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Chapter 5 'A service to the community as a whole': the emergence of bioethics in British universities

Bioethics made inroads into British universities during the 1980s, thanks largely to those individuals, groups and political changes that we have already encountered. During the late 1970s and early 1980s members of medical groups and public figures such as Ian Kennedy called for greater emphasis on medical ethics in student training. They also stressed the benefits of 'non-medical' input, claiming that it relieved clinicians from teaching responsibilities and would help students become 'better doctors' in future. This ensured that many prominent doctors supported new interdisciplinary ethics courses, which were aimed mainly at healthcare professionals.

Many of the academics who taught on these courses were increasingly located in dedicated bioethics centres from the late 1980s onwards. The establishment of these centres reflected a commitment to interdisciplinary teaching on the part of certain doctors, philosophers, lawyers and others. It also owed a great deal to cuts in government funding for universities, which encouraged academics in the humanities and social sciences to work on more 'applied' subjects such as bioethics. This combination of factors shaped the Centre for Social Ethics and Policy (CSEP) at the University of Manchester, which was established in 1986 by the philosopher John Harris, the lawyer Margaret Brazier, the theologian Anthony Dyson and the student health physician Mary Lobjoit. CSEP's establishment reflected Harris's interest in bioethics, Brazier's work on tort law and medical negligence, Dyson's belief that theology should engage with practical issues, and Lobjoit's conviction that student doctors and nurses needed formal ethics training. It also reflected changing priorities in higher education, with CSEP's founding quartet stressing the applied nature of their work and that the new centre benefited doctors, patients and 'the community as a whole'.

Involving non-doctors in medical ethics teaching

During the 1960s and 1970s, as Edward Shotter notes, 'there was no teaching in ethics in British medical education' and leading doctors believed that ethical questions were best 'discussed by consultants, with consultants and *in camera*'. While groups such as the LMG provided a forum where students could discuss ethical issues, Shotter maintained that they 'never claimed to teach medical ethics'. This stance stemmed from uncertainty over whether medical ethics was based on 'the moral codes of religion' or secular frameworks such as utilitarianism. It was hard to teach students, Shotter concluded, 'given the lack of any accepted body of knowledge in medical ethics, and the problems of definition involved'.

While their refusal to teach ethics helped the medical groups appear 'non-partisan and independent of all interest groups', it did not satisfy those who wanted the subject to be included in the medical curriculum. In a 1967 *Lancet* article, for instance, one student noted how controversies over organ transplants and the definition of death ensured that medical ethics had become 'an important facet of the profession's public image', but complained that 'in the training of medical students, however, the subject of a doctor's ethical commitment is presented in a haphazard manner'. The author argued that little mention was 'made of ethics in normal teaching', where most doctors 'were unwilling to make firm generalizations and instead fall back on the time-worn apprenticeship principle – "you'll learn by experience"'. This 'absence of guidance', they concluded, 'leaves many students confused and faintly dissatisfied'.

This view was notably shared by the GMC, which issued a report in 1967 recommending that medical ethics should be given greater priority in 'basic medical education'. Although medical schools were not obliged to follow this advice thanks to GMC rules that gave them autonomy in delivering the curriculum, many introduced lectures on medical ethics during the 1970s. This was clear in the responses to a GMC survey from 1975, where twenty-five out of thirty-four medical schools claimed they now provided lectures on medical ethics, while eleven claimed to have a staff member dedicated to the subject.

But while an increasing number of medical schools taught medical ethics, most continued to believe it was a job for doctors. In a 1972 editorial, the *Lancet* acknowledged that 'ethical training in medicine' was justifiably getting greater attention in the medical syllabus. Although it praised the LMG's 'commendable attempts to stimulate interest', it nevertheless maintained that teaching ethics 'must surely in the first place remain the responsibility of the medical school themselves'. This attitude was also evident in a *Journal of Medical Ethics* article on ethics teaching at the

University of Nottingham, which stated that 'intracurricular aspects of medical ethics' should be taught 'mainly by medical members of staff'. If students wanted to encounter 'non-medical opinion', it continued, then they could do so in 'extracurricular discussion groups' that were open to staff and students of all faculties.¹⁵

But this is not to say that all medical schools left doctors in charge of ethics teaching. In Scotland, and Edinburgh in particular, non-doctors were increasingly involved in ethics teaching during the 1970s. While he was university chaplain and associated with the EMG, the Royal College of Nursing asked Alastair Campbell to teach an ethics course for postgraduate nurses.¹⁶ These lectures formed the basis for *Moral Dilemmas in Medicine*, which Campbell aimed at qualified healthcare professionals and students following advice from the book's publisher, the medical press Churchill Livingstone.¹⁷ In his foreword to the book, A. S. Duncan, the dean of Edinburgh's faculty of medicine, supported outside involvement in ethics teaching. 'The view from the sidelines can be more objective', Duncan argued, since doctors and nurses were 'only able to give a superficial view' of issues that was 'often biased by personal experience'.¹⁸

Following the publication of Campbell's book, and with support from Duncan, academics involved with the EMG set up an interdisciplinary research group to investigate whether ethics could be further incorporated into 'ordinary academic and clinical teaching'.¹⁹ After consulting with students and staff in the medical faculty, they established a series of 'experimental' undergraduate courses on 'Social and Moral Issues in Health Care' in 1976. Aimed at student doctors, nurses and psychiatrists, these dedicated ethics courses were the first of their kind in Britain. While the content varied according to the students' disciplinary background, all courses reflected the belief that no viewpoint should dominate ethical discussions and that there was no obviously 'correct' answer to many problems. The philosopher and group member Ian Thompson argued that the courses should adopt a more 'Aristotelian approach' that was 'as closely integrated into the ordinary theoretical and practical training of doctors as possible'.²⁰ As a result, the courses overlooked formal lectures for group-based discussions of particular cases.²¹

Although the courses were not repeated due to a lack of funding, the heads of seven medical departments asked group members to provide ethics teaching on several undergraduate courses the following year. In a 1978 article for the *Journal of Medical Ethics*, they claimed that the positive response to their 'experimental' sessions highlighted a 'widely felt need for study and discussion of medical ethics in the medical school context'.²² They argued that this necessitated the creation of more opportunities, both in Edinburgh and elsewhere, for 'multi-disciplinary and inter-professional discussion' in the medical curriculum.²³

By the late 1970s small numbers of non-doctors were beginning to contribute to other undergraduate and postgraduate courses. At the University of Glasgow, for example, the lawyer Sheila MacLean taught compulsory modules in forensic medicine, which was where Scottish students traditionally discussed ethical issues.²⁴ In a 1977 piece for the *Journal of Medical Ethics*, doctors at the University of Southampton detailed how lawyers and philosophers made 'a considerable contribution' to a fourth-year ethics course and claimed that students 'benefited greatly from their inclusion'.²⁵ And the following year, the IME helped the Society for Apothecaries to establish a graduate Diploma in Philosophy of Medicine.²⁶

But these changes did not impress Ian Kennedy, who used the prestigious Astor Memorial Lecture in 1979 to complain that 'the formal teaching of medical ethics is a desultory exercise'.²⁷ Kennedy stressed that more ethics teaching was vital for 'ensuring that medical students are properly exposed to medical ethics and moral debate'.²⁸ In his fourth Reith Lecture the following year, he repeated that doctors 'should have some educational grounding in ethical analysis' in order to meet the changing expectations of patients and the public.²⁹ Kennedy believed that this could be achieved by making medical ethics a 'central course' that was taught by someone 'who is not deafened by the rhetoric of medicine'. Prioritising ethics and involving non-doctors in teaching was the only way, he argued, of dragging medical schools 'back into our world and out of their hermetically sealed cocoon'.³⁰ As before, Kennedy dwelt on the benefits of these new arrangements. He stressed that involving non-doctors in ethics teaching would not threaten traditional relations between doctors and patients, but would instead strengthen them by 'exploring the conflicts and tensions between different ethical principles and suggesting ways of resolving them'.³¹

Kennedy was clear, however, that he did not regard the medical groups as an adequate forum for discussing medical ethics. In a 1981 edition of the *Journal of Medical Ethics*, he claimed that they perpetuated the 'unsatisfactory state of affairs' that his Reith Lectures condemned.³² Their existence, he argued, 'allows medical schools to avoid incorporating medical ethics into the curriculum in all but a perfunctory manner'. Kennedy also claimed that since medical group seminars were voluntary, they only attracted 'those who are already interested in ethics and want to learn more. The rest, probably a majority of students, do not attend. Arguably it is these who need the education, yet

they can and do avoid it.'³² This was no doubt true for some universities in the 1970s, where doctors believed that the medical groups provided sufficient coverage of ethical issues and were a voluntary 'soft option'. But we should also bear in mind that EMG members were instrumental in developing more formal ethics courses during the 1970s and that the IME, as we shall see, argued that 'non-medical' perspectives should be incorporated into the medical curriculum during the 1980s.

