LOST VIRTUE:
PROFESSIONAL CHARACTER
DEVELOPMENT IN MEDICAL
EDUCATION
ADVANCES IN BIOETHICS

Series Editors: Robert Baker and Wayne Shelton


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DEDICATED

TO

Jo and Sean Kenny
role models of a good life

and

Rem Edwards
mentor and teacher of virtue ethics
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INTRODUCTION: LOST VIRTUE: PROFESSIONAL CHARACTER DEVELOPMENT AND MEDICAL EDUCATION

No topic in medical education has received more attention and generated more discussion in recent years than that of “professionalism”. In many ways, this should come as no surprise in light of the dramatic technical and scientific advances in medicine, the changing, and often confounding, roles of physicians in complex health care systems, and the growing expectation throughout society that physicians should provide more effective, patient-centered care. Any of these factors alone is sufficient to create anxiety and confusion about basic duties and responsibilities of physicians to patients, the medical profession and to society. In this complex, demanding, commercialized and yet, values-laden, world of health care it is an understatement to say that there are fundamental challenges to what it means to be a medical professional in today’s society.

For many complex reasons medical educators worry about how to restore professionalism in medicine, and particularly in the physician-in-training process of medical education. In previous eras, physicians were assumed to have developed the necessary qualities to be a good physician through the natural process of medical training. Regardless of how true this assumption was at the time, it is no longer a viable assumption for today’s medical setting. In spite of medical advances, there is the perception that physicians are no longer the good doctors, the virtuous doctors they once were. This is ironic since clearly physicians of the past were not nearly as able to help patients with therapeutic options as physicians today. Contemporary physicians are more technically competent, but there is still something missing from the bygone era. The message seems to be, medical skills and an arsenal of therapeutic options notwithstanding, patients want physicians to care about them and to listen to their stories, and use their medical knowledge to forge the right-fitting care plan for each individual patient.
The learning environment of medical education also poses its own challenges. Technical and scientific advances require the physicians-in-training to commit themselves to be dedicated life-long learners about areas of research that are constantly changing and expanding. Those of us who are medical educators observe the predictable pressure and stress in medical students as they struggle to become technically and scientifically competent in basic sciences, and eventually in their chosen specialties. Much of their training occurs in competitive learning environments by time-scarce clinical mentors where educational objectives are focused on technical mastery of challenging material. Often overlooked in the learning process, particularly by the third year of medical school and beyond, are the ethical and professional challenges involved in using medical techniques and knowledge in a responsible and reflective, indeed clinically artful, manner, as new technologies often create difficult questions about their appropriate use. For example, now that we can test patients for their genetic predisposition to acquire a disease like Huntington’s, should the test be offered when we can only predict a 50% likelihood of getting this disease or not, and, even when the disease is identified, not being able to offer any treatment? Or, in the ICU, setting patients who are very sick or injured sometimes have very uncertain prognoses, with a high-mortality rate. Given the current state of ICU technology, their lives can often be prolonged, sometimes at considerable burden to the patient and their families, providing only marginal benefits that some patients might not have wanted. Moreover, there are enormous cost considerations involved for each day a patient stays in the ICU.

Throughout clinical medicine, taxing ethical questions must be taken seriously and thoroughly assessed in advance, if patient encounters are to be constructive. However, the emphasis on scientific knowledge and technical skills and not the person of the patient permeates medical training in clinical learning environments, even in contexts of providing ordinary medical care. Time with a seasoned, clinical mentor who emphasizes total care of the patient and the art of medicine as much as the technical mastery of the pathophysiology of disease is not the rule in the present culture of medicine and medical education. Medical educators dedicated to changing this orientation must grapple with some serious structural factors in the current system. A serious disconnect between the rhetoric of medical education and the reality of practice exists. Medical students’ confusion about what is really valued in professional practice is understandable.

Physicians, including those that mentor physicians-in-training, and the house officers under them who do much of the clinical teaching and role
modeling for medical students, are taxed from all sides in contemporary medical systems. In the United States, the massive shift from a fee-for-service to prospective systems of remuneration and rise of managed care during the past 20 years, medical liability, cost control, pressure to see more and more patients, and time-consuming paperwork, etc., creates significant stressors to practicing, academic physicians. Attending physicians grapple daily with these and other stressors, and lurking in the background is the health care system in which 44 million people are uninsured, posing real risks to the entire system and indeed to the entire economy. In the rest of the developed world with provision of core, universal, publicly funded health care, there are similar pressures regarding access to care and cost control. In such settings, tasks such as conversations with patients and families about informed consent to complex medical options, the appropriate use of technology such as resuscitation end of life care options, etc., can be hastily or ineffectively done. This implicitly gives medical students and residents the false message that such tasks essential to good doctoring are less important than technical skills and knowledge. Even worse, students can unwittingly develop huge areas of professional incompetence around skills essential for excellent patient care. In the long-run, undeveloped professional skills pertaining to the basics of patient-centered care create less satisfying relationships between patients and physicians creating cynicism and distrust for both. For physicians to have a major part of one’s daily work not be an area of conscious focus and appreciation is an invitation to burnout, frustration and unhappiness.

Many medical students enter medical school with high ideals and hopes and go on to take required medical ethics and good doctoring courses for all four years. The omission during the 3rd and 4th years of medical school of the patient-centered, art-of-medicine topics and skills learned during the first two years does not go unnoticed by medical students. But the native idealism is at great risk of being destroyed in the process of medical education. During the past 10–15 years, most medical schools have initiated courses in the physician–patient relationship, ethics and professionalism that create a heightened awareness in students of ethical and professional issues. This means that many medical students learn in the formal curriculum about these topics but are often taken aback in the clinical years to find the disparity between what they were taught in the classrooms and what they find in practice. For many students, perhaps most, the pressure to conform wins out, and there is delicate time in medical students’ development where they face two basic options. Either they learn to ask questions and the courage to speak up about incidents they witness, or they fall into the trap of allowing
their moral sensibilities to be ignored and get pushed aside, stunting their own personal and professional development. The former become innovators and leaders, while the latter, unfortunately possibly the majority, help perpetuate the culture of medicine as we know it. Integrated, four-year courses that provide students protected time and space to discuss and share their experiences in clinical learning environments can serve somewhat as an antidote to the hidden curriculum, but are no real solution. At least they keep alive at the level of consciousness the hopes and values, and the moral sensibilities of the physician-in-training. But medical trainees deserve better. There is no substitute for the ideal: a medical learning environment in which the objectives and ideals of professional development are consistent with what is taught and reinforced by clinical mentors in patient care settings. This would reflect an educational framework in which goals and purposes of education, both the technique and art of medicine, would be unified theoretically and practically.

Thus, the practical learning environment of medical education is in need of reform. Integral to understanding how this reform process might occur is a better understanding of how is it we can train new physicians to embody the character qualities required of good doctoring in today’s society. Can we define a concept of virtue suitable for today’s setting? Given the chaotic state of medicine and the health care system, how should the good doctor be defined, and what is virtue in such a setting? Even with conceptual definitions, can we teach virtue, or more modestly, can we create a new sense of professionalism in new physicians with measurable outcomes? How do we nurture character development during professional training? Although these are partly age-old questions going back to the ancient Greeks, they are also urgent, practical, and, indeed, often perplexing questions for our own time. And, everyone seems to be expecting answers and solutions.

This volume is an attempt to spur discussion, creative thought and action about viable options to renew a sense of professionalism in medicine. Our inclination is to use the term “virtue”, but because this term comes with considerable unintended baggage from our western tradition, so we do with some hesitancy. We think it is important to remember the ancient use of virtue, which referred to character states formed from appropriate life habits that make desirable character traits and behaviors come naturally to the person. Becoming a good doctor, like becoming a good basketball player or a good clarinet player, or a good person, takes practice and time. But once achieved, doing those activities is ingrained and second nature. This is why for Aristotle the right character states provide the basis for good living, for happiness and optimal functioning. We assume that for US contemporaries,
unlike Aristotle, we, including students, educators and all patients must self-
consciously choose the desired characteristics that constitute the character
of the good doctor for our own time. We all have a say. In the end, it is up to
each individual aspiring good doctor to embrace the life-long task of ap-
proximating that goal. Our hope is that the chapters in this volume con-
tribute to our collective understanding of this task.

In Chapter 1, Edmund Pellegrino, one of the founders of the field of
bioethics, worries that medicine is becoming “deprofessionalized” which
means losing the essential set of character traits associated with good
doctoring. His quest to restore the moral basis of medicine requires us to
examine the whole process of character formation in medical education.
For Pellegrino, the most promising alternative is virtue ethics based origi-

nally on the moral perspective of Aristotle and later embraced within the
Catholic tradition. Regardless of whether or not virtue becomes accepted as
an educational goal, virtue ethics is a moral perspective relevant to all
medical educators interested in renewing a sense of professionalism in
medicine.

In Chapter 2, Laurence McCullough reminds us that we need a solid
conceptual foundation in medical education if we are going to sufficiently
understand professional behavior, and, in turn, character development in
medical trainees. Unfortunately, when examining the medical literature on
professionalism, McCullough believes currently such a conceptual founda-
tion is lacking. The antidote to this shortcoming is for him, “taking the
history of modern medical ethics seriously”, which means understanding the
historical emergence of medicine as a profession in the writings of John
Gregory and Thomas Percival. Only by being aware of this history, he
believes, can we appreciate the task of training new physicians to see med-
icine as something more than a market service, i.e. a special service requiring
ethical commitment.

In Chapter 3, Robert Veatch offers a word of caution to those in medical
education who seek to teach professional character development in medical
education. Such a task, in effect, is the task of teaching virtue, which first,
Veatch believes, we must understand conceptually. Veatch claims medical
ethics distinguishes between the ethics of conduct, or moral principles, and
the ethics of character, usually expressed as virtues. This distinction raises
the further question of whether virtue is valued intrinsically, good in itself,
or instrumentally, as the means to right conduct. From here, Veatch goes on
to question whether instilling virtues really increases the probability of right
conduct, and which of the many virtues should be instilled. He concludes by
questioning the whole project of teaching virtues in medicine.
In Chapter 4, Muriel Bebeau turns the discussion of character development toward an examination of the evidence of how people from various professions develop in terms of their ethical decision-making ability. One of the basic challenges is to confront the practical reality that most professional education has a natural technical bias, so that the ethical dimension is easily overlooked. As people do not come to these professions with fully formed professional characters, Bebeau assesses the evidence for various strategies to promote greater ethical awareness, sensitivity and knowledge.

In Chapter 5, Carl Elliott offers a sensitive analysis of the disillusionment that seems to afflict many physicians today. Elliott suggests that such disillusionment may be fueled by the idealism many medical students have while going into a profession riddled with many complex problems and stressors. Theories of virtue and professionalism, he believes, will not fix the deep structural, sociological problems. So, does this mean young people entering the profession of medicine would be better off viewing medicine as just a “job” rather than with what he fears are “illusions”? The reader will be provoked to grapple with some challenging questions.

In Chapter 6, Rosamond Rhodes and Lawrence G. Smith argue that in order to understand the challenge of training physicians to have a certain kind of character, we must first understand the unique nature of medical ethics. Medical ethics, so these authors argue, is not ordinary morality applied to the practice of medicine. It is the task of medical education to understand the unique ethical challenges of medicine and to mold the characters of new physicians accordingly. The authors lay out a strategy for such an educational program based on morality unique to medical ethics.

In Chapter 7, Ron Epstein attends to the importance of character as expressed in the moment-to-moment actions in clinical care. These small and ordinary actions describe the practitioner as a moral agent. He explores the possibility that professional competence and virtue are based, in part, on the clinician’s ability to engage in a “mindful practice” attentive to and reflective upon their lived experience of the virtues of medicine.

In Chapter 8, Karen Mann believes the essential goal of fostering professional character in medical learners is also challenging and sometimes elusive. She begins by exploring how educators might better understand both themselves and their students, and then reviews selected contemporary approaches to learning that could inform medical education. Mann considers the potential of these approaches to enhance the effectiveness of practical strategies aimed at making a real difference in the formation of new physicians.
In Chapter 9, David Doukas agrees with recent interest throughout medical education in North America to focus on professionalism, and to grapple with the basic question of how we prepare medical learners to embody the characteristics of professional standards and values. However, Doukas is not content with the status quo. He calls for a much broader ethical foundation for medical professionalism than has been proposed to date, including “an increased sensitivity to social responsibility, and a greater interaction between the medical profession and society” and other specific strategies.

Finally, in Chapter 10, Nuala Kenny identifies the centrality of professional character for any meaningful education for professionalism. She attempts to identify a set of core virtues for good medical practice in the twenty-first century. Agreeing on such a core is crucial for effective curricular reform and faculty development. Without such a focus, educating for professionalism is just another educational reform project.

In the midst of curricular attention to the important aspects of teaching and evaluating the competencies of professionalism, we believe there is a crucial role for attention to the moral agency of teachers and learners alike. This collection of reflections is intended to provoke further research and reflection on the important issue of the character of the doctor in an increasingly commercialized and commodified practice of medicine. Such reflection and research is, for us, essential if medical education is to facilitate the development of good practitioners.

Nuala Kenny
Wayne Shelton
Editors
CHAPTER 1
CHARACTER FORMATION AND
THE MAKING OF GOOD
PHYSICIANS

Edmund Pellegrino

ABSTRACT

Public and profession alike are troubled by what they perceive as a loss of professional status in medicine. Can it or ought it be retrieved? How? These questions cannot be answered without understanding what a profession is, what professing medicine entails in the way of character traits, and whether, and how, these traits can be taught. Answers are sought in the phenomena of the physician–patient encounter, the theory of virtue ethics and its implication for character formation. In addition, the moral attitudes and practices must also be supportive of the idea of a profession. Courses in professionalism might help but the problem is first of all a moral one.

INTRODUCTION

Many patients, physicians and medical educators are alarmed by the perception that medicine is fast becoming “deprofessionalized,” with damaging results to patient welfare and physician morale. By “deprofessionalization”
they imply a loss of certain attitudes, values and character traits usually associated with the traditional idea of a profession. For educators especially, there is the resulting conviction that character formation and teaching of professionalism are the required antidotes (Cruess & Cruess, 1997). For many, virtue ethics with its emphasis on the moral agent seems the most promising moral basis for retrieval of the idea of medicine as a profession.

In this article I will examine the validity of this line of reasoning via a series of questions: What is the nature of the problem? Why is character formation so central to its resolution? What is virtue ethics? How specifically does it relate to medicine and professionalism? Can virtue be taught in medical school, and how can it be taught? What are the chances of successfully reversing today’s downshift so many perceive in the professional status of medicine?

THE NATURE OF THE PROBLEM

Perceptions of what deprofessionalization entails, what precisely is lost and what can or should be retrieved vary markedly. Some see deprofessionalization positively as a necessary antidote to an entrenched elitism unsuited to our modern democratic society. For them, deprofessionalization is a necessary and long overdue adaptation to the demands of a marketplace ethos and the healthy competition that ethos presumably stimulates. On this view, reducing medicine to an occupation like any other would be salutary. Physicians would become more accountable to the public. Patients would be better empowered to take command of their own health. More regulation by public bodies would assure transparency in the practices of physicians and their organizations. The proverbial arrogance of the doctor would at last be restrained. The ethics of medicine would be reduced to the minimalist ethics of business, commerce and corporation.

A significant number of physicians have embraced this view. They argue that the linch pins of the doctor’s responsibility are technical competence and disclosure of conflicts of interest. A contractual rather than a convenantal relationship seems sufficient to protect the patient’s best interests. Most of the virtues deemed missing by others seem irrelevant to being a good physician. Indeed the distress over deprofessionalization is only a sentimental longing for an inflated set of values that historically never enjoyed wide acceptance among physicians.

On such a view courses in “professionalism” would be archaic and misleading. These would only train students to be “losers,” to pursue
impossible ideals and to deprive themselves of the rewards to which their efforts and education entitle them. More ominously, a return to the elitism of a virtue ethic would simply revive the physician’s hegemony over patients and health care.

At the other extreme are physicians who hope for a life dedicated to something other than self-interest. For them the ethos of the marketplace is morally antithetical to the idea of a profession. The commercialization of medicine distorts their fiduciary relationship with patients. On this view the devices of managed care, industrial measures of efficiency and productivity, and the proliferation of institutional policies dehumanize and depersonalize both the doctor and patient. The traditionalist physicians in this group are among the few in modern society who want to dedicate their lives to something other than their own self-interest. For them a certain degree of altruism and suppression of self-interest is essential to the ethical demands inherent in being a physician.

The values, beliefs and ethics of this group of physicians conform to the traditional ideal of a profession. For them medicine is a vocation and never only a job. Competence and transparency are necessary, but insufficient ethical foundations for ethical practice. They see the patient as a dependent, suffering human being whom they are privileged to treat with the knowledge and skills they possess. Fidelity to trust, honesty, compassion and suppression of self-interest are entailed by the internal morality of the healing relationship. Without these virtues, the physician is defined by his technical prowess alone.

These traditionalists may, or may not, be inspired by religious beliefs that transcend self-interest. They see themselves engaged in a daily struggle to preserve the essential elements of the healing relationship in the face of the techno-economic milieu of today’s practice. Many feel forced to compromise their ideals, others to retire early, or turn to administration rather than patient care or leave medicine entirely (Lipner et al., 2006; Sox, 2006). Some of our most capable and sensitive physicians today feel they practice in a medical dark night of the soul.

Between these two groups are perhaps the majority of physicians. All too many of them conclude that they cannot be professionals in the pristine sense. They live by compromise, worrying whether their compromise is morally defensible. Nonetheless, they see it as necessary to survival. They hope for re-enforcement of their hopes for a more ethically sensitive system. They yearn for leadership from their professional associations. They seek the medical statesmanship, which is no longer there. Unwillingly, out of financial necessity, they accommodate themselves to the values imposed by a commercialized model of medical care.
These transformations in the attitudes and perceptions of physicians about what it is to be a physician are at the heart of the psychological phenomenon of deprofessionalization. These attitudes drastically alter the nature of the physician’s commitment to the sick and the kind of person she, or he, must be to be truly a healer. They abnegate certain character traits or virtues without which the good of the sick person is no longer the gold standard of professional practice.

**WHY VIRTUE ETHICS IS INDISPENSABLE**

For a moment, imagine yourself a traveler in a strange land whose language you do not understand. Entranced by the richness of the countryside through which you are driving, you take a mountain turn too fast, veer off the road and hit a tree. You have compound fracture of the tibia and a cerebral concussion. Otherwise you are very much aware as you are taken to a rural hospital. A white-coated, stethoscope-draped figure, speaking in a language you do not understand examines you and starts giving orders to nurses, assistants and you.

At that moment what is your greatest concern? If you are like most humans in this situation, you will want to know several things: Does this physician possess competence? Will he use his competence for your benefit primarily? Will he serve his own interests, those of the hospital, or some other source of authority? In what order are the human urges for power, profit, prestige and pleasure arranged in his character? What you want to know is what kind of person is treating you. What are his motives? Will he see you as a person as well as a fractured tibia? Will it make any difference at that point whether he is a principlist, a utilitarian, a deontologist or an emotivist in his ethical theory? Will you not focus on who he is and the way he will exert his moral agency?

Like every patient, you know that you want someone you can trust, who will act primarily in your interest, who will do so in a personalized way, who will share some of your predicament and who will be faithful to beneficence, the first principle of all medical ethics (Pellegrino & Thomasma, 1987). Can you expect him, at a minimum, to respect the Hippocratic ethic? Under circumstances like this, in the moment of truth that invests medical decisions and acts, the way the physician interprets whatever ethic he follows is more important than his ethical theory. What you want is a virtuous physician, a “good physician,” one who does his work well, who understands your vulnerability, professes to be able to help and is faithful to that promise. What
you do not want is the entrepreneur, the businessman, the technician, the
bureaucrat, the jobholder, the man who presumes he knows it all or sees you
as an object for exploitation.

THE NATURE OF VIRTUE ETHICS

What is virtue ethics, where does its moral authority come from and how
does it relate to the professional character of the physician who is attending
you? What today is called “virtue ethics,” or virtue-based ethics is the oldest
philosophical foundation for moral conduct. Its origins are firmly rooted in
the philosophies of Plato, Aristotle, and the Greek and Roman Stoics. Virtue
ethics was enriched in the Middle Ages by the infusion of moral
teachings of the Jewish and Christian Bibles and the Koran. This classical-
medieval ethical synthesis constituted the whole of ethics in the Western
World. Its aim was not the formulation of rules, or guides for action. It
enunciated few principles, or obligations directly mostly dealing with things
which ought never be done, e.g. murder, rape, adultery. Rather, moral
guidance was provided by the model behavior of good, or virtuous persons,
those paradigm persons each era respected. In many ways this was equally
true of the ethics in the East as well, e.g. Confucius, or Lao Tse in China,
and to varying degrees it is found within the ethics of the various schools of
Hindu and Buddhist philosophy.

All of this dramatically changed in the Enlightenment and Post-Enlight-
enment periods in Europe. The Enlightenment ideal of a religion-free, meta-
physics-free – ethic (i.e. free autonomous rationality) turned the emphasis to
principles, duties, obligations and consequences as the criteria for right and
wrong, good and bad human acts. While the reality of the moral agent could
not be totally eradicated from ethics, the virtues were overshadowed by
rights, duties, rules and principles. Virtues were pushed further to the back-
ground of the moral life as ethics became progressively secularized and the
good was defined in human rather than theistic terms.

Virtue ethics, though never totally neglected, remained in the background
of moral philosophy until shortly after the emergence of modern bioethics.
Then it underwent revival largely as the result of two works: one the seminal
article by Elizabeth Anscombe (Anscombe, 1982) and an equally significant

As a result over the last two decades, a large literature has accumulated
expanding the classical notions of virtue and applying them to problems in
contemporary ethics and moral philosophy. The professions and medicine
particularly, have been examined from the point of view of the virtues entailed by the ends to which those professions are directed. Almost all of these efforts have been grounded in the virtue theory espoused in Aristotle’s Nichomachean Ethics. It is this theory I will use to define the clinical medical virtues – those related to the clinical encounter – those entailed by the act of “professing” medicine.

ARISTOTLE’S ETHICS AND THE MEDICAL VIRTUES

Aristotle’s ethics is a teleological ethics, one in which character traits are directed to attainment of some defined end (Aristotle 1094a: 103). Virtue ethics is not “teleological” in the modern sense of consequentialist utilitarianism. More specifically for Aristotle, the “end” aimed at is the good for man, i.e. “….The good peculiar to man,” (Aristotle 1098a: 1) a life lived in conformity with reason whose end is happiness (Aristotle NE 1102a: 15). This end is served by certain character traits, which are dispositions to act habitually so that happiness or human flourishing can be most closely achieved.

Aristotle grouped these end-oriented character traits in two classes: the moral and the intellectual virtues. In the first group, he included the so-called Cardinal or “hinge” virtues of wisdom, justice, fortitude and temperance, the same ones previously listed by Plato. These virtues disposed humans to morally right and good human acts. In the second group were the intellectual virtues, those character traits that predisposed the acquisition of truth – philosophic wisdom, understanding and practical wisdom. In one form or another, possession of these two sets of virtues defined the good or virtuous human being for the Western world.

These virtues have been classified as “natural” because they are discoverable by the use of human reason alone. During the Middle Ages, Aristotle’s virtues were supplemented and integrated with the teachings of the three Abrahamic religions – Judaism, Christianity and Islam. Thomas Aquinas, e.g., added three “supernatural” virtues of faith, hope and charity (Aquinas Ia, IIae: 162). These rested on acts of faith in the authority of the Jewish and Christian scriptures. According to Aquinas, they were virtues “infused” by God. Until the Enlightenment virtue ethics had the sanction of both secular and religious moral philosophers.

From this point on our discussion will be limited to the natural virtues as they apply in medicine. Clearly for believers, Jewish, Christian or Muslim, the scriptural and theological teachings relevant to medicine must be taken
into account. For a general ethic of medicine, however, the medical virtues we shall consider are not dependent on religious belief. They may be enriched and strengthened by such belief but do not depend on that belief for their justification. The connection between Aristotle’s virtue ethics and medicine can be made through the relation between the good of a man, and the good of his work, that is between their relevance for the physician as a good person and as a good physician.

In Section 6 of Book II of the Nichomachean Ethics, Aristotle puts it this way:

We may remark then that every excellence both brings into good condition the thing of which it is the excellence and makes the work of that thing done well (Aristotle 1006a: 15–19).

And a little further on:

Therefore it is true in every case, the excellence of man will be the state which makes a man good and which makes him do his own work well (Aristotle N.E. 1006a: 21–23).

Thus the virtues (the excellences) make the physician a good man or woman, and make them do their work of medicine well. The cardiologist, e.g., who practices the medical virtues becomes not only a good cardiologist but a good man as well.

The medical virtues focus primarily on those traits necessary to do the work of medicine well. The good that medicine seeks, i.e. its end in the Aristotelian sense, is ultimately the preservation, promotion and restoration of health. Its more proximate and immediate ends vary with the context within which it functions.

Thus in the clinical context, the individual physician–patient relationship, the end is the relief of pain, suffering and disability, helping human beings to confront their predicament of illness and cure when possible. In the case of social or public health medicine, it is society which is the patient. In medical science, it is the discovery and application of physical and biological science for the good of all the sick and of society.

Our focus here is the clinical encounter, the interaction of a sick person seeking assistance from someone who professes to be able to help and heal. Here the most immediate end is a right and morally good decision taken on behalf of the good of the patient. When properly made this decision, and actions that follow on it, should facilitate achievement of the more distant ends – cure, relief, amelioration of pain and distress, and the ultimate restoration of health.
ARISTOTLE’S ETHICS AND THE MEDICAL VIRTUES

What are the virtues that dispose the good physician habitually to think and act in such a way that the three levels of ends – i.e. immediate, proximate and ultimate – of medicine will best be attained? To respond to this question, it is helpful to reflect on the phenomenological realities of the clinical encounter, the context of medicine that is at the heart of the physician–patient relationship.

