these topics and how they can be tackled when encountered. Also an understanding and review of various position papers such as the EU legislation and the position of the World Health Organisation and the British Medical Association on such issues.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- describe human rights in relation to health care in general.
- discuss the rights of prisoners, armed forces and other groups where health care principles may vary.
- explain human rights for various vulnerable groups including elderly, children, asylum seekers and disaster situations.
- identify the differences of interpretation between various countries of reproductive rights and other rights such as physician assisted suicide.
- Know the various vulnerable groups which may exist in a country, with special attention to European States, and how one can move ethically and legally.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- apply patient rights both within the normal health care setting and be versant in informed consent in vulnerable groups.
- apply patient rights in medical and pharmaceutical research and be versant with codes of practice.
- work with patient organisations.
- explain how health care systems act responsibly in

the application of patient rights.

- How to handle specific cultural requests, such as infibulation following delivery.
-

Ethics Committees, Communication and Conflict Resolution

Description of this Study-unit

The unit describes the structure and function of Health Ethics Committees within a hospital or public health setting. Ethics situations often involve conflict of values and ideas and therefore training on communication skills and conflict resolution is imparted describing the difference of conflicts and disputes and the importance of reaching common ground based on agreed principles. Principles of good practice are also an essential component of professional behaviour.

Study-unit Aims

- Health Ethics Committees: structure and function
- Learning how to communicate effectively with health professionals, lawyers, statutory and non-statutory organisations, and with patients and their significant others.
- Learning the principles of good practice
- Explaining to the stakeholders concerned the ethical issues involved in particular situations.
- Conflict resolution and liaison between staff and patients and helping them to find common moral ground agreed upon principles.

The aim of this unit is to understand the nature of Health Ethics Committees and their structure and function; learning how to communicate effectively with health professionals, lawyers, statutory and non-statutoruy organisations, and with patients and their significant others.

Moreover one should be able to describe the principles of good

clinical practice with regard to research and to relate to the relevant local and EU legislation in this regard, with view also to explaining to the stakeholders concerned the ethical issues involved in particular situations.

The unit also aims to provide teaching in Conflict Resolution in order to be able to liaise between staff and patients and help them to find common moral ground agreed upon principles.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- describe the nature and work of Hospital and Health Ethics Committee
- describe the nature and work of Research ethics committees including special terminology and competing interests of stakeholders.
- identify when Health Ethics Committees should be consulted and their role in hospital management of difficult cases and the setting of protocols.
- explain the composition of the committee and the roles of each member
- describe the principles of good practice as identified by health professional councils
- describe the principles of interpersonal communication
- describe the principles of teamwork and group dynamics

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- contribute effectively on Hospital and Health Ethics Committee
- set up and help in the running or chairing of HECs
- explain the importance of evaluating research proposals and the relevant

local and EU laws and directives in this regard.

- obtain/evaluate a proper informed consent process for research.
- advise on principles of good practice
- practice the principles of interpersonal communication
- practice the principles of teamwork and group dynamics
- 8. practice the skills of effective communication, including the provision of empathy, feedback and assertiveness when required
- practice the skills of effective teamwork and conflict management
- practice the skills of self reflection and reflection on what is occurring in the environment around oneself, leading to ongoing professional growth

Ethics Ward Rounds

Description of this Study-unit

This unit aims to develop the skills of the student to identify ethical issues in cases on the wards. These ethical issues are then discussed in class and the students must keep a log book of all the cases he or she encounters in the time allocated. Whilst some special cases may be identified by the coordinator through contacts with consultants, the candidates attend normal ward rounds and out patients identifying and discussing the ethical issues, if any, of each case.

A biopsychosocial approach is encouraged as ethical issues in many clinical scenarios are not related directly to the pathology but to the psychological and social issues surrounding the disease.

Students will be expected to bring in their work experience. In addition they will be assigned for 30hours in hospital in one of the clinical specialties, for supervised clinical training.

Study-unit Aims

The aim of the unit is to move from the theoretical discussion of cases to real-life situations in which the student is put within the realm of medical teams and their practical daily life, and the patient and his or her family. It is important that the student gain a knowledge beyond philosophical reflection but situational and contextual. Real-life everyday ethics can range from minor issues such as understanding refusal of treatment (and going beyond rights) to end-of-life or beginning-of-life scenarios.

