Medical Ethics in New Zealand

By Howard Brody, M.D., Ph.D.

I had the good fortune during 1991 to be invited as guest lecturer for several conferences in New Zealand. The following summarizes some initial impressions of the development of medical ethics in New Zealand and some thoughts on the important benefits which MSU may reap by strengthening our ties to the international medical ethics community.

NEW ZEALAND

New Zealand is geographically large and incredibly diverse, but with a small population, so that there are numerous regional differences (as well as significant urban versus rural differences) in health care systems. Having originally instituted a national health service even before Great Britain, New Zealand has gradually evolved a system which has many elements of private enterprise, and current reforms call for even greater emphasis on private health care. New Zealand is also trying to face forthrightly its bicultural problem in dealing with the native Maori population.

An important incentive for addressing ethical problems in medicine was the publicity given during the 1980’s to several “scandals” in experimentation on human subjects, and the subsequent government inquiries. As a result, inquiry into ethical issues has a shorter history in New Zealand than in the U.S., but the present status is characterized much more by intrusive government regulation. For example, the formation of hospital and community ethics committees has been mandated by government, and the committees are supposed to serve both to review research proposals as well as to deal with issues in clinical practice and the withdrawal of

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Emerging Bio-Ethics Programs of Norway

By Kjetil Karlsen

(Mr. Karlsen is a medical student from Norway who is currently enrolled in the Masters program in Health and Humanities for the 1991-92 academic year)

A thousand years ago, about half a millennium before Christopher Columbus, Leiv Eriksson landed his viking ship on the coast of a continent he named “Vine land”. According to more current political accounts, the name of this continent has been changed to North America. After this first Norwegian-American encounter, contact and exchange has been sporadic.

But, as historians are fond of asserting, history repeats itself. At the annual meeting of the Society for Health and Human Values in St. Louis this fall, 10 attendees were from outside the U.S. Of these, 8 were Norwegians. With the return of the Norwegians to these shores it is time to begin asking what has happened? In examining that question, we shall take a closer look at the current status of the field of medical ethics in Norway.

Being a social democracy, Norway provides its 4.2 million citizens with a national health

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life sustaining treatment. A typical committee may receive only one day’s training before it is turned loose on this dual task. Moreover, the government also mandates a regular turnover of members of committees, which will insure in the future that the most experienced members may not be allowed to remain. Despite this, important advances are being made in the effective use of these committees, and there is a great deal of interest in their education and function. Despite their dual role, there are many similarities in the types of problems faced by ethics committees in New Zealand and the U.S.

Because some of the "scandals" of recent years involved experimentation with inadequate consent, informed consent has been a special target of new government regulation, and comments by New Zealand physicians showed a great deal of ambivalence over the present system. Informed consent has become a focus for the work of medical disciplinary boards; since 1990 it has been a specific requirement that physicians must give patients adequate information, and it was reported that one surgeon was disciplined in 1991 for failing to do so. A workshop on the use of acupuncture as an alternative medical therapy featured specific consent forms developed by an acupuncture society (as is typical, printed both in English and Maori). A question from the audience was whether the use of these forms would engender the patient’s distrust of the physician. The reply was, "I tell the patient that we can trust each other but that neither of us trust the government!"

Government regulatory activity also led to the perceived need for academic centers in biomedical ethics. The first such center, established at the oldest medical school (at the University of Otago), was only formed in 1988; but through the efforts of Alasdair Campbell and Grant Gillett, it has achieved an impressive record in a short time. Medical school curriculum has been designed; conferences, graduate study, and one year fellowships have been coordinated; a residential course is now being offered; and the Center has been active in advising both government and media. Despite the lack of a formal bioethics center, some impressive medical school teaching in ethics has been inaugurated at the University of Auckland.

WHY COLLABORATION?

Ongoing contacts and collaboration with the above ventures and the organizations discussed by Kjetil Karlson in his article for this issue, would appear to be definitely in the best interest of this Center and of Michigan State University. The University of Auckland, as a newer medical school dedicated more to the philosophy of community service and primary care, would appear to be an excellent partner in scholarly and faculty exchanges with Michigan State University's College of Human Medicine. Because of visits by Reider Lie to Michigan State University, we have already established some personal linkages with the Center at Oslo; and already two of Oslo's medical students have participated in MSU sponsored courses. If we are able in the future to expand our summer course in ethics and history of medicine beyond its present site in London, Oslo would appear to be an excellent additional site for such teaching.