Let me ask you once more to put yourself in the situation I described earlier – injured, in the emergency room in a strange country, without knowledge of the language, and without friends present. When the physician offers to help, and asks “What is wrong?” What does the patient assume? Is it not that the physician is competent technically, and that he will use his competence on the patient’s behalf? By offering himself as a physician, a helper and healer, does he not make a private and public promise – an act of “professing” medicine? Is this not the promise that initiates the patient–physician relationship and all it entails morally? Fulfilling that opening promise entails certain character traits and virtues if the promise is to be creditably fulfilled. These character traits constitute the medical virtues and include the following as a minimum.

First is the virtue of fidelity to the promise implicit and often explicit to put the primacy of the patient’s well-being at the center of the relationship. Without this the whole relationship would be a sham. Altruism would be an illusion. The patient becomes an object for exploitation. The act of professing, and the invitation to trust it implies would be lies.

Second is honesty and truth-telling. The physician must be honest about what is wrong, what can be done about it, what is known and what is questionable, etc. Honesty also includes disclosure of the physician’s lack of knowledge and experience. Without this virtue, the patient is invited to take the unknown risks of being deceived in what affects him most intimately – his body, mind and soul.

Third is compassion, the ability to enter into the predicament of each patient’s illness in all its social, personal and spiritual uniqueness, i.e. free something of that predicament. Without this virtue, healing cannot be holistic, the proper balance between empathy and technique cannot be struck. The meaning of the word “healing” – to be made whole again – becomes impossible.

Fourth is effacement of self interest, i.e. doing what is in the patient’s best interests even when it involves loss of time, money or extra effort on the physician’s part. Without this virtue, the relationship becomes a mere business transaction or a legal rather than a convenantal bond of obligation. This virtue most clearly separates a profession from a business transaction.
Fifth is courage, the willingness to defend the morally right decision and action even when it means loss of social esteem. Without courage, neither truth, nor moral rectitude, nor patient safety is immune to dangerous compromise. Without courage the patient with a contagious disease or in plague times is in danger of abandonment – a vice of which some of medical history’s most esteemed figures were guilty.

Sixth is justice, which can function both as a principle and a virtue. As a virtue it is the disposition to render to others what is owed to them. In the clinical relationship what is owed, and indeed entailed by the initiating act of profession is the exercise of all of the virtues listed above. Justice may also mean treating unequals unequally as well as equals equally. Here justice is mediated by compassion, providing for the vulnerable, the aged, the infant and the poor. Without the virtue of justice in both senses, the relationship becomes commercialized, technicized and formulaic. The letter of the law then dominates and eradicates its spirit.

These six virtues are the major moral virtues of medicine. They underlie the ethical responsibilities of physicians to sick persons and society. They must be, however, accompanied by the intellectual virtues, those that assure competence which is the promise of technical proficiency.

Aristotle lists five intellectual virtues, which predispose to truth just as the moral virtues predispose to the moral good (Aristotle N.E. 1139b: 14–17). The intellectual virtues are: science, art, practical wisdom, intuitive wisdom and theoretical wisdom. Each may be translated into medical virtues in the following way.

Science, as understood by Aristotle, is concerned with the necessary and the eternal, that which is communicable by teaching and which proceeds by demonstration (Aristotle 1139b: 19; 1145a: 15). In medicine, this would correspond to basic and clinical science.

Art is the disposition to do or make a thing, an object which itself is useful for some other end. This is the ancient notion of tekne’, or making things according to a true rule. As a medical virtue it would encompass all the techniques, procedures of medicine as well as the conduct of the clinical encounter (Hofman, 2003).

Practical wisdom is a true disposition toward action – the capacity for deliberation and discernment by which the good can be best attained. In medicine this would be the virtue of prudence or clinical judgment.

Aristotle adds two more intellectual virtues – intuitive reason which refers to the grasp of universal truths, and theoretical wisdom. Ross believes the latter encompasses metaphysics, mathematics and natural science.
The relevance of these last two intellectual virtues to medicine requires more careful study than I can give it here. In a general way I would suggest, as Ross implies, that they refer to the theoretical, speculative and philosophical grasp of the ultimate realities of man, mind and world. These last three virtues predispose humans to an understanding of theos, bios and cosmos, the universal structural setting within which medicine and every human study and activity ultimately rests (Ross, 1959).

Since our emphasis here is education of the physician, the intellectual virtues of intuitive and theoretical wisdom are more in the domain of pre-medical liberal studies than medical education properly speaking. This in no way diminishes the relevance to the formation of their physician. They make the difference between the physician as technician, physician as empiric and the physician as a true professional.

Taken together, the intellectual and moral virtues specific to medicine constitute the character traits necessary for excellence in achieving the goals of medicine, i.e. competence, and moral integrity dedicated to the good of the sick person. They are the promises implicit and explicit in the initiation of the physician–patient relationship. They are what the patient has a right to expect when a physician (or other health professional) offers to help. They are the essential virtues internal to the act of profession, which initiates the healing relationship. Fidelity to these virtues is what constitutes the nature of a profession. Having a degree in medicine, a license to practice, possession of technical expertise, belonging to a professional association or specialty certification cannot make a person a true professional. He may be a good cardiologist technically but without the moral virtues his act of profession or promise cannot be authentic. On the other hand, the cardiologist may be a good person, possessing some of the virtues but without technical competence he cannot make an authentic act of profession.

**CAN THE VIRTUES BE TAUGHT?**

One might agree with this analysis as outlined but object that the virtues cannot be taught, or that they are inherent, or even genetically encoded. This is to argue that it is folly to link education in the virtues with medical education today.

Those who hold this view are very close to the view Plato held in his dialogue with Meno, who asked whether virtue could be taught (Hamilton & Cairns, 1982). Plato’s objection was argued in his customary ironic way leading to an impasse. He reasoned that virtue was knowledge and that it
could be taught if someone could be found who knew what virtue was. Since he did not think there was such a person virtue could not be taught.

Aristotle thought very differently. He said that virtue was the result of certain character traits, that there were people who possessed these traits and that they developed them by practice. They could teach by example. In sum, one learned virtue by being virtuous. In medicine by acting virtuously one develops the habitus of virtue, the disposition to act well and predictably in relation to the end of medicine, i.e. the good of the patient.

To teach the virtues requires models whose virtues are in turn sustained by the society in which they live. Every society has had its paradigm figures whose lives were considered paragons of some character trait, or traits, admired as the best in that society. Examples would be Ulysses, Socrates, Confucius, the Buddha, in the ancient world, or William Osler, Mother Theresa, Ghandi, Albert Schweitzer, etc. Their virtues were different and even contradictory but for their cultures and times they were persons who were models for others to emulate.

We have all had the experience of being influenced by our clinical teachers. We are attracted to them at first because we admire their professional skills. We then absorb their personal character traits – the way they approach patients, respond to stress or confront crises. We might also be influenced by the example of historic figures like Hippocrates, Galen, Osler or Francis Peabody. As we mature professionally and morally we accepted, rejected, justified, or modified the virtues and the vices of our teachers.

The fact of the matter is that the single most powerful positive or negative influence on the professional conduct of medical students, residents and colleagues, is that of their clinical teachers. Whether we agree with Plato’s skepticism or Aristotle’s assurances about the teaching of virtue, we are shaped professionally by our teachers, our schools and hospitals. Gatherings of classmates and colleagues are invariably filled with reminiscences, good and bad, of clinical mentors. We cannot avoid being taught virtues and vices. The question is how to do it as well as possible.

Plato’s skepticism notwithstanding, experience confirms the fact that character traits can be and are taught by the example of clinical teachers. There are, of course, good and bad teachers. Students who are themselves morally mature and in possession of well-formed characters will usually be able to tell the good from the bad. The problem is with the student who is emotionally immature, unsure about his moral beliefs and vacillating in his commitment to medicine. A large number of medical students are in this category today. They need conscious attention to character formation, especially given the demoralizing context of contemporary medical practice.
Medical students do, of course, come to medical school with different kinds of moral beliefs depending on their family, community, church or school. Some would argue that these values are so fixed already that medical education cannot have much effect. This is patently not true of all students. If it were so, most clinical teachers would despair about teaching the clinical virtues. Most medical teachers, however, know that one of the challenges and rewards of teaching is the formation of “good” professionals.

Good examples, good models and consistency between conduct and speech are indispensable in teaching virtue. Courses in ethics or professionalism are no panacea or substitute. They can raise sensitivities to virtuous action. They sharpen the student’s practical wisdom – her capacity to identify virtue and vice. They fail, however, if they are not sustained by the conduct of respected teachers.

The same goes for current programs for teaching “professionalism” (ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine, 2002; Academy of Medicine, 1999; Kirk & Blank, 2005). They are as of yet unproven. They often emphasize the behavioral and psychosocial aspects of being a good professional. Like courses in medical ethics they do not directly teach the virtues. Indeed, there is reason to believe that they may frustrate that objective by failing to put proper emphasis to the moral entailments of professionalism. Deficiencies in professionalism are at their root moral not educational failures.

Some will always argue that a medical student’s moral values are already fixed by the time they come to medical school. This is true for some no doubt. But this objection flies in the face of the reality that persons do change their values throughout life, especially in their formative years. We cannot under-appreciate the impact on medical students of the realities of their first experiences in caring for the sick, suffering and dying human person. These are new and often shattering experiences for most young people. They evoke deep reflection and self-examination. Few of us are totally immune to the immensity of the moral challenges facing anyone who professes to be a healer or helper of others caught in the predicament of illness.

A more Machiavellian objection to teaching the virtues is that they are well and good in theory but in the competitive world of contemporary medicine they are too idealistic. Indeed, they are counsels of failure. How can one be virtuous when others are not virtuous? This is the recurrent complaint of those for whom only perfection will do. They forget that perfection is rarely attainable in human affairs. Most of us can only hope to approach it asymptotically. Few would give up golf because they have never made a hole-in-one. Few pitchers would abandon baseball if they never
pitched a perfect game. Few physicians would give up medicine if they had missed a diagnosis.

Most of us try to do the right thing most of the time. In our more trivial pursuits it is permissible to muddle along without moral reproach. This is not the case in medicine, or any activity involving the welfare of others. To accept the privileges and responsibilities of a medical education entails commitment to the virtues that are requisite if the good of the patient is to be achieved.

Another objection to virtue ethics is inherent in its conceptual structure. Virtue ethics does not provide concrete or specific action guidelines. There is a certain degree of subjectivity in how a virtue is defined. Despite these objections, we must confront the ineradicable reality of the moral agent. If we do this there is no escape from the significance of virtue in any ethical act.

There is nothing inherent in virtue theory that makes it inconsistent with other ethical theories. Any complete theory of ethical conduct involves the integration of the intention of the moral agent, the nature of the act, the circumstances and the consequences of the act. How to effect this integration is a challenge modern ethical theory, and virtue theory in particular have yet to meet. No single theory stands alone.

Perhaps the most serious impediment to teaching virtue in medical schools and residency programs, as well as CME programs, is not virtue theory, the high ideals it inculcates nor its logical circularity or lack of action guidelines. It is rather the dearth of good clinical models among the faculty and the countervailing influence of contemporary societal mores. This is especially true in internal medicine where the need for traditional medical virtues is so obvious (Kirk & Blank, 2005; Sox, 2006). Good clinical teachers are becoming ever more scarce. Many have abandoned personal bedside teaching of clinical fundamentals for greater emphasis on sophisticated imaging and laboratory diagnostic procedures. Some have supposed that the virtual reality of sophisticated teaching laboratories will suffice. The result is less opportunity for students to witness teacher–patient relationships and the way the virtues shape patient care differently with different teachers.

The second serious obstacle to teaching virtue ethics is the dramatic change in societal mores resulting from the social revolution of the mid-1960s. Transformations in what is socially legitimated and not legitimated have been dramatic. So far as medicine goes, these changes are expressed in a variety of attitudes, e.g. far more tolerance of pursuit of self interest, physician ownership of hospitals and other medical facilities, much greater concern for life style, working hours, working conditions, greater tolerance
for employee status, and policy and administrative restraints, interest in learning and practicing “medical economics,” equating professional worth in terms of fees and income.

The result is that beliefs and practices which would have been judged “unprofessional” three or four decades ago are now legitimated or at least far less frowned upon. The net result has been an erosion of the virtue of suppression of self-interest which had so long been a hallmark of the true professional. Medical students, residents and young physicians are thus socialized in a societal matrix in which the virtue of suppression of self-interest is judged too demanding and unrealistic.

**PORTENTS FOR THE FUTURE**

All of this gives substance to the necessity of a community of values to sustain the virtues of individuals (McIntyre, 1981). To be sure paradigm figures like Buddha, Jesus, Socrates, Mohammed, Gandhi or Mother Teresa, stood against the values of their times. Their mission was to transform the values of humanity so that they might become the virtues of all. Hippocrates was such a figure for medicine as was William Osler to a lesser extent for the modern English-speaking profession.

The likelihood of a similar paradigm figure in the immediate future of medicine is very small. Instead, medical educators and medical schools have a responsibility to attend to the character formation of their students, at least to the extent of detecting the behavior predictive of later ethical malfeasance (Papadakis et al., 2005). What these behaviors may be, how they are to be measured and how to deal with them remedially or punitively if necessary are matters medical educators are beginning to understand.

In the meantime, we must face the fact that the values of our society as a whole are not conducive to sustaining the medical virtues. Courses designed to teach “professionalism” are not likely to change character significantly since the fundamental issue is not an educational but a moral problem. Still we cannot abandon the most effective means for teaching the virtues – the behavior of clinical and basic science teachers whose influence is greater than they appreciate.

Good physicians are both born and made. Clearly, clinical teachers especially, must recognize the enormous responsibility they carry, for the influence they exert on their students and house officers. They are knowingly or not accomplices in the virtues and vices the future profession exhibits. They are stewards to whom society has entrusted the next generation of
physicians. As has always been the case, only the virtuous can teach virtues by their conduct in the realities of the physician–patient relationship.

REFERENCES


FURTHER READING


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CHAPTER 2

THE ETHICAL CONCEPT OF MEDICINE AS A PROFESSION: ITS ORIGINS IN MODERN MEDICAL ETHICS AND IMPLICATIONS FOR PHYSICIANS

Laurence B. McCullough

ABSTRACT

Professional formation and evaluation in medical education lacks a reliable conceptual foundation. This shortcoming results from an insufficient appreciation of the history of medical ethics as the source of the concept of medicine as a profession. This chapter therefore explores the medical ethics of the Scottish physician-ethicist, John Gregory (1724–1773) and the English physician-ethicist, Thomas Percival (1740–1804), who between them invented the concept of medicine as a profession. Three components of this concept are identified: the commitment to scientific and clinical competence; the commitment to protect the patient’s health-related interests; and passing on medicine as public trust, not merchant guild.

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THE LACK OF A CLEAR CONCEPT OF MEDICINE AS A PROFESSION

Recent years have witnessed a growing emphasis on the teaching and evaluation of professionalism in medical education at all levels, especially in medical student education and residency training programs (Inui, 2003). These developments have been reflected in and spurred by such documents as “A Physician Charter,” a product of the international project, the Medical Professionalism Project (Members of the Medical Professionalism Project, 2002). These should be regarded as welcome developments, if only because medical education is about the preparation of men and women to enter the profession of medicine and because the state of professionalism in medicine is not nearly as strong as many physicians and medical educators would like to think (Rothman, 2000). Indeed, if one relies on anecdotal reports about physicians’ behavior, especially in response to the policies and practices of public and private payers, there is cause for alarm about the current state of professionalism in medicine.

Coherent and effective medical education in its components of professional formation and evaluation of medical students, residents, fellows, and practicing physicians for professional behavior and demeanor requires a solid conceptual foundation. When one turns to the literature on the subject, however, the absence of a clear ethical concept of medicine as a profession becomes apparent.

This same problem also appears in the work of those who recognize the absence of conceptual foundations in the medical professionalism literature and educational movement. Swick (2000), for example, calls for a “normative definition” of professionalism in medicine but then fails to provide one. Instead, like the authors of the “Charter,” he identifies a set of behaviors that somehow are taken to define medical professionalism.

“A Physician Charter” fails to identify a clear ethical concept of professionalism, a rather startling omission in a document meant to provide international leadership and guidance to physicians and medical educators. Instead, the Charter invokes the “role of healer, which has roots extending back to Hippocrates” and “common themes” that emerge from the “wide variations in medical delivery and practice though which any general principles may be expressed in both complex and subtle ways” (Members of the Medical Professionalism Project, 2002, p. 244). The “Charter” gets the history wrong. As Robert Baker (1993a, 1993b) has shown, the claim that there is an unbroken history of medical professionalism that begins in the Hippocratic Oath and texts is a “myth” without foundation in the history of
Western medical ethics. The “Charter” invokes a concept of medicine as a profession but does not articulate the ethical concept. As a consequence, readers of the “Charter” have no basis upon which to judge the intellectual authority of its claims. Finally, the “Charter” gets the diagnosis wrong: “Changes in the health care delivery systems in countries throughout the industrialized world threaten the values of professionalism” (Members of the Medical Professionalism Project, 2002, p. 243). The correct diagnosis is that physicians’ free and uncoerced decisions in response to changes in the organization and financing of medical care threaten medical professionalism. The threat is internal and entirely under the control of physicians. That leaders in international medicine could embrace the language of victimhood is, at the very least, embarrassing. At worst, to do so is misleading.

THE ANTIDOTE: TAKING THE HISTORY OF MODERN MEDICAL ETHICS SERIOUSLY

There is an antidote to these serious conceptual, historical, and diagnostic lapses: taking the history of modern medical ethics seriously. This is the prescribed antidote, because two giants of the modern period in the history of English-language medical ethics invented the ethical concept of medicine as a profession, the Scottish physician-ethicist, John Gregory (1724–1773), and the English physician-ethicist, Thomas Percival (1740–1804).

Medical practice and research in eighteenth-century Britain, and its North American colonies, was very entrepreneurial. Porter and Porter (1989) have provided a compelling account of this medical world of practitioners and the sick. Physicians had resolved in practice a deep tension within the Hippocratic texts between a life of service to the sick, on the one hand, and entrepreneurial self-interest, on the other in favor of the latter. There had emerged over the centuries a genuine marketplace of medical practice. There was no stable medical curriculum, no licensure (except for ineffective efforts of the royal colleges to use their power of licensure to create monopoly control of the medical marketplace), no third-party payers, and no regulation of drugs and devices. There was a wide variety of practitioners, including university-trained physicians, apprentice-trained surgeons and apothecaries, female midwives who competed fiercely with the man-midwives (physicians who practiced obstetrics, using the new technology of forceps), and many so-called irregulars.

The sick also routinely self-diagnosed and self-treated (self-physicking, it was then called). Many did so out of economic necessity; only the well to do
could afford physicians’ and surgeons’ fees. Many also did so because they did not trust practitioners intellectually – to know that they were saying and doing – or morally – to put the interests of the sick first and their own financial and other self-interests second. This mistrust was well founded. There were almost as many concepts of health and disease, and remedies for the latter, as there were practitioners.

This medical marketplace was oversupplied and so competition was fierce, especially given that the outcome of failure to compete successfully was poverty, unless one married very well and one’s wife therefore brought to her marriage a considerably dowry. Physicians did what they could to stand out, including adopting “little peculiarities” of dress, speech, and manners. It was essential to master the accoutrements of being a gentleman, since those who retained one’s services came from a higher social class and held and wielded the power of the purse over physicians.

The relationship between the sick and practitioners was contractual, with the well-to-do sick paying the piper and calling the tune. The well-to-do sick had power over physicians; physicians had little power over the sick. The great shibboleth of bioethics, the systematically paternalistic physician, simply did not exist in the private practice of medicine.

The situation for the sick poor who were admitted to the newly created infirmaries differed. Here I rely on Risse’s (1986) excellent account of these new health care organizations. These hospitals were created by the employers of what would come to be known as the workplaces of the industrial revolution to provide free medical care for the men, women, and children whom they employed. The “trustees,” as they were known, provided an annual “subscription” or budget for the hospital. The trustees deliberately underfunded the hospital, to put pressure on its lay managers – physicians were not in charge – to control costs.

The infirmaries served mainly the worthy sick poor. Physicians were appointed by the trustees to serve as “faculty” of the infirmary. The faculty were not paid but gladly accepted – indeed, sought out – such appointment, because it brought with it the stamp of approval of the leading lights of the newly wealthy class. This approval could be, and was, used to build one’s private practice.

The unworthy poor, the lazy and shiftless who had brought poverty on themselves, were not admitted to the infirmaries, for their own good. It is worth noting that this distinction between the worthy and unworthy sick poor came across the Atlantic Ocean to the British American colonies and it is with us still. In the United States we have Medicare and the Veterans Health Affairs system for the worthy sick poor, and Medicaid for the
unworthy sick poor. The political support for the former is strong, while for the latter it is weak, reflecting with precision eighteenth-century moral categories.

The trustees created the infirmaries from complex motives, including their interest in advancing their social and political standing vis-à-vis the landed aristocracy. As a consequence, the trustees wanted their infirmaries to look good and looking good meant low mortality rates. Physicians since the time of Hippocrates understood how to achieve this goal: become very good at the prognosis of incurable, life-taking conditions so that one could in a timely, self-interested fashion declare a case incurable and withdraw. By thus abandoning the dying, the disease and not the physician would be likely blamed for the ensuing death. This standard was articulated as late as the early eighteenth century by Friedrich Hoffmann (1660–1742), in his Medicus Politicus (Hoffmann, 1749), the politic doctor (Jonsen, 2000). The trustees took this lesson to heart and instructed lay managers – physicians were not to be entrusted with this important rationing task – to deny admission to the sick with “fever” – a catchall diagnostic category of conditions with a high likelihood of mortality even with treatment. The tactic worked. In a hospital with no conception, and therefore no effective practice, of infection control, mortality was kept very low (Risse, 1986).

The trustees did not trust physicians and surgeons with control of the most expensive resources in the hospital, the drugs, fortified wines, and beers in the formulary. These they put under the control of apothecaries, thus making physicians accountable to non-physicians.

In this new health care organization, physicians for the first time gained power over the sick. The worthy sick poor worried about the abuses of this power, for example, for purposes of conducting experiments of their newly invented secret remedies or nostrums, an abuse that Gregory attacked (Gregory, 1772).

Gregory based his medical ethics on David Hume’s (2000) principle of sympathy (McCullough, 1998). This involves a natural capacity of each morally well-formed human being to enter into and experience the sufferings of others and to be motivated routinely to relieve and prevent such suffering. Based on Humean sympathy, Gregory thought that the plight of the sick, both well to do and worthy poor was not acceptable. Moreover, Gregory was very concerned that the entrepreneurial, self-interested practice of medicine introduced biases that disabled clinical judgment and decision making, calling into question the very competence of physicians. Gregory addressed the problem of competence by appealing to the philosophy of science and medicine of Francis Bacon (1561–1626). Bacon called for medicine to be
based on “experience,” i.e., the rigorously collected and described results of natural and designed experiments. In effect, Bacon called for medicine to become evidence-based, a call that medicine is now answering five centuries after it was issued.

Before Gregory physicians routinely used the word ‘profession’ to describe themselves. They used this word in a self-interested way, to distinguish themselves from practitioners who had not attended a university and received a “regular” education (a dubious claim on its face, given the absence of a stable medical curriculum) and that their competitors – surgeons, apothecaries, and “irregular” practitioners – had not done so and were therefore inferior practitioners.

THE ETHICAL CONCEPT OF MEDICINE AS A PROFESSION

Gregory set out to give ‘profession’ intellectual and moral content. In doing so, he put in place the first two of the three components that constitute the ethical concept of medicine as a profession (Fig. 1).

The first component of the ethical concept of medicine as a profession is that physicians should become and remain scientifically and clinically competent. In contemporary terms, this means that physicians should practice according to the intellectual and clinical discipline of evidence-based medicine. When physicians routinely do so, they justifiably invite the sick to trust them intellectually, to know what they are saying and doing. Gregory was well aware that the sick did not trust their physicians intellectually and

| 1. The physician commits to being scientifically and clinically competent. |
| 2. The physician commits to the protection and promotion of the patient’s health-related interests as the physician’s primary concern and commitment, keeping self-interests systematically secondary. |
| 3. Physicians commit to maintaining and passing on medicine to future patients and physicians and society as a public trust, not a merchant guild that protects the self-interests of its members as its primary concern and commitment |

**Fig. 1.** The Ethical Concept of Medicine as a Profession.
were justified in doing so. Physicians thus gained intellectual authority for their clinical judgments about patients’ health – its preservation through primary prevention and its restoration, through secondary and tertiary prevention in response to disease and injury. The scientific and clinical competence of physicians is confined to health, understood in biopsychosocial terms (Engel, 1977). Physicians set themselves up for entirely preventable ethical conflict when they fail to stay within the bounds of their professional expertise and authority.

The second component of the ethical concept of medicine as a profession is that physicians should commit themselves to the protection and promotion of the health-related interests of the sick as their primary concern and motivation, and keep self-interest systematically secondary. The ethical concept of medicine as a profession thus requires considerable self-sacrifice. The ethically justified limits of the professional virtue of self-sacrifice thus become a central topic for professional medical ethics.

The first two components of the ethical concept of medicine as profession are expressed in the bedrock professional virtue of integrity. The professional virtue of integrity obligates physicians to practice medicine, conduct research, and teach to standards of intellectual excellence (the first component of the concept of medicine as a profession) and to standards of moral excellence (the second component of the concept of medicine as a profession).

Gregory gestured in the direction of the third component of the ethical concept of medicine as a profession when he excoriates the “corporation spirit” of the organized medicine of his own day, i.e., the royal colleges operating under the auspices of a royal charter. The royal colleges were, essentially, merchant guilds that existed and conducted themselves primarily for the sake of the interests of their members in gaining and holding market share. The self-interested nature of the royal colleges was reflected in their moral statutes” or rules of conduct. These included prohibitions against attacking brother physicians in public, so as not to injure the profession, i.e., injure the interests of guild members in presenting an attractive public face to their potential customers among the well to do (McCullough, 1998).