The objective of this study unit is that the student will be taught how to get a "clinical/ethical eye" and identify the ethical issues in each clinical encounter.

A seminar will be held to discuss some of these cases.

Learning Outcomes

1. Knowledge & Understanding: By the end of the study-unit the student will be able to:

- assess different case scenarios
- to apply the communication and conflict resolution skills to select clinical scenarios
- to learn how to find the ethical component in all clinical encounters.
- to engage in dialogue with the medical and nursing teams to discuss ethical resolution

A clear understanding of clinical ethics and law, how ethics committees work, and in-depth knowledge of moral issues related to health care.

Skills in communication, conflict resolution and participating in discussions through dialogue, and the relevance of this for good clinical/ethical practice.

- To handle, with the collaboration of superiors on the ward or the place or

work, clinical scenarios which present with a difficult ethical situations, conflicts and dilemmas, and indeed to identify (and have a 'clinical eye' for) ethical issues which may not be relevant to others.

- To take a proper history of cases, including the medical situation, the psychosocial situation and involvement of other members of the team and the relatives of the patient (and the patient themselves) and show a complete appraisal, understanding and evaluation with proper application of ethical theory and understanding of relevant laws and cultural/normative values, giving possible solutions using appropriate communication and conflict resolution skills whilst showing appropriate medical leadership.

2. Skills (including transferable [generic] skills): By the end of the study-unit the student will be able to:

- to identify potential or actual ethical issues.
- to develop the skills to discuss ethical aspects of cases
- to bring forward such cases for discussion within the medical team
- to initiate a dialogue with the patient and relative

The Dissertation is required not to be a philosophical discussion of an issue but a qualitative or quantitative study of a particular issue (such as the attitudes of doctors and nurses towards removing futile treatment at the end of life) and discussing the relevance of these findings. Whilst a philosophical reflection and literature review remains essential, these studies can provide the necessary evidence to move change and practice and promote policy, which is where indeed medical leadership skills come into practice.

The external reviewers of the Masters degree were very supportive from the beginning, recognising the importance of the niche it was trying to establish and indeed the need for advancement of bioethics into re-defining this new field.

The internal political debate

Whilst a generally good collaborative effort had always been kept open between the two faculties, the faculty of Medicine felt that the Masters turned out to be one-sided, with the Faculty of Medicine inviting academics from Theology to participate in its lectures, seminars, conferences, and to have a member in its own Bioethics Research Programme and indeed in helping to devise the mission statement of the same programme so that the Faculty of Theology did not feel that Bioethics was being taken over. Indeed it was the Dean of Theology who insisted on introducing the term 'Research' into the original title of 'Bioethics Programme'. Many in the Faculty of Medicine however felt that these efforts were not reciprocated and were also concerned that Theology should be the motive force behind a field which was directly related to medicine. Collaboration with the Faculty of Laws and the Faculty of Health Sciences were more productive and in the conceiving of this degree it was thought that it could be an opportunity invite the Faculty of Theology in order to make the degrees complimentary.

There was no general agreement at first from the faculty of Theology, which, perhaps rightly so, felt threatened that their own degree would be compromised. The main arguments was that there was a lot of overlap, that their students may be put in a discriminatory position from the students of the Degree in Clinical Ethics and Law being proposed, and that the Faculty of Medicine has no remit in teaching ethics, whilst it had invited into its own degree people from the Faculty of Medicine it lecture in its degree in Bioethics. The Senate subcommittee had to ponder about the two degrees doubling efforts with the same goals in mind.

Of course the Masters in Clinical Ethics and Law was targeting a different cohort of students, namely the younger ones who intended to use their degree in their profession and carrier choice. Experience had shown that those in the Masters of Bioethics were coming from different field and the average age was indeed much higher. It was a difficult but in reality true issue to

face that younger people may not have wanted a degree from the Faculty of Theology, although this in no way reduces the value of that degree itself. Nevertheless one could expect an overlap.