Kennedy's Reith Lectures prompted considerable debate about how medical ethics should be taught, and who should teach it. Most commentators agreed with his claim that medical ethics should be prioritised more in teaching. In an editorial for the *Journal of Medical Ethics*, Raanan Gillon argued there was a '*prima facie* case for the claim that some formal and probably compulsory teaching of analytical medical ethics should be provided within the medical curriculum'.³⁴ Echoing Kennedy's Reith lectures, Gillon argued that students should undertake '*critical study* of moral decisions, attitudes and actions' in order to prepare themselves for the fact that 'patients in our plural society have various norms and expectations and are often unwilling to accept the moral standards and decisions of their doctors, at least without adequate discussion'.³⁵ In the same issue, the student president of the LMG praised 'Kennedy's important contribution to the health debate' and agreed that 'the need for ethical and humanitarian education in medical schools is now more necessary than ever'.³⁶ He also endorsed outside involvement in ethics teaching, claiming that the traditional focus on medical etiquette 'must be replaced by a more genuinely philosophical approach' where 'philosophers, doctors and students pool their expertise and apply it to both old and new issues and problems'.³⁷

Alan Johnson, professor of surgery at Sheffield University, was one of several doctors who endorsed Kennedy's view that medical ethics should be 'no optional extra'.³⁸ Johnson agreed that there was 'no need for the doctor to feel threatened by advice and analysis from the non-medical [*sic*]', but stressed that they should not completely pass responsibility for ethics teaching to 'a solitary, departmentless, "professional ethicist"'.³⁹ He believed doctors should instead 'get together with non-medical experts' to deliver a course that best captured the realities of clinical practice in a 'pluralistic country and a pluralistic profession'.⁴⁰ Like the members of the EMG, Johnson believed that the absence of obviously 'correct' answers meant that 'formal lectures alone are not the best way to teach medical ethics' and should be secondary to 'small-group teaching'.⁴¹

By 1983, when Johnson's article was published, growing numbers of doctors and 'non-medical experts' were beginning to collaborate in medical ethics teaching. Following a chance meeting with the head of the University of Southampton's medical school, Ian Kennedy had the chance to put his ideas into practice when he co-designed five sessions on medical ethics, timetabled as part of the third-year course in general practice.⁴² During each session, students read a book such as Glover's *Causing Death and Saving Lives*, 'which discussed the nature of moral argument, showing how moral arguments may be rationally defended or questioned', and then related it to a specific case study. Although Kennedy and his colleagues noticed that students initially expressed some antagonism towards the new format, which 'may have come from the common reaction to any "outsider" trying to teach doctors their job', they claimed it soon gave way to 'lively discussion'.⁴³ This encouraging start led the medical school to plan a similar venture for the next academic year, with staff from the law faculty taking over Kennedy's role 'so that in future we shall be able to rely on local sources'.⁴⁴

During the early 1980s Kennedy was also involved in designing ethics courses at the University of Cambridge and St Thomas's Hospital, London, and planned to 'set up teaching at postgraduate level, and indeed at undergraduate level, as soon as possible' through the Centre of Medical Law and Ethics, which he had established at King's College in 1978.⁴⁵ In letters to Alan Johnson and Mary Loboit, Kennedy proposed that the Centre of Medical Law and Ethics could sponsor a 'meeting of all those interested in the teaching of medical ethics so that experience can be shared and a common policy adopted for the future'.⁴⁶ This echoed earlier proposals by Raanan Gillon, who was an affiliate of Kennedy's Centre. In the *Journal of Medical Ethics*, Gillon called for a meeting where representatives from different professions could discuss 'whether or not matters are satisfactory as they are', and also supported the establishment of a 'working party' to suggest new directions in ethics teaching.⁴⁷

Both these demands were met in 1984, when the GMC's Education Committee held a multidisciplinary conference on 'Teaching Medical Ethics' and the IME convened a working party to make recommendations for ethics teaching. All speakers at the GMC conference argued that medical ethics should be an important part of medical training, and most agreed, like one young doctor, that 'non-medical teachers have a role to play'.⁴⁸ This viewpoint was captured by Edward Shotter, who conceded that the success of the medical groups may have hindered the incorporation of medical ethics into the curriculum. Shotter now argued that medical ethics should be taught as a central subject, providing that

doctors collaborated with 'staff from departments of law, philosophy, the social sciences and theology'. This was vital, he claimed, to ensuring that ethics teaching was not 'the sole responsibility of those who might feel morally bound to express their own views to the detriment of others', and to accurately preparing students for dealing with ethical issues 'in a society where values are in conflict'.⁴⁹ Like Shotter, other speakers agreed that since there are many different viewpoints on ethical issues and no obviously 'correct' answer, 'tutorial type teaching, with interplay between tutor and students [is] the most productive method' of teaching medical ethics.⁵⁰

These opinions were shared by an IME working party on medical ethics teaching, which Shotter claimed had been established to make recommendations 'at a time when there is no overriding moral viewpoint, and in the face of diversity of opinion about how the subject might be taught'.⁵¹ The working party was chaired by the psychologist Sir Desmond Pond, then Chief Scientist at the DHSS, and the eighteen other members included doctors, nurses, lawyers, philosophers and theologians.⁵² After deciding that reliable information on ethics teaching was 'not readily available', the working party sent out questionnaires to the deans of thirty British medical schools and received twenty-six replies.⁵³ The responses indicated considerable variety in how medical ethics was taught. While all schools claimed to teach medical ethics, some taught it more than others; some focused on traditional questions of a doctor's rights and duties, while others looked in greater depth at the ethical problems raised by medicine; and some taught it in formal lectures, while others used 'problem-oriented' methods and group discussion.⁵⁴

The working party also found little consistency in who taught medical ethics, especially when it came to the involvement of 'nonmedical teachers'.⁵⁵ When they asked if non-medical staff were involved in ethics teaching, only two schools replied in the negative. But the replies from the others indicated clear differences. Students in six medical schools only encountered non-medical opinions via the voluntary medical group seminars, while six others used health visitors in formal teaching, seven used hospital chaplains, five used representatives from patient groups, three used theologians, eight used philosophers and five used lawyers, although in four of these cases it was 'the same lawyer' (presumably Ian Kennedy).⁵⁶

When the working party published their recommendations in 1987, which became known as the 'Pond report', they 'decided against recommending a specific syllabus for medical ethics' on account of GMC rules that gave medical schools flexibility in how they delivered the curriculum.⁵⁷ But they nevertheless issued 'general recommendations' – with the first being that 'medical ethics teaching should occur at regular intervals throughout medical training'.⁵⁸ They also recommended that ethics sessions 'should involve a teacher or teachers with training in the analytic disciplines (moral philosophy, theology or law)' working alongside doctors and 'representatives of the professions associated with medicine (nursing, social work, chaplaincy and others)'.⁵⁹ Like the speakers at the GMC conference, the Pond report argued that disciplinary collaboration was essential in order to 'avoid leaving ethics teaching in the hands of a teacher whose tendency is to promote a single, political, religious or philosophical viewpoint'.⁶⁰ This was as true for non-medical teachers as doctors, it continued, since 'some lawyers or philosophers may not be as even-handed as their profession suggests'.⁶¹