Percival should be given the credit for picking up on Gregory’s gesture and then explicitly expressing it in conceptual terms. Percival does so in his discussion of the ethics of when a physician or surgeon should retire from practice. He provides insightful analysis of the intellectual skills such as an acute memory and the ability to reason by analogy from present to past cases and, for surgeons, skills such as “quickness of eye-sight, delicacy of touch, and steadiness of hand, which are essential to the skilful performance of operations” (Percival 1803, p. 52). This passage is especially moving in
light of the fact that Percival by then had become blind himself and had retired from medical practice, thus following and exemplifying his argument. He concludes

Let both the physician and surgeon never forget, that their professions are public trusts, properly rendered lucrative whilst they fulfil them; but which they are bound, by honour and probity, to relinquish, as soon as they find themselves unequal to their adequate and faithful execution (Percival, 1803, p. 52).

IMPLICATIONS OF THE ETHICAL CONCEPT OF MEDICINE AS A PROFESSION

Gregory and Percival were the first in the history of Western medical ethics to use the word ‘patient’ rather than the phrase ‘the sick’ – for the Latin, aegrotus, which is used in previous texts. In doing so, they drew an important implication from the ethical concept of medicine as a profession. Until medicine became a profession, a process that started with Gregory and Percival and still has a long way to go if critics such as Rothman (2000) are correct, there are no physicians, only practitioners of various kinds. Routinely fulfilling the three commitments required by the concept of medicine as a profession turns medical practitioners into professional physicians. In other words, the profession of medicine is not a given that comes down to us robustly intact from the pen of Hippocrates. Rather, the profession of medicine exists as a function of the collective clinical judgments, decisions, and behaviors of physicians. External entities such as payers do not create the profession of medicine and they cannot destroy or injure it. Physicians are fully in charge of both and should hold themselves accountable for both.

When there are professional physicians, the sick become patients. They can and should trust professional physicians both intellectually and morally. The older, contractual relationship of the sick and hired practitioners becomes replaced with a physician–patient relationship as a fiduciary relationship of protection and promotion of the patient’s and research subject’s health-related interests.

The ethical concept of medicine as a fiduciary profession creates the conceptual foundations for the professional virtues that should shape the physician’s character and demeanor, and the ethical principles that should serve as action guides in clinical practice, research, and teaching (McCullough & Chervenak, 1994). These virtues do not come from some mysterious and unexplained extrapolation from “wide variations in medical delivery and practice though which any general principles maybe expressed in both
complex and subtle ways” (Members of the Medical Professionalism Project, 2002, p. 244). This will not do as the conceptual basis for professional medical ethics.

The ethical concept of medicine as a profession has important implications for how physicians and trainees should responsibly manage economic conflicts of interest. Conflicts of interest can be precisely defined in terms of the ethical concept of medicine as a profession: conflicts of interest in medicine involve conflicts between a physician’s professional obligations to a patient and the physician’s self-interest. Consider, for example, the relationship that should exist between medical students and the pharmaceutical industry, the “pharmas” whose representatives provide gifts and meals to medical students routinely. The American Medical Student Association (AMSA) has recently launched its “PharmFree Campaign” (http://www.amsa.org/prof/pharmfree.cfm) to address the ethical challenges in this relationship.

A major implication of the ethical concept of medicine as a profession is that, as a rule, self-interest should be sacrificed when it is in conflict with professional obligations to a patient or research subject. This means that the burden of proof is on a physician or medical student to justify acting on self-interest rather than routinely on professional obligations. The first step in meeting this burden of proof is to ask whether the conflict is avoidable or necessary. Physicians are paid for their services, so economic conflicts of interest seem unavoidable in the practice of medicine – at least until we move systematically to pay-for-performance. Medical students are not paid and are not so impecunious that they are unable to afford the very small cost of reliable writing instruments (which are becoming increasingly irrelevant in the era of electronic records) and they can afford the modest cost of meals (just as the non-medical world does day-in and day-out). Entering into a financial relationship with the pharmas on the part of a medical student is thus entirely unnecessary and also completely voluntary. (Any suggestion that students face economic coercion is implausible on its face.)

Now, the pharmas know very well that all of us, medical students included, are subject to varying degrees to the influences of advertising, a sense of gratitude and reciprocity for gifts, and to brand loyalty. The pharmas also know, because it is well known in medical education, that physicians’ prescribing practices are laid down firmly during residency training. It seems plain that the pharmas are attempting to purchase the autonomy of medical students, as a foundation step to their later doing so during residency and in subsequent years of practice. Students who accept pharmas’ gifts should be seen as voluntarily violating the standards of professional integrity, because
the students are acting solely from economic interest and a trivial economic interest at that. The AMSA PharmFree initiative invokes professionalism, to be sure, but does not provide an ethical analysis of the implications of the ethical concept of medicine as a profession. This is because, like “A Physician Charter,” the AMSA initiative is not grounded in and thus guided by an ethical concept of medicine as a profession.

CONCLUSION

Professional medical ethics is a very serious matter. In the absence of a professional medical ethics, affirmed and put into practice every day by physicians, there will be no more physicians and therefore no more patients. We will revert to the marketplace, entrepreneurial, self-interested world of practitioners preying on the sick. Given these stakes, it simply will not do to invoke professionalism, as if we could do so with integrity, in the absence of a clearly articulated ethical concept of medicine as a profession. We get this concept from the recent, not ancient, history of medicine. The ethical concept of medicine as a profession should therefore be understood as a very young idea in the context of the history of ideas. It will not preserve itself. Nor will it be preserved by earnest, but conceptually anemic, invocations of medical professionalism.

REFERENCES


CHAPTER 3
CHARACTER FORMATION IN PROFESSIONAL EDUCATION: A WORD OF CAUTION

Robert M. Veatch

ABSTRACT

This chapter questions the role of virtues in health professional medical ethics. It distinguishes between the ethics of conduct – usually expressed as moral principles – and the ethics of the character – expressed as virtues. It questions whether virtues are intrinsically valued or valued instrumentally as the means to right conduct. It poses two problems for virtue theory: (1) The “naked virtue” problem – whether instilling virtues increases the probability of correlative morally right conduct, and (2) the “wrong virtue” problem – which of many sometimes controversial virtues should be promoted. The chapter ends by arguing that these are less serious problems for the morality of conduct.

A hypothetical:

A physician had had all he could take of a particularly difficult patient. He was ventilator dependent, but when he had an opportunity to speak or write notes he was impossibly obnoxious – rude and insulting to the nurses, demanding, unreasonable with physicians, and an all-around pain. The attending, Dr. Malevolent, couldn’t stand it any
more. He felt he had to do something. He had been off for several days. While he was away, he had come on his plan:

When on call that night, he entered the patient’s room intent on disconnecting the vent to get rid of his problem. He knew it would be a homicide if he got caught, but no one else was around, and he felt sure he could cover his tracks. He would enter in the chart that the patient had demanded that the vent be disconnected and then do the job.

He entered the room, picked up the chart, and read reports from nurses on the two previous shifts saying that, unbeknownst to Dr. Malevolent, the patient had indeed demanded that the vent be disconnected. He also read that a psychiatrist had been called by the resident and had determined that the patient was mentally competent to make the decision. From the chart he read that the nurses had known about this persistent choice of the patient for several days. The rest of the team was waiting for Dr. Malevolent to return who they thought, as the patient’s primary care-giver, should be the one to disconnect the ventilator. Dr. Malevolent disconnected the ventilator.

How should we assess Dr. Malevolent’s behavior and his moral character? His moral character is easy: he was, well, malevolent. He was lacking in the virtue of patience. He was not the long-suffering, compassionate, tolerant, loving doctor we imagine when we think about medical ethics. But what about Dr. Malevolent’s behavior? We can come very close to saying that he did exactly the right thing in this circumstance. We would want the attending to honor the patient’s choice and disconnect a ventilator when, according to the patient’s competent and persistent decision, the treatment had become so burdensome that it was intolerable. All right, perhaps, we would prefer that Dr. Malevolent followed a rule that, when, in spite of himself, he despised a patient, he should ask someone else to take over the case or at least concur in the morality of following the patient’s demand, but aside from this aspect, Dr. Malevolent did precisely what all the rules of contemporary medical ethics would require. I do not think we can escape the conclusion that Dr. Malevolent did the right thing. His behavior was close to impeccable; it was his character that was deficient.

This poses something of a problem for the subject of professional character formation of physicians. Teaching virtue or moral character has been a core objective in professional education, even if we have known how difficult it is and how we have failed. But problems like the one presented in this hypothetical raise a more fundamental problem: is it possible to engage in essentially morally correct conduct even if one has blatantly despicable character? Conversely, is it also possible to engage in morally wrong conduct even if one is a saint?

In terms of ethical theory, moral character and moral conduct is logically distinct. We know of the well-meaning do-gooder who fails in conduct. We
have encountered clinical colleagues who we know have corrupt motivation, but nevertheless do what is right. The clinician whose only goal in life is to impress colleagues in order to make money, gain referrals, and become chairman of medicine may be clever enough to realize that he can accomplish his selfish objectives by engaging day after day, week after week, in perfectly correct conduct.

I do not mean that this person would merely engage in technically correct medicine. We know that technically correct medicine can be practiced in a callous, uncaring, and morally offensive manner. Consents can be ignored; lies can be told; all the moral standards of the professional codes of ethics can be violated while practicing technically correct medicine.

But what of the self-centered, ambitious physician who is smart enough to know that the only way to advance his career is to put forth the impression of a caring, compassionate physician as well as carefully following all the ethical principles specifying morally right conduct? He would certainly be lacking in good character, but, in theory, might consistently practice not only technically correct medicine, but morally correct medicine as well. The question here is how we should evaluate such a colleague and whether his teachers should believe they have failed in some way?

Ethical theory distinguishes the ethics of virtue or character from the ethics of action. The ethics of action assesses conduct: actions or groups of actions governed by moral principles. Most professional codes of ethics spell out moral rules governing conduct. The code says that the physician must get consent. It does not say that it must be done while manifesting certain virtues. To be sure, good quality consent must include an adequate explanation of the treatment risks and benefits as well as the alternatives. This information must be presented in such a way that the patient understands adequately and can make an informed choice. Whether the physician manifests the virtues such as humaneness or compassion may not be essential to adequately following the moral norm of getting consent as long as the informational and voluntariness criteria are met.

The other major branch of ethical theory is virtue theory. Virtues are persistent traits of morally praiseworthy character. Different ethical traditions identify quite different virtues: the Greeks favored the four Cardinal virtues (wisdom, temperance, tolerance, and justice). Classical Christian ethics favors the theological virtues (faith, hope, and charity). The Hippocratic ethic included two virtues (purity and holiness). The World Medical Association’s Declaration of Geneva currently touts two others (conscience and dignity). Roman Catholic moral theology influenced by Thomas Aquinas has traditionally endorsed both the Greek and Christian virtues.
providing a list of seven, while some Protestant theologians have insisted on retaining the difference between the pagan Greek view and the Christian. In the extreme case, someone might reject one set of virtues while extolling the other. For example, some lovers of Greek culture might reject a loving character full of compassion for the genetically afflicted claiming that such a disposition lacks the Homeric virtue of courage necessary to advance natural selection. Some who believe that the meek are blessed might not look favorably on a character manifesting such courage.

What is critical here is that virtue theory addresses the character of the actor while action theory deals with assessment of the conduct, theoretically independent of the character of the actor. A project to restore or retain professional character formation in medical education is, in effect, an effort to claim that morally right conduct is not sufficient to the practice of medicine. The other branch of morality, virtue theory, is a necessary (if not sufficient) condition for adequate professional education. This chapter presses the question of whether this is correct and, if so, what will be necessary for reintroducing professional character formation into professional education.

**THE RELATION OF CONDUCT AND CHARACTER**

The most common response to the examples I have presented is that, even if conduct is what counts in the relation of the professional with the client or patient, good character is essential to assure that the professional’s behavior is going to be consistently good. We want the physician to do the right thing when no one is watching. Moreover, we want health professionals to have the ability to appreciate what is morally required of them, to discern what the code of ethics or other source of norms for good moral conduct requires. That, the critics claim, requires good character formation. Some would argue that some set of good character traits is required for consistently accurate discernment. The claim is that it is only out of compassionate, caring dedication or a persistent practical wisdom that a physician or nurse can be depended upon to do the right thing.

Is there a correlation of character and conduct? It is an empirical question. I do not know any studies that have shown that physicians with good character more consistently engage in morally right behavior than those of bad character. It seems plausible, but it may not work out that way. We all know of physicians (or nurses) who, beyond question, have the character of saints, but still make mistakes. They not only make technical
mistakes – mistakes of knowledge or mistakes of technique – but they also make moral mistakes.

In an earlier era, physicians caring for terminally ill patients lied to patients about their terminal diagnoses. We now take that behavior to be morally wrong. It violates the ancient moral norm, “Tell the truth.” If it leaves the patient so uninformed she cannot give an adequately informed consent, it is also illegal. Nevertheless, there seems little doubt that some of the old-fashioned doctors who told benevolent lies did so out of dedication to the benign motive of wanting to avoid harming the patient. In the jargon of ethics, they were benevolent. They clearly wanted to be kind and avoid harm. These dedicated, benevolent doctors might be said to have been doctors of good character who nevertheless did the wrong thing. Some oncologists of yesteryear had a persistently benevolent disposition and nevertheless persistently did the wrong thing.

On the other hand, some less well-motivated professionals may have good track records of doing what is morally right. Although it seems strange, it could be that in some settings, selfishness and a fear of being caught could just turn out to more consistently produce good behavior than what I have called “naked virtue” (Veatch, 1985, pp. 329–345). By “naked virtue” I mean virtue out there on its own, unchecked by a system of moral rules and societal mechanisms of control. It could be that in some settings, the truly compassionate, dedicated professional whose only agenda is to manifest virtuous character could get it wrong (could engage in morally wrong actions) more often than the more normally selfish professional who knows that rules should be followed and that morally wrong conduct can get one in trouble.

We may have in professional ethics a kind of equivalent of Adam Smith’s invisible hand. Smith held that relentless pursuit of self-interest in the economy can, in some circumstances, promote the common good. It could be that professionals manifesting enlightened self-interest that includes taking seriously the moral code and the risk of getting caught in wrong behavior do more right things than those who merely put themselves on the scene correctly believing that they possess virtuous character. In this case, naked virtue would not be enough to guarantee morally right behavior.

Whether naked virtue is a problem will depend a lot on the situation. Certain circumstances will increase the probability that virtuous character by itself would not be sufficient. For example, a missionary physician in a foreign land who, beyond question, cares deeply about the welfare of her patients may be so unfamiliar with the beliefs and values of the local culture
that compassion alone would not cut it. The more the cultural variation between professional and client and among different clients, the greater the risk that naked virtue will be insufficient.

Other variables are probably critical as well. The greater the emotional tension, the greater the risk that good character will fail to lead to right conduct. Doctors triaging a disaster may do better following triage rules than going on faith in their integrity (Baker & Strosberg, 1992). The greater the need for rapid fire, momentous decisions and the more pluralistic the environment, the greater the risk that well-meaning good character will lead to mistakes.

This is not to say that application of moral principles and codes of conduct to clinical decision making will always out-perform good character. It is merely to question the presumption that good character is important in professional education in order to assure right conduct. It is likely that in some settings character will count more than others and that we have very little basis for asserting that professional character formation is crucial to protect patients from immoral behavior.

**THE REASON WE VALUE GOOD CHARACTER**

There is a more basic problem with the argument that the reason we value good character is that it will increase the probability of right behavior. Such an argument values character instrumentally. Someone who advocates the teaching of virtues in medical education because it will promote wise discernment of what behavior is morally required is actually acknowledging that it is really conduct, not virtue, that is the moral bottom line. Such an argument makes character important merely because it will pay off with better conduct. Even if in some settings empirical evidence could be produced showing that virtuous physicians more consistently followed the norms of morally right action, such a position would be using virtues as a means to producing morally appropriate behavior, not as something that is intrinsically important.

There is a debate among ethical theorists over whether morally good character should be valued instrumentally or intrinsically (May, 1983). While some no doubt value the virtues because they believe it will produce better behavior more reliably than any other approach, others see virtuous character as intrinsically valuable. These people claim that a society that has people of good character is simply a better society, not because it will guarantee good behavior, but because it is intrinsically more valuable. Just
like a society with great art is a better society intrinsically, not because the
great art will produce better, more reflective, more temperate behavior, so a
society with people of good character might simply be seen as a better place
to live regardless of any pay off.

Now how does this apply to medicine as a profession? Some would claim
that a society that has an institution of medicine whose physicians have
experienced character development during their professional education has
a better medicine than one that has merely developed physicians who both
demonstrate technical competence and engage in morally right behavior.

I do not know how professional educators of the next generation of
medicine should incorporate this special value of having a professional class
of physicians of good character. Some, no doubt, will see this as important;
others may be more pragmatic in simply wanting to get morally right,
technically competent medicine practiced consistently.

It is likely that all of us assess the relative importance of good character as
an intrinsic good differently in different settings. For example, when we are
in the parenting role, we probably care a great deal about raising children of
good character. We care not only, not primarily, because it will lead to right
conduct in our children and keep them out of trouble. While we may hope
for that outcome, we would consider that we have produced something
worthwhile if we produced children of good character who are just as likely
to do wrong as our neighbors’ children who lacked good character. We
might even say we would rather produce a son who, while working in an
after school job at McDonalds, gave a customer the wrong change while
trying to count it correctly than a son who gave the right change only
because he knew that the video monitor was recording his hand movement
and therefore he counted cautiously. We would not be comforted if told that
our child could not get away with short-changing his customer because the
manager had installed automated change dispensing cash registers. We want
a son whose heart is in the right place; not one whose enlightened self-
interest forces him to place his hand in the till correctly.

I suspect that in the practice of medicine, our trade-off between good
character and right conduct will vary depending on the situation as well. I
know a physician who is a devout Roman Catholic and who gave up a
lucrative medical career to become the volunteer medical care-giver in a
monastery where she would care for a group of monks and live among them
on a subsistence wage. She had a close bond with her patients, and they
came to be like a family. I suspect that in that setting there was high value on
good character. The monks would, of course, still want technically com-
petent medicine, but they would probably risk a moral mistake, an error in
the negotiating of the consent, for instance, before they would accept a provider lacking in good character.

The physician among the monks was living not only in a setting like that of a family, but also one where there was assured a very close compatibility in moral perspective. The devout Roman Catholic lay woman who was the physician for the devout Roman Catholic monks undoubtedly shared a common Roman Catholic moral theology. Turning her loose to follow her moral instincts guided only by her good character was a reasonably safe bet for the monks. She is, in an important way, at the opposite end of the spectrum from the equally dedicated Baptist missionary physician providing health care for African peasants whose culture, beliefs, and values can, at best, can only be poorly understood. In this case, virtuous character is much more likely to get it wrong from the perspective of the patients.

Strangers arriving in an ER unconscious from an automobile accident are somewhat like the African peasants. The ER physician is practicing among patients who are strangers, people whose values the physician cannot be expected to know. That ER physician guided by his own virtuous character can, at best, do what he would want done if he were in the patient’s position. If governed only by his good character, he has a high probability of getting it wrong. Moreover, there is no reason (as there would be in the case of parents or the monks) to justify the physician’s conduct by appealing to the intrinsic value of good character. The unconscious patient probably does not care whether the physician has manifested good character as long as he gets the behavior right (morally and technically).

Thus the setting where medicine is practiced could determine whether to place intrinsic value on good character or merely value good character instrumentally as a means to right conduct. In some settings no doubt professional character will be critical; in others it may, at most, be a means to morally right conduct.

This poses a serious problem for professional educators. If they are training young professionals for those roles where virtue is intrinsically important, then, to the extent good character is teachable, it is essential to spend the resources necessary to build character. If, however, they are training physicians whose patients care less about the intrinsic value of good character, then they may choose to invest in character formation only to the extent that it is instrumental to good conduct payoff. The alternative would be to choose to develop medicine according to some professional vision even knowing that that is not the medicine that patients would want.
WHICH VIRTUES TO TEACH?

Professional educators face a more serious problem. Assuming that they decide to restore character formation as a goal of health professional education, assuming that the virtues of good character are teachable, and assuming we can figure out the relative importance of virtue and conduct, we still would need to figure out which virtues to teach.

The Chaos of Lists of Virtues

I have suggested that different cultures with different moral theories will incorporate radically different virtues (Veatch, 2003, pp. 184–191). Roman Catholics would develop their concept of the virtuous physician from the combination of the Greek cardinal virtues and the Christian theological virtues. The classical Hindu text, the Caraka Samhita, lists four virtues — care, attention, humility, and constant reflection (Oath in Initiation (Caraka Samhita, 1978)). Confucian texts refer to three virtues — humaneness, compassion, and filial piety. Lest one think that none of this makes much difference, consider “filial piety,” the Confucian notion that a physician should relate to the patient like a brother, like a family member. This was understood to mean that the Chinese physician should provide care as one of the family would. This is significantly different from Western notion of “detached concern” (Harold & Fox, 1963, pp. 12–35), which gives rise to the norm that a doctor should abstain from providing care to family members at least in serious matters. In China, since the physician was to practice like a family member, that included the norm that he was not to take payment for services (Unschuld, 1979).

A similar problem arises in the ethical systems in the medical profession. In contrast to the Hippocratic Oath’s “purity and holiness” and the Declaration of Geneva’s “conscience and dignity,” the AMA in 1957 endorsed “respect for the dignity of man” and “devotion” (American Medical Association, 1957, pp. 1119–1120). In 1980, the AMA shifted its language, now endorsing “respect for human dignity” and “compassion.” It not only fixed the gender neutrality problem, but changed from the religious-sounding “devotion” to the fashionable “compassion” (American Medical Association, 1981). The Canadian Medical Association Code of Ethics lists “respect” as the only identifiable character trait it praises. This is radically different from the classical Greek and Christian virtues. Were there ever a Canadian physician who was also a Roman Catholic nun, it is hard to imagine the dilemma she would face picking which virtues to tout.
Lest these differences are seen as trivial, one should note that Thomas Percival, the leading medical professional of the eighteenth and nineteenth centuries in the English-speaking world, adopted the four virtues of tenderness, steadiness, condescension, and authority. Yes, condescension (Percival, 1803). And to prove it was no mistake, the AMA fifty years later repeated these virtues verbatim (American Medical Association, 1848). While condescension can actually be made to make sense in the eighteenth century world (when the meaning was that it was that the physician should get down to the level of the patient – presumed to be on a lower level not only in education, but also in social class), it is hard to put it forward as the basis for health professional education in the twenty-first century.

The important point is that different people from different cultural, religious, and national groups have very different ideas of what virtues a virtuous physician would manifest. A Talmudic physician steeped in orthodox rabbinical teaching would have a different view of the virtuous physician than does the practitioner working in a feminist health clinic. It is possible that the leaders of a sectarian medical school say a Roman Catholic school or a Jewish school could agree on a package of virtues around which to build the character of their students. This would be possible if, contrary to current practice, these schools were really sectarian, insisting that their students reflect the basic values of the sponsoring groups. It is impossible in modern medical schools that claim only vague memories of their religious founders. It is impossible even in theory in secular schools such as the public schools of liberal society that insist on value neutrality. Those schools would have no way of knowing which character traits to instill into their students even if they wanted to do so. Should a school affirm the virtue of passivity in patients or a militant feminist view? Should they endorse the Hindu virtue of humility or the Greek virtue of courage?

**ON THE POSSIBILITY OF A COMMON CORE OF VIRTUES**

Educators may think they can escape this dilemma by seeking until they find some consensus virtues upon which all can agree. Compassion, care, benevolence, humaneness, and integrity have been suggested as candidates. That quest may prove fruitless, however. Some of these virtues are more controversial than they may appear. Ethical theorists sometimes claim that normally virtues have correlated norms of right action. Thus, to the extent
that the naked virtue problem can be overcome, affirming a virtue will increase the likelihood of its correlated right action.

For example, benevolence is a virtue that has beneficence as its correlative norm of right action. Beneficence is the norm that an action is right to the extent that it produces benefit. Benevolence, the correlated virtue, holds that morally good character is one that persistently wills the good. The first problem we addressed was whether willing the good is enough, whether willing the good will increase the probability of producing more good for people. In medicine, in which beneficence is individualized and directed to doing good for the patient, the question is whether willing the good for the patient leads to doing good for the patient. I have argued elsewhere that physicians need to stop trying to benefit the patient in part because they cannot have the knowledge of what counts as a benefit from the patient’s point of view (Veatch, 2000, pp. 701–721).

The more complicated problem is that the benevolent physician may really end up benefitting the patient – even when morality requires something else. The old Hippocratic ethic that the sole or primary duty of the physician is to benefit the patient is controversial at best, morally offensive at worst. There are many situations in which it would be morally wrong for a physician to benefit his or her patient. Morality might require compromising the patient’s welfare in order to promote the welfare of others. That, in fact, is what is required in an era of scarce resources when giving each of one’s patients everything that could benefit them would not only be immoral, but is actually illegal when it commands resources rightfully belonging to others. (That is why surgeons are not permitted to decide whether their patients should get a transplantable organ they procure.)

More frequently, morality may require sacrificing patient benefit in order to protect the rights of patients. For example, in recent medical ethics, unless a patient agrees, a physician is forbidden from disclosing confidential information about a patient in the case when the physician believes that disclosure would, in the long run, benefit the patient.

Successfully instilling benevolence into young medical students could lead to having the resulting physician benefitting the patient when the patient wanted to make a sacrifice to benefit others in the family. It could lead to benefitting the patient when society has determined that the resources should be used to benefit others. It could lead to benefitting the patient when the patient would prefer to have her right of confidentiality respected. Instilling a virtue can, at best, lead to the correlative behavior. If the behavior is morally wrong, then making the virtue a part of the physician’s character is a mistake. I call it the “wrong virtue” problem.
The same problem of instilling the wrong virtue can arise with any other purported virtue. Instilling courage in an aggressive, over-confident, domineering surgeon may lead her to just the wrong behavior. Instilling humility in a retiring, intimidated nurse may push him in the wrong direction.

