Healthcare Ethics Education in the UK

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Introduction

Both authors of this chapter had the great privilege of working with Alastair Campbell throughout his stay in Bristol. It is, therefore, fitting that we begin by paying tribute to his outstanding contribution to Healthcare Ethics Education in our city and beyond in his almost 10 years in the University of Bristol. Alastair came to Bristol from the University of Otago, Dunedin in April 1996, as foundation Professor of Ethics in Medicine in the Department of Clinical Medicine and Director of the newly established Centre for Ethics in Medicine in the University of Bristol, the first in the UK to be nested within an acute Department of Clinical Medicine. In the all-too-short time until his first retirement in 2003, Alastair made a huge impact locally and nationally, while his international reputation went from strength to strength

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Healthcare ethics is, by definition, multi-disciplinary and multi-professional and medical ethics is a significant component of it. In *Medical Ethics Today* (Brannan *et al* 2012: 737) the British Medical Association (BMA) emphasises 'that the aim of medical education is to provide doctors with the knowledge and skills needed to practise medicine within an ethical and legal framework'. Given that 'doctors are confronted by ethical issues every day of their working lives -- the medical training they receive must equip them with the skills and confidence needed to deal with these situations in an appropriate manner' (Brannan *et al* 2012: 739]. This applies to education and practice in all healthcare professions.

Ethics and Medical Education: The development of ethics in medicine and its place in medical education in the UK has been well documented and much of it has been embraced by other healthcare disciplines.

The Hippocratic Oath (*c.*400 BC) has been adopted and adapted as a guide to conduct by the medical profession throughout the ages. It also dictated the obligations of the physician to students of medicine and the duties of pupils to their teacher (The Editors

of Encyclopædia Britannica, 2017). Major contributions also came from those such as Ibn Sina (Avicenna) and Maimonides in the 10th and 12th centuries respectively. Thomas Percival (1740-1804), a physician in Manchester (now Royal) Infirmary, published the first modern code of ethics entitled 'Medical Jurisprudence or a Code of Ethics and Institutes adapted to the Professions of Physic and Surgery' in 1794 following a major dispute among surgeons. In it the terms Medical and Professional Ethics were first used. An expanded version of this code, the first in the world, was initially published in 1803 (Percival, 1987) which, in 1847, became the foundation of the first Code of Ethics of the American Medical Association. Regrettably, save for in his own hospital, it was ignored by the medical profession in the UK

Over 170 years after Percival published his code, Pless (1967: 291) found that there was no formal teaching on moral problems in UK medical schools and discussions on ward rounds were very limited. As Calman states, in his experience in the 1960s, 'there was very little medical ethics in the curriculum and what there was could be best described as the rules of etiquette for doctors' (Reynolds and Tansey, 2007: xxi). A General Medical Council (GMC) survey of medical education in the UK and Ireland in 1975-6 still found opposition to the formal inclusion of medical ethics in the curriculum; of the 34 schools that responded, nine had no plans to do so and four still believed strongly that it would be 'wrong to attempt any formal teaching since ethics is not a subject and cannot be taught by definition' (Nuffield Trust, 1977: 582-3). One respondent felt it to be quite clear that a good clinical teacher would be constantly discussing ethical problems and thus saw 'no point whatever in having it as a separate subject in an already overcrowded curriculum' (Nuffield Trust 1977: 584). The same survey found that 25 of the responding schools now included ethics formally in the curriculum (Nuffield Trust, 1977: 582). The way in which ethics was gradually included in the education of medical and other healthcare students has been the subject of several comprehensive reviews (Boyd, 1987: Reynolds and Tansey, 2007: Shotter *et al,* 2013: Stirrat, 2015).

The main impetus for deeper consideration of difficult questions in medical ethics and law came from junior doctors and medical students. The way in which their energy was channelled and brought to fruition through the London Medical Group (LMG) and its successor the Society for the Study of Medical Ethics (SSME), which, in 1984,

became the Institute of Medical Ethics (IME), has been well told elsewhere (Barr, 2003; Reynolds and Tansey, 2007: Shotter *et al,* 2013: Stirrat, 2015)..