This last point was elaborated in the report's appendix, where Jonathan Glover wrote a short paper arguing that non-doctors should simply help students 'think more clearly about issues and understand them better'.⁶² To do otherwise, he claimed, would 'leave people more dogmatic or muddled than they were before'.⁶³ Glover proposed that ethics teaching should thus 'start with cases, not theory' and was better taught in group-based sessions than lectures, since this allowed teachers and students to 'state their own approaches and think out the implications and problems'. Although he reiterated the commonly held view that there were 'no objective true answers', Glover argued that group-based argument could achieve the 'more modest' aim of giving students a 'clear grasp of the complex issues involved'. This approach, he concluded, would make future doctors more tolerant of different views and might also allow them to identify inconsistencies in certain arguments, which might encourage patients or colleagues to 'abandon or modify' particularly dogmatic lines of thought.⁶⁴

Like Kennedy's Reith Lectures, there was nothing particularly new about the Pond report. By using the dismissal of 'correct' answers to support interdisciplinary and group-based teaching, it echoed the individualistic view of ethics held by many British philosophers. And it embodied the core philosophy of the medical groups and the IME, which believed that interdisciplinary debates made students better doctors by reconciling them to moral pluralism. Like other advocates of interdisciplinary teaching, Pond's working party also reflected the British view that medical ethics and bioethics was a 'partnership' between non-doctors and the medical profession.⁶⁵ They argued that in contrast to the United States, where medical ethics was often taught by a 'solitary' philosopher, it should be a collaborative enterprise where the doctor remained central.⁶⁶

These arguments were well received before the IME's report was published, as medical support for the EMG group's proposals and Kennedy's Reith Lectures indicates. But the Pond report was certainly influential, partly thanks to the illustrious nature of its working party, which included renowned doctors, scientists, philosophers and lawyers, and partly thanks to the way that it framed 'non-medical' teaching as beneficial to doctors. Its proposals were endorsed by the GMC's 1993 report, *Tomorrow's Doctors*, which stated that sessions on 'the ethical and legal issues relevant to the practice of medicine' should become part of the core curriculum.⁶⁷ Although *Tomorrow's Doctors* did not promote multidisciplinary teaching as explicitly as the Pond report, it nevertheless noted that doctors were increasingly likely to rely on the 'social sciences and philosophy' to help them handle 'ethical issues that will increasingly impinge on the problems of health'.⁶⁸

In 2007 Kenneth Boyd, a founding member of the EMG, recalled that the Pond and GMC reports 'gave teeth' to existing support for multidisciplinary teaching.⁶⁹ During the late 1980s and early 1990s greater numbers of non-doctors became involved in teaching medical students, which went from being something they did rarely and on an *ad hoc* basis to a major activity. By 1996, when the University of Bristol appointed Alastair Campbell to one of the first British chairs in medical ethics, it was clear that in universities, just as in public and Parliament, medical ethics was no longer considered solely a matter for doctors.⁷⁰

Creating academic centres for bioethics

The non-doctors who taught medical students were initially based in law, philosophy and social science departments. Medical ethics constituted a small part of their workload and was secondary to general teaching in their respective subjects.⁷¹ However, by the publication of the Pond report in 1987, and certainly by the publication of *Tomorrow's Doctors* in 1993, they were often located in new and interdisciplinary centres dedicated to medical ethics or bioethics. Many of these centres were established by those advocates of 'multidisciplinary teaching' we have already encountered, who believed they provided an institutional base for lawyers, philosophers, doctors and others to collaborate on undergraduate and postgraduate courses. Ian Kennedy opened the first dedicated Centre of Medical Law and Ethics at King's College in 1978, to facilitate interdisciplinary teaching and research, and members of local medical groups helped establish similar centres at the universities of Swansea and Manchester during the mid 1980s.⁷²

But the promotion of 'multidisciplinary teaching' was not the sole reason that these centres emerged; nor was it the sole reason that increasing numbers of academic lawyers, philosophers and others engaged with practical issues during the 1980s and 1990s. We cannot understand the growth of academic bioethics without also appreciating the impact of budget cuts on higher education in the 1980s, which forced staff in the humanities and social sciences to work in more 'applied' areas and stress the utility of their work. As we saw in chapter 3, Margaret Thatcher's Conservative Party sought to reform many professions and public services after the 1979 general election, and universities were no exception. Thatcher believed that the guaranteed distribution of government money through the University Grants Committee (UGC) had insulated universities against the current recession and, crucially, had distanced them from the commercial approaches that the Conservatives believed would transform Britain. She made her views clear in 1981, when she informed Geoffrey Warnock, then vice-chancellor at Oxford, that universities were arrogant, elitist and indifferent to economic needs: 'wasting time and public money on such subjects as history, philosophy and classics'.⁷³

The same year, the government announced that it was taking steps to reform universities by making them more competitive and self-sufficient. Mark Carlisle, Secretary of State for Education and Science, claimed they wanted to encourage a 'leaner university system ... better oriented to national needs and operating within the context of what the nation can afford'.⁷⁴ Carlisle announced that the government was cutting UGC funding, and that reductions would be imposed selectively between institutions and subject areas. In July 1981 the UGC informed all vice-chancellors of the cuts that were being imposed on their universities, and offered guidance on how they felt the reduction should be spread across particular disciplines.⁷⁵

Given the government's emphasis on meeting 'national needs' and enthusiasm for commercial approaches, academics rightly predicted that the UGC would prioritise disciplines that were seen to contribute to economic growth, while penalising those they viewed as unproductive.⁷⁶ As one pro-vice-chancellor at the University of Manchester noted, the UGC's guidance clearly 'favoured "big science", particularly engineering, physics, chemistry and computer science'.⁷⁷ As expected, the UGC also advised vice-chancellors to use budget cuts to 'downgrade the arts'.⁷⁸ In a newsletter, the Society for Applied Philosophy outlined how the UGC had warned that fields such as philosophy 'will be receiving low priority in its deliberations in the coming years', and reported that they had advised philosophers to set up a review to 'assist in the closing of some departments'.⁷⁹

In 1985 philosophers formed a committee to defend their subject against UGC cuts. This National Committee for Philosophy (NCP) submitted a report to the UGC arguing that cuts to philosophy 'should be proportionate to the cuts suffered by other disciplines'.⁸⁰ To support their argument, the NCP framed philosophy as an increasingly practical discipline, with growing numbers of philosophers now 'applying their insights to other disciplines, and to the philosophical and ethical problems of everyday life'.⁸¹ At the same time, A. J. Ayer and Mary Warnock publicly asserted that philosophy was vital to maintaining a society that valued reasoned debate, analytical rigour and intellectual originality, and protested that the government and the UGC's 'new vocationalism' represented an assault on the notion of learning for its own sake.⁸²

In spite of these protests, faced with severe financial pressure and fearing the consequences of ignoring the UGC's guidance, most universities did protect the sciences and 'downgrade' their arts and humanities departments. Senior academics in these fields were encouraged to take early retirement and were not replaced, which made it easier for politicians and administrators to criticise shrinking departments as 'weak and ineffectual'.⁸³ By the end of the 1980s seven philosophy departments had closed and many others faced an uncertain future.⁸⁴