If I am correct that virtues are controversial and that different cultural traditions affirm different virtues, then picking the wrong virtue is a major problem. And, if secular, public medical schools are preparing vastly different kinds of students from different kinds of cultures, any one set of virtues will be a mistake. We have seen that even a benign virtue like benevolence can be controversial.

The same can be said for other fashionable virtues. Consider “integrity,” a trait that rarely gets a bad word. It is particularly attractive in nursing ethics where nurses appeal to the term to encourage nurses to stand up against authorities (read physicians) who they think are engaging in unethical actions.

The problem with integrity is that, while sounding like a trait everyone would like to have, it really has very little meaning. Integrity is a term related to words like integration, integral, and integer. The core meaning is oneness or wholeness. In ethics, it conveys a character trait of acting at one with one’s core values. The problem is that consistent affirmation of one’s core values may end up consistently affirming immoral values. Acting with integrity only works if one is integrated with the right character. In this sense Hitler was, unfortunately, a man of great integrity. We only wish he had been less consistent in his character.

Still, the defender of the teaching of the virtues may hold out hope that there is some set of core traits that patients desire or need or prefer from physicians regardless of the setting for medical practice. Compassion and care, two closely related virtues, may come closer to consensus character traits. (That is why they show up in contemporary professional codes.) Even they can end up being controversial, however. They can drift into paternalism at the wrong time. They can lead to following the Golden Rule when the other does not want those things done unto him or her. The most serious problem is probably how vague compassion and care are. Being compassionate or caring can mean about anything the health professional wants them to mean. At their best, they will certainly be desired by patients. At their worst, they will lead to health care professionals who lack respect, courage, or decisiveness.

There may, in fact, be some core traits that generate sufficient consensus that a medical educator could strive to teach them. This would particularly be true in sectarian medical schools reflecting a religious or political
tradition for which some consensus virtues were recognized. For secular, pluralistic schools, however, only platitudinous virtues at such a level of generality that they are almost meaningless will fit the wide range of beliefs and styles of students and their future patients. The wrong virtue problem is a serious one for educators contemplating renewed emphasis on character formation. They will have to determine just which virtues are on the agenda as well as how the virtues can be taught.

If exemplars are used, they will have to determine which exemplars. (Is Marcus Wellby the exemplar physician or Che Guevara?) If repeated patterned behavior is chosen, they will have to determine which patterns. (Is it the patterned stubbornness of Francis Kelsey or the humility of a Mother Teresa?) If rewards for good character are the strategy, they will have to determine which characters get rewarded. (Is it right-wing corporate medicine’s Bill Frist or TV’s fictional rebel, Hawkeye Pierce?)

ARE THESE PROBLEMS FOR NORMS FOR RIGHT ACTION?

Whether virtue by itself can lead to right action (the naked virtue problem) and which virtues should be instilled (the wrong virtue problem) are substantial issues confronting those who would restore character formation to the agenda of medical education? Critics might argue that a similar problem confronts medical ethics educators who concentrate on the more traditional theory of right action. This is the kind of medical ethics exemplified in the codes of conduct, the principle-based theories of medical ethics, and the case studies that focus on whether the behavior of the provider was right or wrong. The final issue in this word of caution is whether these same concerns arise in these conduct-oriented ethics.

No doubt these are also issues in action theory. The medical ethics educator dealing with action theory has to worry about whether teaching of norms will lead to the correlated behavior. He or she will have to worry about which norms to teach. But there are important differences.

First, whether virtue leads to correlated behavior is a question that involves two steps. It involves connecting the virtue with the relevant behavioral norm. Then it involves connecting the behavioral norm to the behavior itself. The second problem is the same whether teaching focuses on norms for behavior or virtuous character traits. Teaching devoted to instilling character traits, however, involve the second step – connecting the virtues with the relevant behavior. Thus, if the purpose of teaching that focuses on
character formation is to ensure morally right conduct, the teacher has an extra layer of work where things can go wrong.

The more significant difference between teaching character formation and teaching behavioral norms is that, if we are right, in many (but not all) medical settings, patients need not worry about virtuous character in physicians for any reason other than that it might increase the probability of the correlated behavior. What patients are really concerned about is whether the conduct of their physicians is right, not whether the physician engages in the right conduct from the right character traits. There are, as I have suggested, exceptions. The monks may worry about their physician community member acting out of the right character, but in the ER if I am treated properly, I do not really care why the physician treats me right. That, of course, requires that the physician’s conduct be both technically and morally correct, but it does not require that he or she act correctly out of the right character traits. If I arrive in the ER unconscious having suffered a massive stroke, it is critical to me that I be euthanized if and only if it is the morally right thing to do. Under every circumstance I can imagine I want my ER doctor to avoid killing me (even though I want her to follow my advance directive and surrogate instructions when it comes to forgoing life support). Whether she manifests the proper virtues when she avoids killing me is less critical.

There is one final important difference. I have suggested that the theory of virtues varies tremendously from one cultural group to another and so picking which virtues to teach, especially in secular schools, is a major problem. I would maintain that this problem is much less severe in action theory. Of course there are different theories of the norms of right action, but there is considerable agreement that, even though the theoretical frameworks are different, the content of the moral norms for right action are substantially the same.

Recently, this position is being expressed in the language of a “common morality.” Those who affirm a common morality hold that all (or almost all) reasonable people accept a small number of moral norms that are applicable for all times and all cultures. Philosopher Bernard Gert and his colleagues Charles Culver and Danner Clouser have developed this view in terms of 10 universally affirmed moral rules (Culver & Clouser, 1997; Gert, 2004). Bioethicists Tom Beauchamp and James Childress endorse the common morality theory in terms of four moral principles, but claim that more specific moral rules can be “specified” based on these principles (Beauchamp & Childress, 2001). There are, at most, minor differences in their norms and those of Gert. (Gert, for example, calls his norms “rules,” while Beauchamp and Childress refer to “specified principles.”)
To accept the common morality thesis one needs to understand that its defenders do not by any means claim that all cultures in all times have precisely the same views on specific behaviors. They know people differ on abortion, organ transplant, human subjects’ research, stem cells, and euthanasia. They hold, however, that these differences are accounted for by several factors. First, some differences are accounted for by different beliefs about the nonmoral facts. If some believe that lower animals feel pain and others believe they do not, both can agree on the norm that, other things being equal, one should not cause pain in animals, but still differ on how certain animals are treated. Second, some people may lack moral imagination so that they have not stopped to think about the effects of behaviors on other people. Third, the norms of common morality sometimes come into conflict so that two cultures can affirm the same set of norms and still disagree on how two conflicting norms should be ranked or balanced against each other (Veatch, 1995, pp. 199–218). Fourth, differences in time and culture may change the relevant facts. One can consistently accept just war theory in the Middle Ages and conclude that all war is immoral in the nuclear age because the destructive power of weapons has changed so significantly. For all of these (and other) reasons, sophisticated common morality theory can maintain that there is a common set of moral norms that can provide the content for moral education in professional education even though there may be no consensus on the theory of virtues.

This common morality has, over the years been expressed in many different terms. Some people have talked about “universal human rights.” Others use more Kantian language to affirm universal duties. Still others talk about natural law. In human subjects’ research, there is overwhelming agreement on the general norms of beneficence, justice, and respect for autonomy. Many would differentiate beneficence into the pair – beneficence and nonmaleficence. I have advocated a further subdivision of respect for persons into the principles of autonomy, veracity, fidelity, and avoidance of killing. Gert, as I have indicated, emphasizes 10 more specific rules, but they can be reformulated to look much like my seven principles or Beauchamp and Childress’s four.

One clear example of a statement of a set of norms that reflects the common morality is the Universal Declaration of Human Rights. That so many countries from so many perspectives can agree on at least more abstract rights statements suggests a foundation for a common morality. In the medical profession, there is similar worldwide acceptance of the moral norms of the Declaration of Geneva and, in research medicine, the Nuremberg Code and the Declaration of Helsinki. Of course, there are
differences at the margin. Different language is used and different resolution of complex problems of competing norms leads to some differences, but, by and large, medical moral norms are shared in common when approached at the abstract level.

It is the medical derivative of this common morality that provides the basis for the moral norms of right conduct that must be part of health professional education. Insofar as the common morality comes from outside of the profession of medicine, this is not a morality internal to the profession. It comes from a more universal source and it is knowable to all reasonable people, not just members of the profession. It is knowable by reason, through experience, or through other ways of knowing. Like all knowledge, knowledge of these norms is fallible, but, when it comes to norms of right conduct, it is plausible to strive for teaching the medical derivatives of this common morality in the education of health professionals and lay people. This provides the content of the norms of conduct that must be part of any professional education.

Whether the norms of virtuous character can be similarly part of professional education remains to be determined. I have suggested that it is much harder to develop an agreed upon list of virtues that could be taught to medical students and other health professionals. Moreover, it often makes much less difference whether health professionals are acting based on a particular set of character traits. Thus I have introduced a word of caution. There is, I suggest, nothing like a common morality in virtue theory. There is thus no possibility of identifying a set of character traits that can be taught in professional education. There is not only a problem of whether instilling virtue leads to the correlated behavior. There is the much more serious problem of identifying which character traits would be good to instill. Certainly, there will be special circumstances where professionals and their patients can agree on what virtues are worth promoting. Sectarian medical schools may be able to accomplish this. There may also be some consensus virtues like compassion and care that will work most of the time for most if not all cultures. Even then, however, patients are more likely to be concerned about the behavior of their health professionals than they are about their character traits.

It would be good if Dr. Malevolent could learn when it is morally acceptable to disconnect ventilators. It would be even better if he disconnects them when, and only when he should. It might be nice – but perhaps an impossible goal – for him to act out of the morally right character when he disconnects them.
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CHAPTER 4

EVIDENCE-BASED CHARACTER DEVELOPMENT

Muriel J. Bebeau

ABSTRACT

This chapter reviews the evidence of the development of ethical decision-making competencies of medical professionals. Selected studies are reviewed that use a theoretical framework that has shown the most promise for providing evidence of character formation. The evidence suggests that entering professionals lack full capacity for functional processes that give rise to morality (sensitivity, reasoning, motivation and commitment, character and competence). Further, following professional education, considerable variations in these abilities persist. Whereas many perceive that role modeling is the most effective way to teach professionalism, there is no empirical evidence to support the role of modeling in professional development. The chapter concludes with suggestions for facilitating character development resistant to influence by negative role models or adverse moral milieu.

INTRODUCTION

Defining Character from the Psychologist’s Perspective

Webster’s New World Dictionary (1984) describes character as “the pattern of behavior or personality found in an individual or group; moral
constitution … moral strength; self-discipline, fortitude, etc.” Notice the focus on both the behavior of the individual and the internal qualities, traits, or virtues that seem to be associated with such behavior. Is there a relationship between internal qualities and behavior? The assumption seems to be that there is. What is that relationship and what evidence is there that promoting the development of such qualities results in moral behavior? These are age-old questions for moral psychology and questions that bear some reflection, as we consider professional character development and modern medical education. If professional practice is essentially a moral enterprise – which the authors of this volume seem to assume – we must be as concerned about the development of professionalism and character as we are about the development of technical expertise. What then is known about the development of the character of the professional and what kinds of activities (if any) are likely to promote professional character development? To proceed with such questions, the psychologist (Rest, 1982) asks: Why is it that people sometimes fail to do what others think they should? If we understand the reasons for moral failure, is it possible to orchestrate a professionalism program to promote character development? What evidence is there that such curriculum will actually influence the development of both the internal qualities and their external manifestations?

This chapter takes up these questions. It begins with a discussion of the processes that give rise to morality, operationally defines them, describes various measurement instruments that have been devised to assess them, summarizes research findings with respect to them, and draws some implications for professional education.

The Components of Morality

Beginning with the question “How does moral behavior come about?” Rest (1982, 1983) described four internal processes, each of which must be activated for moral behavior to occur: (1) sensitivity, (2) reasoning, (3) motivation and commitment, (4) moral character and competence. The articulation of these four processes (elaborated below) was the result of an extensive review of empirical literature that integrated research findings from multiple theoretical perspectives (Rest, 1983) and research traditions. As a consequence of that review, Rest and colleagues (Bebeau, Rest, & Narvaez, 1999a) concluded that research on ethical development had been hampered by a conception of morality consisting of cognitions, affect, and behavior, as though these were independent of each other. Such a view was particularly prevalent in professions’ education, as researchers tended to
study affective responses, cognitive responses, and behavior as though they were distinct. If progress was to be made in understanding ethical development, a reconceptualization of the processes that give rise to morality was required.

The Ethics Movement and the Development of the Components

Today, most professional schools recognize the importance of ethics instruction to professional education, and accreditation bodies include ethics, values, and communication as explicit requirements for certification. Many of the arguments launched in the 1970s and 1980s – that values were well established by the time students reached professional school (thus little could be accomplished), that teaching ethics was simply moralizing (which had no place in a public institution), and that even if something could be accomplished, faculty were ill equipped to teach it – seem to have fallen by the wayside. In the early days of the movement, ethicists had to argue for the importance of instruction that focused on ethical reasoning (Hastings Center Report, 1980). Some (e.g., Harvard President Derek Bok, 1976) argued that ethics instruction needed to attend to moral perception and moral aspirations in addition to reasoning. Coincidentally, three of Rest’s defined processes are consistent with the goals of ethics instruction as described by Bok and as later proposed by the Hastings Center. Absent from these visions of ethics instruction is the emphasis on the fourth of Rest’s processes. Debate about objectives was followed by a debate about methods.

In the early days, the predominant method for resolving moral issues (Beauchamp & Childress, 1979) was the application of principles (autonomy, nonmaleficence, beneficence, and distributive justice) to the resolution of dilemmas presented in condensed case descriptions. When assessment of ethical decision making did occur, the preferred model was the analysis of written responses to cases (Howe, 1982). In medicine, some educators (Self, Baldwin, & Wolinsky, 1992) used measures such as Rest’s Defining Issues Test (DIT) to assess the impact of curriculum, but philosophers and ethicists pushing for ethics instruction argued against the use of such measures (e.g., Caplan, 1980) stating that the test was grounded in a Rawlsian/Kantian concept of justice that was biased against other moral frameworks that could and should be used to resolve tough problems in the professions. It was not until the early 1990s that challenges to principlism (Clouser & Gert, 1990) resulted in a rethinking of principled approaches to resolving moral issues (see Beauchamp & Childress, 1979). Just as challenges to principlism encouraged a rethinking of approaches to resolving ethics cases, such
Challenges influenced a data-based rethinking of what was measured by the DIT (Rest, Narvaez, Bebeau, & Thoma, 1999a). Today, evidence supports the DIT as a measure of postconventional moral thinking, rather than a measure of principled thinking (Rest et al., 1999a; Thoma, 2006).

Because the ethics movement in medicine was precipitated by technological advances that posed difficult moral questions for patients and families, it was only natural that philosophers and ethicists would be brought in to help debate these new and emerging issues. As ethics centers were established in academic health centers, ethicists and physician ethicists, in addition to assisting physicians and families with emerging issues, also began to give attention to ethics education for physicians, nurses, and medical students and residents. Thus, because the resurgence of ethics education in medicine originated with challenging moral problems in health care (the domain of philosophers and ethicists), rather than concerns about the development of moral character (as is the case in elementary and secondary education), moral psychology has not been the guiding force behind curriculum design and assessment development in medicine, as it has been in professions where issues are less dramatic. However, when psychologists have collaborated with philosophers in the design of instruction and assessment (e.g., dentistry and nursing [Rest & Narvaez, 1994]), both theory and practice have benefited.

**DIMENSIONS OF CHARACTER**

*Ethical Sensitivity*

**Operational Definition**

Moral sensitivity (Rest, 1983) focuses on the interpretation of a situation, the various actions that are available, and how each action might affect the self and others. It involves imaginatively constructing possible scenarios (often from limited cues and partial information), knowing cause–consequence chains of events in the real world, and having empathy and role-taking skills. This process highlights the idea that moral behavior can only occur if the professional codes the situation as moral. Both cognitive processes (perception, appraisal, and interpretation) and affective arousal (e.g., anger, apathy, anxiety, empathy, and revulsion) contribute to the interpretation of problematic situations.

For individuals being socialized to professional practice, ethical sensitivity involves the ability to see things from the perspective of other individuals...
and groups (including other cultural and socioeconomic groups), and more abstractly, from legal, institutional, and organizational perspectives. Thus, it includes knowing the regulations, codes and norms of one’s profession, and recognizing when they apply.

Measurement
Methods for assessing ethical sensitivity, as Rest conceptualized it, were first developed in dentistry (Bebeau & Rest, 1982; Bebeau, Rest, & Yamoor, 1985), and the most extensive work on the validity of the method has been conducted with the Dental Ethical Sensitivity Test (DEST, Forms A and B), the Geriatric Dental Ethical Sensitivity Test (GDEST) (Ernest, 1990), and the Racial Ethical Sensitivity Test (REST) (Brabeck et al., 2000; Brabeck & Sirin, 2001). In a recent review of the ethical sensitivity literature, You and Bebeau (2005) cite 37 studies in which 19 measures are identified that claim to assess Rest’s operational definition of ethical or moral sensitivity. The measures were designed to assess ethical sensitivity in nine different professional fields (business – four measures, computer science – one measure, counseling psychology – six measures, dentistry – two measures, journalism – one measure, medicine – one measures, nursing – one measure, school personnel – two measures, and social work – one measure), plus two measures designed to assess undergraduate students’ sensitivity to scientific issues and one to assess general moral issues affecting undergraduates.

A careful review of the stimulus materials, as well as published information concerning validity and reliability, indicates that although each of the measures claims to assess ethical sensitivity as Rest defined it, only about half of the measures designed the stimulus in a way that actually elicits the interpretive process as Rest conceptualized it. Measures of ethical sensitivity that adhere to Rest’s operational definition are performance based (e.g., the DEST, Bebeau & Rest, 1982). In measures where the construct is well-elicited, a drama is presented consisting of an interaction between two or more persons. The drama includes many clues to a moral or ethical problem, but never offers any interpretation of the clues. For example, a video or audiotaped drama may present acts of racial or gender intolerance exhibited by professionals as they interact with others. Or, a patient may exhibit forms of dementia as she or he interacts with a health care provider. The challenge for the observer is to recognize that what is exhibited is a significant problem, and that the professional has a responsibility to do something aside from the normal routine.

In a typical assessment, participants respond to an audio or videotaped conversation between the professional and a patient or between professionals.
At a certain point in the evolving drama, participants are asked to take the role of the professional and interact with the patient or client as they see fit, using actual dialog. Following that, participants respond to a series of probe questions designed to further elicit their interpretation of the situation. Such questions are effective in revealing a participant’s biases. Participants’ responses are recorded and transcribed for scoring. Responses are scored by assigning ratings to indicate the degree (usually on a 3-point scale) to which the participant (1) seems to have appropriately interpreted characteristics of the patient that need to be addressed if the patient’s needs are to be met, and (2) recognizes the responsibilities of the professional in meeting those needs. Judgments are based not on the quality of the solution offered or the quality of the interpersonal interaction skills displayed, but upon the extent to which what is said reflects recognition of the issues.

One additional feature of the measures in which the construct is well-elicited has to do with the extent to which the problems sample from the domain of issues within a profession. Measures in category one were as follows: The scenarios were developed from actual reports obtained from experienced professionals concerning ethical problems typically encountered in professional practice. Although the measure may not represent all issues that are likely to emerge, an attempt was made to sample from the range of issues.

In measures where the construct is not well-elicited, a synopsis of the issues is presented – much like a typical ethical problem presented in professional ethics texts. Whereas the respondent may be required to name the moral issue (e.g., patient’s right to autonomy is at stake) and may be asked to project what is likely to happen, and so on, the respondent is not asked to diagnose the issue from vague or ambiguous verbal or visual clues. This is not to suggest that naming the issue is not, in and of itself, a challenging task; in fact, many students and professionals have difficulty identifying the moral issue in professional dilemmas. It is just that Rest conceptualized naming the issue when a condensed synopsis of a moral problem is presented as part of the reasoning process, rather than the critical dimension of the interpretive process. Eight of the measures reviewed by You and Bebeau (2005) fall in this category, including the one measure designed for medical education (Hebert, Meslin, & Dunn, 1992).

In a third category, five measures were identified where the stimulus cases present a mix of the two methods, though the primary emphasis appears to be on naming the moral issue – i.e., less attention to the interpretive process than the naming process. A fourth category is evident in a study from nursing (Lutzen, Nordin, & Brolin, 1994), where the stimulus is designed to
elicit self-perception of sensitivity, rather than judgments of actual sensitivity as determined by some validated criteria. Since moral blindness is essentially a failure to see what others see, or the possibility that the inference one makes reflects biases, it is hard to imagine how self-assessment alone could provide useful insights about one’s ethical sensitivity.

**Research Findings**

Ethical sensitivity measures classified as well-developed and validated demonstrate the following psychometric properties: good interrater reliability, acceptable internal consistency, and test retest reliability. For some measures (e.g., the DEST, the REST, the GDEST), evidence of convergent validity has been established based on high correlations between moral sensitivity scores and practitioners’ intuitive rankings of protocols. Divergent validity is evidenced by low correlations with measures of verbal fluency, technical knowledge, and word count of participants’ responses. For the REST, divergent validity is evidenced by low correlations with the Multicultural Awareness–Knowledge–Skills Survey.

Consistent with theoretical expectations, studies demonstrate that ethical sensitivity can be influenced by educational interventions. Further, participants who had previously taken multicultural and ethics courses scored significantly higher on the test than students without such coursework. And, there is some support for the notion that level of education has a positive relationship to ethical sensitivity. Further, some studies indicate that professional experience is positively related to sensitivity. For the DEST, expert novice differences were evident in that physicians exhibited greater sensitivity than physicians’ assistants, and dentists exhibited greater sensitivity than dental auxiliaries. Equivocal findings include gender differences – some studies report gender differences favoring women, some do not.

The most promising new development in sensitivity assessment is evidence in the work of Sirin, Brabeck, Satiani, and Rogers-Serin (2003), who are experimenting with a computed-assisted response mode to elicit sensitivity. Preliminary studies suggest that this more economical method provides reasonable estimates of sensitivity. Whether results are simply a function of the fact that sensitivity is evident, even with assessment strategies that tap into only part of the construct Rest articulated, is a question for further study.

**Implications for Character Development**

Professional problems are usually a mix of technical and moral issues. Without intending to do so, professional education, with its necessary emphasis on acquisition of technical competence, may be conditioning
students to focus on the technical rather than on the moral aspects of a situation. It is not unusual for novices to be so focused on the technical aspects of diagnosis and treatment that they miss the moral implications of their prescribed treatment. Also, as evidence from studies of moral sensitivity attest, professionals often fail to diagnose characteristics of the patient that interfere with their acceptance of treatment recommendations. For example, a dentist’s failure to diagnose a patient’s beliefs about the cause of his/her condition (e.g., soft teeth run in my family), or a lack of understanding or misperception about the cause of disease, may result in a failure to address this concern when attempting to help the patient decide on a course of treatment or a modification of health habits. Even when noticing some important dimensions of care (e.g., inflammation of the tissue), the professional may make erroneous inferences about the meaning of an observation (e.g., assumes the patient does not care about their oral health), and thus not pursue a further diagnostic or educational intervention. One useful exercise to promote sensitivity to characteristics of people that are likely to interfere with treatment recommendations is to ask students to make lists of “problems with patients” and then help them sort problems into classifications of underlying characteristics.

Having done this exercise with hundreds of student and practitioner groups, we have arrived at eight general characteristics (Bebeau, 1996): four categories describe characteristics the patient brings with them to the care setting that the professional must diagnose, but probably cannot alter (health status, intellectual ability, psychological status, financial resources), and four categories describe characteristics the practitioner could alter, assuming he/she has the competence to do so (perceptions of health status; knowledge of cause and prevention of disease; values, beliefs and habits; trust in the profession and the professional). By sharpening awareness of these factors and helping students devise interview questions to illicit information about beliefs, values, and habits, and understanding of the causes of disease (without shaming and blaming), we empower them to conduct a more expansive diagnostic assessment (i.e., beyond disease status), one that enables them to gain understanding of all the factors that are likely to influence acceptance of treatment recommendations, as well as long-term outcomes of care. By asking students to systematically collect observations and information, and then compare interpretations (first on hypothetical cases and then on patient interactions), we are able to challenge biases, address misconceptions, and thus enhance sensitivity to ethical issues in the profession. By this process, we also promote respect for persons, as we help students see their role as one who helps the patient identify their oral health goals, and then to consider
treatment options and health habits, as they contribute to the attainment of the patient’s goal, rather than the professional’s.

**Ethical Reasoning and Judgment**

**Operational Definition**

Once a person is aware that various lines of action are possible, one must ask which line of action is more morally justified. This is the process emphasized in the work of Piaget and Kohlberg. Even at an early stage, people have intuitions about what is fair and moral, and make moral judgments about even the most complex of human activities. The psychologist’s job is to understand how these intuitions arise and what governs their application to real-world events. The educator’s job is to understand how best to promote reasoning development, especially for professional school students who have not developed this ability prior to professional education.

Because professional practice is essentially a moral enterprise in which new issues are likely to arise with societal change and technological advances, the ability to reason carefully about the dilemmas of one’s profession is an essential capacity for practitioners. [See links between theory and day-to-day behavior (below) for a discussion of this issue.]

**Measurement**

**Classroom Measures.** The most familiar approach to assessing reasoning in professional ethics courses is the analysis of written arguments, typically conducted by faculty with a background in philosophy (Howe, 1982). In dentistry (Roehrich & Bebeau, 2005) and nursing (McAlpine, Kristjanson, & Poroch, 1997), researchers demonstrated that essays can be reliably assessed and that instruction is effective in promoting the ability to develop well-reasoned essays, assuming that criteria for judging the essays are specified in advance of instruction and there are frequent opportunities for practice with feedback. A study by Stern and Elliott (1997) confirms the importance of these two conditions. Examining essays written before and after a research ethics course, they attributed the lack of a measurable effect to (1) challenges in establishing interrater reliability, and (2) the fact that criteria used to judge moral arguments were not presented as part of the instructional program. The method of assessment is labor intensive and typically requires subject matter expertise in order to arrive at reliable judgments. Nonetheless, requiring students to submit written essays is a particularly effective way to promote learning, especially when accompanied by clearly stated criteria, frequent opportunities for practice, and feedback.
Further, such instruction influences moral judgment, as measured by tests of life-span moral judgment development (Bebeau & Thoma, 1994).

