

Virtual Mentor

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VIEWPOINT

Commemorative Issue: Lessons from 30 Years of Teaching Clinical Ethics

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The best clinical medicine, Plato tells us, is practiced when the scientific and technical aspects of care are placed in the context of a personal and professional relationship in which the physician strives to win the patient's support and trust¹.

In this regard, the professional and ethical values described by Plato and those expected of contemporary physicians are remarkably similar. Both are based on a medical relationship with the patient in which the physician's core ethical and professional values are the foundation of good clinical care.

Although disagreements persist among experts about what aspects of medical practice are captured by the term "medical professionalism," wide agreement has nevertheless emerged in recent years within academic medicine that it is essential to try to teach the concept of professionalism to medical students and residents². Based on 30 years of experience in teaching clinical medical ethics, I believe that any such educational endeavor must address the following 4 questions: Why teach it? Who should teach it? What should be taught? How and when should it be taught?

Why Teach Medical Ethics?

The fundamental justification for teaching clinical medical ethics (or, for that matter, any other medical school or residency subject) is based on its contribution to the care of patients. Therefore, the principal goal of teaching clinical ethics is to improve the quality of patient care in terms of both the process and outcome of care. If young physicians are equipped with the skills required to reach ethical decisions with their patients, their patients' dignity will be protected. This means that in educating young physicians, emphasis must be placed not only on the ethics of the actual decision but also on the ethics of the decision-making process. The skills of ethical analysis are part of the competence-set of young physicians and are a necessary complement to the scientific and technical aspects of clinical medicine.

Who Should Teach Clinical Medical Ethics?

Medical ethics should be taught by those who do it well and who have the capacity to motivate students and residents to improve the quality of both patient outcomes and their patient-physician interactions. These teachers could be either practicing physicians who have received training in ethics or bioethicists who have clinical experience. Physician teachers are especially desirable because they can teach

ethics in the clinical setting by reference to actual clinical cases, which is similar to the way most other effective clinical teaching is done. Physicians are responsible for resolving, rather than just analyzing, clinical-ethical problems in order to reach good decisions with their patients. Lastly, physicians also demonstrate ethically appropriate professional attitudes and values to students so that students learn both from the formal teaching of clinical ethics and from their teachers' modeling of ethical behavior and professional conduct.

However, it must be noted that an unfriendly institutional culture can easily undermine the well-intentioned efforts of those trying to impart professionalism by means of the curriculum. The greatest challenge in teaching professionalism is to modify the internal culture of the academic health center so that it better reinforces the values that medical educators wish to impart. Recently, I supervised a particularly empathic and compassionate resident who had admitted 10 patients in the previous 12 hours. She was tired, irritable, and overwhelmed by her clinical responsibilities. I tried to serve as her teacher and mentor but I now find myself with less time to teach because I am forced to document patient records in order to prove that I am not engaged in fraud and abuse. Also, many of the patients we care for are uninsured in our health system and are often neglected medically between acute in-patient hospitalizations. Further, our teaching hospital faces serious financial constraints, some of which have required firing nurses and other patient care personnel. Many of their tasks now fall to the overworked resident. As physician-historian Kenneth Ludmerer suggests, it is not easy to model and teach medical professionalism in such a commercial atmosphere which "does little to validate the altruism and idealism that students typically bring with them to the study of medicine"³.

What Should Be Taught?

The teaching of clinical medical ethics should include 3 dimensions: cognitive knowledge, behavioral skills, and character development.

Cognitive Knowledge. Students should be introduced to the literature of clinical ethics, to the research methodologies used in ethics, and to a practical approach for ethical analysis. The specific curriculum should reflect the incidence and prevalence of clinical situations that are encountered in the students' or residents' work. Curriculum design also can be based upon published studies of the epidemiology of ethical dilemmas that are seen in inpatient settings⁴, outpatient settings⁵, or consultation settings^{6,7}. Another approach to curriculum design is to target teaching to the perceived needs and preferences of students, a list of which will be different for students and residents at different levels of training and in different specialties^{8,9,10}.

Behavioral Skills. The assimilation and mastery of cognitive knowledge is not an end in itself for clinicians. To be effective in caring for patients, clinicians must have the behavioral skills necessary to put their knowledge to work in everyday clinical encounters³. A physician who knows the legal and ethical requirements of

writing an order not to resuscitate should also be expected to know how and when to approach patients and families in a thoughtful and sensitive way to initiate discussions about DNR status. Instruction in the behavioral skills of clinical ethics requires teaching and role modeling by experienced clinicians who can demonstrate the skills in practice. It further requires that students have the opportunity to practice these skills while being supervised by experienced clinicians.