The pressure on philosophy departments was compounded when the government replaced the UGC with a new Universities Funding Council (UFC) in 1988. The government's enthusiasm for external oversight was reflected in the UFC's composition, in which academics were outnumbered by outsiders, and particularly businessmen, who shared the Conservative belief that 'the purpose of higher education was to satisfy the needs of industry'.⁸⁵ The UFC distributed money on the basis of 'research assessment exercises' that judged the quality of a department's academic work. 'Quality' here involved acquiring large grants from research councils, collaborating with industry and publishing regular articles; and these criteria, as Mary Warnock noted, clearly favoured applied fields such as the sciences and engineering.⁸⁶ In order to meet the new standards and combat declining government funds, academics in fields such as philosophy were obliged to seek money from outside sources such as research councils and charities.⁸⁷ Many now believed that they stood a better chance of gaining funding and meeting demands that research had to confer 'social benefits' if they worked in areas with obvious practical relevance.⁸⁸

Budget cuts and the new assessment criteria also encouraged the reconfiguration of traditional disciplinary structures. University managers and some academics believed it was 'possible to improve both performance and image by casting down old-fashioned departmental barriers and abandoning worn-out subject divisions'.⁸⁹ This belief led to the creation of interdisciplinary institutes, both in the sciences and the humanities, which 'brought together scholars with shared interests to consider common problems'.⁹⁰ As Robin Downie and Jane MacNaughton note, during the 1980s this combination of factors encouraged growing numbers of academics to 'become involved with bioethics'.⁹¹ Bioethics appealed to staff in the humanities who sought funding for applied work, and its presentation as a 'partnership' made it an obvious subject for interdisciplinary collaboration.

Support for 'multidisciplinary' ethics teaching and the changing political climate were both evident in the 1986 formation of the University of Manchester's Centre for Social Ethics and Policy (CSEP). CSEP brought together academics from medicine, theology, law and philosophy, who all believed that medical students would benefit from interdisciplinary ethics teaching. Although CSEP's founders did not directly cite UGC cuts as an influence, financial constraints nevertheless ensured that they stressed the applied nature of their work when seeking money and publicising new courses. Changing priorities for higher education also ensured that CSEP was well received by senior university figures, who praised it as good evidence of the 'transdisciplinary co-operation' that was increasingly expected of academics.⁹²

One of CSEP's co-founders was Mary Loboit, a student health physician who had organised the Manchester Medical Group (MMG) since its formation in 1975. Loboit had long believed that increased ethics teaching, with input from several professions, was vital to helping medical students become 'better doctors'.⁹³ She supported Ian Kennedy's claims that medical ethics should be a 'central course' and corresponded with him after his Reith Lectures to discuss 'ideas concerning a more formal approach to teaching medical ethics'.⁹⁴ Between 1984 and 1987 Loboit was also a member of Desmond Pond's working party on ethics education, whose final report reflected her existing support for interdisciplinary teaching.

As organiser of the MMG, Loboit invited several non-doctors to talk on ethical issues. One of her speakers was John Harris, who had been appointed to the University of Manchester as lecturer in the philosophy of education during the late 1970s.⁹⁵ Although he mainly taught philosophy of education, Harris pursued his interest in bioethics by talking to the medical groups, arranging a 1983 workshop on 'Philosophical and Ethical Issues in Medicine', writing on the ethics of IVF, and extending his arguments from here and the 'Survival Lottery' in a 1985 book on *The Value of*

Life.⁹⁰ This work ensured that Harris was often asked to comment publicly on bioethical issues by the mid 1980s, with the Society for Applied Philosophy selecting him as a preferred speaker for their 1985 'conference on bio-ethics'.⁹⁷

In 1984, during the train journey to a debate on surrogacy at the University of Aberdeen, Harris met Anthony Dyson, professor of social and pastoral theology at the University of Manchester. Like Ian Ramsey and Gordon Dunstan, Dyson believed that theology needed to engage with contemporary concerns to remain relevant. He also shared their enthusiasm for interdisciplinary collaboration, which he had had the chance to satisfy when he served on the Warnock inquiry between 1982 and 1984.⁹⁸ These convictions were clear in a talk to the Manchester Literary and Philosophical Society, when Dyson outlined how:

many different kinds of human experience from many different directions are necessary contributions to the future shape and content of medical ethics, as we explore wider definitions of the healing community, and seek to discover the social and political arrangements which will help the health care professionals to identify more fully their own central, crucial and indispensable role in the evolution of a medically moral society.⁹⁹

Dyson shared his enthusiasm for interdisciplinary collaboration with Mary Lobjoit, who he knew through the MMG. He also shared it with John Harris; but despite working at the same university, they had never met or heard of each other before their trip to Aberdeen.¹⁰⁰ After returning to Manchester, Harris and Dyson began discussions with Lobjoit about establishing an interdisciplinary MA degree in Healthcare Ethics, which would bring together local academics with an interest in medical ethics. During 1984 and 1985 they set about gaining support from senior figures in the medical school and the faculty of science – 'without which', Dyson wrote to one scientist, 'we cannot easily go ahead'.¹⁰¹

These letters framed the potential MA as a timely venture and a catalyst for greater collaboration. As Lobjoit informed Max Elstein, head of the department of obstetrics and gynaecology, it was 'a response to increasing interest, both in Manchester and nationally, and we hope that such a course will both stimulate and focus the interests of many of our colleagues'.¹⁰² Lobjoit claimed that the MA was needed to keep pace with new degrees being offered in places such as King's College, where Ian Kennedy's Centre started a Diploma in Medical Law and Ethics in 1984, and to meet the growing support for 'multidisciplinary teaching' from bodies such as the IME and the GMC. As they did nationally, local doctors and scientists supported proposals for an interdisciplinary ethics degree. Elstein viewed it as 'a splendid idea' and told Lobjoit that ethics was 'something that the students feel they need to be taught in greater depth'.¹⁰³ After seeing a draft of plans circulated in the medical school, Mark Ferguson, professor of basic dental sciences, wrote to Dyson and pledged his 'wholehearted support' for the new MA.¹⁰⁴

Buoyed by the 'outstanding measure of support' from scientists and doctors, Dyson, Harris and Lobjoit broadened their plans to include the establishment of a 'more general forum in which the crucial problems facing our society can be examined from a wide variety of perspectives'.¹⁰⁵ They now proposed the establishment of an interdisciplinary centre where they and others could pursue their mutual interest in 'medical ethics and applied ethics broadly conceived'.¹⁰⁶ Planning for this centre soon included the lawyer Margaret Brazier, who had written on medical negligence as part of broader work in tort law and also knew Lobjoit through the MMG.¹⁰⁷ The title this quartet chose for their new venture indicated that they wanted it to be a 'more broadly "bioethics" venture' than Kennedy's Centre of Medical Ethics and a recently opened Centre for the Study of Philosophy and Health Care at the University of Swansea.¹⁰⁸

This broad remit was apparent in a planning document for the prospective 'Centre for Social Ethics and Policy', which stated that it would look at 'the ethical and policy implications of developments in all areas of society'. These included 'the necessity for education about AIDS and for an educational response to medical and biotechnological advance', as well as more general topics such as 'race and gender issues in education and the wider social role of education and educational institutions'.¹⁰⁹ These broad aims reflected Harris's interest in the moral consequences of new biotechnologies and philosophy of education, Brazier's interests in patient rights and Dyson's interest in 'the contribution of feminist thought to medical ethics'.¹¹⁰ They also indicate that while new ethics centres may have been broadly shaped by demands for multidisciplinary teaching and 'applied research' in the 1980s, their orientation and focus differed according to specific local conditions and the interests of the staff involved.