Rather the contention was about skills. The Dean of Theology, in a note to the Pro Rector for Academic Affairs stated that 'the formation of ethical skills...is only possible through ethical reflection and interaction with the particular situations that arise in the practice of any profession'. This is where the Faculty of Medicine begged to disagree as it saw the skills necessary for people actually training to become clinical ethicists as needing to learn skills beyond ethical reflection as described above. There was a proposal by the Faculty of Medicine that the two degrees may have a common core of the philosophical areas. Till now this has not been put in place but a discussion ensued in Senate about the possibility of having shared degrees between faculties. However the objectives of the two degrees were accepted to be rather different and finally the Academic Programmes Quality and Resources Unit (apcru) of the university voted unanimously in favour of this new degree. With regard to the contention whether the Faculty of Medicine had it within its remit to impart degrees in ethics the argument that once it already had modules in place at undergraduate level, and that Faculty members were already contributing to the Bioethics degree to a small extent, and more importantly, once internationally many medical school have degrees in Ethics and Law themselves, then it could not be considered inappropriate that the faculty does ot have the remit to teach ethics of its own profession.

It was however clearly pointed out that one should not make comparisons with international degrees with the same name of Clinical Ethics and Law, whose focus, be they from Faculties of Law or Medicine were mostly legal or applied philosophy. Rather the focus was to be on peripheral skills necessary to do clinical ethics as well s a clear understanding of the law. It was not a degree in which applied philosophy was being debated, but rather a hands-on approach.

In the end it was decided that the degrees open on alternate years and the fact that the Masters in Bioethics remained popular amongst the same age group has shown that the niches they target are different.

The Aftermath

The debate between the two faculties continued on a healthy level. The original proposal of collaborating in a common degree between the two faculties was accepted in principle by the Faculty of Theology, but it was also recognised that the degree in Clinical Ethics and Law was significantly different. On the other hand the first round of the Masters in Clinical Ethics and Law prompted its board of studies to audit and have quality control. It was observed that the modules on the Beginning of Life and that of the End of Life can be merged in order to introduce another module on critical thinking which is given in the Masters degree of nursing by the Faculty of Health Sciences and who a ready to service the Faculty of medicine and Surgery in this regard. This module prompts students to bring problems and cases from their own work and to reflect upon it within the group in a facilitative environment. They are made to brain-storm and consider options and what can be done to solve the moral problem. This course is imparted by the Coordinator of the BRP and he had noticed the value of this kind of reflection. To mention but one problem, in the labour ward babies born after 22 weeks are considered legally live birth; but protocol dictates that resuscitation should only be attempted after 24 weeks. This caused great concern for the nurses involved and they were made to reflect on why this is so and what can actually be done. What may seem as morally illicit, may upon reflection, either find a better solution, or indeed the helplessness of the situation and the correctness of the protocols may surface.

Conclusion

In conclusion, Clinical Ethics is emerging not only as a subcategory of the broader field of Bioethics, or Bioethics and Law, but as a field which requires a set of skills and knowledge not usually thought in Bioethics courses. To be effective as a professional carrier a clinical ethicist must develop the communication skills and necessary knowledge of governance and public policy which go beyond the philosophical realm. Whilst ethicists can certainly provide sound ethical advice, working on daily ward rounds and helping to change hospital policy may require a more focussed approach. It is with this philosophy that this degree was implemented.

There is of course the possibility of universities having both types of degrees – one in a broadly philosophical realm and one oriented towards those who intend to work as clinical ethicists. Another option is for degrees to take into consideration not merely academic nature of this area of 'applied' ethics but introduce immediately its application within the context of the ward. As in Medicine, to re-quote Osler, to study medicine (or anything clinical, for that matter) without patients is like not going to sea at all: *"To study medicine without books is to go to sea without a map;* t*o study medicine without patients is not to go to sea at all".*

