

# WHY TEACH ETHICS? EDUCATION COLLOQUIUM: ETHICS AND EDUCATION

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## Introduction

Medical ethics has always been a part of medical education, from the time of Hippocrates onward. When young doctors entered into the profession of medicine, they learned the rules and standards and behavior expectations from their teachers. The original Hippocratic Oath asked new physicians to promise to be of benefit to their patients, and minimize harm. There were several other specific promises, such as not cutting on a patient, honoring one's teachers, and serving all patients in need, regardless of status.<sup>1</sup>

After the original Oath, it was several centuries before the next medical ethics became codified and longer still before it was formally included in medical education. Thomas Percival wrote his *Medical Ethics, or A Code of Institutes and Precepts adapted to the Professional Conduct of Physicians and Surgeons* in 1803.<sup>2</sup> The American Medical Association was founded in 1847, and the statements that guide physician behavior and patient expectations today began.<sup>3</sup>

## Why Teach Ethics?

Perhaps because of the long history of medical ethics always being part of the profession, there are often questions about why we need to include formal ethics education within medical training. Indeed, if physicians have long learned medicine and its standards from their teachers in an apprenticeship model, why would we need to do anything different now? There are several reasons, which I will touch on here.

First, medical ethics are cultural and contextual. That is, there are rules in ethics, but how those rules are interpreted changes over time as cultures and climates change; they also may be variously applied, depending on the specifics of the clinical situation. For example, the tenet of truth-telling has been an important principle of medical practice for some time; however, only over the past few decades has the culture of patient autonomy truly grown in such a way that patients and families are expecting new levels of truth-telling from their physicians.<sup>4</sup> Even so, many patients may not want to hear all the details about their disease or prognosis; some may elect not to hear the prognosis at all. Knowing when, and how, and what, and to whom to disclose information is a subtle judgment that takes time to develop. Depending on when and where one's teachers trained, a trainee may only get exposed to particular practices of truth-telling. Formal ethics teaching can help trainees develop the skills and foundational knowledge to know when and how to apply subtle rules such as this.

Another common concern about teaching ethics within medical training is the sense that trainees' ethics are likely already formed by the time they reach medical school. Indeed, many of us learn important life lessons from our families about honesty, integrity, respect, and compassion. With such personal traits and capacities at stake, how could medical education – a knowledge and procedure-based training – impact these? Many medical schools are working toward admissions interviews and processes that would, in fact, screen for personality and character traits that are desirable in medicine.<sup>5</sup> Even so, because of the practice-based and apprenticeship-model we still rely upon within medicine, trainees are learning de facto medical ethics everyday they are working with other trainees and attendings. We teach values and practices within medicine through our daily actions; however, because of the time-stressed environment in which most medical training occurs, the values we can teach are not necessarily the ones we would hope to impart to students.<sup>6</sup>

Finally, in a related argument to those above, students may enter medical school with a sense of the importance of honesty and respect that came from their upbringing. However, they have yet to learn how to enact those values within the context of patient care situations. How much is enough when telling the truth? How can you show respect to a patient who is acting out because of a head injury? What does it mean to be of benefit when a patient is in P.V.S.? Learning ethics in the context of medicine is essential to earn and maintain public trust.<sup>7</sup>

There is a long history of medical ethics within the profession, and one that is evolving over time as our technical capacities change and our cultural context transforms. Formal ethics education can provide students and trainees with a foundation of core knowledge, key skills, and important perspectives about professional responsibility that will help prepare them for the highly dynamic and unpredictable world of clinical medicine.

### What Should We Teach?

An important starting assumption for ethics education is that there are multiple dimensions to the skills of ethics. “Ethics education” can bring to mind required training programs in HIPAA protocol, conflicts of interest, and billing practices, to many within the academic medical center. Rather than focusing on key rules and regulations alone, the skills of ethics are much broader and require more creative attention that mandatory web-based tutorials alone can provide.

Skills of Ethics:<sup>8</sup> To become fully competent in ethical practice, there are four skills to develop:

- ✓ Recognition: Can you recognize the issues?
- ✓ Reasoning: Can you reason through the dilemma?
- ✓ Responsibility: What are your professional obligations?
- ✓ Response: What will you do?