The dilemma discussion technique and the assessment of written essays have been applied to research ethics in a collaborative project with Indiana University’s Poynter Center. As its title implies, Moral Reasoning in Scientific Research: Cases and Materials (Bebeau, Pimple, Muskavitch, Borden, & Smith, 1995) was designed to facilitate improvement in moral reasoning, as well as assessment of such improvement. A booklet is available on the Poynter Center’s website which features case studies, facilitator notes, and a handout for students that details criteria for judging the adequacy of moral arguments. The developers encourage users to download and use the materials. No special permission for use is required.

Life-Span Developmental Measures. Grounded in Kohlberg’s (1984) pioneering work on the development of moral judgment across the life span, several measures of moral reasoning and judgment have been devised: The Moral Judgment Interview, Gibb’s Socio-Moral Reflection, The Defining Issues Test and Lind’s Moral Judgment Test. They vary in terms of the target populations for whom they are designed (children vs. adolescents vs. adults), the ease of administration and scoring, as well as the extent to which they have been validated. For a brief overview of these measures, see Appendix B of the Institute of Medicine Report (2000b).

The most widely used test for assessing adult development is the Defining Issues Test (DIT) (Rest, 1979; Rest et al., 1999b; Thoma, 2006). Similar to the Kohlberg interview, the DIT begins by presenting the respondent with stories that highlight a moral dilemma (e.g., the story of a doctor who must decide whether to honor a terminally-ill patient’s request for an overdose of drugs). But unlike the Kohlberg interview (or like essay responses to dilemmas), in which the respondent must produce a response, the task on the DIT is to rate and then rank 12 short issue statements, the majority of which reflect Kohlberg stages. The issues are distillations of themes found in interview data. After contemplating a choice, the respondent decides, on a 3-point scale, what the protagonist ought to do (e.g., on the doctor’s dilemma, the choice is to give the overdose, to not give the overdose, or cannot decide). Following the action choice, 12 items are presented and rated on a 5-point scale (very important to not at all important). After rating each item, the respondent is asked to rank the four items that best reflect their thinking about what the protagonist ought to do. By focusing on the ranking of issues the respondent judged as most important, Rest and his
colleagues were able to demonstrate that the measure produced results consistent with developmental theory. Further, research using the DIT supported Kohlberg’s claim that moral judgment developed rapidly over the high school and college years, and that the measure distinguished groups that ought to differ in moral judgment development (e.g., philosophy and political science graduate students scored higher than physicians and dentists who in turn scored higher than college students, and college students scored higher than high school students, while also demonstrating that the measure was sensitive to educational interventions, moral actions and choices, and other validating criteria). Thus, Rest claimed, one could measure moral judgment development without having to interview, interpret, or score verbal protocols. Also, one could develop a reasonable estimate of the effects of an ethics course, without having to invest in the time-consuming process of establishing inter-rater reliability and scoring student essays.

Initially, the major index for reporting DIT scores was the \( P \) index, which represents the proportion of times the respondent selected postconventional arguments. In the mid-1990s, and in response to the criticisms of Kohlbergian theory (both from moral philosophy and moral psychology), Rest and colleagues began the shift to a more contextualized, schema-based view of moral judgment development – a neo-Kohlbergian model of moral judgment development. Based on empirical evidence from hundreds of studies, some conducted with data sets as large as 44,000, it was possible to examine different patterns of development reflected by groups of individuals as a function of education and as a result of educational interventions designed to promote ethical development. Empirically, participants who are able to take the DIT (it requires an eighth grade reading level) tended to view items representing Kohlberg’s stages 2 and 3 as less important and similar. Such items appeal to self-preservation, self-interest, and personal relationships. In other words, distinctions between these clusters of items, which are apparent in children and early adolescents, were not prominent in the DIT data sets. However, items that appealed to maintaining social norms to govern the collective order were viewed as distinct from the personal interest cluster and distinct from the postconventional cluster of items (items classified as Kohlberg’s stages 5 and 6). In sum, the major distinctions measured by the DIT are the differences between conventionality and postconventionality (what Kohlberg regarded as distinctions between stage 4 and stage 5). The maintaining norms moral schema explicitly views maintaining the established social order as a moral obligation. The schema suggests that without law there would be no order; people would instead act on their own special interests and the result would be chaos. For this schema, no further
A rationale for defining morality is necessary beyond simply asserting that an act is prescribed by the law, is the established way of doing things, or is established by a higher authority that is not open to challenge. The neo-Kohlbergian model assumes a different definition of what constitutes a postconventional system. Following from many philosophical traditions, the essential feature of postconventional thinking is that moral obligations are to be based on shared ideals, are fully reciprocal, and are open to scrutiny (i.e., subject to tests of logical consistency, experience in community, and coherence with accepted practice). See Rest et al. (1999a) for a more detailed description.

**New Indices and Measures.** In addition to an updated measure (DIT-2) (Rest et al., 1999b), a number of new indices have been developed. One outcome of ethics instruction observed in professional education is greater sensitivity to arguments that appeal to self-interest considerations. To reflect this distinction, a new index (N2) was developed to take into account not only the proportion of postconventional items that the individual selects based upon the ranking data, but also the respondent’s ability to discriminate between P items and lower stage items. The N2 score provides better trends on the seven validation criteria than the older P score. Similarly, rather than just report to a participant their P score, educators are able to present students with a profile showing the proportion of times a participant ranks each of the moral schema. Such information helps the individual see the kinds of arguments he or she finds most appealing (i.e., the “default system” the individual naturally applies when considering a moral conflict) and how they are distinguishing among different kinds of arguments. In addition to the N2 and the three schema scores, other indices indicate the degree of consistency the individual exhibits between action choices and kinds of moral arguments, and the extent to which an individual’s moral judgment profile is similar or dissimilar to other professionals and to persons with special expertise in ethical reasoning. The idea is to provide students with feedback to heighten awareness of the approach they typically use, and whether they should trust their judgment or seek advice when confronted with a challenging moral problem.

**Profession-Specific Measures of Ethical Reasoning and Judgment.** Tests like the DIT have been used extensively to assess the outcomes of higher education (Pascarella & Terenzini, 2005) and even the outcomes of ethics instruction (McNeel, 1994; Bebeau & Thoma, 1994; Bebeau, 2002). Whereas the ability to appeal to abstract moral ideals when attempting to resolve
complex moral issues (as measured by the DIT) is undoubtedly a desirable outcome for aspiring professionals, some (e.g., Strike, 1982) have argued that a good grasp of moral ideals, though necessary, may not be a sufficient condition for effective professional practice. The question for educators, whether in medical education or in new and emerging areas like “integrity in scientific research,” is often whether to teach the codes and policy manuals of the discipline – perhaps the most common approach in the research integrity movement – or to teach concepts particular to the discipline: intellectual honesty; humane care of animals; intellectual property; collegiality in scientific investigations; and so on (Institute of Medicine, 2002c, pp. 36–40). Following Strike (1982), Bebeau and Thoma (1999) refer to such profession-specific concepts as “intermediate-level ethical concepts,” as they reside between the more prescriptive directives of codes of professional conduct and the more abstract principles (e.g., autonomy, beneficence, and justice) described by Beauchamp and Childress (1979).

Currently, there is work underway in medicine by two physician ethicists – Catherine Caldicott and Kathy Faber-Langendoen (Personal communication, 2005) at the Center for Bioethics and Humanities, SUNY Upstate Medical University – to devise a Medical Ethical Reasoning and Judgment Test for use in medical ethics education. To date, these researchers have devised 22 profession-specific cases to assess 11 intermediate concepts they defined through an extensive data collection process. Their strategies are similar to those employed by Bebeau and Thoma (1999) in the design of the Dental Ethical Reasoning and Judgment Test (DERJT) – a test for dental professionals. Designed as a prototype measure, the DERJT presents five common ethical problems in dentistry. Respondents rate a list of possible action choices and justifications and then are asked to rank order the two best and the two worst actions and the three best and the two worst justifications. The action and justification choices were generated by dental faculty and residents. No actions or justifications were included that were not perceived as plausible choices by at least some professionals. The scoring key reflects consensus among a national sample of dental ethicists as to better, worst, and neutral choices and justifications. It does not prescribe a single best or worst action or justification. Scores are determined by calculating the proportion of times a respondent selects actions or justifications consistent with “expert judgment.”

Research Findings
General Findings. A strength of the DIT research program is its focus on construct validity. The number and types of studies supporting the DIT as a
measure of moral judgment development is extensive (see Thoma, 2006). Validity for the DIT has been assessed in terms of seven criteria (Rest et al., 1999a, cite over 400 published articles): (1) differentiation of various age/education groups; (2) longitudinal gains; (3) correlations with cognitive capacity measures; (4) sensitive to moral education intervention; (5) correlations with behavior and professional decision making; (6) links to political choice and attitudes; and (7) psychometric evidence of internal consistency and response stability across test-taking sets. In addition, the DIT shows discriminant validity from verbal ability/general intelligence and from conservative/liberal political attitudes (see review of more than 20 studies in Thoma et al., 1999). Moreover, the DIT is equally valid for males and females, because gender accounts for less than one-half of a percent of the variance of the DIT, whereas education is 250 times more powerful in predicting DIT variance (Thoma, 1986).

**Profession-Related Findings.** Moral judgment development is the most studied component of morality. Research shows dramatic growth in moral reasoning during college (King & Mayhew, 2002; Pascarella & Terenzini, 2005). Whereas a liberal arts undergraduate education has a powerful effect on the development of moral judgment, programs that are narrowly focused on the technical aspects of job performance or are too careerist or dogmatic (closing off questioning and inquiry) inhibit growth in moral judgment. A meta-analysis of studies of moral judgment development in schools of medicine, dentistry, law, and veterinary medicine (Bebeau, 2002) shows such growth does not continue in the absence of a well-validated ethics curriculum. As with ethical sensitivity, diversity in the ability to apply moral ideas to complex moral problems abounds for both entering students and mature professionals.

Three kinds of studies are reported: (1) those that compare subgroups of students, faculty, or practicing professionals within a profession, and perhaps across institutions or even across professions; (2) those that contrast beginning students with graduates from the same program – usually to establish some kind of baseline for judging development prior to implementing an educational intervention; and (3) those that use the DIT in a pre–post evaluation study in an effort to document the effectiveness of an educational intervention. One of the challenges for professional educators is to determine whether an educational intervention is effective, since it is rarely possible to randomly assign students to experimental and control groups. Consequently, one of the frequent criticisms of this body of work, and any attempted claim of educational effectiveness, is the lack of
contemporaneous control groups. However, experience in professions' education shows that such studies are neither practically possible, nor likely to be approved by an institutional review board (Dubois, 2002). One advantage of meta-analysis is the ability to assess the consistency of findings in the face of shortcomings in study design.

Bebeau (2002) summarizes findings related to moral judgment from 33 studies (approximately 6,600 respondents) representing five professions. Four general questions guided the review: (1) Does professional education promote moral judgment development? (2) Does the addition of ethics instruction promote reasoning development? Are some ethics courses more effective than others? How much curriculum time needs to be devoted to ethics instruction to influence reasoning development? Are changes in reasoning sustained? (3) Are there differences in moral judgment development among subgroups within a profession? For example, are surgeons, who confront life and death moral issues on a daily basis, better able to reason about complex issues than family practice physicians? Or, are attending physicians in teaching hospitals better able than residents and medical students to reason about moral issues? (4) Is moral judgment linked to professional performance?

These general conclusions emerged: [Numbers correspond to above questions.]

1. **Hidden curriculum effects.** In the absence of a well-designed ethics curriculum, growth in moral reasoning is not evident in these post baccalaureate professional education programs: medicine, veterinary medicine, dentistry, and law. This conclusion was based on pooled findings from ten cross-sectional studies ($n = 1934$ students) and from ten repeated measures studies ($n = 547$ students and residents) that showed no effect, compared with two studies ($n = 106$) showing modest change. Although some educators (Self & Baldwin, 1998) claim that professional school actually inhibits growth in reasoning, available evidence suggests that the curriculum does not promote change, at least for the volunteers who provided data. It is possible that volunteers may be more motivated than nonvolunteers; however, data from a cross-sectional study involving 554 dental students are consistent with studies using volunteers.

2. **Intervention effects.** The review of intervention studies across professions extends our understanding of what constitutes an effective intervention. The technique most often recommended for facilitating development (Schlaefli, Rest, & Thoma, 1985) is dilemma discussion. However, other strategies appear to be as effective. For example, Self et al. (1992) observed significant effects for a film course that was comparable to the effects for
their medical education lecture and case study method. Bebeau’s (1994) dental curriculum, though it provides only about 12 hours in actual dilemma discussion over a four-year program, accompanies that discussion with requirements for writing well-reasoned arguments that apply criteria for judging the quality of arguments that have been presented in advance of the small group discussion. Hartwell’s (1995) student-centered moral discourse in law schools seem to provide the largest gains, effect sizes estimated at 0.77–0.97. As compared with the average effect size (0.45) calculated from the data provided by the nursing studies, or the average effect size (0.43) reported in the dentistry studies, the effect achieved with Hartwell’s technique is large, similar to the 0.80 effect size attributed to college (McNeel, 1994).

3. Subgroup differences. Of the 33 studies reviewed, 18 addressed differences within a profession. Some studies report differences favoring faculty physicians over practicing physicians, American-trained residents over foreign-trained residents, as well as differences among residents in various specialty groups. With respect to cohort differences, an Israeli study reported significantly higher moral judgment scores for medical school applicants accepted vs. those rejected when decisions were based on an admissions interview in addition to admission tests. No differences were apparent when decisions were based solely on admissions tests. When gender is reported, most studies report small, but statistically significant, differences favoring women. Regional and cultural differences are suggested by some studies – especially for foreign-trained residents, but findings are likely confounded by language differences. Recognizing the postconventional arguments presented on the DIT requires an understanding of complex English language and syntax. Thus, the measure may underestimate the reasoning of respondents for whom English is a second language.

4. Links to professional performance. Moral judgment is linked to a wide range of prosocial behaviors (Thoma, 1994), including clinical performance ratings for nurses (Duckett & Ryden, 1994; Krichbaum et al., 1994), physicians (Sheehan et al., 1980, 1985), and dentists (Bebeau, 1994), and to preferences for the more altruistic law disciplines for law students (Landsman & McNeel, 2002). In addition to the often cited studies by Sheehan and colleagues (see Bebeau, 2002, for an extensive review), some early work by Candee, Sheehan, Cook, Husted, and Bargen (1982) reported that the content of a physician’s affect was related to the structure of moral thought. Residents whose moral judgment was more developed were less aggressive in their treatment of neonatal defects, and more attentive to
family concerns. In a similar vein, Self and Baldwin (1998) observed a relationship between the number of malpractice claims and moral judgment scores, noting that a high DIT score had a kind of protective effect, insulating one from claims. For dental practitioners referred for ethics instruction by a licensing board, disciplinary actions were directly tied to significant deficits in one or more of the components of morality (Bebeau, 2006). Further, one consistent observation, in addition to a deficiency in sensitivity, reasoning, or implementation (when compared to fourth year students), is the difficulty of the referrals had in articulating the expectations of the profession. After targeted instruction, directed toward role concept development and remediation of one or more other deficiencies, statistically significant change (effect sizes ranging from 0.55 to 5.0) was observed for ethical sensitivity (DEST scores), moral reasoning (DIT scores), and role concept (essays and PROI scores). Analysis of the relationships between ability deficiencies and disciplinary actions supported the explanatory power of Rest’s four-component model, and self-assessments of learning confirm the value of the process for professional renewal.

**Implications for Character Development**

Studies show a great deal of variability in professional school students’ ability to appeal to postconventional arguments in defense of their position on a moral issue. As studies of ethical sensitivity show, students even have difficulty identifying the moral conflict. Most have not been helped to reflect on the fact that they do make moral judgments all the time, but may not be able to articulate the criteria they use to make the distinctions. They often have intuitions about what is right and fair, but have trouble articulating why they think so. Much of the inability has to do with inexperience in advancing and critiquing moral arguments and a lack of awareness of the criteria they bring to bear, or the moral framework from which they intuitively argue. Because professional school students are already intellectually mature, a well-structured set of exercises can very quickly develop a student’s ability to critique and construct well-reasoned arguments.

There appear to be sufficient reasons to include the DIT as a measure of outcome: it is a well-validated measure of an important ability, and the ability is related to professional decision making. When the test is appropriately presented and constructive feedback is given, it can serve useful curricular purposes. It can empower students by informing them about the development of an important ability that relates to professional decision making.
Moral Motivation and Identity Formation

Operational Definition
Moral motivation and commitment involves prioritizing moral values over other personal values. People have many values (e.g., careers, affectional relationships, aesthetic preferences, institutional loyalties, hedonistic pleasures, excitement). Whether the individual gives priority to moral concerns seems to be a function of how deeply moral notions penetrate self-understanding, i.e., whether moral considerations are judged constitutive of the self (Blasi, 1984). For behavior to occur, the moral agents must first decide on a morally correct action when faced with a dilemma, and then conclude that the self is responsible for that action. One is motivated to perform an action just because the self is at stake and on the line – just because the self is responsible. Moral motivation is a function of an internal drive for self-consistency. Blasi (1991) argues: “The self is progressively moralized when the objective values that one apprehends become integrated within the motivational and affective systems of personality and when these moral values guide the construction of self-concept and one’s identity as a person.”

Two lines of research have guided inquiry on identity formation in professional education. One emerges from developmental psychology. A second line of research flows from philosophers’ observations of models of professionalism that appear to guide moral action. The theory, the measures, and the findings will be reviewed for each.

Identity Formation: Studies of Life-Span Development
Considerable empirical support has been amassed for Blasi’s constructivist theory of the moral self (Lapsley & Narvaez, 2004). However, attention has not been directed to the formation of measures to assess stages of identity formation. Thus, we turn to the work of another constructivist, Harvard psychologist Robert Kegan. Like Blasi, Kegan’s (1982) view is that all humans are continuously involved in a process of constructing meaning. Rather than responding immediately and directly to external events and internal experiences, individuals organize experiences into a meaningful whole, and it is that constructed whole to which they respond. As individuals gain experience, they construct progressively more complex systems for making sense of that world. The progressive shifts in complexity are more clearly evident when comparing a child’s understanding of the social world with an adult’s understanding. It is not just that adults know more than children; adults possess a more complex system of thought. They see and understand things that children may not see and
understand. Similarly, physicians and dentists construct an understanding of what it means to be a professional, and their understanding may be qualitatively different from the public in general. The Appendix provides brief descriptions of stages 2 through 5, as these reflect conceptions of the moral self that would be of interest to medical educators. As we hope to make clear, how a young professional makes meaning of professional values and expectations is distinctly different from how moral exemplars understand them and is profoundly influenced by his or her stage of identity development.

Briefly stated, individuals move from self-centered conceptions of identity through a number of transitions, to a moral identity characterized by the expectations of a “profession” – to put the interests of others before the self, or to subvert one’s own ambitions to the service of society or to the nation. The fully integrated moral self (one whose personal and professional values are fully integrated and consistently applied) tends not to develop until midlife – if it develops at all (Forsythe, Snook, Lewis, & Bartone, 2002). What seems to distinguish moral exemplars (Colby & Damon, 1992; Rule & Bebeau, 2005) and sets them apart from ordinary good people is a kind of unity of the self with moral concerns – a stage 4 or 5 identity. For professional exemplars, Rule and Bebeau (2005) noticed a tendency to see as obligatory what others in the profession would consider good to do, but not ethically required (e.g., serving the poor and needy).

Understanding how the individual conceptualizes the self in relation to others provides valuable insights into lapses in ethical behavior, especially in instances where the moral choice is well-understood. Of particular interest in this regard is an observation of board referrals who have been disciplined by a licensing board. In five instances (Bebeau, 2006), a professional’s unbounded sense of responsibility to others, rather than self-interest, explained acts of insurance and Medicaid fraud.

**Measurement.**

**Interviews.** Developmental assessments involve semistructured interviews using the method detailed by Lahey et al. (1988). A trained interviewer prompts respondents to recall recent experiences in response to stimulus words printed on an index card. The interviewer asks a series of follow-up questions to elicit the respondents’ underlying understandings. Several events are explored until the interviewer feels the respondent’s most encompassing perspective has been discovered. Interviews are audiotaped and transcribed for scoring. As with conducting the interview, training is required to score the interview and achieve interrater agreement. Forsythe
et al.’s (2002) analysis of interviews of Army cadet and officer identity development established clear age and education distinctions (described below).

**Scoring Essays.** Noticing that a series of essays written by West Point Cadets seemed to give information about identity development that was consistent with the levels observed with the interview method, Bebeau and Lewis (2004) developed a scoring guide, grounded in Kegan’s (1982) theory, to assess distinctions they saw in the professionalism essays. The researchers were able to achieve agreement on stages across a series of essays. Thus, it seemed reasonable to conclude (1) that it would be possible to develop reasonable estimates of identity development with a less costly method, and (2) that the essays themselves could provide educators with an opportunity to challenge student thinking and, thus, to promote development.

Recently, Roehrich and Bebeau (2005) demonstrated that written responses to open-ended questions concerning entering dental students’ understanding of professional and societal expectations elicited statements reflective of Kegan’s identity stages and transition phases. Since the exercise is much like journaling, an expectation is created for ongoing dialog with the instructor.

**Profession-Specific Research Findings.**

**Age- and Stage-Related Change.** Until recently, descriptions of developmental changes in identity were based on clinical observations rather than longitudinal or cross-sectional studies of adult development. Studies by Forsythe and colleagues indicate that transitions in identity occur somewhat later than estimates based on Kegan’s clinical observations. For example, 63 percent of entering cadets (college freshmen) at a highly selective military academy were functioning in the stage 2 to stage 3 transition, with 21 percent still functioning at stage 2 and only a few (16%) at stage 3. By graduation, only 6 percent were still at stage 2; 28 percent were still negotiating the stage 2 to 3 transition; 47 percent were a full stage 3; and a few appeared to be involved in the transition beyond stage 3 to stage 4.

Assuming college would have a similar affect on students entering the dental or medical profession, we could expect a few entering students to still be negotiating the stage 2 to stage 3 transition, with nearly half a full stage 3, and some involved in the stage 3 to stage 4 transition. Responses to essay questions did illuminate differences in stages of identity formation for dental students (Roehrich & Bebeau, 2005), but the distribution of responses looked more like the 18-year-olds entering the academy than like 22-year-old graduates (i.e., entry leaders in the military profession). Responses to dental student essay questions classified 13 percent of the students at a stage
most (70%) to be in the stage 2 to stage 3 transition, with a few students (7%) giving evidence of a stage 3 understanding, and a few (7%) appearing to be in the stage 3 to 4 transition. Reflecting on these differences, it is important to keep in mind that mode of assessment may be responsible—written responses, compared with verbal responses, typically underestimates the ability. On the other hand, dental students are, on average, four years older. A question of interest is whether the explicit character development and professional socialization that goes on in the academy is responsible for the growth in identity.

With the dental student sample, it was also possible to examine the relationship between identity scores and other indices of ethical abilities (i.e., DIT scores and exam scores requiring articulation of the “six expectations” of professionalism). Students with a more advanced conception of professional identity were more likely to be postconventional thinkers and more likely to be able to express abstract conceptions of professionalism. Students at the stage 3–4 transition preferred postconventional arguments (high P and N2 Scores, whereas stage 2 students preferred arguments that appealed to existing norms (had high Maintaining Norms schema scores). Examination of the particular deficiencies in students’ ability to articulate the “six expectations” of professionalism is consistent with the view that students with a more advanced conception of professional identity are better able to assimilate the more abstract concepts of professionalism. For example, across all stages and transition phases, students tended to do particularly well at articulating the “continuing education” expectation and poorly at articulating the “ethics” expectation. In our view, the “continuing education” expectation is familiar and concrete, whereas the “ethics” expectation is abstract and unfamiliar.

If the identity transformations of medical and dental professionals mirror those of midcareer and senior military leaders, we would not expect a full stage 4 identity until midcareer. In addition to data on student development, Forsythe and colleagues (2002) report findings from a cross-sectional study of military leaders: By midcareer, 43 percent had attained a full stage 4, 28 percent had attained a stage 3, and 28 percent were still negotiating the stage 2 to stage 3 transition. For senior leaders, 50 percent had attained a full stage 4, another 18 percent were nearly a stage 4, 22 percent were in the stage 3 to 4 transition, and none were below a stage 3. These findings seem to support Kegan’s observation (1982) that advanced levels of identity are rarely achieved before midlife and not by everyone. The stage 5 individual is the rare and exceptional person—perhaps someone like our exemplars or those identified by Colby and Damon (1992).
Findings from Studies of Moral Exemplars. Patterned after the work of Colby and Damon (1992), Rule and Bebeau (2005) identified dentists who were thought of by their peers for their dedication to professional ideals – hereafter referred to as moral exemplars. Following a national nomination process, ten individuals were selected and interviewed, usually over a three to five day period. Interviews focused on the development of events for which they were nominated and how each nominee viewed the factors that influenced his or her development. Of interest was the meaning they assigned to events in their lives, as well as how they saw their moral identity developing. From the narratives, stories were developed, which in turn were returned to the nominee for review, correction, and final approval. Following the creation of a story, meaning was derived from the story through the use of the three different lenses: (1) the expectations that follow from characteristics that distinguish among professions (Hall, 1975; May, 1999), (2) the virtues important to medical practice (Pellegrino & Thomasma, 1993), and (3) the age- and stage-related shifts in identity formation (Kegan, 1982) that characterize the evolving moral self. To illuminate the development of a moral identity, and the professional virtues and values that defined the exemplar’s identity and shaped their lives, a commentary was prepared for each story. A final chapter synthesizes lessons from the stories and draws implications for professional socialization.