In 1984 the IME convened a working party to review current practice in teaching medical ethics in UK medical schools that was published as the highly influential Pond Report (Boyd, 1987). Among its foundational proposals were that medical ethics should be taught at regular intervals throughout the medical course: clinical teaching of ethics should normally begin from clinical examples and small group discussion should be emphasized: interested medical teachers should be encouraged and assisted to undertake further study: multidisciplinary ethics teaching should be encouraged: care should be taken to ensure that teaching was not undertaken by those who held particular views or promoted a personal agenda: examinations and other assessments should have an ethics component: and elective courses should be arranged for interested students. Recognising that students also needed a reasonable understanding of medical law, in 1998 the IME produced a consensus statement on teaching medical ethics and law within medical education intended to be a model for the UK core curriculum (Consensus Group of Teachers of Medical Ethics and Law in UK Medical Schools, 1998). Eight years later a report commissioned by the IME found that, although medical ethics and law were represented in the curricula of the 22 of the then 28 UK medical schools that responded, significant concerns remained about the status, content, delivery and assessment of the teaching of ethics and law (Mattick and Bligh, 2006) The consensus statement was updated in 2010 to provide a learning outcome based indicative core content of learning for medical ethics and law in UK medical schools that was consistent with the GMC's up to date guidance on undergraduate education. (Stirrat *et al,* 2010) The IME is currently undertaking a further comprehensive review of this core content of learning and its assessment that will be found at *www.instituteofmedicalethics.org/.*

Since the GMC's 1975-6 survey of medical education in the British Isles (Nuffield Trust, 1977), it has become more pro-active in its emphasis on medical ethics and law as it holds medical schools responsible for standards in medical education. Between 1993 and 2016 these were set down in *Tomorrow's Doctors* (GMC, 2009), all the outcomes of which the graduates of each medical school were required to achieve. This has been superseded by *Promoting excellence: standards for medical education and training* (GMC, 2015). The GMC has long stipulated that the graduate must be

able to behave according to ethical and legal principles and know about and keep to the GMC's ethical guidance and standards.

Ethics and Nursing Education: The evolution of nursing ethics (and indeed ethical frameworks within other professions) owes much to the foundations laid down by the medical profession. Nursing ethics is 'the examination of all kinds of bioethical issues from the perspective of nursing theory and practice which in turn, rest on the agreed core concepts of nursing, namely: person, culture, care, health, healing, environment and nursing itself' (Johnstone, 2004: p14). It provides a very practical approach to clinical dilemmas and focuses upon the patient as a whole, taking into consideration relationships and environment. It encompasses the caring rather than the curing of the patient (Storch, 2009). Nursing has always encouraged autonomous and collaborative care of both individual patients and their families and the communities they live in (Fowler, 2017) and this ethos is strongly reflected within the teaching of nursing ethics.

Nursing ethics takes advantage of the particularly close and continuing contact with patients and, whilst the medical profession is often deemed to have the last word in ethical dilemmas, nurses often act as advocates to protect the patients' autonomy, rights and freedom (Melia, 1994). This advocacy is complementary rather than adversarial thus promoting an inter-professional approach to ethical debate.

Ethics and Dental Education: Patrick (2016) noted that ethics and professionalism had formed part of the dental curriculum for the previous thirty-five years, and that the General Dental Council (GDC) requires that they be included in the UK dental curriculum.

The Role of Statutory and Other Bodies in Healthcare Ethics Education

There are 12 statutory Health and Social Care Regulators in the UK responsible for the regulation of individual practitioners across these sectors. Their regulatory role encompasses education at all levels. Among these are the **General Medical Council** (GMC -www.gmc-uk.org/); the **Nursing and Midwifery Council** (NMC - www.nmc.org.uk); the **General Dental Council** (GDC - www.gdc-uk.org); and the **Health and Care Professions Council (**HCPC - www.hcpc-uk.co.uk) that currently regulates a wide range of allied professions.