Tools of Ethics: Ethical Frameworks<sup>9</sup>. There are a number of tools to build and keep in your clinical ethics “toolbox”. The ethical frameworks offered below help provide tools for trainees working on the skill of “reasoning” outlined above. I have introduced and used these tools in short case-based discussions (noon conferences) as well as more in-depth training situations. Because a short-hand version of the following three approaches are used in most ethical arguments, they are often readily recognized when introduced in the context of a case example. I frequently review justifications for alternative solutions from each framework perspective, as we work toward the best possible solution:

- ✓ **Rule-based: an action is right if it follows fundamental moral rules**
  - Rules and principles may come from multiple sources, including one’s profession, society, religion, or an institution. Rules or principles, even from within the same system, may come into conflict at any one time. Principles in medical ethics include: respect for persons, beneficence (be of benefit), do no harm, and justice.
- ✓ **Consequence-based: an action is right if the good consequences outweigh the bad consequences**
  - The reasoning process here involves identifying specific anticipated, as well as unintended, outcomes of various options.
- ✓ **Virtue-based: an action is right if it enacts a core purpose**
  - The reasoning process in this approach involves identifying what role the decision maker will take in the situation (is it one of physician? Student? Citizen? Scientist? Physician? Policymaker?). From there, one must decide what the core values are for that position (e.g. what would the ideal physician do?). These core values should capture the core purpose (e.g. as a mother, my core purpose is to protect my children from harm). What would physicians you admire do? What kind of physician do you want to be? What is the decision you can live with? “Character is what happens when no one is watching.”

After considering alternative courses of action, to resolve the case you will need to justify a preferred course of action. What will you do, and why? Closing the case analysis gets to the other skills in ethics, including identifying your professional responsibility and obligations in a given circumstance, and being able to take action.

Tools of Ethics: A case-based approach to ethical decision making<sup>10</sup>

There is a common approach to ethics cases that models the clinical workup. This process is followed by many ethics consultants and committees, and can be adapted for more time-sensitive decisions as needed.

1. What are the facts of the case? What do we need to find out?
2. What is the core issue? Where is the core conflict?
3. What precedent do we have in the profession? State? Hospital?
4. What should we do, and why?

To map out the facts of the case, there are four topic areas to review, with questions for consideration in each realm.

<p><b>MEDICAL INDICATIONS</b></p> <ul style="list-style-type: none"> <li>• What are the patient's important medical problems? What are the key decisions to be made?</li> <li>• What are the goals of treatment?</li> <li>• What is the likelihood of achieving those goals?</li> </ul>	<p><b>PATIENT PREFERENCES</b></p> <ul style="list-style-type: none"> <li>• What has the patient expressed about preferences for treatment?</li> <li>• Does the patient have the capacity to decide? <ul style="list-style-type: none"> <li>- If not, who will decide for the patient? Is that person using an appropriate decision-making standard?</li> </ul> </li> <li>• Do the patient's wishes reflect a process that is <ul style="list-style-type: none"> <li>- informed (<i>understanding</i> the alternatives, risks, benefits, and consequences)</li> <li>- voluntary</li> </ul> </li> </ul>
<p><b>QUALITY OF LIFE</b></p> <ul style="list-style-type: none"> <li>• Describe the expectation of the patient's quality of life in the patient's terms.</li> <li>• Is the patient's present or future condition such that continued life might be judged undesirable by him?</li> <li>• Are there biases that might prejudice the providers' evaluation of the patient's quality of life?</li> </ul>	<p><b>CONTEXTUAL FEATURES</b></p> <ul style="list-style-type: none"> <li>• Are there family issues that might influence treatment decisions?</li> <li>• Are there financial or economic factors?</li> <li>• Are there any societal, cultural, or institutional factors that might influence treatment decisions?</li> <li>• What are the legal implications of the treatment decisions?</li> </ul>

Suggested Content for Ethics Curricula. The national organization for bioethics, the American Society for Bioethics and Humanities, formed a Task Force to examine and develop recommendations for undergraduate medical education to meet ethics education requirements.<sup>11</sup> Specifically, this Task Force was asked to (1) review ethics education literature and curricula, and (2) propose model or sample curricula for the purpose of providing guidance to educators working within undergraduate medical school environments. Using a modified Delphi-technique, the six multi-disciplinary Task Force members identified a list of core content recommended for undergraduate medical school ethics programs. This list should be reviewed and assessed for specialty-specific graduate training programs, as appropriate.

