

ETHICS MAN Daniel K Sokol

Argus and the cyclops in the clinic

Improving moral vision should be the first step in teaching ethics in medicine

Over a beer Jim celebrates his first draw against an international chess master, the rank just below the coveted title of grandmaster (GM). I joke that GMs are next on the menu. “No,” he says, “these guys see things on the board which us mortals can’t see.”

A magician asks a spectator to name any playing card. The five of hearts. The magician opens his wallet, then the zipped compartment within, and pulls out the chosen card. After the show three magicians search in vain for a solution. An experienced magician joins the group and immediately suggests an ingenious and plausible method.

Harvey Cushing, in one of his essays, wrote of a patient who was admitted to hospital with an unexplained fever. Various tests were done: blood, urine, sputum, stool, cerebrospinal fluid. Specialists were called in. Meanwhile the fever continued. A country doctor who was visiting the hospital walked past the patient’s bed and said, “I am surprised to see that you still have an occasional case of typhoid fever in your neighborhood.”

In each of these vignettes one individual is blessed with greater vision than the rest. Each shares the ability to identify salient features, a meaningful pattern or a constellation of signs and symptoms, and to derive a hypothesis or an appropriate plan of action. They have vision.

In the realm of ethics we talk of moral vision or moral perception. Like the mythical hundred eyed giant Argus, whose eyes now adorn the tail of the peacock, a morally perceptive person sees ethical aspects of a situation that may not be readily apparent to others.

After several failed attempts to lose weight, Gloria, a morbidly obese 44 year old woman, was eligible for gastric bypass surgery (*J Gen Intern Med* 2004;19:281-5). As she had had an open cholecystectomy previously, she was scheduled for an open procedure. Her hypertension and diabetes were

well controlled, and Gloria told her doctor that she was looking forward to caring for her disabled son. At this point the doctor could have sent her to the operating theatre and moved on to the next patient on his list. Instead, concerned by that last statement, he asked her about her son. He was in the final stages of muscular dystrophy.

Gloria’s alcoholic husband was violent and unhelpful. She stayed with him only for financial reasons to support her disabled son and young daughter. After discussing the likely effect of the operation on her ability to care for the children, Gloria postponed the procedure. “They need me now more than ever,” she observed. The doctor displayed moral perception by thinking beyond surgical eligibility and considering the suitability of the procedure for this individual in this situation at this time. Picking up on an important cue, the doctor saw the patient within a broader social context.

The antithesis of moral vision is moral blindness. The morally blind person fails to see the ethically problematic nature of a situation. In 2003 a study in the *BMJ* showed that almost a quarter of intimate examinations of anaesthetised patients by medical students were performed without consent (*BMJ* 2003;326:97-9). In an interview one fourth year student said, “I was told in the second year that the best way to learn to do PRs [rectal examinations] was when the patient was under anaesthetic. That way they would never know.” A myopic cyclops, this student: the moral issue does not even appear on his radar. The patient seems little more than an instrument for his own clinical development.

Improving moral vision should be the first step in the teaching of ethics in medicine, for sound skills in reasoning are useless without the moral vision needed to trigger the reasoning process. A host of obstacles—whether due to moral ignorance or naivety, to



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the clinical mindset, with its emphasis on physiology and hard science, or to the many pressures and distractions on the ward—can prevent students from seeing clearly. Judith Andre, a US bioethicist, believes that one of the greatest obstacles is lack of time (*J Med Ethics* 1992;18:148-52).

When time is short, ethical issues are missed. (And so are clinical issues; recall Osler’s famous words: “Hurry is the devil. More people are killed by hurry than by disease.”) Patients may even be seen as “consumers of time” who impede other priorities. Time is also essential for reflection, an activity central to moral growth. Although junior doctors, traumatised by recent job application forms and portfolios, may growl at the sight of the word, reflection is, for Andre, “the stage which allows half-perceived problems to be fully seen.” One obvious requirement to improve moral acuity, then, is to give students and clinicians time to reflect on their experiences and on how their background, colleagues, surroundings, institution, and society shape their views on medicine, bringing some aspects into focus and pushing others out of sight.

If we can provide this all important time for reflection (however difficult this may be), if we can show in our teaching how moral choices (such as those involving futility and best interests) may be disguised as purely medical choices (*BMJ* 2003;326:97-9), if we can encourage clinicians on the wards to instruct and inspire their juniors through their own attitudes and behaviours, and if we can give students the confidence to speak up and ask questions when in moral doubt, then more Arguses and fewer cyclopes will inhabit the ethical landscape of the clinic.

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Cite this as: *BMJ* 2008;337:a1562