Acknowledgements

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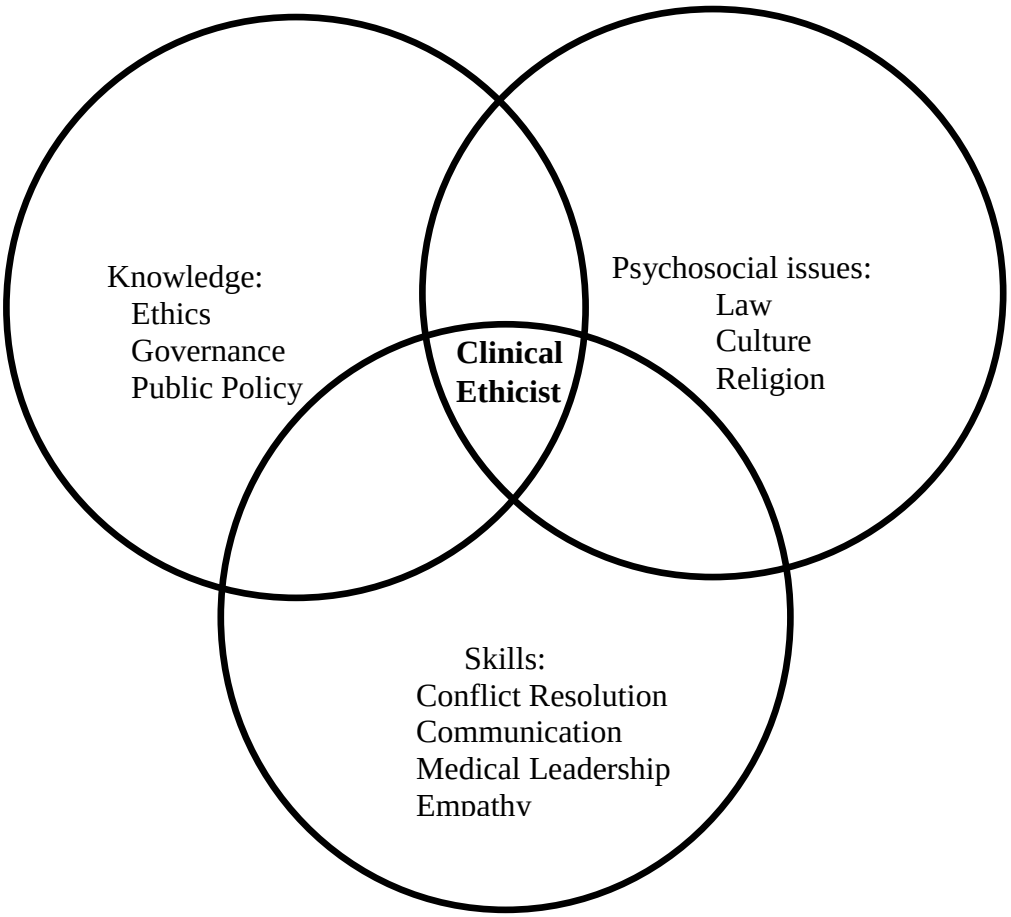
Figure 1

Scope of Clinical Ethics beyond moral discourse and analysis: three main areas of overlap.



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Report to reviewers:

I thank the reviewers for their insightful criticism of the paper and I am sure that with the revisions suggested it has improved considerably and even made it more focussed on the proposed degree in discussion. I apologise for not being able to revise the paper earlier and had informed the editor that I am involved in coordinating a project. The editor was happy to receive the revision when I informed him so recently. I thank the reviewers for their understanding and patience.

Reviewer 1.

I thank this reviewer for pointing out that the paper seemed to be focussed on two issues – that of a discussion of the difference between clinical ethics and bioethics and that of the contextual devising of the Masters in Clinical Ethics and Law. Major revisions were suggested. Indeed I have almost re-written a lot of the text to make it more focussed on our perspective of why we should have a degree complimentary to the existing one in Bioethics but which focuses on skills needed by CEC and those wishing to study CE in order to better their skills in dealing with them. Although not the aim of the paper I still kept some of the discussion of the differences involved but only in the context of showing the reasoning behind this degree and that indeed it is not altogether a completely novel idea (although it is the first degree that I know of which focuses on skills and ancillary subjects as well to equip health professionals or those intending to work in the health sector with tools complimentary to sound moral reasoning.

The article become a little longer but this is mainly due to the fact that I retained the table describing the modules – however as this reviewer suggested I felt compelled to explain the modules in the text. Should the reviewer/editor require me to shorten the table it would be possible but may remove some important detail.

Reviewer 2.

Again I thank this reviewer for the sightful comments on the text. Some of the paragraphs have been removed/replaced. In particular I did clarify that clinical ethics and bioethics are not infact mutually exclusive as was suggested.

I trust the article is in a better position to reflect the objective – that of presenting the new Masters degree. Indeed a deeper discussion of the differences and additions which CEC need may be the subject of another paper.