The **British Medical Association** (BMA - www.bma.org.uk) is the trade union and professional body for doctors in the UK. It owns the *BMJ* that, in turn, co-owns the *Journal of Medical Ethics* with the IME. Among the roles of its Medical Ethics Department are to promote good practice and knowledge and understanding of medical ethics and provide advice to members on general or specific ethical issues. It also supports the Medical Ethics Committee that publishes *Medical Ethics Today*, which includes detailed recommendations for undergraduate medical education and educational goals for teaching ethics and law (Brannan *et al*, 2012: 739–745)

The **Academy of Medical Royal Colleges** (www.aomrc.org.uk) and its constituent Royal Colleges play an important role in postgraduate education, training and assessment for foundation level doctors (i.e. the first two years of professional development following graduation from medical school), specialists and general practice. The **Medical Schools Council** (www.chms.ac.uk) works to improve and maintain quality in medical education often in collaboration with the GMC.

These bodies provide the frameworks for healthcare education but these need to be translated into real world teaching and clinically relevant learning opportunities.

Current and Persistent Issues in Teaching and Learning Healthcare Ethics

Does teaching and learning of healthcare ethics translate into better ethical practice? In the opinion of Pellegrino 'it is hard to see how a discipline that aims to make ethical decisions more orderly, systematic and rational could be deleterious or how leaving everything to sentiment or feeling could be preferable' (Pellegrino, 1989: 702). Thus teaching and learning of healthcare ethics and law should be at the heart of all stages in the education of healthcare professionals (HCPs) because they are integral to all healthcare and public health encounters and interventions.

Sokol (2016) observed, 'probably for the first time in history UK trained doctors at all levels, and in all specialties, now receive formal ethics training at medical school. This raises an important but uncomfortable question for those who teach the subject: has it made any difference?' Campbell *et al* (2007) concluded that there was paucity of good evidence, conflicting findings and major design problems in the studies to that date. Walpole (2016) considers it 'important and worthy that we continue to question how effective medical education is and how to improve it'. While Sokol (2016) has 'become less certain over time of the effect of ethics teaching at medical

school on the future behaviour of doctors, especially if it is delivered in the early years' he acknowledges 'that we do not know whether teaching ethics to medical students makes any long term difference to their clinical practice'. Johnston and Houghton (2007) found that, as the course progressed, students in their medical school increasingly recognised that the resolution of ethical dilemmas required more than common sense and, for students in the later years, teaching of medical ethics and law had helped their ability to understand, appreciate and resolve difficult issues that would arise in practice. A similar study from Cardiff University Medical School (Saad *et al,* 2016) found that the great majority of students surveyed agreed or strongly agreed that the teaching of ethics and professionalism was an important part of a doctor's training and that learning about it would make them better doctors.

Sokol (2016) quotes Andre (2002) as saying that teaching ethics is 'fundamentally an act of hope.' and concludes that 'the very presence of ethics in the curriculum is important. It sends a message that ethics is an intrinsic and valued part of medical practice. The teaching of ethics, even if its worth can't be proved, is consistent with common sense and may reassure members of the public that the medical profession --- has not lost its moral compass' (Sokol, 2016).

Ethics and Professionalism

Professionalism is a way of behaving in accordance with certain normative values (Cohen, 2007: 1029) appropriate to one's occupation or vocation. It 'is the keystone of the social contract between medicine and the public at large' (Whitcomb, 2007) – and it is what all HCPs should be and do! Ethics deals with the moral principles or values that underpin professionalism. Supported by moral theories and arguments, it requires critical reflection about 'norms or values, good or bad, right or wrong and what ought or ought not to be done in the context of medical practice' (Gillon, 1985:2) whereas the law describes and defines standards of behaviour to which one is required to conform.

The ability to make consistent ethical decisions is an essential part of professionalism. (Arnold, 2002:502). The codes of practice promulgated by each of the regulatory authorities for HCPs, are rightly dominated by professionalism but all have the ethics of 'How should I live?' and 'What should I do?' at their heart. Although the BMA's *Medical Ethics Today* (Brannan *et al,* 2012) is predominantly about medical

professionalism, it too is underpinned by ethics and, for example, discusses both the teaching of ethics and law and the ethics of teaching.