Finally, it would seem particularly wise for Michigan State University to work actively with this newly emerging international network. The value of this is emphasized by anecdotal reports from ethicists in Norway and Denmark, on previous lectures given by distinguished professors from some of the more prominent U.S. centers for study of medical ethics. The tone of these presentations was perceived to be dogmatic and arrogant, suggesting that everything of importance in medical ethics had already developed in the U.S.A., and that their countries simply had to follow the U.S. example without further question. There seems to be an excellent opportunity for visiting American scholars who wish genuinely to learn from international examples and perspectives, and to engage in an open dialogue across different nations and cultures. Michigan State University, with its strong history of international programs and its newly emerging Institute of International Health, would provide an excellent basis for such contacts in the future.
Opportunities to Learn in England: History of Medicine and Medical Ethics in London

By Brian Brown, M.A.

I am very pleased to be able to submit a complement to the other contributions in this issue dedicated to bioethics in international perspective. I would like to focus on pedagogy by commenting on our summer program, "Medical Ethics and the History of Health Care in London." Regular readers of the Medical Humanities Report will likely have heard of the London program, which will be offered for the seventh time in 1992 from July 7 to August 6. This summer I will be team-teaching it with Fred Gifford, Ph.D. of the Philosophy department and Gerald Osborn, D.O., M.Phil. of the Psychiatry department, who maintains an adjunct appointment in History.

In short, the goal of the program is for students to learn about the social and historical factors which led to the development of today's British National Health Service (NHS), and to assess ways in which the NHS deals with complex bioethical issues. To facilitate this interdisciplinary task, the program has been regularly team-taught by a historian and a philosopher, starting with Peter Vinten-Johansen and Howard Brody in 1986. This summer we aim to make a little more explicit the anthropological approaches to social history and bioethics that have always been an understated component of the program, and have added a third instructor. Our institutional base in London is the Department of General Practice and Primary Care at the Medical College of St. Bartholomew's and the London Hospitals, with whom MSU has recently completed an affiliation agreement. Dr. Lesley Southgate and her predecessor, Dr. Mal Salkind, have been our hosts at Bart's; they and their staff have been gracious and tremendously helpful to the MSU faculty and students over the years.

The program generally draws an even mix of graduate, undergraduate, and medical professional students, with an occasional faculty member from another institution; roughly one-third of our participants come from schools other than MSU. Students come in with a wide range of background and personal history; likewise, each faculty and student participant comes to London with a unique set of ideas about what constitutes appropriate medical practice and social welfare policy. It is not long before we all begin to identify a broad diversity of perspectives within the group that make for spirited discussions at times. In the end, we aren't aiming for consensus, rather that people leave with reasoned opinions that reflect thoughtful consideration of others' positions.

This range of diversity adds to the challenge (and value) of "doing" history and ethics as an integrated course. To cement the two components, we emphasize two primary issues, in historical perspective: (1) the changing nature of relationships among patients and healers; and (2) how a society makes decisions about allocating resources to "health care." The program is designed to be introductory, and requires no prior experience in history or bioethics. A majority of our students feel somewhat uneasy that they don't have as much of a background in history as they feel they "should." In the same way, many have not yet had the opportunity to think through why they maintain strongly held personal opinions about controversial bioethical problems. We expect that coming in, so it is not a problem. When they've completed the program, on the other hand, we expect that they have developed a higher level of sophistication to their thinking about these issues.

While this all sounds quite fine as the basis (London continued on page 4)
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for a course of study, the big question is this: Why is it particularly worthwhile for students to spend $2400 (exclusive of airfare, meals, and spending money) to join us in London for five weeks? I think there are several good reasons. Most obvious is the access to resources not available elsewhere. Although there is some classroom lecturing by the regular faculty, and a good deal of large and small group discussion among the students, we strive to take the greatest advantage of greater London as a laboratory. We invite a range of authoritative guest speakers—who often hold opposing views on controversial issues. We also visit a few hospitals, to get a first-hand sense of how they operate. Many of our students have been exposed to clinical contexts of some sort in the U.S., and can quickly see marked contrasts.

Because most of our students have a limited background in British history, early on we schedule semi-structured visits to several museums—including the Museum of London, the Science Museum, and the Imperial War Museum. These visits help students immeasurably to understand the historical and cultural context in which the British social welfare system arose.

In addition, our students spend a full class day in a joint session with a group of Bart's medical students who are in the midst of a general practice clinical rotation. In a small group setting, British students are asked to present a specific case they have experienced which raises ethical concerns. Then the American and British students together discuss the cases.