Character Development. In *Meno*, Plato asks Socrates, "Is virtue something that can be taught? Or, does it come by practice? Or, is it neither teaching nor practice that gives it to a man but natural aptitude or something else"¹¹? This ancient question defies an easy answer. In my view, medical education and training provides students not only with a new vocabulary and a new knowledge base, but also serves as a moral pilgrimage in which character and attitudes are molded by the experience of caring for sick patients. While most students will change during training, not every student will emerge from the training pilgrimage with a set of character traits that insure that ethical and professional standards are always maintained. This, in turn, places a heavy burden on those who help select medical students for admission to medical school. Medical school admissions committees do very well, but sadly, there is no gold standard to identify with precision those students whose character flaws may prevent them from developing the kind of ethical and professional attitudes that society wants and demands of its physicians. Left to myself, I always would select positive character traits (if I could identify them) over GPAs or MCAT scores, but I acknowledge that such a selection process is an art, not a science.

How and when should clinical medical ethics be taught?

At the University of Chicago, we emphasize 6 principles (the 6 C's) in teaching clinical medical ethics. (1) Clinically-based: Teaching should center around a clinically oriented situation. (2) Case-based: Real patient or clinical cases should serve as the teaching focus. (3) Continuously reinforced in class: Teaching clinical ethics should be continuously integrated throughout the 4 years of medical school and residency training. Whenever possible, ethics teaching should be linked with students' other learning objectives. For example, an ideal time to teach about brain death and the vegetative state is during a basic science course on neuroanatomy and neurophysiology. Similarly, the introductory anatomy course offers a unique opportunity to deal with issues of death, dying, and respect for the dead body. The course on history taking and physical diagnosis is the optimal time to engage students on topics such as the doctor-patient relationship, truth-telling, confidentiality, and informed consent. (4) Coordinated with clinical clerkships: Clinical teaching about ethics and professionalism is best accomplished by integrating teaching into each of the students' clinical clerkships. Coordination disrupts the pattern of clinical education least, takes advantage of student involvement with actual cases, and eliminates the problem of designing a course to cover all the major ethical and professional issues encountered in all major specialties. (5) Clean: Clinical medical ethics teaching should be clean (ie, simple). Our model for teaching clinical medical ethics includes cognitive training in the fundamentals of ethics with a core set of lectures on 8-10 important topic areas, a

recommended text that is clinically oriented, a basic approach to ethical decision making¹², and a bibliography of accessible articles and reference materials for further reading. This cognitive information is supplemented by providing students with opportunities to develop behavioral skills in their clinical work ("See one, do one, teach one"). For example, after reading about the core elements of informed consent, a student observes a skilled clinician negotiating consent with a patient and the student is then given an opportunity to elicit informed consent while the instructor observes the student-patient interaction. (6) Clinicians as instructors: Clinicians should participate actively in the teaching effort both as instructors and as role models for the students.

Although medical ethics has been taught in most American medical schools since the 1970s, there is little data to document whether such ethics training has been successful in improving the process of patient care or patient outcomes, strengthening the doctor-patient relationship, or improving the way medical decisions are reached. Very few studies, if any, have examined the impact of medical ethics teaching or of medical ethics generally on the quality of patient care. For example, one major study showed that despite medical ethics' 30-year preoccupation with end-of-life issues, the care dying patients received in American hospitals is inadequate both clinically (in terms of failing to provide sufficient pain medication) and ethically (in failing to respect the wishes of dying patient)¹³. Professor Leon Kass, one of the pioneers of the American bioethics movement, recently commented critically about the achievements of bioethics: "Though originally intended to improve our deeds, the practice of ethics, if truth be told, has at best improved our speech"¹⁴. As we move forward to develop and implement a national effort to teach medical professionalism, one lesson to be learned from teaching medical ethics relates to the failure of medical ethics to document its achievements. This suggests that in developing teaching in medical professionalism, it is essential to specify the goals of such new teaching, to demonstrate how such teaching improves the process and outcome of patient care, and to develop from the outset methods to evaluate its impact on students¹⁵.

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