*Awareness-Sensitivity:*

Students should develop an awareness of, or sensitivity to, the following issues:

- laws relevant to clinical care
- ethical principles relevant to clinical care
- limits of confidentiality and truth-telling
- surrogate decision making processes and challenges
- conflicts of interest
- issues of access, health care economics, and health disparities
- chronic illness and aging
- diverse health beliefs and spirituality practices as they relate to health
- the hidden curriculum in medical school: ethical issues for students
- history of medicine and medical education
- specialty specific ethical issues, such as: pediatric ethics, maternal fetal conflict, reproductive issues, genetics, research ethics, and organ transplantation

### *Reasoning-Judgment:*

Students should develop the skills to reason through dilemmas or difficulties in clinical care when they arise, with the following tools:

- methods for ethical analysis/clinical ethics
- narrative competence, including moral imagination
- critical thinking, including weighing arguments and evidence
- tolerance of ambiguity

On issues including:

- treatment refusal
- medical futility
- cross-cultural conflicts

### *Motivation-Commitment:*

Students should develop a sense of professional responsibility and an obligation to act in certain ways, such as:

- Addressing impaired colleagues
- Negotiating end-of-life decisions with patients, including with-holding, with-drawing, and developing a position on PAS
- Discuss medical errors with colleagues, supervisors, and patients/families
- Self-awareness of burnout and self-care needs
- Addressing domestic violence and abuse with patients
- Community service
- Giving attention to local and national policies that impact health care
- Developing appropriate boundaries with patients

### *Action:*

Students should develop the abilities to act in difficult situations that require communication skills, negotiation, and humility, such as:

- Breaking bad news
- DNR discussions
- Assessing decisional capacity
- Managing inter- and intra-collegial conflict
- Informed decision making/Patient-centered communication
- Cross-cultural communication, including translating the culture of medicine

## **When and How Should We Teach Ethics?**

The majority of required ethics training occurs within the preclinical years of medical school, despite wide-agreement that this is not the most effective time for the content. On the one hand, students need to develop an awareness of entering a profession with core responsibilities. The classroom-based time afforded by early medical school training lends itself to exposure to foundational knowledge and practicing core skills, before the pressure of the wards arrives. Much as we teach introduction to clinical skills within the first 2-years of medical school, providing some basis and background in ethics for students before they enter into the clinical years is critical. That said, as we do with clinical skills, a good ethics education program should continue into the clinical years (including residency and fellowship), when trainees have more context for the skills and have had a first-hand opportunity to be challenged by some of the ethical dilemmas under discussion.

As with clinical skills, ethics skills need to be developed and practiced overtime. Lecture-based ethics courses alone do not provide sufficient skill development opportunities for trainees. In general, an ethics education program should:

- foster trainee professional development
- provide knowledge, skills, attitudes that will lead to improved patient care
- be integrated, multidisciplinary, and relevant to clinical practice
- be rigorous, with clear expectations and benchmarks for achievements

Medical school curriculum committees and training program directors are responsible for meeting LCME and ACGME requirements. While these requirements are likely to be quite familiar to most of you, I highlight a few here to make the point that leading accreditation bodies have identified ethics as a core competency area within clinical skills training. By working within guidelines, we have an opportunity to have ethics teaching meet the needs of our training programs and trainee professional development.

Relevant LCME requirements:<sup>12</sup>

ED-19. There must be specific instruction in **communication skills** as they relate to physician responsibilities, including communication with patients, families, colleagues, and other health professionals.

ED-20. The curriculum must prepare students for their role in **addressing the medical consequences of common societal problems**, for example, providing instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse.

ED-21. The faculty and students must demonstrate an understanding of the manner in which people of **diverse cultures and belief systems** perceive health and illness and respond to various symptoms, diseases, and treatments.

ED-22. Medical students must learn to recognize and appropriately address **gender and cultural biases in themselves and others**, and in the process of health care delivery.

ED-23. A medical school must teach **medical ethics and human values**, and require its students to **exhibit scrupulous ethical principles** in caring for patients, and in relating to patients' families and to others involved in patient care.

ACGME Core Competencies.<sup>13</sup> Relevant highlighted features for ethical practice from the six competencies:

1. Patient Care:
  - a. Demonstrate their abilities in providing patient care that is compassionate, appropriate and effective for the treatment of health problems and the program of health.
2. Medical Knowledge
3. Practice Based Learning and Improvement
4. Systems Based Practice:
  - a. Incorporate considerations of cost awareness and risk benefit analysis in patient care;
  - b. Advocate for quality patient care and optimal patient care systems;
  - c. Work in inter-professional teams to enhance patient safety and improve patient care quality; and
  - d. Participate in identifying system errors and in implementing potential systems solutions.
5. Professionalism:
  - a. Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles;
  - b. Demonstrate:
    - i. Compassion, integrity, and respect for others;
    - ii. Responsiveness to patient needs that supersedes self-interest;
    - iii. Respect for patient privacy and autonomy;
    - iv. Accountability to patients, society and the profession;
    - v. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
6. Interpersonal Skills and Communication Interpersonal Skills and Communication requires the resident/fellow to skills that are effective in the exchange of information and collaboration with patients, their families, and health professionals. Residents/fellows are expected to develop skills and habits to be able to:
  - a. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
  - b. Communicate effectively with physicians, other health professionals, and health related agencies;
  - c. Work effectively as a member or leader of a health care team or other professional group;
  - d. Maintain comprehensive, timely and legible medical records, if applicable.

**Example: Neurology Clerkship at the University of Washington**

At UW, each of the clinical clerkships has identified key ethics or professionalism topics that are relevant for the specialty. During the 6-week rotation, students are required to complete an activity, assignment, or exam relating to those topics. In the Neurology clerkship, under the direction of Dr. Eric Kraus, students can choose to focus on one of three topics: breaking bad news, DNR orders, or withholding and withdrawing life-sustaining treatment.

Students access background information, cases, and resources on these topics through our Ethics in Medicine website (a publicly available resource): <http://depts.washington.edu/bioethx/>.

The objectives for the mini-CEX in bioethics within the Neurology clerkship are to:

1. Recognize that bioethical issues arise frequently in neurology;
2. Identify, observe and reflect on at least one clinical scenario.

Students submit a brief reflection and analysis of the case they have observed during the rotation, using tools available to them on the Ethics in Medicine website.

### **Can We Evaluate Ethics?**

While the focus of this panel is on teaching ethics, well-designed evaluation can also contribute to student learning, either through formative or summative feedback. There are a number of standard evaluation approaches which can track with the four core skills of ethics, depending on your priorities and interests.

1. Recognition: through paper or in-person case presentations, asking trainees to identify ethical issues or value-based assumptions within a case can assess their ethical awareness and ability to recognize issues when they arise in practice.
2. Reasoning: again, through paper or in-person cases, evaluating whether trainees can (1) identify alternative courses of action and (2) evaluate and justify a best option based on considering (a) rules, (b) consequences, or (c) virtues – or what someone enacting the core values of the profession would do. We have developed a grading rubric that helps faculty identify the presence or absence of certain components of an ethical argument, even without much ethics training.<sup>14</sup> Using a structured approach to teaching and evaluation of ethical analysis helps students learn an approach to difficult cases that can be readily adapted when faced with new issues.
3. Responsibility: evaluating whether or not trainees understand what the obligations of the profession are in certain complex circumstances is best done in practice, that is, using tools such as the 360-degree evaluation protocol described at length by the ACGME<sup>15</sup>. There are knowledge-based components to this skill in ethics, however, which can be evaluated on paper-based exams.
4. Response: we use OSCE stations in medical school to assess students' ability to carryout the planned course of action identified above. In residency and fellowship, we also use Standardized Patients to assess critical skills such as breaking bad news, DNR orders, or running a family meeting. At early stages of a trainee's career, we use paper/electronic cases and ask students to write out what they would do in a certain circumstance, including what they might say to the patient or family. While this approach is necessarily limited by students being able to guess "the right answer" and write responses they would never actually say in a live circumstance, we find that it sets an early bar to (1) push students to come up with words they would use to raise a difficult topic, and (2) frequently identifies major gaps in student understanding about the roles and responsibilities of physicians.

### **Further Resources**

The AAN offers several resources to help members deal with the ethical issues they confront in their practices, as well as help to educate the public about ethical issues in neurology. <http://www.aan.com/go/about/ethics>

#### AAN Position Statements

The American Academy of Neurology (AAN) has developed position statements on a variety of ethical issues to help guide neurologists and others in decision making. The following position statements are available either online or through AAN Member Services:

- Assisted Suicide, Euthanasia, and the Neurologist (1998).
- Cerebrovascular Disease, Consent Issues in Management of (1999).
- Chronic Pain, Ethical Considerations for Neurologists in the Management of (2001).
- Clinical Research in Neurology, Ethical issues in (1998).
- Code of Professional Conduct (March 2008).