Of all our scheduled activities, students seem to regard most highly the opportunity to interact with health care practitioners on a one-to-one basis. We reserve a half-day for each program participant to spend time individually with a general practitioner in his or her surgery seeing patients. For some students this makes for a very hectic morning, with patients being seen at ten minute intervals. For another student, the morning may be much quieter, allowing time to discuss issues raised in class with someone who works "in the trenches." Another half day is reserved for each student to accompany a health visitor on her rounds. Most of these visits take place in the "City and Hackney" district, an area of East London which manifests equally profound poverty and ethnic diversity. Students do not quickly forget what they experience in these visits—particularly those students who have not yet had to confront such challenges in their own personal and professional lives.

What takes place outside of scheduled activities magnifies the impact of the program on the participants. First, they are immersed in a new and unusual environment, many for the first time. As much as possible, we want the students to feel not like tourists, but like residents of London. It is only by living like Londoners that students can really develop a sense for the values underlying the provision of medical care there. For example, this summer our students will reside in Campbell House, which unlike most dormitories, does not provide meals. Instead, several kitchens are provided for students to prepare their own food, or they can take advantage of the vast array of restaurants in the area. By design, students live far enough away from the classroom that they must join the morning rush hour Tube journey to make it to class on time. By the end of the first week, most of them know exactly the time to leave the dormitory to reach the classroom moments before starting time.

Secondly, students are exposed to many apparently trivial cultural differences that cause them to reconsider their assumptions about how everyday life is supposed to operate. After all, why do the British drive on the "wrong" side of the road? Why are 10p coins so large, while £1 coins are relatively small? And why are we expected to bag our own groceries at the supermarket? These are the sort of questions outsiders ask; they lead to a strong but subtle understanding that ours are not the only legitimate and reasonable rules of life. That understanding goes a long way toward helping students understand how different historical and cultural traditions lead toward differences in British and American views toward
health and health care.

Thirdly, in Britain we are looking at a system which is, like ours, in a state of crisis. It is truly invigorating for students to observe a government, a medical profession, and a public trying to come to grips with rectifying perceived inadequacies of the NHS, while at the same time trying to maintain the integrity of an institution that the majority of British people hold up as an example of civilized social welfare at its best. A few students in search of solid answers are initially frustrated when our guest speakers are asked to explain the current status of the NHS because it is changing so rapidly, our guests do not paint a consistent picture. What they do is bring into relief the ideological differences that underlie conflicts within the NHS. It’s up to the students to assess their own positions relative to those differences.

This leads me to conclude by noting a couple of pedagogical challenges that come with a program of this sort. First, students need to understand that this is not a course that offers simple resolutions to complex problems. Coming from an educational tradition wherein one undertakes coursework to get at least some answers, some students find this rather unsettling. It was to me as a student in the program in 1987—after all, it didn’t seem fair that, having paid my money, I finished the program with more questions than I had going in! Now I know better.

Secondly, as I alluded to above, trying to explain a system in flux is not easy—especially when each day’s newspaper provides another surprise. The faculty needs to be ready to abandon lecture notes made obsolete over the course of a week. It is not a task for the weak-hearted. Already, Fred, Gerry, and I are meeting on a bi-weekly basis to refine the themes and readings for this summer’s program. In this sort of an interdisciplinary endeavor, it is so important that all the pieces fit together as smoothly as possible, and that the each of us know how the others interpret the material we present. Coming from relatively disparate intellectual backgrounds ourselves, we learn a great deal about seeing the same material through the eyes of the others, and that’s the model we hope to carry over to London.

If you know of anyone (perhaps yourself) who would find this program appealing, please let them know about it; I and the other faculty welcome all inquiries. You can reach me by phone at (517) 353-9417; by e-mail at: 19910 BXB @ MSU.EDU (Bitnet); or by mail at 328 Morrill Hall, IPHH; Michigan State University; East Lansing MI 48824.

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insurance. Compared to the U.S., the Norwegian population is quite homogeneous, both culturally and racially. The social-democratic program works: taxes are high, whereas class differences are minimal. Except for a couple of recent, specialized hospitals in the Oslo area, all hospitals are owned and run by the State. Health Service in Norway is divided into 5 regions, each with one university hospital.

National and Regional Ethics Review Committees.

A great part of patient-related biomedical research is carried out at universities and university-hospitals. The universities and the Norwegian Research Council (NRC) are the main sponsors, although the pharmaceutical industry helps fund drug-testing studies. In 1978, the NRC established an internal committee to examine some of the ethical questions regarding medical research. This committee was designated to coordinate ethics committee work at a national level when, in 1985, regional ethics committees were established for each of the 5 regions. Since 1990 this central committee has been called the National Committee for Medical Research Ethics (NEM). The Ministry of Research and Education allocates the budget for the ethics committees and appoints the chairpersons. Each of the regional committees has 7 members: two medical professionals (one named by the regional medical faculty, and one by the health authorities); one nurse; one hospital board representative; one ethicist; one lawyer; and one lay

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representative. Members are appointed for four years and can be re-elected once. NEM has 12 members: three physicians, three ethicists, two lay members, and four others with background in relevant disciplines such as biotechnology, social sciences etc. Jan Helge Solbak, the secretary for the NEM, is a theologian and MD.