Levenson *et al* (2008:4) observed that 'doctors do not become professionals by virtue of starting their first job as a qualified medical practitioner. The process of becoming a professional begins in university and the task of sustaining professional behaviour continues for a lifetime'. Neither the skills necessary for critical analysis, reasoning and reflection nor an understanding of the ever developing law arise spontaneously - they must be learned (Levenson, *et al*, 2008: 5-10). These caveats apply to all HCPs. However, 'formal teaching of professionalism is only part of the issue' of how students can best prepare students for the challenges of being a 21st century professional (Levenson *et al*, 2008: 5-6). 'Although professionalism can be nurtured and refined if the potential is there in the first place, teaching is unlikely to make much difference when an individual lacked the personal qualities, values and attitudes that are the foundation of professionalism' (Levenson *et al*, 2008: 8). They doubt the feasibility and desirability of trying to select students for professional qualities before entry to medical school (Levenson *et al*, 2008: 6-7).

The regulatory bodies set out ethical and professional standards of behaviour that apply to all students as they prepare to become HCPs. The GMC, for example, states that medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme (GMC, 2015). The GMC (2016a) sets out the professional behaviour expected of medical students, areas of misconduct and the sanctions available and the key elements in student fitness to practise arrangements. Among the other guidance documents is *Achieving good medical practice: guidance for medical students* (GMC, 2016b). Nursing and all allied health professions (AHPs) also have fitness to practice guidelines. For nurses it is part of the nursing code (NMC, 2015) and for others it is incorporated within their codes of ethics. Hickson *et al* (2007:1040) are right to assert that 'failing to address unprofessional behaviour simply promotes more of it'. Thus it is mandatory that each school has clear and specific policies on how to deal with the few students who consistently and persistently display unprofessional conduct. While

emphasising that no single strategy fits every situation, the model advocated by Hickson *et al* (2007:1040), focuses on four graduated interventions - informal conversations for single incidents, non-punitive awareness interventions when data reveal patterns, leader-developed action plans if patterns persist, and imposition of disciplinary processes if the plans fail.

In the UK, the GMC requires that medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should also be given career advice (GMC, 2015:27).

There is a tendency in some UK medical schools to separate the organisation and delivery of the teaching of professionalism from that of medical ethics. We consider that they are so intertwined that such separation devalues both. 'Medical Ethics has become part of Bioethics. On one hand this has led to the subject being recognised as a rigorous academic discipline and progress in teaching and learning medical ethics and law could not have happened or continue without the close involvement of, for example, lawyers, social scientists, philosophers and theologians as well as doctors. On the other hand non-medical bioethicists sometimes fail to grasp clinical realities and clinicians feel inadequate, making them apprehensive about getting involved in formal ethics teaching' (Stirrat, 2015:10). Thus it may be that, since clinicians tend to feel much more comfortable with thinking and talking about the more concrete aspects of professionalism, they wish to leave the more philosophical ethics to the 'experts'. In a survey of 32 ethics leads in UK medical schools, of the 20 who responded, only 3 had clinical backgrounds (Oldroyd and Fiavola, 2014: 851). To encourage more clinicians to become involved in formal healthcare ethics teaching we suggest that greater emphasis should be placed on 'teaching the teachers' and strategies to develop the careers of the increasing number of graduates who take a special interest in medical ethics as students.

Curricular issues:

Each school of Medicine, Nursing, Dentistry etc. in the UK is currently still free to organise what, how and when to teach each element of the curriculum, as long as it can demonstrate that it complies with the required standards. The GMC's quality

assurance mechanisms for medical education include detailed reports submitted by, and visits to, medical schools. However, in 15 of 22 UK medical schools who responded to a survey in 2004, it was possible for students to fail ethics assessments and still graduate (Mattick and Bligh, 2006:184). That should not be possible today if the standards set down by the GMC (2015) are properly enforced.

The 2010 indicative core content of learning for medical ethics and law in UK medical schools (Stirrat, *et al* 2010) resulted from extensive consultation and was specifically formulated in line with the then current GMC guidance on undergraduate education. It includes suggestions for the generic competencies to be aimed for as the course progresses (Stirrat *et al,* 2010:58-9).