- Conflicts of Interest, American Academy of Neurology Policy on (1998).
- Demented Patient, Ethical Issues in Management of (April 1996).
- Direct-to-consumer Advertising, Participation of Neurologists in (2001).
- Genetic Testing Alert (1996).
- Humanistic Dimensions of Professionalism in the Practice of Neurology (2001).
- Life-Sustaining Treatment, Including Artificial Nutrition and Hydration, For Patients Lacking Decision-Making Capacity, Position Statement on Laws and Regulations Concerning (2007).
- Palliative Care in Neurology (March 1996).
- Physician Expert Witness, Qualifications and Guidelines for (January 2006).
- Profoundly and Irreversibly Paralyzed Patients with Retained Consciousness and Cognition, Care and Management of (1993).
- Persistent Vegetative State Patient, Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the (1989).

#### AAN Federal Legislation Position Statements

The AAN's Legislative Affairs Committee develops comprehensive position and policy statements as guides for AAN members and legislators.

- Anticonvulsant Drug Coverage (.pdf)
- Mandatory Reporting (.pdf)
- Electromyography (EMG) as a Practice of Medicine (.pdf)
- Artificial Nutrition and Hydration (.pdf)
- Pay-for-Performance (.pdf)
- Stem Cell Research (.pdf)
- Pain Legislation (.pdf)

#### Ethics Education: Review Articles

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Miles SH, Lane LW, et al. Medical Ethics Education: Coming of Age. *Acad Med.* 64(1989): 705-714.

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Singer PA. Recent advances: Medical ethics. *BMJ.* 2000 Jul 29;321(7256):282-5.

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## ENDNOTES:

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- <sup>1</sup> Smith L. A brief history of medicine's Hippocratic Oath, or how times have changed. Otolaryngol Head Neck Surg. 2008 Jul;139(1):1-4.
- <sup>2</sup> Percival T. Medical Ethics. Manchester: S. Russell, 1803.
- <sup>3</sup> Starr P. The Social Transformation of American Medicine. Basic Books, 1984.
- <sup>4</sup> Katz J. Silent World of Doctor and Patient. 2<sup>nd</sup> edition. Johns Hopkins University Press, 2002.
- <sup>5</sup> Eva KW, Rosenfeld J, Reiter HI, Norman GR. An admissions OSCE: the multiple mini-interview. Med Educ. 2004 Mar;38(3):314-26.
- <sup>6</sup> See Brainard AH, Breslin HC. Viewpoint: learning professionalism: a view from the trenches. Acad Med. 2007 Nov;82(11):1010-4; Coulehan J, Williams PC. Vanquishing virtue: the impact of medical education. Acad Med. 2001 Jun;76(6):598-605; Stern DT, Papadakis M. The developing physician – Becoming a professional. NEJM. 2006;355: 1794-9.
- <sup>7</sup> Wynia MK. The short history and tenuous future of medical professionalism: the erosion of medicine's social contract. Perspect Biol Med. 2008 Autumn;51(4):565-78.
- <sup>8</sup> Rest JR. Moral Development: Advances in Research and Theory. Praeger Press, 1986.
- <sup>9</sup> These ethical frameworks can be found in any introductory ethics textbook. An accessible approach is used by the Singers by using excerpts from literature to illustrate key ethical theories and dilemmas. See Singer P, Singer R. The Moral of the Story: An Anthology of Ethics through Literature. Wiley-Blackwell, 2005.
- <sup>10</sup> Jonsen AR, Siegler M, Winslade W. Clinical Ethics, 4th edition. McGraw-Hill, 1999. The introductory chapter, and the "4-box" tool can also be downloaded from the University of Washington Ethics in Medicine website: <http://depts.washington.edu/bioethx/tools/index.html>
- <sup>11</sup> The ASBH Task Force was comprised of the following members: Catherine Belling, Michael Green, John Moskop, Diane Timberlake and Co-Chairs Kelly Fryer-Edwards and Clarence Braddock, in consultation with Art Derse and David Doukas.
- <sup>12</sup> LCME Current Accreditation Standards. Accessed at: <http://www.lcme.org/standard.htm#current>
- <sup>13</sup> ACGME Core Competencies can be found on the ACGME Outcomes Project website: <http://www.acgme.org/outcome/Comp/compFull.asp>.
- <sup>14</sup> Smith S, Fryer-Edwards K, Diekema DS, Braddock CH 3rd. Finding effective strategies for teaching ethics: a comparison trial of two interventions. Acad Med. 2004. Mar;79(3):265-71.
- <sup>15</sup> ACGME Evaluation Toolbox is part of the ACGME Outcomes Project, accessed at: <http://www.acgme.org/Outcome/assess/Toolbox.pdf>