No research involving human subjects can start prior to consent by the regional committees. Meetings are every six weeks, and roughly two percent of the projects are not approved. Among the main assignments of NEM are: coordinating and advising regional committees, educating politicians and public in current and potential medical ethical questions, and submitting special reports on matters of principle relating to medical research ethics (the titles of these reports briefly correspond to chapter-titles in medical ethics textbooks: informed consent in research involving human subjects; in vitro fertilization, etc.). The first issue of NEM-Nytt (NEM-News), a quarterly journal, was published the fall of 1990 and it is currently being distributed as a separate part of the Bulletin of Medical Ethics, London.

The Center for Medical Ethics.

The Center for Medical Ethics in Oslo (CME) has a relatively brief history. Indeed, the center just celebrated its second anniversary. The center functions as an independent entity, with a board consisting of representatives from the main sponsors: 3 University representatives, and one representative each from the Medical Research Council, the Norwegian Medical Association, the Norwegian Nurses' Association, and Hafslund Nycomed (one of the four Norwegian pharmaceutical companies). The CME has an annual budget of 16 mill. nkr (approximately 3 million dollars) and eight staff members. Of these, three are women (one MD, one lawyer, and one philosopher). Reidar Lie, the director of the center, received his MD in Norway, and his Ph.D. in the U.S. At the moment, two other physicians are associated with the center - one as staff, and the other as a Ph.D. student. Other disciplines represented are political science, nursing, and theology. Currently, two medical students are closely connected to the center, both receiving tutoring and participating in the formulation of future projects.

The mandate of the CME is to be an interdisciplinary center for research and teaching in the field of medical ethics. During 1990, 17 original papers were published. The hectic process of establishing new routines and getting the center started accounts for this somewhat modest number. A total number of 50 prepared papers were presented by the staff and an additional 330 hours were spent on different teaching engagements. Currently, the research by the CME staff ranges from theoretical work to questions of applied ethics. Some of the recent topics being examined by the staff are: The intrusive effects of technology on society considered from epistemological, anthropological and ethical perspectives; How clinical knowledge relates to the basic sciences; A comparison and analysis of Catholic and Lutheran ethics applied to medical ethical questions concerning artificial insemination; Medicine as science and technology -- the relationship between theory and tradition in medical philosophy of science; Theory, principles, and casuistry in medical ethics; The role of paternalism in the rationale for preventive health care. Future projects include work in nursing ethics and a study of justice in various health care systems.

The CME is responsible for teaching ethics to medical students. A weekly introductory seminar in medical ethics, open for politicians, nurses, physicians, philosophers and others, was held during winter and spring of 1990. Presently, a more ambitious seminar, aimed at health care professionals, is meeting on a monthly basis. Other seminars have been arranged, aimed specifically at nurses; physicians; health administrators; pharmaceutical industry, etc.

The CME also budgets a certain amount each year to sponsor visiting researchers and lectures. This is regarded as key to establishing and inspiring an academic milieu for medical ethics in Norway. Among others, the CME has
been visited by Ron Carson, Texas; Baruch Brody, Texas; Anne Davis, California; Norman Dahl, Minnesota; Rein Voss, Netherlands; Ken Schaffner, Washington; Mark Siegler, Chicago; and Howard Brody, Michigan.

As possibly the only country to do so, Norway houses the secretary for the national ethics review committee, the secretaries for the regional committees, and the center for medical ethics in a single building. They are all located in the Science Park of the University of Oslo. This allows NEM and the CME to more easily cooperate on tasks like establishing a national library of medical ethics, education, conducting seminars, etc. As part of establishing the library, the NEM/CME receives 32 journals in the field of medicine, ethics, philosophy of science, etc. The Ministry of Education and Research recently chose the NEM/CME center to conduct a national five year research program investigating the normative and fundamental basis for medical science, technology and resource allocation within research and health care. Being located in the Science Park also has the advantage of placing these groups only a short distance from The Center for Technology and Human Values, several private enterprises of various kinds, and a number of research institutions in biotechnology and genetic engineering. Says Jan Helge Solbak: "The location of the center of medical ethics gives us a unique chance of practical collaboration with medical and technological research institutions"(1).