The teaching and learning of medical ethics, law and professionalism should be integrated vertically and horizontally throughout the whole undergraduate curriculum beginning early and being reinforced throughout the course (Levenson *et al,* 2008: 9); Saad *et al,* 2016: 3). Indeed, Alastair was instrumental in this notion becoming a reality within the medical curriculum in his time at Bristol. It is a shared obligation of all teachers and not the sole responsibility of designated teachers of healthcare ethics and law. 'It is important that medical (and other) educators do not confine ethical considerations to a few elements of a curriculum. It is not possible to divorce any part of clinical practice from ethics, for even routine decisions presuppose moral judgements which doctors may or may not be aware of' (Saad *et al,* 2016: 4). Medical ethics also needs to be specifically integrated with other complementary subjects such as the World Health Organization recommendations on patient safety (WHO, 2009), clinical communication (von Fragstein *et al,* 2008), medical humanities, psychology (Bundy *et al,* 2010) and 'there is a need for a coherent ethical and pedagogical framework to locate the appropriate roles of emotion in ethical deliberation and practice' (Gillam *et al,* 2014: 331). Margetts (2016) has designed an applied law and ethics toolkit for medical education in professionalism encompassing knowledge, skills and attitudes. Legal knowhow in medical schools also 'needs to be cascaded to all staff, teachers, researchers and educationalists to tackle lack of knowledge and undeveloped skill and attitudes' (Margetts, 2016:140) This applies to the education of all HCPs.

It is for each institution delivering the pre- and post-qualification education of HCPs to determine the best context and method for teaching and learning ethics, law and

professionalism in line with the guidance from the statutory bodies. However, clinical contact with patients from as early as possible in the course is fundamental as, to be useful, teaching and learning needs to be contextualised (Vivekananda-Schmidt and Vernon, 2014: 279) and the GMC (2015: 33) requires that students have early contact with patients that increases in duration and responsibility as students progress through the programme. In a small study on how medical students learn ethics, the single largest contributor to ethics learning experiences in Year 4 was observation during clinical encounters (Johnston and Mok, 2015: 856). McCarthy and Fins (2017: 529-30) recommend that 'trainees should be taught to think beyond evidence-based treatments. By examining the legal, historical, and ethical precedents regarding seemingly mundane interactions with patients, they will be prepared to have more thoughtful interactions with their patients amidst the flurry of activity on the hospital wards'; and 'the implications of ethical decisions should be discussed and dissected on ward rounds with the same rigor, enthusiasm, and attention to detail with which differential diagnoses are generated and treatments are rendered'.

The cultural pluralism among our students, teachers, fellow HCPs and patients further requires that students learn to work harmoniously with colleagues and care for patients who have a different world view. Alastair Campbell (Campbell, 1972) pioneered an inter-professional approach to teaching and learning ethics in the UK. Hanson (2005:167) argued that teaching medical and nursing students health care ethics in an interdisciplinary setting is beneficial for them and that the benefits of interdisciplinary education, specifically in ethics, outweigh the difficulties many schools may have in developing such courses. The GMC (2015:8) considers that an 'effective learning culture will value and support learners from all professional groups'.

All regulatory authorities require that educational facilities and infrastructure be appropriate to deliver the curriculum. Thus it is the responsibility of each teaching establishment to provide adequate teaching and learning time and resources for healthcare ethics, law and professionalism.

Knight (2017) notes that, as healthcare ethics becomes increasingly broad and complex with more issues, settings and stakeholders, teaching and learning it in an increasingly constrained curriculum is more challenging. It is, therefore, understandable that there continues to be resistance from those responsible for

education in schools of medicine, nursing and allied professions to, as they see it, 'load more on to the curriculum'. In the context of medicine, Stirrat (2015:10) has previously suggested that the IME work with other cognate bodies to help medical schools properly to integrate these disciplines horizontally and vertically in curriculum without overburdening it. Similar co-working could take place in other disciplines. Such co-working and curriculum design will need to build in the flexibility to respond to important emerging issues. An example is the dramatic increase in the use of social media by everyone, including our students, which means that teachers need to become more 'savvy' about their effective use and students require clear guidance about the ethical issues that they raise.