Stories were designed to serve as models of professional commitment for young persons entering the profession. Because the authors had come to see the development of a professional moral identity as a lifelong process, they also thought that such stories could serve as a source of inspiration and renewal to those who are well-established in their professional lives. Indeed, Dentists Who Care not only provides interesting stories about the lives of ten dental professionals engaged in a diverse mix of professional and academic pursuits, but the book encourages the reader to engage in self-reflection about the events that shape his or her identity and to discuss this with peers in a study group format. What stands out from the study of exemplars?

(1) The Value of Self-Examination and Reflection

Many exemplars commented on the value of the interview and the development of their stories in helping them become clearer about themselves and the forces that shaped their identity. We know from studies of competency development that self-reflection and self-assessment are important dimensions of professional growth (Mentkowski & Associates, 2000). We also know that the ability to self-assess is a capacity that does not develop in the absence of instruction and practice.
(2) The Reconciliation of Internal Conflicts is a Mark of Moral Maturity

Balancing competing claims is the challenge for all developing professionals. Whereas exemplars are not “perfect people,” free of adversity or interpersonal struggles, they appear to have had constructed a “self-system” (i.e., a stage 4 identity) that provides an internal compass for negotiating and resolving tensions among these multiple, shared expectations. By adhering to an internally-constructed set of standards that embody the profession’s values, the exemplary professional is able to negotiate the conflicting roles and obligations that are inevitable in their working lives.

(3) Competence and the Will to Succeed: Distinguish the Exemplar from the Ordinary Good Person

Competence is an essential virtue for the professional, and the development of competence must be the aspiring professional’s primary goal. Yet along the way, each aspiring dental professional will need to determine whether the pursuit of competence has motivational power for the self. If it does, the individual will happily complete professional education and pursue professional practice. If not, reevaluation is required.

Exemplars were extraordinarily skilled, not just in technical competence – an essential virtue for a professional – but in the wide range of practical abilities. Beyond technical, organizational, and problem solving skills, and at least as important, the exemplars also knew what to say and how to say it. Often we know the right thing to do in morally difficult situations and want to do it, but fail because we are uncertain about how to manage the inevitable sensitive obstacles that we face. Competence, so defined, appears to be a powerful source of self-motivation. As Owens, a highly effective dentist and civil rights activist, said: “[I was able] to do things that other people needed to have done, but couldn’t do for themselves.”

(4) The Concept of Service Unfolds as Exemplars Move through Various Stages of Life

Consistent with developmental theory (Kegan, 1982), the exemplars’ concept of service undergoes transformations during and after professional education. Again, the exemplar Owens – in giving advice to young professionals – says, “First excel, then help others.” Owens’ words point out the responsibility, not only for competence to benefit others, but also to one’s self to first satisfy basic needs. Sometimes young professionals come to professional practice with great enthusiasm for helping others, but lack the organizational or implementation skills to look after the economic stability of their practice. Without a bounded sense of service, one can become resentful. Young
professionals will need to be aided in setting realistic aspirational goals for helping others and creating a balance between altruism and self-orientation.

(5) Exemplars are Inspiring to Others and Respect the People they Serve

Exemplars seem able, by the power of their personalities, to be inspiring to others. They also have overcome one of the hardest challenges for the beginning professional: overcoming the repugnance one is likely to feel for a person whose personal demeanor, oral or physical health, and/or personal appearance are offensive. How exemplars manage to demonstrate respect for others who so deviate from the standards we hold for ourselves, is worth reading about and reflecting on. Also, reflecting on strategies to assist those you cannot help is worthy of reflection. Today, centers, like the Minnesota Center for Spirituality and Healing, are assisting health care professionals to help, rather than alienate, patients for whom standard medical practice has no ready solutions.

(6) Exemplars Show a Willingness to do the “Harder Right”

Each of the exemplars, though in varying degrees, is engaged in some form of social activism. Four of our exemplars (Echternacht, Whittaker, Owens, & Johnson) were nominated specifically because they had engaged in actions to right an injustice. In each case, they did so at considerable personal risk and without active support from their colleagues. For Whittaker, whose actions righted injustice, but ultimately exposed his colleagues’ less altruistic motives, or for Johnson, whose actions exposed a colleague’s incompetence, the efforts to right injustice had acutely distressing consequences. What sustained them was a set of self-goals that were consistent with the moral ideals espoused by their profession – to serve society and to monitor their profession. Whereas we might see their actions as acts requiring tremendous courage or fortitude as Pellegrino and Thomasma (1993) would describe it, they (like Colby and Damon’s exemplars) simply saw their action as something they must do. Janet Johnson, reflecting on other professionals who had quit their jobs rather than challenge a superior’s mistreatment of patients, said, “There was no way I could leave the situation the way it was.” Jack Echternacht, thinking about his 30-year battle with antifluoridationists, remarked: “I’m basically peace loving, but if there’s a just cause involved, that’s another matter. Then, we go to war.”

Identity Formation: Studies of Role Concept Development

Prominent in the biomedical ethics literature are descriptions of models of professionalism advanced by ethicists to explain a wide variety of
professional choices and actions (Veatch, 1972; May, 1983; Ozar, 1985; Emanuel & Emanuel, 1992). As such, the particular professional role one adopts may be very important in explaining a wide range of behaviors, ranging from different patterns of practitioner and client interactions to concerns about professional oversight and social scrutiny (Bebeau, Born, & Ozar, 1993). This section focuses on measures of identity and findings from studies that illustrate how professionals or professional students conceptualize role expectations.

**Measurement.** Short essays written before and after instruction in role concept can reflect student understanding of professional norms and values, e.g., “What does it mean to become a dentist, or physician, attorney, nurse, or scientist? (See Bebeau, 1994, for an example). A second method is the use of a measure of role concept, perhaps patterned after measures developed in dentistry, medicine, and law.

The **Professional Role Orientation Inventory.** To assess commitment to privilege professional values over personal values, Bebeau et al. (1993) designed four 10-item rating scales to assess dimensions of professionalism described in models of professionalism cited in the professional ethics literature (Guild Model, Service Model, Agent Model, Commercial Model) (e.g., Emanuel & Emanuel, 1992; Ozar, 1985; Veatch, 1972). The Professional Role Orientation Inventory (PROI) scales, in particular the responsibility and authority scales, have been shown to consistently differentiate groups expected to differ in role concept (i.e., beginning from advanced students and students from practitioner groups). By plotting responses of a cohort group on a two-dimensional grid (see Bebeau et al., 1993), it is possible to observe four distinctly different views of professionalism which, if applied, would favor different decisions about the extent of responsibility to others. In comparing practicing dentists with entering students and graduates, Minnesota graduates consistently express a significantly greater sense of responsibility to others than entering students and practicing dentists from the region. This finding has been replicated for five cohorts of graduates \((n = 379)\). Additionally, the graduates’ mean score was not significantly different from a group of 48 dentists, who demonstrated special commitment to professionalism by volunteering to participate in a national seminar to train ethics seminar leaders. A comparison of pretest/posttest scores for the Classes of 1997–1999 (Bebeau, 2001) indicated significant change \((p < 0.0001)\) from pretest to posttest. A cross-sectional study of differences between pre and posttest scores for a comparable dental program suggests that ethics instruction accounts for change.
A series of studies described by Thoma, Bebeau, and Born (1998) and a recent study by Kang (2005) attest to the construct validity and test–retest reliability. Further, the measure has been adapted for other settings, e.g., physical therapy (Swisher, Beckstead, & Bebeau, 2004). Studies in other professions are in progress.

The Professional Decisions and Values Test. Rezler et al. (1992) designed the Professional Decisions and Values Test (PDV) for lawyers and physicians to assess action tendencies and the underlying values in situations with ethical problems. Patterned after the DIT and the Medical Ethics Inventory, the test consists of ten case vignettes, followed by three alternative actions and seven reasons to explain the chosen action. Actions are arranged from least to most intrusive and the reasons represent one of the seven values commonly employed to resolve an ethical dilemma. Cases were selected to represent three themes: (1) obligation to the patient versus obligation to society; (2) respect for patient/client autonomy versus professional responsibility; and (3) protecting the patient’s interest versus respect for authority. Data from two consecutive classes of entering medical and law students ($n = 340$) are presented, as their action choices and values are compared. Whereas findings support the construct validity of the test, test–retest reliability is stable over time for action choices, but not for values. The developers hypothesize that values do not become stable until later in the curriculum, thus the test may be more useful for assessing change over time than for tracking change for individuals. Sex differences and profession differences were observed using the measure. Whether the lack of stability in the retest reliability study can be attributed to changes that are influenced by the curriculum is a question worthy of further study. The test is cited because its format shows promise for the design of a role concept measure.

Profession-Related Findings. Identity formation is seen (Blasi, 1984; Kegan, 1982) as a lifelong developmental process. Whether a professional identity has formed by the time a person enters a profession is of considerable interest. Commenting on the relation between identity formation, Forsythe et al. (2002) observed that at least 30 percent of West Point graduates have not achieved key transitions in identity formation that would enable them to have the broad, internalized understanding of codes of ethics or the commitment to professional standards. Without internalized standards, codes and professional regulations may be perceived as guides for behavior, and such individuals are likely to conform to the guides, in order to garner rewards and avoid negative consequences. Forsythe et al. (2002) concluded that unless the broad educational environment promotes identity development
toward a shared perspective on professionalism, professional development programs would not be successful in instilling desired values in less mature preprofessionals. Studies of role concept development in dentistry (Bebeau, 1994) lend support to Forsythe’s observations. Students entering the profession are not able to articulate the key concepts of professionalism. Even after instruction and practice, some students are unable to do so, suggesting that the conceptual frameworks for a professional identity are not a part of initial self-understanding, and must be revisited frequently during professional education.

The most direct evidence of a relationship between role concept and professionalism comes from the study (Bebeau, 2006) of practitioners disciplined by a licensing board. Although they varied considerably on measures of ethical sensitivity, reasoning, and ethical implementation, only three were able to clearly articulate role expectations for a professional. Of particular interest were those disciplined for Medicare or insurance fraud. These professionals exhibited and unbounded sense of responsibility that, when coupled with other deficiencies in ethical abilities, explained their failures.

Studies Confirming the Need for Professional Socialization. A longitudinal study of doctoral students aspiring to become researchers revealed that upon entry to graduate education, students could not articulate basic expectations for integrity in research. Interestingly, they were not able to do so later in their program either. Anderson (2001) concluded that students do not intuit the values of the discipline and do not seem to learn them from the hidden curriculum or from mentors. Similarly, entering dental students (Bebeau, 1994) could not articulate professional expectations, sometimes even after explicit instruction. In some instances, students seemed to lack a conceptual framework for key professional concepts – like the responsibility for self-regulation and professional monitoring. They conflate professional reporting of dishonesty or incompetence with “tattling.” In fact, the usual socialization process seems to develop a sense of camaraderie among peers that contributes to a reluctance to engage in self-regulation – one of the hallmarks of a profession.

In a study of Scottish medical students’ perceptions of the duty to report misconduct (Rennie & Crosby, 2002), less than 40 percent said they should report, and only 13 percent said they would. Further, the proportion who thought they should report declined over the years of medical school. When interviewed about the reluctance to report, students indicated that it was not that misconduct should not be addressed – it was just, they thought, that someone else should do it. Similarly, 65 percent of students from a prominent
U.S. medical school (Feudtner, Christakis, & Christakis, 1994) expressed discomfort at challenging members of the medical team over perceived wrongdoing. Thus, it is unlikely that factors that seem to work against professional self-regulation can be overcome, unless professional socialization includes appropriate practice in confronting real or perceived misconduct.

**Implications for Character Development**

Given the importance of a professional identity that incorporates moral concepts, those that are the core expectations which the profession and society has for the individual who aspires to become a professional, educators need to consider how best to facilitate the development of such an identity.

Before introducing students to quandary ethics, it seems important to convey foundational expectations of the profession and society. Some professional expectations are foundational and not open to debate, and students need to know the difference. With an understanding of such expectations students are in a better position to critically evaluate both positive and negative role models. Stories of outstanding professionals may serve as models for aspiring professionals, but without an understanding of the distinctive professional qualities the model is exhibiting, the story may not be so effective. This is an important consideration, as claims are often made that modeling is the most effective way to teach professionalism (e.g., Duff, 2004). Whereas the claim has intuitive appeal, we have been unable to find any empirical evidence to support that claim.

**Moral Character and Competence**

**Operational Definition**

Moral character and competence is having the strength of your convictions, having courage, persisting, overcoming distractions and obstacles, having implementing skills, and having ego strength. A person may be sensitive to moral issues, have good judgment, and prioritize moral values; but if he or she is lacking in moral character and competence, he or she may wilt under pressure or fatigue, may not follow through, may be distracted or discouraged, and moral behavior will fail. This component presupposes that one has set goals, has self-discipline and controls impulse, and has the strength and skill to act in accord with one’s goals. For the professional, this is the place where technical competence, problem solving, interpersonal skills, and characterological dispositions come together in the implementation of an action plan.
**Measurement**

Performance-based assessments are typically used to assess the integrated abilities required for effective, responsible professional practice. Certainly objective tests of personal styles or personality traits can sometimes provide insight about dimensions of character that the individual needs to address to increase personal effectiveness, but such measures lack fidelity to professional practice. What is needed are measures that reflect both technical knowledge and practical know-how. For example, Objective Structured Clinical Examinations (OSCEs) have been designed for ethics instruction that approximate the kind of integrated performance required for assessing “character and competence.” In the Minnesota dental ethics program (Bebeau, 1994), students complete exercises that build competence and confidence in resolving challenging ethical problems. Using real-life enactments of situations that are likely to occur in practice (communicating with a parent whose child’s health care is being neglected, speaking to a patient about an adverse outcome, confronting a peer or superior about substandard performance, responding to a complaint about your performance, achieving consent for treatment from a patient with dementia, etc.), students are required to plan strategies for handling the case, try out dialog on a peer, then submit a case write-up that includes (1) key facts and their interpretation that influenced their plan of action case; (2) an action plan; and (3) verbatim dialog to illustrate how the action plan can be implemented. Peers and clinicians, using checklists validated for each case, judge responses. Responses can be reliability assessed, but doing so often requires that consensus is developed among faculty on principles of effective communication, procedures for attaining consent, and so on. Responses to a series of such cases serve as a proxy for judging competence in ethical implementation. An alternative to observations of interactions is to collect examples of professional performance (e.g., video or audiotapes of professional interactions on either hypothetical or real cases, letters prepared to communicate with patients or colleagues, etc.) for evaluation by faculty and students, similar to the portfolios becoming increasingly common in education.

**Research Findings**

**General Findings.** Research on self-regulation (Bandura, 1977) illustrates the relation between cognition and affect as it applies to implementing solutions to challenging problems. If a person thinks of a task as “fun” or “challenging,” he or she is more likely to persist in efforts to resolve the problem. Conversely, if a problem is approached with dread, perseverance is less likely. Practice in resolving difficult and recurrent problems – like responding...
to an angry patient, or discussing a disciplinary issue with an offending peer – changes the expectations of efficacy, which in turn changes behavior. The importance of practitioner attributes and practical skills are particularly evident when comparing physicians who have been sued for malpractice vs. those that have not. Studies (Levinson et al., 1997; Ambady et al., 2002) indicate that even a small increase in the amount of time spent in patient communication can reduce the likelihood of malpractice complaints. However, equally critical is demeanor and tone of voice.

**Profession-Related Findings.** Educators are now able to take an evidence-based position that habits/behaviors exhibited during professional school are important indicators of professionalism that must be demonstrated for a student to graduate from medical school. Students display warning signs of future disciplinary action while in professional school. Indeed, such problematic behavior in medical school (Papadikis, Hodgson, Teherani, & Kohatsu, 2004) predicted subsequent disciplinary action by a state medical board. Consistent with educator’s frustrations in trying to address behavioral issues, a link between competence and professionalism was not as evident. A small, but significant, difference between controls and disciplined was apparent on GPA, but not on NBME Part 1. In a follow-up study (Teherani, Hodgson, Banach, & Papadakis, 2005), three domains of behavior were related to disciplinary outcome: poor reliability and responsibility, lack of self-improvement and adaptability, and poor initiative and motivation.

In a related study, Stern, Frohna, and Gruppen (2005) were able to show that simple indicators of noncompliance and inaccurate self-assessments of performance during medical school, rather than data from admissions records, predicted future disciplinary action. Whether such habits/behaviors are reflective of character traits that are resistant to change or are an indication of an underdeveloped professional identity is an interesting question for future research.

**Implications for Character Development**

Fundamental to responsible conduct in any profession is the ability to perform with integrity the complex tasks of the discipline. The fourth component in Rest’s model attends to the importance of character to effective and responsible practice. A practitioner may be ethically sensitive, may make good ethical judgments, and place high priority on professional values; but if the practitioner wilts under pressure, is easily distracted or discouraged, or is weak willed, then moral failure occurs because of a deficiency in character and competence. Professional education assists
individuals in understanding the fundamentals of their discipline, gaining depth in the details of a particular subarea, and obtaining practical experience through clinical practice, residency training, and advanced specialty training. But equally important is coaching that enables self-assessment and reflection on the implementation of actions. Fisher and Zigmond (2001), speaking in the context of research ethics, point out that an essential dimension of such educational programs is often neglected. They argue for the development of a set of general professional skills that, when performed badly, reflect negatively on the individual’s integrity. Assessing essential skills requires performance-based assessment.

Professional ethics programs underestimate the importance of appropriate practice in the implementation of action plans for the garden variety of issues they are likely to encounter in professional practice. As with the other capacities, both students and professionals vary considerably in the courage and capacity to address the tough problems they will likely encounter in practice. But sometimes what appears to be lack of courage is actually practical wisdom. Wading into a problem when you lack practical knowledge may create a bigger mess than the failure to act.

**SUMMARY AND CONCLUSIONS**

This chapter explores character development from the perspective of developmental psychology and cites evidence to support recommendations for promoting the ethical development of the individual. It does not address the culture or climate of the institution or its dampening effect on an individual’s ability to act at the leading edge of newly acquired ethical abilities. Its focus is on the advantages to defining character in terms of capacities that give rise to behavior.

First, conceptualizing the processes that give rise to morality as capacities that develop across the lifespan helps individuals see that we can and do learn from experience. We do not come to professional practice fully formed. Even persons judged as exemplars were once like us. The particular capabilities that distinguish them from persons not so admired were developed over a lifetime.

Second, the model has intuitive appeal. Helping aspiring and experienced professionals to conceptualize character in terms of processes that give rise to morality is empowering. It shifts the emphasis from summary judgments about character to a recognition that each of us is capable of missing a moral issue, misconstruing facts, arriving at judgments our colleagues think
are indefensible, giving in to self-interest when professional and personal interests conflict, and making mistakes in the words we choose or the actions we take to resolve a problem.

Third, the model provides guidance for the design of assessments that have high fidelity to professional practice. Opportunities to demonstrate our developing capacities – especially if accompanied by constructive feedback and opportunities for self-reflection – can have motivational power. For persons who have been disciplined by a licensing board (Bebeau, 2006), educational opportunities have restorative power. Well-focused educational activities can bring about substantial growth in capacities that relate to decision making. Professionals are intellectually mature, and often quite easily learn to reason more carefully, to rethink priorities to be sure they are aligned with professional expectations, and to modify habits that undermine personal and professional goals.

Fourth, the model has explanatory power. Evidence from studies designed to assess each of the capacities show: (1) striking individual differences among students and practicing professionals of each of the measures used to assess the capacities; (2) that the capacities appear to be independent of one another, i.e., that competence in ethical sensitivity does not predict competence in ethical reasoning, and the capacity to reason does not predict to a well-articulated commitment to professional responsibilities; (3) that strengths and weaknesses in each of the capacities are linked to real-life behaviors; and (4) that curricula of rather modest duration can influence performance in measurable ways (Rest & Narvaez, 1994).

Finally, reflecting on the reason for moral failing helps educators establish a more refined view of the goals for courses and insights about ways to design educational activities that promote professionalism. Much is made in the medical education literature about the importance of good role models and the negative effect of poor models. Yet, little is said about helping aspiring professionals to learn from both. Rather than bemoaning the hidden curriculum that appears to be more powerful than the intended curriculum, thoughtful plans that are theoretically-grounded in what is known either about identity formation or the other capacities that influence behavior can be developed and carefully sequenced. For example, before engaging in quandaries that pit professional obligations against each other, it is important to convey the foundational expectations that are not open to debate. Evidence from studies of identity formation suggests that this is an important place to begin. Students need a firm grasp of basic professional expectations before they can profitably engage in debate.
Because development of a professional identity is a lifelong process, the aspiring professional needs multiple opportunities during professional education and afterward to reflect on these values and the way in which they can be implemented consistently in professional practice. Each year, as part of the admissions process, thousands of young people write statements declaring their commitment to becoming a good professional. They reveal their hopes, their ideals, and their conceptions of the “good professional.” Those chosen proceed through a process of education and professional socialization. Most complete their education, without ever revisiting their initial statement of professional commitment. Others become disillusioned when they discover how difficult it is to act upon these ideals. Still others may give up on their ideals when they look around them and see colleagues who seem not to act on ideals.

The job of the educator is: (1) to convey the foundational expectations; (2) to help students reflect on the challenges inherent in meeting these goals; (3) to help individuals set realistic standards for themselves; and then (4) to assess progress toward them, reflecting along the way on the ideals of professional practice as exhibited by moral heroes in the profession, but recognizing also one’s humanity and the potential that in the process of becoming what we aspire to be, we may from time to time exhibit the less desirable qualities of the majority of our colleagues. Only with a sense of humility and humanity can any of us become what we aspire to be.

NOTES

1. Whereas terms like “moral” and “ethical” tend to be used somewhat interchangeably both in the general ethics literature and in some studies of the construct, studies following the Minnesota model (e.g., Bebeau, Rest, & Yamoor, 1985) to design profession-specific sensitivity measures use the term ethical sensitivity expectations associated with professional practice.

2. Whereas the primary purpose of the measure is to assess the interpretive ability in cases where mature professionals are being assessed (Bebeau, 2006), the measure is also used to assess Rest’s fourth component – ethical implementation.

3. This became an important feature in the construction of the DIT, especially when considering whether the DIT produced a biased assessment of postconventional reasoning because of its links to a Rawlsian/Kantian kind of justice. Because the responses are distillations of many participant responses, they represented themes that were representative of the kinds of postconventional rationales ordinary people were likely to offer. See Rest et al., 1999 for further discussion of this point.

4. Measures of role concept and their relationship to identity are described in the next section.
5. See the behaviors of professionalism described by the National Board of Medical Examiners (2003–2004).
6. Colby and Damon observe that the notion of courage simply did not capture anything that their exemplars had felt or done. Feelings of moral necessity had given them a sense of certainty that relieved them of fears and doubt.

REFERENCES


**APPENDIX: KEGAN’S STAGES OF IDENTITY FORMATION**

**Stage 2: The independent operator.** Personal success is paramount, and is measured by concrete accomplishment of individually valued goals and the
enactment of specific role behaviors. Lacking a broader understanding of what it means to be a professional, motivation for meeting standards is wholly individual; it is expressed as a personal desire to be correct and effective. As one aspiring professional put it, *There are professional guidelines and codes that shape your life.*

**Stage 3: The team-oriented idealist.** Stage 3 professionals are both idealistic and internally self-reflective. They understand and are identified with (or worry that they are not yet fully identified with) their chosen profession. Rather than seeing professionalism as enacting certain specific behaviors or fixed roles (the Stage 2 view), they see professionalism as meeting the expectations of those who are more knowledgeable, more legitimate, and more professional. They are oriented to shared experiences, societal obligations, and internal qualities, but often find themselves torn among multiple shared identities (physician, parent, spouse, etc.). As one Stage 3 professional remarked, *The profession offers the opportunity to interact and give back to the community by being a compassionate and understanding dentist.*

**Stage 4: The self-defining professional.** Stage 4 professionals are no longer identified with their professional role. Instead, they have a sense of having freely committed themselves to being, e.g., a member of the profession. They have constructed a self-system, and it is that self-system, with its personal values and principles of living, that is self-defining. Because they are not embedded in their profession, Stage 4 individuals have greater freedom to criticize aspects of the profession with which they do not agree. They remain committed to the profession because it permits them to be themselves and be recognized as themselves within the profession. Because they are not identified with the profession, the Stage 4 individual can “think outside the box” and become a change agent for the profession.

**Stage 5: The humanist.** As Stage 5 unfolds, the individual gradually comes to see the Stage 4 “self-system” as only one of many possible ways of being in the world. The Stage 5 individual begins to see the self as a set of universal, deeply humanistic longings and sensitivities, qualities that are shared by all humankind. Identities become like different suits of clothing, personas that can be put on or taken off, as circumstances dictate. No longer is there a need to defend a particular identity or to demand that others relate to one through one’s Stage 4 identity. Instead, deeply intimate contact with other human beings becomes possible (though it is probably rarely achieved) through direct contact between fellow human beings.
Transitions. In the lifelong process of identity development, individuals spend a considerable amount of time (typically many months) in the transition between stages. Transitions are characterized by the process of encompassing one’s current way of making meaning within the broader and more complex framework of the next developmental stage. Both stages may be demonstrated, with the higher stage expressed in a tentative and less well-articulated manner.
CHAPTER 5

DISILLUSIONED DOCTORS

Carl Elliott

ABSTRACT

Disillusionment among doctors is common. It is not uncommon for even highly successful doctors to say they wish they had gone into another field or that they would not encourage their children to go into medicine. In this chapter, I explore why this might be so. For many, medicine has become just another job dominated by technical skill and technology. I suggest that educating for professionalism as the remedy for this disillusionment is almost certain to fail as the issues are as much sociological as personal and professional. Perhaps disillusionment is a clue to a much more complex reality for modern medicine.

DEGREES OF DISILLUSIONMENT

Maybe I am unusual, but I know a lot of disillusioned doctors. In fact, sometimes it seems that all the doctors I know are disillusioned, and that the extent of their disillusionment is merely a matter of degree. It could be me, of course. It is true that I feel a special kinship with failing medical students, burned-out residents, and ex-surgeons who are turning to literature or theology. Yet, it is not uncommon to hear even highly successful doctors say that they wish they had gone into another field, or that they would not encourage their own children to choose medicine as a career. It is almost as
if disillusionment has become the spirit of the age, at least for doctors. Why should this be?