CSEP was established at a time when the university hierarchy was promoting interdisciplinary collaboration and asserting the value of applied research. The vice-chancellor Mark Richmond, a microbiologist by training, had been appointed in 1981 to help the university deal with the UGC's budget cuts. Richmond was a member of the

government's advisory group on genetic manipulation, the successor to GMAG, and had strong connections with the UGC. He shared the UGC and the government's enthusiasm for practical research, both in the arts and humanities, and was pictured in *The Times* wearing a train-driver's hat emblazoned with the logo 'Universities Work!'¹¹¹ Richmond also believed that the university would be better equipped to deal with budget cuts and changing priorities by establishing 'research units' that brought academics from different fields together to work on common problems.¹¹² He encouraged a wholesale reform of biology in 1986, when eleven separate departments merged into a unified School of Biological Sciences that prioritised 'applied' work in molecular biology and built links with pharmaceutical firms.¹¹³ CSEP was formally established in the same year and was administered as a centre within the department of education, with Lobjoit acting as administrative director, Dyson as academic director and Harris as research director.¹¹⁴ Although CSEP was a much smaller enterprise than the School of Biological Sciences, it nevertheless attracted praise from Richmond, who told John Harris that he considered it 'a most interesting example of transdisciplinary co-operation'.¹¹⁵

By dwelling on the practical benefits of interdisciplinary collaboration, publicity for CSEP reflected changing priorities in higher education during the 1980s. A front-page article in the university magazine *This Week*, which detailed the opening of this 'new ethics centre', asserted that the 'crucial problems facing society today' were best 'examined from a variety of perspectives'.¹¹⁶ A promotional brochure from 1987 also claimed that CSEP was 'a product of, and committed to, inter-departmental and inter-institutional collaboration'.¹¹⁷ This collaboration was vital, it asserted, 'if we are to harness the benefits while protecting ourselves from the all too probable catastrophes of a technological age'.¹¹⁸ The brochure emphasised the practical benefits of CSEP's MA in Healthcare Ethics and of research projects on autonomy and consent, theological issues in nuclear disarmament and the ethics of biotechnology, which it argued would help professions and the public develop 'the ability to resolve the dilemmas they pose'.¹¹⁹

There were clear motives behind this emphasis on the applied nature of CSEP's work. In line with government and UGC criteria, the university hierarchy expected its departments and 'research centres' to generate their own income by obtaining money from charities, research councils and commercial firms. This was made clear in CSEP's promotional literature, which stated that the university had provided 'very limited resources' towards 'the work of the Centre and its future development'.¹²⁰ In order to obtain money for a series of lectures on 'Experiments on Embryos', which doubled as CSEP's public launch event, Lobjoit requested money from a variety of commercial sources and Brazier wrote to several charities and legal firms. Their letters acknowledged that any donation 'would be a different form of investment from the usual clinical research', but stressed that 'we are convinced of equivalent importance in improving healthcare practice'.¹²¹

Many firms turned these requests down, claiming that 'research departments in the pharmaceutical industry find themselves under great restraints these days for any sponsorship other than clinical research projects'.¹²² But some were more forthcoming, and ICI, Hoechst, Boots and the charitable Hamlyn Trust all contributed to publicity for CSEP's embryo lectures and paid the costs of speakers, who were Robert Edwards, the neurologist John Marshall, the lawyer Douglas Cusine and the theologian Keith Ward.¹²³ Thanks largely to Edwards's attendance, these lectures attracted a large audience and, John Harris recalls, 'really put us on the map as dealing with something that was a public interest and general interest'.¹²⁴ Buoyed by this success, Mary Lobjoit told her contacts at ICI that CSEP intended 'to continue with this format for next year' and was planning a series of lectures on 'The Ethics of Experimentation on Children'.¹²⁵

While they arranged the open lectures and lobbied potential funders, CSEP's founders continued to promote the MA in Healthcare Ethics to the medical school and across the university. In letters to senior lecturers and the dean of the medical faculty, Lobjoit used her position on Desmond Pond's working party to claim that the MA would bring Manchester into line with forthcoming proposals that 'ethical teaching should take a more prominent place in medical education'.¹²⁶ Like Kennedy, she presented interdisciplinary teaching as a 'partnership' that would benefit doctors – since 'it is not either feasible or appropriate for your discipline to bear the whole responsibility for such enterprises if they are to be expanded'.¹²⁷ As with Kennedy's Reith Lectures, this tactic was successful. Several doctors agreed to teach on the MA and the Board of Studies for medicine decided that the medical school would be one point of entry for the new degree (the others were the departments of education and theology).¹²⁸

CSEP's founders decided to aim the MA primarily at healthcare professionals and 'hoped the course will attract, *inter alia*, doctors, nurses, psychologists, health-care administrators, the whole range of social workers involved in care or therapy and all those, including teachers, involved with handicap'.¹²⁹ This was made clear in publicity, which

portrayed the MA largely as a professional development course. A promotional brochure and press release claimed that it met 'the need for study training and research in healthcare ethics' and was 'centred firmly on healthcare practice'.¹³⁰ Perhaps unsurprisingly, when the course started in October 1987 its intake consisted mainly of 'nurses, including midwives, and a number of doctors from several branches of medicine'.¹³¹ At the same time, publicity for CSEP was also aimed at non-medical professionals and humanities graduates, and claimed that the MA 'does full justice to the philosophical, legal, religious, historical and social dimensions to healthcare ethics'.¹³² This ensured that the MA intake also included smaller numbers of 'solicitors, philosophy graduates and ministers of religion'.¹³³

Launched the same year as an MA at Kennedy's Centre of Medical Law and Ethics, CSEP's MA course was one of the first dedicated medical ethics or bioethics degrees in Britain.¹³⁴ In a 1987 letter Kennedy told John Harris that it 'looks exciting' and hoped 'the course is a great success – in my view there can't be too many of them'.¹³⁵ As Kennedy and CSEP's founders had hoped, both degrees were successful from the outset. In a 1987 edition of the *Journal of Medical Ethics*, Harris, Dyson, Lobjoit and Brazier claimed that the 'high rate of applications for the MA indicates a level of interest and enthusiasm which has astonished and pleased the degree's organisers'.¹³⁶ Indeed, the level of interest was so high that they discussed 'the question of a ceiling on student numbers'.¹³⁷ This ceiling was never implemented, however, and fees for the MA in Healthcare Ethics provided a regular source of income from 1987 onwards.

The degree's structure and focus, with input from many staff and departments across the university, reflected the British attitude that no one profession should dominate medical ethics or bioethics. Students took two compulsory modules in 'moral philosophy', taught by Harris and the philosopher Harry Lesser, and two modules in 'cases in healthcare practice', taught by Lobjoit and several medical staff. The handbook for Harris's module also reflected the general belief that 'the importance of medical ethics does not lie in its ability to provide any answers in advance to the difficult problems faced by healthcare professionals and others'. Harris claimed that it lay instead 'in its ability, first, to widen awareness of the issues involved and sensitivity to them; secondly, to clarify one's thinking about these issues'.¹³⁸ Like other British philosophers, Harris was sceptical of the principles-based approach that dominated American bioethics and taught it more as a 'problem-based subject'.¹³⁹ In addition to these courses and a 20,000 word dissertation, students also had to pick two options from courses in 'medico-legal problems', taught by Brazier, 'religious issues in medical ethics', taught by Dyson, 'medical ethics in historical context', taught by historians of medicine, and 'medicine in modern society', taught by staff in a department for science and technology policy.¹⁴⁰

Following the publication of the Pond report, CSEP staff also became more involved in undergraduate medical ethics teaching. As Harris and Max Elstein outlined in 1990, they scheduled interdisciplinary ethics sessions during the third-year obstetrics and gynaecology course, since 'many of the problems which cause concern to students are within the field of human reproduction'.¹⁴¹ Harris and Elstein acknowledged that this format was something of a compromise though, as students had 'requested a specialised course in medical ethics' but senior staff rejected the 'idea of "giving up valuable teaching time" within the medical curriculum'.¹⁴² They nevertheless believed that wherever it was scheduled, 'an essential component of this teaching is its interdisciplinary nature'.¹⁴³

In order to give students experience 'of moral argument and of the disciplines that make moral argument possible', the sessions were taught by a combination of 'theologians, social workers, senior nurses, philosophers and lawyers'.¹⁴⁴ They took up a single morning, with three lectures devoted to specific issues. Harris gave an introductory lecture that outlined the moral problems raised by an example such as the *Arthur* case, Brazier outlined the associated legal issues, and students were then split into small discussion groups led by 'a clinician and an ethicist from a non-clinical background'.¹⁴⁵ Harris and Elstein echoed the Pond report and previous discussion of ethics teaching when they argued that this format was essential to enabling students 'to think their way through a problem and come to an appropriate solution, or equally important, to the realisation this may not be possible'.¹⁴⁶

In addition to these undergraduate sessions, the MA attracted increasing numbers of students each year. While this boosted CSEP's profile in and beyond the university, it also presented problems. In 1991 Mary Lobjoit wrote to a contact at Boots claiming that it was 'gratifying to find that we are getting known, that our students are regarded with respect and people actually enjoy getting involved in this particular form of study'. But she noted that this success meant that CSEP had ceased to be 'a part time enterprise'.¹⁴⁷ Teaching on the MA and undergraduate courses now constituted a significant workload for Harris, Dyson and Brazier, who Lobjoit claimed were already 'snowed under' with work for their own departments.¹⁴⁸

Although she had taken early retirement in 1990, following a reform of the student health service, Lobjoit still taught her MA module on a voluntary basis. As her letters demonstrate, she also continued to seek outside funding for CSEP.