Role models – Good and Bad

The GMC (2013:22) emphasised that every doctor who comes into contact with trainee doctors, medical students and other healthcare professionals in training should act as a positive role model in their behaviour towards patients, colleagues and others. Students learn not only from their formal teaching, but also from their experiences of observing and working with practising doctors as role models. As Pellegrino (1989: 702) observed, 'courses in ethics cannot close the gap between knowing what is good and doing it' and (Virtue) is 'best taught by good examples on the part of those we respect'. *Medical Ethics Today* (Brannan *et al,* 2012:758) emphasises that, although many doctors (and other HCPs) are excellent role models and reinforce the lessons and principles that students have learnt throughout their studies, the example of how their tutors practice can be a far more powerful influence in the development of ethical, or unethical, practice than the edicts of formal ethics teaching; and senior colleagues may unwittingly give the impression that medical ethics gets in the way of good practice. Indeed, two students in a medical school in the USA went as far as to assert that 'the chief barrier to medical professionalism education is unprofessional conduct by medical educators, which is protected by an established hierarchy of academic authority' (Brainard and Brislen, 2007: 1010).

Medical Ethics Today (Brannan *et al* 2012: 758) emphasises that 'the potential for conflict between formal and informal learning underlies the tension that many medical students, motivated as they are to be 'good doctors', articulate in their response to the teaching of ethics. One possible effect of this tension is the growth of cynicism and the erosion of ethical beliefs and conduct (Yarney and Roach, 2001).

'When…. -- there is a discrepancy between what students are taught about good ethico-legal practice and what they experience on clinical firms, anger, disillusionment, and cynicism may follow' (Loyal, 2001: 685). In recognising the importance of professional culture and the working environment in contributing to burnout among HCPs, Lemaire and Wallace (2017: 183) suggest that it can be one consequence of learners witnessing and adopting their teachers' maladaptive behaviours which are often reinforced throughout their career. These problems are not easily resolved and speaking out can require courage (Brannan *et al,* 2012: 783). Singer (2003) argued that medical schools and teaching hospitals needed to develop formal guidelines for ethics in clinical teaching that highlighted the responsibility of teaching staff to serve as appropriate role models to medical students and to provide them with an opportunity to discuss ethical challenges: develop processes for reporting ethical concerns; provide access to individuals for medical students and their tutors to approach with ethical problems; and ensure that, when medical students express concern about ethical issues or decline take part in certain activities for ethical reasons, this will not have any repercussions for them. This should take place in a blame-free environment in which errors and difficulties are openly reported and discussed; and instead of apportioning blame, which can lead to evasion and cover up, systematic solutions should be found for the ethical challenges of medical education.

Assessment

The GMC (2015 & 2016c) has produced comprehensive criteria for the assessment of medical students and doctors in training. In summary, assessments must be fair, reliable, valid, mapped to the curriculum and carried out by a trained assessor with appropriate expertise in the area being assessed. Assessment strategies should be clear and comprehensive, setting out a school's philosophy about the value of assessment and how it selects assessment tools. Students' moral and ethical reasoning, attitudes and behaviour as well as knowledge of laws relevant to clinical practice should also be assessed in conformity with the standards set down by the GMC (2015). These criteria are relevant to all institutions responsible for the education of healthcare students.

In 2013, the IME produced a practical guide for the assessment of medical ethics and law (Fenwick *et al*, 2013) to complement the core content of learning (Stirrat *et al*,

2010). It provides examples of methods of assessment and some pointers for deciding what methods might be appropriate for particular learning outcomes.

In 2013–14, the GMC (2016c) reviewed the assessment systems used in 31 medical schools across the UK. They acknowledged that the assessment of professionalism is both critical and challenging and suggest that 'it should be embedded in the values of the school from the beginning, and then continue to be assessed and monitored while being taught throughout the programme' (GMC, 2016c: 12). In some schools assessment and monitoring relied only on informal arrangements and many schools were not comprehensive or structured enough in their approach to teaching and assessing professionalism and some only assessed clinical assessments and placements (GMC, 2016c: 13).