The day-to-day stresses of modern medical practice could be partly to blame, especially in the United States: the mountains of paperwork, the arbitrary reimbursement schemes, the outrageous malpractice insurance fees, and the crushing medical school debt. To bring up the state of contemporary medicine with an American doctor is to invite a bitter sermon about managed care functionaries, personal injury attorneys, manipulative patients, and hospital bureaucrats. But I suspect that the currents of disillusionment felt by many doctors feel run a lot deeper than the everyday frustrations of stressful work. Toward the end of my medical school years I remember talking to a classmate who said, “You know, medicine is just not as cool as I thought it would be. In the end, it’s really just another job.”

To people unfamiliar with medicine, that sentiment might seem a little odd. What else should medicine be, if not a job? But the fact is that some students still go into medicine expecting it to be something more – a calling, a vocation, a noble profession. For them, coming to believe that medicine is just a way to earn a good living feels like a disappointment. It is as if Harry Potter were notified that he had been chosen to study wizardry at Hogwarts but discovered that the wizardry business is all a charade. There is no magic, only technique and commerce, and the only wizards at Hogwarts turn out to be hucksters, like the bald man behind the curtain in *The Wizard of Oz*.

“Many doctors – I would even say most – harbor a harsh and dirty secret: medicine is a disappointment,” writes the doctor-turned-journalist David Brown (Brown, 2001, p. 42). Nothing in a prospective doctor’s youth accurately indicates the skills the job of doctoring demands, writes Brown, nor does anything predict the payoffs. Most prospective doctors come to medicine with nothing more than hope and fantasy, and when they find out what it is really like, it is too late to turn back. At least part of Brown’s bleak diagnosis is echoed by Julie Rosenthal, a fourth-year medical student at the University of Pennsylvania who recently published an article on depression among medical students in *The New England Journal of Medicine* (Rosenthal & Okie, 2005). The trigger for depression is often the third year of medical school, Rosenthal said in an interview, because it is in the third year that medical students discover what the life of a doctor is really like. Often that life is not what they imagined it would be. Rosenthal quotes one of her fellow students who says, “This really isn’t the life that I wanted, but I’m sort of stuck. I have all this debt; there’s no other way out for me” (Rosenthal & Tjia, 2005).
Since the mid-1980s when I was in medical school (and probably a lot earlier than that) medical educators have been worrying publicly that medical students are losing their idealism. Study after study suggests that with each passing year of training, medical students become more cynical. This cynicism is generally treated as a bad thing, a problem to be fixed, but it should not be out of bounds to ask why. Maybe cynicism and disillusionment reflect something important about the state of the profession.

The media certainly understand this. Rarely will you see anywhere in television, film, or fiction a straightforwardly idealistic, heroic portrayal of a physician. (One exception is the recent television ads by the American Medical Association, which portray doctors as heroes and encourage patients to send them thank-you cards to show their appreciation.) At least since the 1970s the media has preferred the physician to be an antihero: less Ben Casey, more Hawkeye Pierce. The flawed, disillusioned physician, battling under the most miserable circumstances, has become a stock figure in medical iconography, from *The House of God* through *ER*, and doctors have embraced it. If teenagers ever dreamed of being Marcus Welby, they do not anymore. Which raises the question: could the notion that doctors were once idealistic and sincere just be another medical myth? In fact, might doctors be less disillusioned if they were not obligated to put on a mask of idealism?

**THE FUTURE OF MEDICAL CARE**

A few years ago, in a medical humanities seminar at our medical school, I had a group of students read an essay by the surgeon Atul Gawande. The essay had been published in *The New Yorker* with the subtitle: “The future of medical care – machines that act like doctors, and doctors who act like machines” (*Gwande, 1998*). That future was illustrated by two case studies.

Gawande’s first case study was Shouldice Hospital, a specialized facility located outside Toronto. Shouldice specializes in hernia repair. It employs a dozen surgeons who do hernia operations and nothing else. Each surgeon performs between 600 and 800 hernia operations a year. The hospital is designed exclusively for hernia repair. Its rooms have no televisions or telephones, and meals are served in a central dining hall. Patients are thus forced to get out of bed and walk, which helps prevent complications from surgery.

For most surgeons elsewhere, a hernia repair takes about an hour and a half. At Shouldice, it takes 30–45 min. At most hospitals, a hernia repair
costs upwards of 4000 dollars. At Shouldice, it costs about half of that. At most other places in the world, 10–15% of hernia repairs eventually fail, and the hernia returns but not at Shouldice. Their recurrence rate is 1%.

How do they do it? The general surgical training at Shouldice is by no means superior to that of the rest of the world. In fact, several of their surgeons are not even fully trained as general surgeons. One is a family doctor. Another went from medical school straight to hernia repair. The surgeon-in-chief is an obstetrician. And yet, after a year or so of doing nothing but hernia repairs, these physicians were among the best hernia surgeons in the world. They had become great through sheer repetition. Eventually, doing a hernia repair had become automatic.

Gawande’s second case study – a machine that behaves like a doctor – concerned a computer that Gawande called “cardiology’s answer to Deep Blue.” Computer specialists have known for a while that computers can be designed to read EKGs. They have also known that computers can read them pretty well. Studies have shown that computers are better at diagnosing heart attacks by EKG than medical residents are. What was not known, until recently, was whether a computer could read EKGs as well as an expert could. Can a computer beat an experienced cardiologist?

A few years ago a team of Swedish researchers tried to answer this question. They matched a computer with Hans Ohlin, one of Sweden’s top cardiologists, who reads upwards of 10,000 EKGs a year. They presented both Ohlin and the computer 2000 EKGs of patients who had been seen at a hospital with symptoms of heart attacks. Only half of these patients had actually been experiencing a genuine heart attack, however. The others had later been diagnosed with other medical problems masquerading as heart attacks. The question was presented with the initial EKGs of these patients, who would be better at diagnosing the heart attacks, a computer or a cardiologist? As it turns out, the contest was not even close. When presented with the charts and EKGs, the computer beat the cardiologist by a margin of 28%.

What interests me is not so much the fact that, at least in these two scenarios, doctors and machines are not so different. What is interesting is how disappointing these case studies feel, at least to the medical students I read them with. One of them told me it was the most depressing article she had ever read. Another said it made him want to quit medical school. No one said that it made them want to go into surgery or cardiology.

I can understand their reaction. If you see the heart of medicine as the doctor’s knowledge and technical skills, as many aspiring doctors do, these scenarios will seem threatening. They will seem threatening, I think, because
we have come to see technical skill as somehow being what medicine is all about. It is deeply disturbing to think that the most effective medicine is medicine that is the most machinelike. Would it be as disturbing if a study showed, say, that nurses were as good as psychiatrists in the emergency room talking to a 16-year old who has just slit her wrists? Or that they did a better job than oncologists talking to a woman with breast cancer? I do not think so. Because we have gotten used to the idea that this is not what medicine is about anymore. Medicine is about technique, not morality; the care of the body, not the care of the soul.

Yet, it is not just the reduction of medicine to technique that feels threatening. It is also the thought that economic pressures might transform medicine into a branch of the service industry. Many doctors still wish that medicine was about something more than cost-effectiveness. If doctors can be replaced with machines, or even with mere technicians, then it seems as if the soul of the enterprise has been ripped away. Medicine is no longer about a fundamental human relationship. It is more like shop class. And as much as doctors might admire the mechanics and craftsmen in the shop class, they also feel superior to them, because they believe that medicine is not just a matter of trading a specialized skill for fair payment. It is a moral enterprise. Once medicine is stripped down to a service traded for money, its moral vision seems to fade out of sight.

Of course, this is the idealist’s view. It is the sort of sentiment that is delivered with depressing regularity to doctors and medical students in commencement speeches, white coat ceremonies and medical humanities initiatives. Whether it accurately reflects the state of medicine is another matter. The reality of medical practice (at least in America) is probably better reflected in a prescient article written 30 years ago by the cardiovascular surgeon Robert Sade, the current vice president of the American Medical Association’s Council on Ethics and Judicial Affairs. Writing in The New England Journal of Medicine, Sade argued that medicine was no more and no less than a specialized service sold by doctors. “Medical care is neither a right nor a privilege,” Sade wrote. “(I)t is a service provided by doctors and others to people who wish to purchase it” (Sade, 1971, p. 1289).

When Sade wrote these words, however, the political landscape looked a lot different than it does now. The big worry on doctors’ minds was “socialized medicine.” Socialized medicine, like the communist menace, would treat doctors like cogs in a vast totalitarian machine. Doctors would be at the mercy of the federal government. Government bureaucrats would tell doctors how to practice medicine and strip them of their autonomy as clinicians. Or so it was thought. Doctors never actually gave much thought to
big business – that is, not until a decade or so later, when their practices were bought up by urgent care centers and their hospitals by for-profit chains and all their reimbursement checks started coming from managed care organizations. By the mid-1990s, all of the medical profession’s worst fears about “socialized medicine” had come true, only the totalitarian bosses did not work for the federal government. They worked for corporate America.

I began medical school in 1983, just when the move toward corporate medicine was getting underway. One of the many things that surprised me about medical school then was how just heavily money seemed to weigh on everyone’s mind. It is not that I did not expect to make a good living as a doctor. I simply had a Presbyterian view of the whole enterprise. I thought medicine meant a kind of shabby gentility, where you could make money without ever really having to think much about it. While you would probably never really get rich, neither would you have to worry about paying your bills. You would make enough money so that you could afford to be generous toward sick people who did not have enough, for which they would be grateful. Above all, I expected that doctors would never actually talk about money. That would make medicine like other jobs.

Instead, I found a world in which concerns about money were literally everywhere. The attendings talked bitterly about how little money they made as academic physicians, at least compared to what they could make in private practice. In the medical school hierarchy, money was a stand-in for status: the most prestigious and competitive specialties were those that paid the most, such as radiology, dermatology, and the surgical subspecialties, while the lowest in prestige were those that paid the least, like psychiatry, pediatrics, and family medicine. The medical students were angry at being mistreated by the system, and by the time they left, they felt as if they deserved to make as much money as possible, as payback for what they had endured. Everyone in the teaching hospitals seemed angry at the patients, especially the poor and uninsured patients, and tried as hard as possible to figure out ways to turf them to other hospitals. Meanwhile, the main teaching hospital reserved a special floor for VIP patients. The rooms were furnished with fake mahogany furniture, and access to them was guarded by a special check-in desk at the elevator doors.

What was often overlooked in all these conversations about money, then as now, was that the business of medicine contains at its heart a very tenuous relationship between the vulnerability of a sick person and the doctor’s self-interest. Sick people need doctors, and often they need doctors desperately. Yet the financial well-being of doctors is precisely dependent on this
vulnerability. In other areas of economic life this kind of relationship would lead us to worry about exploitation. A very thin line separates the profitable profession that helps sick people and the profitable business that exploits them. Doctors have flirted with crossing that line. The more that doctors insist on their right to perks from the drug industry; the more they argue that they should be compensated at the level of corporate lawyers and CEOs; and the more they agitate against political remedies that guarantee health care for the poor, the more they will be resented. And the more they are resented, the more disillusioned they will become.

A gap is growing wider between the perception that the medical profession has of itself – which is still as an essentially humanitarian enterprise (how else could the AMA actually encourage patients to send their doctors thank-you cards?) – and the external perception of medicine, which is increasingly shaped by the pressures and demands of business. Doctors may want to make a lot of money, and they are more than willing to work hard (I would argue that there are few professions whose members work harder) yet they still bristle at the limits of economic rationality. Doctors generally do not want to be instructed by bureaucrats; they do not want to their practices to be limited by money; they do not want to imagine their jobs as anything like those of accountants or middle managers. Yet as the forces of economics become more powerful that is precisely what medicine is coming to resemble.

According to a recent editorial by Robert Wachter in _The New England Journal of Medicine_, for example, hundreds of American hospitals have begun to outsource radiological services to larger, less expensive corporations, many of which are located in the developing world (Wachter, 2006a). Wachter believes it is only a matter of time before laboratory medicine, pathology, and even aspects of critical care medicine are outsourced as well. Wachter, who is associate chair of medicine at the University of California at San Francisco, says that this is the direction where our health care economy is headed. “In the rest of our economy, when we think about that value equation, we have found certain kinds of things that we buy where we make choices about purchasing them from providers from other countries,” Wachter said in an interview. “Medicine is coming to resemble our purchasing decisions about other things more and more” (Wachter, 2006b).

On one level, this kind of appeal to economics is easy to understand. Radiologists rarely see patients anyway; why shouldn’t they be located in a company in Bangalore, if that is the most cost-effective way to do radiology? Yet it is not hard to see why doctors might find it depressing to hear medicine described with phrases like cost-effectiveness, value equations, and
purchasing decisions. I suspect this is partly what my medical school friend was getting at when he called medicine “just another job.” As contemporary medicine has become increasingly technocratic, impersonal, and bureaucratic, driven by the demands of economics, it loses its magic. The romance disappears, and it is replaced by something else – maybe something more efficient, maybe even something that produces “better health outcomes,” but something much less appealing to the practitioners who must do it. Family farmers probably feel the same way when they look at multinational agribusiness conglomerates.

**MEDICAL PRACTICE: A MORALLY SATISFYING PURSUIT?**

In 1967, John Berger published a book called *A Fortunate Man* (Berger, 1967). The fortunate man in question was Dr. John Sassall, a general practitioner who worked in a remote country village in England. Although Sassall, the son of a dentist, had grown up in relatively prosperous circumstances near London, he had chosen to practice in a part of the country that was extraordinarily poor and culturally deprived, even by the dismal standards of the English working class. After Naval service, Sassall had begun working as the junior partner of a well-liked but unambitious older doctor, and this arrangement had given him plenty of opportunity to work as a medical lifesaver to the poor. Sassall did appendectomies on kitchen tables, rescued accident victims, and delivered babies in caravans. He was proud of being overworked. He had no patience with any medical problems except grave illnesses and emergencies. As Berger puts it, “He dealt only with crises in which he was the central character” (Berger, 1967, p. 50).

Over time, however, Sassall’s practice became more complicated. Because he was living among his patients in a small village, he began to see into their lives for the first time. Children grew up. Families changed. A girl whom he had once treated for measles later came to him pregnant with her own child. A man who had never been ill in his life blew his brains out with a gun. When Sassall’s older partner died, Sassall was no longer able to limit himself to surgical rescues and emergencies. He had to spend more time in his office, listening to patients. The problems he was faced with were a lot messier and more troubling. His own role became less clear. No longer was it plain what he should do, or whether he could even help. No longer was he the central character in every crisis. He had to reexamine his own motives for practicing medicine.
It was not easy for Sassall to adjust. He went into psychoanalysis. For several months he became sexually impotent. Eventually, however, he carved out a place for himself. Not that it was an entirely comfortable place. Sassall was one of the few educated, middle-class people in the village. By the standards of the other villagers, he was conspicuously well-to-do. The villagers liked and respected Sassall, and they saw him as a very competent, approachable doctor, even if they also considered him moody and eccentric. Yet over time Sassall began to find satisfaction in working on different kinds of cases. He sought out problems where no previous explanation would fit – cases whose solution depended on a patient’s particular history and personality. His new role became less that of a technician than of a witness to the illness and vulnerability of the villagers. Berger describes Sassall as “a foreigner who has become, by request, the clerk of their own records” (Berger, 1967, p. 83).

Why did Berger call Sassall a fortunate man? Because, unlike many other doctors of his time, Sassall practiced in a way that was not only true to the needs of his patients, but in which the internal meaning of what he did aligned itself with the external expectation of what he needed to do. He had to work hard to stave off boredom and his own gnawing sense of inadequacy, but he managed to make his practice both morally admirable and intellectually satisfying. He no longer measured success in terms of lives saved and illnesses cured. He avoided disillusionment by changing his expectations of what doctoring meant.

It had not always been easy. Occasionally Sassall sank into depression. He wondered whether his nineteenth century style practice was compatible with twentieth century medicine. He understood that the problems of the impoverished patients he saw were as much social as medical, yet he did not dedicate himself to social causes. But for all that, Sassall was a man pursuing what he wanted to pursue, and that fact, writes Berger, made him unique. “Like an artist or like anyone else who believes his work justifies his life, Sassall – by our society’s miserable standards – is a fortunate man” (Berger, 1967, p. 138).

Was he a fortunate man when he was rescuing accident victims and performing appendectomies on kitchen tables? Yes, but this kind of good fortune is much easier to parse. It does not require an existential crisis. Like the doctors who do hernia operations at Shouldice Hospital, this kind of doctor performs an activity that justifies itself. A problem exists; its solution is clear; the doctor carries it through. The doctor is given fair payment in exchange for his or her work. Doctors who see their practices in purely technical terms do not really have to think too much about how to justify their lives, any more than a mechanic or a carpenter does. You limit your
vision; you avoid ambiguity and messiness; you stay away from problems outside your specialty.

The problem comes when you expect your job to be something more. What do you make of a practice that has always justified itself in terms of illnesses diagnosed and cured when your patients do not have straightforward medical problems and your treatment often makes them worse? How do you justify yourself when you see your profession in moral terms, but the system in which you practice says that you are selling a specialized skill? How can you continue to describe your job in the language of altruism when the world describes it in the language of economics? How do you keep going to work in the morning when there is a yawning gap between what you expected of the job and what the job has turned out to be like?

What Sassall understood is that a medical practice that has been stripped of romance needs a different set of internal meanings to make it a morally satisfying pursuit. If medicine is simply about effective crisis management – about fixing simple problems effectively – then there is no problem. Such an activity justifies itself. Sassall remained very good at technical tasks, and he applied himself to them with skill and concentration. Nor it is not too much of a stretch to fit this kind of practice into an economic model: fair payment for honest work. The problem comes when you must do what Sassall was forced to do once his older partner died. How do you justify your work when it is no longer clear what you need to do or what the value of it really is? What is the value of being a witness to suffering, a clerk of the villagers’ records?

Old-school doctors and many humanities scholars suggest that the remedy to disillusionment is a renewed emphasis on virtue and professionalism. They believe that academics and professional bodies should try to instill doctors with a sense of social justice, professional integrity and a dedication to meaningful relationships with their patients. The reason these efforts are almost certain to fail is their failure to take account of the realities of contemporary medical practice. The problems with contemporary medical practice are at least as much sociological as they are personal. It does little good to appeal to high-minded ethical theory and professional idealism when the sociological structures in which doctors’ practice treat them as skilled technicians trading services in the marketplace. In fact, the result of these appeals is likely to be even more disillusionment (Frader, 2006).

Many of the people I know who seem happiest practicing medicine are the people for whom it was never anything more than a job. Perhaps they found diseases interesting; perhaps they had a talent for science; perhaps they enjoyed doing technical procedures. They were not looking for any higher meaning to it all. There was just something about the day-to-day business of
doctoring that they liked. For the most part they have wound up in fields like radiology, pathology, or sports medicine. The people who have become disillusioned are those who expected the practice to carry some deeper significance. They are the ones who thought medicine was a moral calling.

My two closest friends from medical school chose very different paths after graduation. Both of them have wound up in very different places. One chose pediatric oncology. As an academic physician, he specialized in brain tumors. After 15 years or so of pediatric practice, during which he became increasingly bitter, frustrated, and angry, he finally decided to leave medicine entirely. My other friend, in contrast, chose to practice dermatology. Today she has a thriving private practice, performs a lot of cosmetic procedures, and by almost any standard, is exceptionally happy in her work. Her patients are grateful for what she does, and they are happy to pay for it. It is true that she does not treat children with brain tumors, but then again, that is not what she set out to do. What she expected of medicine and what medicine expects of her have aligned themselves nicely. By Berger’s standards, she is a fortunate woman.

Yet it is not unfair to ask: which one is better off? What sort of doctor should we prefer? If doctors go into medicine without illusions, they will not become disillusioned. We could have more doctors like this if we wanted. All we have to do is be honest with them from the start. But is disillusionment really a problem to be fixed? Or is it, perhaps, a clue?

REFERENCES

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CHAPTER 6
MOLDING PROFESSIONAL CHARACTER

Rosamond Rhodes and Lawrence G. Smith

ABSTRACT

This chapter argues for appreciating the distinctiveness of medical ethics. If the ethics of medicine is different from the ethics of everyday life, it follows that the character of physicians is and should be different from the character of others. Molding the character of future physicians therefore becomes an important matter for the attention of medical educators. In that light, this chapter explains the appropriate goals for such an educational program and discusses the means for teaching and inculcating the principles, attitudes, and behaviors that physicians need to embrace in order to fulfill their special social role and professional obligations.

INTRODUCTION

Just as clinical practices can seep into medicine without a sound basis in evidence, many beliefs about medical ethics and medical education have become broadly accepted, and, although they lack robust support, they stand unchallenged in the medical literature. In particular, it is commonplace to make three assumptions that we shall question in this chapter. (1) people assume that ethics cannot be taught. Because of that presumption,
they leave matters of physician character to medical school admission committees, trusting that, based on the universally glowing recommendations from undergraduate faculty members and a couple of very brief interviews, applicants of sterling character are selected who then, necessarily, develop into exemplary professionals; (2) people assume that the standard theories of ethics are simply applied to questions of medicine to produce medical ethics (Beauchamp & Childress, 2001; Clouser, 1978; Gert, Clouser, & Culver, 1997); and (3) people assume that there is something about the “silent curriculum” in standard medical education that corrupts the character of our medical trainees, transforming them from compassionate humanists into calloused cynics (Haidet & Stein, 2006; Hafferty, 1998; Hafferty & Franks, 1994; Lempp & Seale, 2004).

From all that is written and said invoking these convictions, it appears that those who accept them are oblivious to the apparent contradiction between these three positions. But, the assumption that medical trainees should be selected for their extraordinary character and commitment (in addition to intelligence) is at odds with the idea that the ethics of medicine is just like the ethics of everyday life. In fact, the idea that extraordinary character is necessary for being a good doctor supports other common views: that medicine is a higher calling with special responsibilities and that being a good doctor is different from merely being a good citizen (Pellegrino & Thomasma, 1993). The idea that ethics cannot be taught conflicts with the idea that the sterling characters of trainees can be corrupted by the silent curriculum because if character can be deformed by the wrong examples, it can be molded through a well-conceived and effective educational program.

Eschewing the tradition, we begin with what we take to be reasonable goals for an educational program that aims to create exemplary physicians. In addition to providing a robust grounding in the biomedical sciences, we side with those who see that medical education has an essential role in molding professional character (ABIM et al., 2002; Branch, 2000; Hilton & Slotnick, 2005). In general terms, we want the physicians who we train to recognize and appreciate their distinctive professional responsibilities and to fulfill them with exemplary professionalism. To do that, they have to understand their special responsibilities and develop the virtues and skills that will enable them to perform what duty requires. Specifically, at the end of their course of education, our trainees should be able to understand the basic principles of medical ethics and acknowledge their distinctiveness and priority, be able to use these concepts in determining their actions and in reasoning about the dilemmas that inevitably arise in clinical practice, be
willing to discuss difficult or controversial decisions with their peers in terms of reasons that can be endorsed by all medical professionals, have the attitudes that incline them to fulfill their professional responsibilities, and have the skills to accomplish what they conclude they ought to do.

In what follows, we shall explain our view that medical education for professionalism requires attention to all of these components. To do so, we present a novel but intuitively powerful account of the ethics of medicine and argue against conceptions of medical ethics as ordinary morality applied to the practice of medicine. Because of the distinctiveness of medical ethics, and because students learn about the kind of person they need to be as well as how to behave as doctors during the course of medical education, we shall also explain the importance of an intentional focus on professional character and behavior in medical education. With that as our starting point, we shall then explain how trustworthy physicians can be molded through medical education. We shall also explain the curricular implications entailed by accepting character molding and professionalism as legitimate and important goals of medical education.

TRADITIONAL MEDICAL ETHICS

The well-entrenched view, reflected in the vast bioethics literature of the past thirty-odd years, is that medical ethics is the application of traditional ethical theory to questions of ethics that arise in medicine. In that light, authors discuss autonomy in Kantian terms, allocation of scarce resources in utilitarian terms, access to health care in terms of rights theory, and professionalism in terms of virtue theory. This dominant view was articulated by K. Danner Clouser in his *Encyclopedia of Bioethics* article on “Bioethics” where he explained that “bioethics is not a new set of principles or maneuvers, but the same old ethics being applied to a particular realm of concerns” (Clouser, 1978). The strategy is further explained by Clouser and colleagues Bernard Gert and Charles Culver in *Bioethics: A Return to Fundamentals* when they identify 10 moral rules as the crux of ordinary morality (Gert et al., 1997). It is also the approach most prominently expounded by Tom Beauchamp and James Childress in the five editions of their *Principles of Medical Ethics* (Beauchamp & Childress, 2001). In those volumes, they identify the four principles of respect for autonomy, beneficence, nonmaleficence, and justice as the common features of prominent moral theories, and they show how to apply those principles to the practice of medicine.
On the contrary, we have recognized that the ethics of medicine is distinctively different from ordinary morality. With more to follow, consider a few examples as compelling evidence of the distinctiveness of medical ethics:

- In ordinary life, the bulk of our moral responsibility is negative; we must refrain from harming others by not killing, injuring, deceiving, or stealing. In medicine, doctors and other health professionals have a positive duty actively to promote their patients’ good.
- In ordinary life, we are free to associate with whomever we choose, and we are supposed to care most about those who are closest to us. In medicine, doctors are supposed to serve any patient with medical needs and to care about the well-being of each one.
- In ordinary life, we freely share what we learn in the course of our interactions; exceptions require explicit requests for keeping shared information in confidence (e.g., making promises, signing non-disclosure agreements). In medicine, confidentiality is presumed, although exceptions can be justified.
- In ordinary life, unless force or deception is involved, sexual interactions between adults are morally acceptable. In medicine, disclosure and consent do not legitimize a physician’s sexual involvement with a patient.
- In ordinary social situations, it is considered rude to ask probing and personal questions. Taking a complete and detailed patient history includes asking about a patient’s bowel habits, sexual practices, drug use, etc.
- In ordinary life, we expect those nearest and dearest to act on behalf of their loved ones who cannot make decisions for themselves. Parents select the names for their children, they choose whether or not to inculcate religious beliefs, they decide on where to raise them and the schools they should attend. Family members typically make decisions about where elderly relatives who have lost decisional capacity should reside, their health care, the management of their finances. In medicine, a doctor should not be the physician for family members because strong feelings can interfere with judgment.