In order to ease her colleagues' workloads and 'get the centre on a more secure footing', Lobjoit now wrote to Boots exploring the possibility 'of a number of interested parties donating a fixed sum, per year, rather like a covenant', which would pay for an administrator and additional staff.¹⁴⁹

While Lobjoit's contact at Boots agreed to donate £500 'toward your costs', he was unable to sanction more permanent support and doubted whether any other firm 'would wish to sign a covenant guaranteeing support for any length of time'.¹⁵⁰ But CSEP did gain a more 'secure footing' in 1992 when it secured a major European Commission grant for a three-year project titled 'AIDS: Ethics, Justice and European Policy'. The project was co-ordinated by Harris and brought together participants from fourteen European countries to look at issues associated with AIDS, such as the ethics of compulsory screening, confidentiality and euthanasia.¹⁵¹ Crucially, the award of over £300,000 lightened the workload for CSEP's founders by funding the appointment of an administrator and research staff, who taught on the MA course and worked on the AIDS project. It also consolidated CSEP's growing reputation within the university, drawing praise from Martin Harris, who replaced Mark Richmond as vice-chancellor in 1992 and shared his predecessor's belief that academics needed to be 'entrepreneurial' in order to gain funding.¹⁵² In a 1992 letter the new vice-chancellor congratulated John Harris on the AIDS grant and claimed that 'in the present financial climate, it is crucial that the University is able to attract significant recognition and funding of this kind if we are to maintain our momentum as a leading research institution'.¹⁵³

By this point Margaret Brazier and John Harris had been promoted to chairs at the university. The fact that CSEP was now a recognised centre was reflected in the title of Harris's chair, which was not a professorship of applied ethics or philosophy of education, but of 'bioethics'.¹⁵⁴ CSEP gained further recognition and funding in 1995 with another European Commission grant for a project on 'Communicable Diseases, Lifestyles and Personal Responsibility: Ethics and Rights'. By the late 1990s this research income and an annual intake of around forty MA students ensured that CSEP was at the forefront of a growing network of centres for bioethics and medical ethics, which brought together staff from different fields in King's College, Cardiff, Liverpool, Bristol, Glasgow, Keele, Newcastle, Edinburgh, Nottingham, Swansea and Oxford.

Although they all broadly looked at ethical issues associated with medicine or biological science, institutional factors and the interests of particular staff ensured that these centres were often located in different departments and prioritised varying approaches to bioethics. Some were based in medical or veterinary schools, while others were based in law or philosophy departments. Many, such as CSEP, adopted a case-driven approach to bioethics, while a minority, such as the University of Nottingham's Centre for Applied Bioethics, organised their work around principles-based methods.¹⁵⁵ While these centres increasingly provided an institutional home for bioethics, this did not mean that it became a narrow academic activity. In addition to teaching and carrying out research, their staff spoke publicly on ethical issues, established links with politicians and policymakers, and served on regulatory bodies such as the HFEA.¹⁵⁶

Many academics in the humanities and social sciences believe that the focus on 'applied' topics such as bioethics ensured the future of their subjects, by providing funding and jobs in an increasingly competitive and austere climate. Writing on the emergence of academic bioethics, Downie and Macnaughton claim that it is hard to disagree with Stephen Toulmin's contention that 'medicine saved the life of ethics'.¹⁵⁷ Changing priorities in higher education certainly provided an opportunity for like-minded academics to engage with practical issues and collaborate across disciplinary lines. By establishing ethics courses and centres such as CSEP, which secured outside money and postgraduate fees, these academics won the approval of senior managers and ensured that academic bioethics became a 'growth industry' into the 1990s. In addition to proving their utility by helping 'doctors become better doctors', these courses also sustained the growth of bioethics by acting as an entry point to the field.¹⁵⁸ Several students on CSEP's MA in Healthcare Ethics, such as Søren Holm, have gone on to have successful careers as bioethicists, and the same is true of graduates from other centres.¹⁵⁹

But not everyone took a positive view of these new centres and courses. Mary Warnock, for example, did not believe that philosophers should concentrate solely on medical issues or work 'in a special medical ethics department'.¹⁶⁰ In a 1990 lecture she claimed that if philosophers, lawyers and theologians were 'fed nothing but a diet of medical ethics, or, even worse, if they have taught nothing but this subject and have conducted all their research in it, they are likely to become as tunnel-visioned as the doctors and scientists themselves'.¹⁶¹ Warnock argued that while they should be 'acquainted with some of the issues they are likely to encounter as members of ethical committees ... a moral philosopher who deserves the name must concern himself with the nature of morality in general, and must be prepared to consider examples from all kinds of areas, public and private'.¹⁶² She also stressed that moral philosophy 'should

not be studied separately from all the rest of philosophy, epistemology, for example, or the philosophy of mind', and defended these subjects against 'spiteful and short-sighted' budget cuts.¹⁶³

Yet while Warnock viewed bioethics as an important component of philosophy,¹⁶⁴ some regarded it as inferior to more theoretical approaches and often resented the prestige and money it attained.¹⁶⁴ This was not necessarily a problem for ethicists who worked in interdisciplinary centres, but it often left those in more traditional departments 'out in the cold'.¹⁶⁵ And while their interest in bioethics may have proved fruitful for staff in new centres, it was often not a central concern for staff or undergraduates in the schools and faculties in which these centres were based, such as law, philosophy or medicine. This ensured that in order to justify their existence, staff in bioethics centres often had to work harder to maintain a strong postgraduate intake and generate research income.¹⁶⁶

Michael Whong-Barr has also argued that the emphasis on clinical matters in ethics teaching came at a price, marginalising those broader issues that were previously discussed in the medical group seminars and running the risk of 'complacently supporting social structures and assumptions'.¹⁶⁷ This criticism no doubt stems from the fact that the emergence of bioethics centres and courses contributed to the demise of the medical groups. As ethics teaching became a full-time occupation for many academics, their enthusiasm for organising medical groups diminished. And once ethics was increasingly taught on formal undergraduate and postgraduate courses, universities stopped subsidising the medical groups and student demand tailed off significantly. The LMG disbanded in 1989, after Edward Shotter was appointed Dean of Rochester Cathedral, and the regional medical groups followed suit during the 1990s.¹⁶⁸ Recalling the end of the Newcastle medical group in the early 1990s, the Revd Bryan Vernon states that 'as medical ethics became something that was taught more, so it became less something that was done outside [in medical groups]'.¹⁶⁹

Whong-Barr is certainly right to claim that undergraduate courses discussed a narrower set of issues than the medical groups and 'lacked analysis of the social processes that ... help generate moral dilemmas in the first place'.¹⁷⁰ As Harris and Elstein acknowledged, timetabling constraints ensured that they only had time to look at one or two issues that students were likely to encounter in clinical practice.¹⁷¹ Nevertheless, we should bear in mind that some of the postgraduate courses that emerged in the 1980s looked at a broad range of issues, including the social and historical aspects of medicine and science. And we should also bear in mind that in contrast to the medical group seminars, compulsory undergraduate sessions guaranteed that all medical students encountered some interdisciplinary perspectives, which had been the original aim of the LMG's founders in the 1960s.