Changing patterns of care and increased workloads:
Education of healthcare professionals in the UK occurs within the context of our National Health Service (NHS). The authors have over 50 years' cumulative experience of working in the NHS to which we are totally committed. In common with all developed nations, funding of health and social care in the UK raises major financial, ethical and political issues. It is not within the scope of this chapter to consider these save inasmuch as they affect the education of all HCPs and, in particular, the teaching and learning of ethics and ethical practice.

According to the GMC (2016d: iii) there is evidence that, when services are under pressure, time and resources for education are the first to be sacrificed. Our experience suggests that ethical analysis, reflection and discussion among healthcare teams and with students and trainees are diminished by these pressures. Similar problems are present in other healthcare settings.

Junior doctors and other healthcare personnel in the NHS are experiencing alarming levels of stress (Clarke and McKee, 2017) and the GMC (2016d: i) describes 'an unmistakeable state of unease within the medical profession across the UK that risks affecting patients as well as doctors'. The report recognises that the reasons are complex and multifactorial and some are long standing; but they suggest that 'at the heart of this are systems of healthcare across the UK that are struggling with the impact of a growing number of people living with multiple, complex, long-term

needs' (GMC, 2016d: ii). It is an ethical and pastoral priority that all bodies responsible for the pre- and post-qualification education of HCPs prepare students and trainees to cope with stress and have effective strategies in place to prevent, reduce, and treat its effects. This is only part of the solution as it is increasingly clear that effective interventions must be directed at professional and healthcare organisations as well as at individuals (Lemaire and Wallace, 2017: 183).

When things go wrong:

The general public and all HCPs working in our NHS were appalled by the dreadful events that occurred in Mid-Staffordshire NHS Foundation Trust between 2005 and 2009 and wondered how such things could have happened when 'the quality of care was subject to more inspection and regulation than ever before and doctors [and other HCPs] had unprecedented access to guidance on ethical practice' (Kong and Vernon, 2013: 671). The comprehensive and detailed report by Sir Robert Francis QC on this tragedy makes sombre reading (Francis, 2013). In his Chairman's statement he wrote that 'there was an institutional culture in which the business of the system was put ahead of the priority that should have been given to the protection of patients and the maintenance of public trust in the service' (Francis, 2013: 3). He thought that five things were needed: a structure of clearly understood fundamental standards and measures of compliance, accepted and embraced by the public and healthcare professionals, with rigorous and clear means of enforcement; openness, transparency and candour throughout the system; improved support for compassionate caring and committed Nursing; strong and patient-centred healthcare leadership; and accurate, useful and relevant information (Francis, 2013: 5-8)). We may argue that all of these are already explicitly or implicitly contained in the ethical and professional guidance from our regulatory bodies but the fact that the tragedy occurred underlines the responsibility for those of us teaching medical ethics, law and professionalism to address the underlying problems.

Healthcare managers are another important professional group encompassed by these recommendations. The 1983 'Griffiths report' (Griffiths, 1983) ushered in the era of 'managerialism' in the NHS (Jarman, 2012) but managers do not have an ethical or regulatory body equivalent to the GMC (Jarman, 2012). Francis (Francis, 2013: 8) recognised this anomaly and suggested the creation of a NHS leadership staff college

'supported by a common code of ethics and conduct for all leaders and senior managers'; but do ethical values, behaviour and attitudes not need to be inculcated from the earliest point in managerial training as occurs for HCPs? He also proposed a registration scheme 'to ensure that only fit and proper persons are eligible to be directors of NHS organisations' (Francis, 2013: 8) but we consider that this should apply to everyone training for management roles in the NHS. While we accept our responsibilities as educators of HCPs we would have greater confidence that such tragedies could be prevented in the future if healthcare managers learned ethics and professionalism and were regulated in the same way as we are.

The Way Ahead

Massive changes have occurred in our society in general and in healthcare in particular since 1972 when Alastair Campbell produced his course book in ethics for doctors and nurses (Campbell, 1972). Although healthcare ethics education has, by and large, kept pace with these changes we must learn from our failures. It took Sir Robert Francis QC (Francis, 2013: 9) to remind us that we are still at the beginning, not the end, of a journey 'towards a healthier culture in the NHS in which patients are the first and foremost consideration of the system and all those who work in it'. Let us pray that we are currently growing leaders like Alastair who will lead and guide us on that journey.

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