Medical ethics, on both the organizational and academic level, is at the pioneer stage in Norway. As pioneers, the people associated with the center face hard work in clearing new ground. But, in the Viking spirit, we may say, they face the new challenges fearlessly and with enthusiasm. All this can, I assume, be confirmed by those who encountered the modern Viking invasion in St. Louis this fall.

Footnotes

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**Literature in Review**


Andrew Hunt, founding dean of the College of Human Medicine at Michigan State University and founding coordinator of the Medical Humanities Program, has produced a thoughtful and readable study of the present state of medical education in the U.S. His basic thesis is that we must change our health care system to control costs, increase access, and alter how care is organized in community settings. To do this we must change the system of medical education. But the bodies that have power over the educational structure-- notably, government agencies which fund research (but not education) and the accreditation agencies-- are profoundly ambivalent over allowing and encouraging the changes that are needed.

In developing his thesis, Dr. Hunt draws upon some of his personal experiences-- as dean at MSU and later associate dean at Mercer Medical school, and finally as a patient undergoing neurosurgery and postoperative complications. These personal reflections are used effectively and are not allowed to detract from the balanced and historically-informed tone of the study.

For many years Dr. Hunt achieved a reputation as an implacable foe of the Liaison Committee on Medical Education (LCME), which used its accreditation authority to derail some of the innovations introduced in the early days of MSU-CHM. It is therefore reassuring to see that the discussion of the LCME is quite balanced, and includes mention of recent changes in LCME personnel and policies which augur well for the enhanced support of educational reform. Still, the overall story is that (Review continued on back page)
of a body whose worst fear is that medical schools may produced graduates who are not fully competent in a scientific/technological sense; and has therefore been unwilling to countenance any educational innovation that involves significant risk.

I noted one possible gap in the discussion. The book offers a good deal of evidence that the academic medical centers and the accreditation agencies which use them as the models for medical education are increasingly out of touch with the real needs and issues in American health care— that they are effectively becoming obsolete without knowing it. Yet Dr. Hunt assumes that any change in medical education will ultimately come through this system. I would have enjoyed some creative thinking about how forces for change might work around the existing establishment.

For an MSU audience, this book offers a fascinating account of CHM's educational innovations (focal problem teaching; the Upper Peninsula campus; use of community hospitals) and how they caused friction, some of it deserved, with the national educational establishment. Also of great interest is the experience of the newer medical school at Mercer and its similarities with MSU-CHM. Some might be unaware, for instance, that Mercer began by proposing even more radical reforms, such as replacing required clinical experiences in medicine, pediatrics, and obstetrics with a comprehensive family practice clerkship.——Howard Brody
UPDATE ON RECENT ACTIVITIES OF THE CENTER

The Center Welcomes New Staff Member

The Center welcomes its newest member, Professor Judith Andre. Professor Andre received her doctorate in philosophy in 1979 from Michigan State University and has been teaching at Old Dominion University in Virginia since 1980. She joined the Center officially this summer and began her duties this fall.

Professor Andre has received numerous awards and fellowships including a fellowship to Harvard in 1988 and a Rockefeller Foundation fellowship to the University of Texas Medical Branch. She has published on a variety of topics including: moral growth in medical school, privacy as a value and a right, racial and gender stereotypes, teaching ethics courses and rethinking college athletics. Her present areas of research are on the issue of moral growth and constructing an analysis of what should and should not be commodifiable in society. Her article, "Learning to See: Moral Growth During Medical School," will be published in the *Journal of Medical Ethics*; "Blocked Exchanges: A Taxonomy" has just been accepted by *Ethics*.

There will be an interview with Professor Andre in the next Medical Humanities Report, for which she has also consented to write the lead article. Her topic will be the role of confidentiality in using patient's case histories as educational stories for medical students. Once again, welcome, Professor Andre.

Annual Report On the Center's Activities Now Available

The Center has prepared an annual report, summarizing our teaching and public service activities and the scholarly accomplishments of our faculty over the past year. Also included are issues around administration and budget, and an introductory essay on the importance of cultural diversity in the study of ethics and humanities in health care.

It has been our practice to distribute this report only on the Michigan State University campus. The primary purpose of the report is to inform the Deans and Unit Directors at Michigan State University of how our Center impacts on their various programs.

Nonetheless, we will be very happy to share this document with the directors of other programs in health and humanities around the country, or any other interested readers of this Report. If you desire a copy, please notify our office at: Center for Ethics and Humanities in the Life Sciences, C-201 East Fee Hall, Michigan State University, East Lansing, MI 48824-1316.