The realisation of these ambitions in the 1980s stemmed from the efforts of the individuals encountered in this chapter and reflects the importance, once again, of the political changes that followed the 1979 election. In stressing how bioethics benefited doctors and 'the community as a whole', figures such as Lobjoit, Harris, Brazier and Dyson were well placed to benefit from the increasing emphasis on 'applied' work and ensured that new ethics courses and centres were increasingly prized by students, doctors and university managers alike.

Conclusion

As elsewhere in Britain, the interplay between professional concerns and political changes underpinned the emergence of 'multidisciplinary' courses and bioethics centres in universities during the 1980s and 1990s. Support for interdisciplinary teaching first emerged in the 1970s, when medical group members argued that it would give students a greater awareness of moral issues, including the fact that they often lacked clear answers. This argument was reiterated in Ian Kennedy's 1980 Reith Lectures, and it also underpinned the 1987 Pond report. By presenting 'non-medical' input as beneficial to both practising and future doctors, these arguments secured the support of influential bodies such as the GMC and ensured¹⁷² that medical schools increasingly involved philosophers, lawyers and others in ethics teaching during the 1980s.

Support for these multidisciplinary approaches was consolidated by budget cuts for universities, which favoured the growth of 'applied' subjects such as bioethics. This emphasis boosted those supporters of formal ethical training and applied ethics, making it easier for Lobjoit, Harris, Dyson and Brazier to establish and promote CSEP. And the success that CSEP and similar centres enjoyed in attracting students and research funding sustained the growth of bioethics, encouraging greater numbers of academics to engage with 'applied' issues and leading vice-chancellors to praise it as an important field 'in the present financial climate'.¹⁷³

But we should nevertheless refrain from making broad assumptions about how and why bioethics emerged at particular universities. While the broad factors noted above were undoubtedly influential, local factors such as individual personalities and institutional politics also played a decisive role. This is illustrated by the fact that new

bioethics centres emerged in different faculties, prioritised varying approaches and often had contrasting relationships with their local medical groups. While Mary Loboit's role as organiser of the MMG ensured that it had strong links to CSEP, for instance, Ian Kennedy's scepticism towards the medical groups ensured that the Centre of Medical Law and Ethics had little connection to the LMG.¹⁷⁴

The interplay between national and local factors was also evident in the way that Mary Loboit helped shape broad policies as part of Desmond Pond's working party, and then used her position on this group to promote CSEP's courses to doctors at the University of Manchester. This demonstrates how academics in particular institutions both generated and utilised the growing enthusiasm for interdisciplinary teaching. They did so in order to advance their own agendas: to demonstrate the utility of particular approaches, to formalise ethical training for doctors and to work with like-minded colleagues in other disciplines. With this in mind, we should therefore see national factors as *enabling* local changes rather than simply directing them.

Footnotes

- 1 Brazier Margaret, Gillon Raanan, Harris John. Helping Doctors Become Better Doctors: Mary Loboit – An Unsung Heroine of Medical Ethics in the UK. *Journal of Medical Ethics*. 2012;Vol. 38:383–385. [PMC free article: PMC3359522] [PubMed: 22518049]
- 2 Ibid.
- 3 Anon. Draft Begging Letter. 1991 March; Archives of the Centre for Social Ethics and Policy, the University of Manchester (henceforth CSEP archives).
- 4 Edward Shotter, cited in, Reynolds and Tansey (eds), *Medical Ethics Education in Britain*, p. 8; Shotter Edward. London: London Medical Group; Director's Report: Can Medical Ethics be Taught? 1974:1–4. (p. 2). Wellcome archives: GC/253/A/31/8.
- 5 Shotter. Director's Report: Can Medical Ethics be Taught? :1.
- 6 Ibid.
- 7 Ibid.
- 8 MacDonald JB. Medical Ethics Today: A Student's Uncertainties. *Lancet*. 1967;Vol. 289:563. [PubMed: 4163918]
- 9 Ibid.
- 10 Ibid.
- 11 General Medical Council, Recommendation as to Basic Medical Education. London: General Medical Council; 1967. p. 18.
- 12 This GMC adopted a flexible approach to education in 1957. For more detail, see Crisp AH. The General Medical Council and Medical Ethics. *Journal of Medical Ethics*. 1985;Vol. 11:6–7. [PMC free article: PMC1375118] [PubMed: 3981575]
- 13 General Medical Council, Survey of Basic Medical Education in the British Isles. London: Nuffield Provincial Hospitals Trust; 1977.
- 14 Anon. Ethics at Medical School. *Lancet*. 1972;Vol. 299:1406.
- 15 Jones JSP, Metcalfe DHH. The Teaching of Medical Ethics. *Journal of Medical Ethics*. 1976;Vol. 2:83–86. [PMC free article: PMC2495131] [PubMed: 940142] (p. 83). These 'extracurricular' lectures were not part of the medical group network. Indeed, by the 1980s Nottingham remained one of the few medical schools not to have its own medical group seminars.
- 16 Campbell, interview with the author (2009).
- 17 Ibid.
- 18 Duncan AS. Campbell, editor. Foreword. *Moral Dilemmas in Medicine*. :v–vi. (p. v).
- 19 Boyd Kenneth, Currie Colin, Thompson Ian, Tierney Alison J. Teaching Medical Ethics: University of Edinburgh. *Journal of Medical Ethics*. 1978;Vol. 4:141–145. [PMC free article: PMC1154664] [PubMed: 691019] (p. 141).
- 20 Thompson Ian. The Implications of Medical Ethics. *Journal of Medical Ethics*. 1976 Vol. 2;:74–82. [PMC free article: PMC2495121] [PubMed: 781252] (p. 76).
- 21 Boyd, et al. Teaching Medical Ethics. See also Shotter Edward. Reynolds, Tansey, editors. A Retrospective Study and Personal Reflection on the Influence of Medical Groups. *Medical Ethics Education in Britain*. :71–118. (p. 107).
- 22 Boyd, et al. Teaching Medical Ethics. :145.

- 23 Ibid, p. 141.
- 24 MacLean, interview with the author (2009).
- 25 Dennis KJ, Hall MRP. The Teaching of Medical Ethics. *Journal of Medical Ethics*. 1977;Vol. 3:183–185. [PMC free article: [PMC1154600](#)] [PubMed: [604487](#)] (p. 185).
- 26 Shotter Edward. *Twenty-Five Years of Medical Ethics: A Report on the Development of the Institute for Medical Ethics*. London: The Institute of Medical Ethics; 1988. p. 7. Wellcome archives: [GC/253/A/31/8](#).
- 27 Kennedy. What is a Medical Decision? :31.
- 28 Ibid, p. 30.
- 29 Kennedy. Medical Ethics are not Separate from but Part of Other Ethics. *Listener*. 1980 November 27;:713–715. (p. 715).
- 30 Ibid.
- 31 Kennedy. *The Unmasking of Medicine*. :117.
- 32 Kennedy. *Response to the Critics*. :208.
- 33 Ibid.
- 34 Gillon Raanan. Medical Ethics and Medical Education. *Journal of Medical Ethics*. 1981;Vol. 7:171–172. (p. 172). Emphasis in original. Gillon replaced Alistair Campbell as editor of the *Journal of Medical Ethics* in 1980.
- 35 Gillon. Medical Ethics and Medical Education. :172. Emphasis in original.
- 36 Schamroth Alan. A Medical Student's Response. *Journal of Medical Ethics*. 1981;Vol. 7:191–193. [PMC free article: [PMC1154954](#)] [PubMed: [7334495](#)] (pp. 193, 192).
- 37 Ibid, p. 193.
- 38 Johnson Alan G. Teaching Medical Ethics as a Practical Subject: Observations from Experience. *Journal of Medical Ethics*. 1983;Vol. 9:5–7. [PMC free article: [PMC1060839](#)] [PubMed: [6834404](#)] (pp.5–6).
- 39 Ibid, p. 5.
- 40 Ibid, pp. 5–6.
- 41 Ibid.
- 42 Jewell MD. Teaching Medical Ethics. *British Medical Journal*. 1984;Vol. 289:364–365. [PMC free article: [PMC1442356](#)] [PubMed: [6432101](#)] (p. 364).
- 43 Ibid, p. 364.
- 44 Ibid, p. 365.
- 45 Ian Kennedy to Mary Lobjoit, 14 March 1983. CSEP archives. For more on the Centre of Medical Law and Ethics, see Reynolds, Tansey, editors. *Medical Ethics Education in Britain*. :46–47.
- 46 Kennedy to Lobjoit, 14 March 1983. CSEP archives.
- 47 Gillon. Medical Ethics and Ethics Education. :172.
- 48 Law SAT. The View of a Young Doctor. Paper given at GMC 'Teaching Medical Ethics Conference'. Conference proceedings are held at the National Archives. 1984. [FD7/3628](#).
- 49 Shotter Edward. The View of the Society for the Study of Medical Ethics. Paper given at the GMC 'Teaching Medical Ethics Conference'. 1984. National Archives: [FD7/3628](#). This talk was reprinted as Shotter Edward. *Self Help in Medical Ethics*. *Journal of Medical Ethics*. 1985;Vol. 11:32–34. [PMC free article: [PMC1375127](#)] [PubMed: [3981569](#)]
- 50 Law. *The View of a Young Doctor*.
- 51 Shotter. *The View from the Society for the Study of Medical Ethics*.
- 52 For more on the working party's background, see Reynolds, Tansey, editors. *Medical Ethics Education in Britain*. :58–59. Desmond

- Pond (chair), Report of a Working Party on the Teaching of Medical Ethics. London: Institute of Medical Ethics; 1987. p. vii. Pond was listed as a member of the FMG in Daniel Jenkins's *The Doctor's Profession*. He served as Chief Scientist at the DHSS between 1982 and 1985, and died shortly before his working party's report was published in 1986. See Anon. Obituary: Sir Desmond Pond. *Journal of Medical Ethics*. 1986;Vol. 12:130.
- 53 The deans were asked seven questions concerning their school's policy on medical ethics; timetabled periods; encouragement of informal discussion; involvement of non-medical teachers; assessment of student's familiarity with ethical issues; extra-curricular activities; and the respondent's views on ethics teaching. See Pond (chair), *Teaching of Medical Ethics*. :18–33.
- 54 *Ibid*, pp. 19–20.
- 55 *Ibid*, p. 21.
- 56 *Ibid*, p. 22.
- 57 *Ibid*, p. 35.
- 58 *Ibid*.
- 59 *Ibid*, p. 37.
- 60 *Ibid*, p. 38.
- 61 *Ibid*.
- 62 Glover Jonathan. 'Appendix Two: Philosophy', in Pond (chair). *Teaching of Medical Ethics*. :51–55. (p. 51).
- 63 *Ibid*, p. 51.
- 64 *Ibid*, p. 52.
- 65 Kennedy. *The Unmasking of Medicine*. :124.
- 66 See, for example, Johnson. *Teaching Medical Ethics*. :5.
- 67 General Medical Council, *Tomorrow's Doctors: Recommendations for Undergraduate Medical Education*. London: General Medical Council; 1993. p. 14. For more on the report's influence, see Calman Kenneth. *Medical Education: Past, Present and Future*. London: Churchill Livingstone; 2006. See also Brazier, et al. Reynolds, Tansey, editors. *Helping Doctors Become Better Doctors. Medical Ethics Education in Britain*. :41–43. 59–60.
- 68 General Medical Council, *Tomorrow's Doctors*. :10.
- 69 Kenneth Boyd, quoted in Reynolds, Tansey, editors. *Medical Ethics Education in Britain*. p. 60.
- 70 Campbell, interview with the author (2009).
- 71 *Ibid*; MacLean, interview with the author (2009); O'Neill, interview with the author (2009).
- 72 Kennedy, interview with the author (2010).
- 73 Warnock. *People and Places*. :174.
- 74 Mark Carlisle, quoted in Pullan Brian, Abendstern Michelle. *A History of the University of Manchester, 1973–1990*. Manchester: Manchester University Press; 2004. p. 131.
- 75 The total sum distributed by the UGC was cut by a total of 17 per cent, although this varied considerably between universities. For example, the University of Salford, a former technical college, suffered a 44 per cent reduction in its UGC grant, while prestigious universities such as Cambridge only experienced a 6 per cent reduction. For more background, see Scott Peter. *The Crisis of the University*. London: Croom Helm; 1984.
- 76 For example, see Austin Dennis. *A Memoir. Government and Opposition*. 1982;Vol. 17:469–482.
- 77 *Ibid*, p. 484. See also Pullan, Abendstern *A History of the University of Manchester*. :121.
- 78 Austin. *A Memoir*. :477.
- 79 Anon. *Philosophy Postponed?* Society for Applied Philosophy Newsletter (Spring 1987) p. 2. Society for Applied Philosophy archives.
- 80 NCP Submission to the UGC Philosophy Working Party (1988). Information on the formation of the NCP can also be found online at

www.heacademy.ac.uk/resources/detail/subjects/prs/The_National_Committee_For_Philosophy-Its_Origins_And_Activities
(accessed 21 February 2014).

- 81 NCP Submission to the UGC.
- 82 Warnock. *People and Places*. :185–188. Midgley Mary. *The Owl of Minerva: A Memoir*. London and New York: Routledge; 2005. p. 208. On criticism of the 'new vocationalism' from other fields in the arts and humanities, see Pullan, Abendstern *A History of the University of Manchester*. :159–160.
- 83 Midgley. *The Owl of Minerva*. :205.
- 84 The philosophy departments that closed were Surrey, Bangor, Exeter, Leicester, Newcastle, Aberystwyth and City. For a first-hand account on the closure of philosophy at Newcastle, see Midgley. *The Owl of Minerva*. :205–209. By 1988 other small departments also appeared threatened, as the NCP noted that 'Many UGC subject reviews have recommended departmental closures on the grounds that all departments must be at or above a certain minimum size.' NCP submission to the UGC (1988).
- 85 Warnock. *People and Places*. :185.
- 86 *Ibid*, pp. 185–8.
- 87 O'Neill, interview with the author (2009); Warnock, interview with the author (2009).
- 88 Pullan, Abendstern *A History of the University of Manchester*. :246.
- 89 *Ibid*, p. 243.
- 90 *Ibid*. On how these new priorities helped change disciplinary structures in other fields, see Wilson, Lancelot *Making Way for Molecular Biology*.
- 91 Robin Downie, Jane MacNaughton. *Bioethics and the Humanities: Attitudes and Perspectives*. Abingdon: Routledge-Cavendish; 2007. p. 32.
- 92 Richmond Mark, Harris John. 1987 March 3; CSEP archives.
- 93 Brazier, et al. *Helping Doctors Become Better Doctors*. [PMC free article: PMC3359522] [PubMed: 22518049]
- 94 Kennedy Ian, Lobjoit Mary. 1983 March 14; CSEP archives.
- 95 Harris, interview with the author (2011).
- 96 Harris. *The Value of Life*. Harris John. *In Vitro Fertilization: The Ethical Issues*. *The Philosophical Quarterly*. 1983;Vol. 3:202–227. Anon. *Preliminary Information: Workshop on Philosophical and Ethical Issues in Medicine*, 12 November 1983. 1983 August 11; *Society for Applied Philosophy archives*.
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