Such considerations suggest that the ethics of everyday life is significantly different from the ethics of medicine in dramatic and important ways. That distinction calls for an account of the special responsibilities of medicine.

**THE DISTINCTIVE ETHICS OF MEDICINE**

Society allows medicine to develop its special knowledge, skills, and privileges that could be particularly dangerous to members of society, where
medicine is not constrained by a powerful professional morality. Physicians are allowed to learn about anatomy through the dissection of human cadavers, physiology, pharmacology, and biochemistry. Medicine is also permitted extraordinary powers and privileges that could be a hazard if used careless, recklessly, or without goodwill. Physicians are allowed to ask probing questions and examine nakedness (i.e., invade privacy), they are given license to prescribe medications (i.e., poisons), they are granted the privilege to perform surgery (i.e., assault with deadly weapons when performed by anyone else). Although medicine is granted these uncommon commissions, society provides them on the condition that physicians can be trusted to wield them for the good of patients and society.

Misplaced trust can be dangerous to people’s health and a lack of trust impedes medicine’s ability to provide services. Yet, to the extent that medicine provides care, patients have to invest doctors with role-based trust. Combining these insights about trust and medicine makes it obvious that a foundational principle of the ethics of medicine is “trust.” In other words, it is essential for clinicians and the institutions of medicine to be trustworthy and to seek the trust of patients and society in all of their actions.

Because the profession and institutions of medicine are social goods and social artifacts, and because individuals make themselves vulnerable by trusting medical institutions and clinicians based on their social role, medicine’s basic principles require broad endorsement from the profession. In other words, patients need to trust their doctors from the first moment of their first visit. They know little about medical science and medical procedures, yet they yield to the advice of their physicians. They can hardly know enough about their individual doctors for their requisite trust to be earned as an individual achievement. Trust is extended by patients and their families because the doctor wears the white coat and carries the professional title. Similarly, society extends the authority to assure the trustworthiness of individual practitioners and medical institutions to the oversight of the profession with the expectation that medical institutions can be trusted to meet their needs. In sum, patients and society rely upon medicine to be trustworthy. Their reliance and the conditions of medicine’s monopoly over medical practice explain the importance of trust and the importance of clinicians conforming with “the standard of care.” The role-based trust of medicine means that doctors are not counted upon for their personal judgment but for their professional knowledge, wisdom, and judgment in providing treatment according to medical science and the well-accepted principles of medical practice (Stell, 1999).
People appreciate their susceptibility to injury and disease. So, with respect to medical need, they would want attention from skilled and knowledgeable practitioners who could cure disease, alleviate symptoms, restore function, and ease suffering. These realizations create a broadly accepted consensus on the “fiduciary responsibility” of physicians. Furthermore, because we appreciate the potential danger that physicians can present through wielding their special knowledge, powers, and privileges, as well as the special vulnerability of the patient, it becomes critical that physicians and medicine be “trustworthy.”

In other words, medicine is not defined by a particular perfectionist conception of the good (e.g., health), or by naturalist concepts (e.g., disease, normal species function), or by teleological realism (e.g., the goal of medicine). Consider that firemen are called to rescue cats and children from tall trees and policemen are called to subdue escaped tigers even when no fire or law enforcement issues are involved. Because they have the wherewithal and we trust them to use their tools for our benefit, they get the job. Similarly, the special knowledge, powers, and privileges of medicine explain why assisted reproduction as well as birth control, pain management, and cosmetic surgery are included within the domain of medicine even though neither health nor disease need be at issue. Starting with the foundational commitments to the patient’s good, seeking trust, and being deserving of that trust, several corollary principles of medical ethics can be deduced: professional competency, caring, confidentiality, non-judgmental regard, non-sexual regard, respect, and truth-telling. Students need to understand each of these concepts as important commitments of medical professionalism. They need to appreciate their rationale and how commitment to these principles is applied to and expressed in clinical practice (Rhodes, 2001).

Together, these distinctive principles of medical ethics comprise the “ethical standard of care” for medicine (Rhodes, 2006). They are the profession-endorsed principles that should be used to guide medical behavior. Although peer judgment is largely irrelevant in personal morality, peer judgment is crucial in medical ethics. That is because doctors are primarily trusted because of their role. Patients and society expect doctors to act in accordance with the ethical standard of care, and they rely upon them to meet that shared standard. They also expect the profession to guarantee those standards. In other words, a patient who arrives in an emergency department does not expect Catholic medicine from a Catholic physician, Jehovah’s Witness medicine from a Jehovah’s Witness physician, or self-centered medicine from an egoist physician. Patients reasonably expect good medical practice in accordance with the standard of care from every
physician. This means that medical practice is not a matter of private judgment. Rather, medical decisions should be the ones that similarly situated physicians would endorse as matters of professional judgment. Conflicts between principles that arise in individual cases have to be resolved in terms of principle-related reasons that other medical professionals would also find compelling. Deviations from the “ethical standard of care” have to be justified to peers in terms of principles of medical ethics.

THE DISTINCTIVE VIRTUES OF PHYSICIANS

Besides the intellectual understanding of the ethics of medicine, students have to be helped to develop the virtues that will enable them to fulfill those responsibilities. A virtue is the habitual inclination to act and to feel as one should with respect to an object or a situation. It is an attitude that disposes a person to choose and behave one way rather than another. Similarly, a vice is the habitual inclination and attitude that dispose someone to act in opposition to virtue. Character, then, is the entirety of a person’s virtues and vices (Aristotle, 1954). If the ethics of medicine is markedly different from the ethics of everyday life, how one should act and feel is different, the medical meaning of common virtues is different, and the character of physicians must be similarly distinctive to enable physicians to act in accordance with their special duties. This means that character transformation must be part of making an exemplary person into a doctor (Pellegrino & Thomasma, 1993).

For example, in ordinary life, it may be a source of satisfaction and personal esteem to develop some expertise or skill. People pride themselves on the outstanding abilities they have nurtured (e.g., skiing, music, cooking, language mastery), but these excellences are all personal options. In medicine, competence is a professional responsibility. Without professional competency, someone who bears the title, “Doctor,” is a quack and a charlatan. Hence, the commitment to life-long learning must be incorporated into the character of a physician.

In ordinary life, it is quite acceptable, and perhaps even laudatory, to carefully choose your friends and to bestow kindness on those whom one chooses as nearest and dearest. It is often useful to quickly assess unsavory characters and to distance oneself from them. Great wits are often especially adept at identifying flaws in others and making them the butts of jokes and the objects of derision for our amusement. And, it is often a mark of the cool sophisticate or the ruthless entrepreneur to display studied disinterest.
Physicians have to learn instead to care about the well-being of each of their patients and to be non-judgmental in their allocation of caring concern and medical attention. Caring is an important virtue of physicians because it enables doctors to devote themselves to their patients’ welfare and because it promotes the trust of patients. For that reason, love of mankind and one’s patients in particular and, therefore, putting the patients’ needs above one’s personal advantage must be inculcated in medical trainees so that they can be relied upon to fulfill their fiduciary responsibilities (Rhodes, 1995).

Perhaps, the most difficult physician virtue for students to accept and accommodate is the physicianly attitude of respect. In ordinary morality, the governing moral rule instructs people to presume, as far as possible, that others are acting autonomously and to respect their choices by leaving them alone. The rule in medicine requires doctors to be both more skeptical in the presumption of autonomy and to be more accepting of patient values.

Medicine requires physicians to constantly assess a patient’s decisional capacity so as to determine when, and to what extent, paternalistic intervention may be required. Because life and future function may be on the line, and because disease, medication, and psychological distortions (e.g., fear, denial) can all impede patients’ judgment, doctors are expected to assess decisional capacity and to intervene with patients whose impaired preferences threaten health. Sometimes the intervention requires repeating a warning (i.e., unwelcome remedial education), sometimes cajoling, sometimes involving family members to ratchet up the level of guilt, sometimes going so far as taking a judgment-impaired patient to surgery over objection. Such judgments require: first, accepting the responsibility for the assessment of decisional capacity and, second, adopting the attitude of making such determinations about one’s patients’ capacity as a matter of professional responsibility.

While ordinary morality allows people to distance themselves from the unpalatable choices of others, that luxury is incompatible with the practice of medicine. Medicine requires physicians to use their knowledge and skills to promote their patients’ good. Respect for autonomy in this sense requires physicians to accept their patients’ view of the good and their patients’ ranking of values. This commitment, for instance, requires a doctor to accept a Jehovah’s Witness’s refusal of a blood transfusion even when the commitment appears irrational and silly to a non-believer, and to provide what the physician takes to be the second best-treatment option when that is what the patient chooses. And, when a patient with decisional capacity requests, for instance, that a life-sustaining ventilator be disconnected, or desires a surgical procedure that a physician finds too risky or disfiguring.
(e.g., Van Ness rotationplasty, translumbar amputation), or asks for birth control or pregnancy termination, the doctor is required to set aside personal values and refer to the “ethical standard of care” in deciding how to proceed.

Clear understanding of the principles of medical ethics, the courage to challenge a patient’s decisional capacity, and the integrity to stick by the clear conclusions of one’s reasoning are constantly part of a physician’s duty. Performing up to professional standards requires all of the virtues that comprise the character of a physician.

**TRANSFORMATION INTO MEDICAL PROFESSIONALS**

Because becoming a doctor is a process of acquiring knowledge and skills as well as character transformation, it is reasonable to expect a learning curve in virtue formation as well as in other competencies. Whereas everyone accepts that novices have a distance to travel before becoming competent physicians, most authors who address the behavior and attitudes of medical trainees remark upon their failings and the negative impact of the “hidden curriculum.” They see an educational process that dehumanizes noble characters and they find support for their opinions in surveys of medical residents (Haidet & Stein, 2006; Hafferty, 1998; Hafferty & Franks, 1994; Keegan, 1982; Lempp & Seale, 2004).

Apparently, these critics are not mindful of the uniqueness of medical virtues or the progress that is required for the development of a physician’s character. And, perhaps, the surveys that find novices exemplary and those in the midst of training lacking are searching for the wrong things or looking at some intermediate point before the process of moral character development is complete. And, perhaps, our educational programs have failed our students by ignoring their responsibility in molding professional character.

Yet, drawing on authors who describe a process of moral development (Kohlberg, 1980), becoming an ordinary ethically competent moral agent involves a process of moral development. Once we appreciate that training a doctor involves creating a new professional persona, that is, a person with a new and different character, it is not surprising that medical trainees often require a period of learning before becoming the professionals we want them to be. Although some students seem to arrive in medical school with a developed sense of medical professionalism, we see many students who move through a staged pattern of professional character development.
Some begin their training very much focused on their own survival and achievements, following a pattern of learned behaviors which have served them well in the past. Students who are decent human beings are frequently surprised when they notice that their usual behaviors are contrary to the new professional culture of medicine in which they find themselves. Being highly intelligent, most quickly formulate what they take to be the rules of the new game and begin to act accordingly. Yet, they may have misread the rules and their behavior is still motivated exclusively by self-interest rather than the internalized core values and principles underlying the profession. As they progress further, they experience intense socialization into the world of medicine. They begin to perceive through medicine’s concepts and focus and they begin to consider their responses in terms of medical role models. At this stage of development, the need to belong to the team of doctors and to be accepted by peers is the dominant motivator. These goals make students very susceptible to the negative effects of the hidden curriculum. But by the time they become senior residents and fellows, many trainees seem to have internalized the hallmark medical commitment to patients and accepted the personal transformation in character that has occurred. That said, medical educators can more reliably produce physicians who model professionalism by making a more deliberate effort in that direction (Smith, 2005).

To be a medical professional, a trainee has to develop from being a decent individual with personal virtues who makes decisions about personal action with reference to personal values and commitments and sees situations from a personal viewpoint to being a physician who acts from professional virtues and makes professional decisions with reference to medical commitments and professional values. Although we try to carefully select medical trainees, we should expect that the process of medical education involves students’ progression from starting off as bright and compassionate individuals to their becoming a part of the medical team (joining a new family) to becoming clinicians who incorporate professional values in sound medical decisions and who also mentor future generations of physicians. In the process, our trainees have to learn how to work collaboratively in a medical team, how to put their patients’ good before their own, how to convey trustworthiness, and how to be trustworthy medical professionals.

The challenge for medical education is to make the transformation explicit and to consciously train students to have the virtues and skills of the exemplary physician. Once the distinctiveness of the medical character is acknowledged and once the importance of character development is accepted as an educational goal, medical educators are called upon to nurture
the development that is necessary and to inhibit the inculcation of counter-productive attitudes and habits.

EDUCATIONAL IMPLICATIONS

It is important to appreciate two factors about molding professional character. Because virtues are, essentially, habits of feeling and acting, molding the necessary and distinctive habits of a physician requires repetition. Also, because character formation is a process, the judicious cultivation of physicianly virtues must be threaded throughout medical education and treated as a crucial aspect of medical training. The educational obligation cannot be discharged with a short course tacked onto the beginning of the first year or the end of the final undergraduate year as an irrelevant but decorous appendage. The educational efforts have to be distributed over the full course of medical education in order to allow the emotional exposure to clinical settings and the social learning from peer mentors to take hold.

Both teaching and evaluation of professionalism have to occur throughout the continuum of medical education. Professional character development requires benchmarks and measures appropriate to the stage and activities of each level of learners. Furthermore, we now know that seemingly innocent infractions early in medical training can predict serious professionalism problems later in a physician’s career. Remediation efforts require early identifying problems so that interventions have the time to habituate the needed changes (Papadakis et al., 2005).

Although it is important for this aspect of medical education to convey the content and rationale for the distinctive principles of medical ethics, it is also crucial for students to accept the principles of medical ethics as core professional values. These factors dictate two further features of the educational program.

(1) Short lectures can be used to convey content and an overview of the philosophical material, but most of the teaching has to be done in small groups (Branch, 2001). Small group sessions are necessary because students need to have the experience of publicly endorsing the principles of medical ethics as their own and bearing witness as their peers do so as well. These activities make it clear that the principles of medical ethics are broadly shared and endorsed by the profession. Students also need to learn that discussing ethical issues that arise in clinical medicine is as legitimate and important a professional activity as discussing the choice of a medical procedure or the dosage of a medication. Furthermore, they
need to experience the process of reaching a consensus on clinical dilemmas by providing each other with principle-based reasons. Such exercises allow them to appreciate how medical ethics employs the “ethical standard of care,” rather than a personal perspective, in reaching moral decisions.

(2) Esteemed members of the medical faculty have to play a leading role as mentors for these small group sessions. Their participation communicates that medical ethics is an important concern of real physicians and demonstrates that commitment to the core principles of medical ethics is a genuine feature of being a doctor. Not only do these physicians say that medical ethics is important, but by giving their time to this particular educational activity, they vividly demonstrate its priority.

In order to fully prepare students with the subject matter, to nurture the desired habits, and to develop the requisite skills, small group sessions in medical ethics education should be horizontally and vertically integrated into the curriculum. Following the traditional model of medical education, a structured curriculum in medical ethics should be sequentially advanced so as to be developmentally appropriate. Sessions in the preclinical years should begin by noting the long tradition of the profession’s distinctive commitments by examining the oaths and codes that have guided medicine over the centuries and until the present (e.g., the Hippocratic Oath, the Oath of Maimonides, contemporary codes). Small group sessions should then focus on basic concepts such as the duty to provide care and the physician’s fiduciary responsibility, informed consent, truth telling, confidentiality, and the relationship between medical practice and clinical research. Later sessions should focus on more complex and nuanced concepts such as clinical justice, decisional capacity, sexual attraction, responsibility for action and inaction (e.g., issues of killing and letting die), the primacy of professional responsibility over personal values, and management of the kinds of conflicts that are likely to arise in clinical life between education and the benefit of patients, among members of a medical team, and between family life and clinical responsibilities. During the preclinical years, before students have much first-hand experience to draw upon, illustrative cases will have to be provided. Cases are useful in teaching an approach to clinical moral reasoning and for providing examples of the range of settings in which a principle is relevant. Cases have to be carefully constructed to demonstrate how principles are applied and to provide a template for clinical reasoning about similar cases. At this stage, reading and written exercises are useful tools in clarifying concepts, promoting critical reflection, and reinforcing learning.
Common behavior and real issues that are relevant to the students’ role as medical students should also be emphasized and explained in terms of molding professional character. At this stage, it is important to address issues such as cheating on exams, collaborative versus competitive learning, compliance with the administrative tasks of medical school, and the use of patients in medical education. All of these are actually matters that confront students, but they can also be used as opportunities for teaching students to thoughtfully consider their actions and behaving as a physician should. In this respect, it is important to convey that the trustworthiness and caring of physicians (or the lack of these qualities) is communicated in everything a physician does. The cleanliness of a white coat (or the opposite), respectful speech (or the opposite), greetings (or the lack), concern for the person who appears to be lost (or the studied disregard), making eye contact and exchanging smiles (or refusing to) can all communicate medical professionalism (or its absence).

In the clinical years, the students’ own clinical experience should be engaged as the basis for at least some small group discussions. In these sessions, basic concepts can be revisited in the contexts in which they are likely to arise (e.g., truth-telling in the surgery clerkship, adherence in the family medicine clerkship). Difficult concepts can be reviewed, subtle distinctions can be clarified, and students can learn to negotiate conflicts between basic principles. Skills in medical ethics can also be advanced by requiring students to identify cases that raise the issues for discussion, by asking them to formulate relevant questions, by requiring them to search and use the ethics literature, and by giving over to students the role of leading their peers in discussion in order to reach a consensus on what should be done or what further information should be pursued in order to make an ethical decision. By placing students in these roles, they actually practice the behaviors that we want them to internalize. Through all of these activities the focus should remain on reinforcement of the principles of medical ethics, developing skills in clinical moral reasoning, and developing the habit of discussing ethical issues with peers. In addition, medical educators must take steps to guard against the danger of students acquiring unprofessional habits from a hidden curriculum. Faculty mentors must be vigilant about the behaviors that students are learning, and explicit in encouraging professional character transformation.

Attending to medical ethics education is no less important in graduate medical education. Residents and fellows have to see that professional responsibility and professionalism are not just window dressing in undergraduate medical education, but a crucial aspect of being a doctor. They
must also be made aware of the enormous influence of their behaviors on shaping the professional character of younger trainees, and they need to learn to set and enforce standards within their peer group. Efforts to maintain desired virtues and inhibit unprofessional behavior and attitudes require deliberate attention. As part of such an endeavor, ethics discussions should be incorporated into the regular pattern of clinical life by designating time for such topics on the schedule of team or unit rounds at least once a month. And when a lacuna in the ethics education of house staff is noticed, a curriculum should be designed to meet their training needs and integrated into their educational program.

Because fulfilling a physician’s ethical responsibilities often turns on the ability to say the right thing, to the right people, at the right time, and in the right way, communication skills become a crucial aspect of molding medical professionals. It is not enough for a physician to know what to do and why. The exemplary doctor must also know how to do the job well and have sufficient training so as to feel confidence in her/his ability and sufficient inclination to accomplish the task so that it actually gets done. In this respect, students need training and practice in communicating with patients, not only in how to take a medical history, but in eliciting informed consent, providing a diagnosis and prognosis, communicating bad news, disclosing errors, managing confidentiality responsibilities, discussing non-adherence, offering a health care proxy, conducting family meetings, and engaging in end-of-life discussions. Students also need training in how to communicate with peers. Beyond knowing how to present a case at rounds, students need to learn how to elicit and convey information to colleagues, how to question treatment decisions, and even how to engage others in a discussion of clinical ethics. Many of these conversations can seem daunting, threatening, and hazardous, and for that reason many clinicians do them poorly or avoid having them entirely. That is precisely why communication skills training has to be seen in the context of molding medical professionals and incorporated throughout the preclinical and clinical years of a training program. These skills too must eventually become habitual behaviors (Rhodes & Cohen, 2003).

Finally, for medical ethics and communications skills training to be valued, components of medical education must be evaluated along with factual content and other clinical skills. Students learn to value whatever is assessed. If ethics and communication are important aspects of medical training, then we have to find ways to assess them. Standardized patient exercises have become accepted as an effective method for assessing communications skills. Exercises for the assessment of medical ethics can be designed to dovetail
with standardized patient evaluations and also incorporated into the clinical clerkship curriculum. In the end, there is no substitute for direct faculty observation and feedback to learners on the array of learning situations in medical school and residency.

**CONCLUSION**

Molding the character of future physicians is too important a matter to leave to chance. It is far too much of a moral danger to give up this aspect of medical education by default to the “hidden curriculum” and to allow medical trainees to develop unprofessional habits of feeling and acting as matters of luck. Medical educators have to appreciate that medical education is a transforming activity and not merely the conveyance of a body of knowledge. In that light, they have to take seriously their role in nurturing the distinctive character of the excellent physician and use their educational programs in teaching and inculcating the principles, attitudes, and behaviors that physicians need to embrace in order to fulfill their special social role and obligations.

Medical school deans have to take the lead in focusing institutional effort on the importance of molding professional character. When explicit commitment to this goal flows from the very top, it can inspire the faculty as well as the students. Encouraging an attitude of mindful attention to the development and support of the virtues of medicine can infuse the entire curriculum and the annual calendar of school activities as the focus of ceremonies throughout the academic year. Most importantly, commitment from the highest rung in the administration can promote an atmosphere of valuing moral development that permeates educational activities, conversations, and behaviors, and ultimately promotes trustworthy excellence in patient care.

**REFERENCES**


CHAPTER 7

MINDFUL PRACTICE AND THE TACIT ETHICS OF THE MOMENT

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ABSTRACT

One way of defining the character of clinicians is to examine their moment-to-moment actions during the course of clinical care. These small actions, cumulatively, describe the clinician as a practitioner and moral agent. In this chapter, using clinical examples, I explore the possibility that professional competence and virtue are based, in part, on clinicians’ ability to engage in a “mindful” practice in which they can be attentive to their own actions, curious enough to examine them and present and flexible enough to change them.

The Guest House

This being human is a guest house.
Every morning a new arrival.

A joy, a depression, a meanness,
some momentary awareness comes
as an unexpected visitor.

Welcome and entertain them all!
Even if they are a crowd of sorrows,
who violently sweep your house
empty of its furniture,

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still, treat each guest honorably.
He may be clearing you out
for some new delight.

The dark thought, the shame, the malice –
meet them at the door laughing,
and invite them in.

Be grateful for whoever comes,
because each has been sent
as a guide from beyond.


While patients and their problems may have familiar names, the particular ways in which patients present their distress are unique and unpredictable (McWhinney, 1989). These “unexpected visitors” are often embedded in situations that involve ambiguity, uncertainty and strong emotions, and require some sort of decision among possible courses of action. Each physician is faced with a flow of hundreds of these small choices each day: Do I spend more time with this patient even if it means that the next will wait? Do I suggest a choice of medications or just one? How long should it be before the patient should return? As physicians, we normally make these contextualized, individualized decisions with inadequate data, time or support. Each of these small actions also has an ethical dimension, as Rumi reminds us – they communicate not only directives, suggestions and inquiries, but also the physician’s values, virtues and character. By character, I refer not to enduring features – it can be illusory to say “I am a good person.” Character, or virtuous presence, is ephemeral, momentary and re-invented with each right intention, right thought and right action.

The small decisions that clinicians make are largely tacit and below the level of conscious awareness. Most of these ethical actions are automatic; they feel like second nature. Physicians learn to make decisions rapidly and accurately because conscious deliberation of all medical decisions is hardly practical given constraints on time and resources. They are based on personal knowledge of clinical medicine and the patient, and also their own predispositions to attend to, or ignore, a particular issue. Automaticity, though, carries with it several risks. The physician may make assumptions that may not be true; emotional reactivity may override good judgment or lead to premature closure (Borrell-Carrió & Epstein, 2004). Precisely, the same factors that allow physicians to practice efficiently and not get bogged down with each small decision also allow some of those decisions to go unexamined, and perhaps lead the physician to make choices that do not necessarily conform to his or her values, or to distort reality to rationalize
his or her actions. However, on reflection, most physicians will realize that their knowledge is impermanent, their competence is fragile and their sense of control is illusory.

Conversely, clinicians who are mindful of their own thoughts, feelings and behavior can recognize those situations and respond consciously, thoughtfully and intentionally. Mindful practitioners employ a non-anxious, reflective presence that involves “paying attention, on purpose, to one’s own mental and physical processes during everyday tasks to act with clarity and insight” (Varela, Thompson, & Rosch, 1991); they “observe the observer while observing the observed” (Epstein, 1999) to overcome tendencies to ignore the obvious, be overly concrete, make inappropriate assumptions and become distracted.

This chapter is about the application of mindfulness during daily clinical practice to achieve a level of practice that is not only more error-free, but also more virtuous. I will specifically examine the tacit ethics of the moment – “micro-ethical” (Komesaroff, 1995) choices which define virtuous actions and the summation of which defines character. Starting with a perspective informed by cognitive psychology (Varela et al., 1991; James, 1975; Damasio, 1994, 1999), educational theory (Eraut, 1994) and research (Schmidt, Norman, & Boshuizen, 1990), I will introduce mindful practice as one way of developing awareness of, and guiding responses, to these situations. I will discuss approaches to cultivating mindfulness, and suggest that greater moment-to-moment self-awareness can help clinicians frame and modify their actions to generate improved mutual understanding, trust, compassions and clinical outcomes. One caveat, though: although the concept of mindfulness originated in Buddhist philosophy (Kabat-Zinn, 1994), it is not necessarily linked to a particular meditative practice; rather it refers to a more general approach that leads to insight, compassion and correct action through self-awareness. My use of “mindful practice” refers to a more clinically oriented secular approach. While much has been written about fostering mindfulness in patients (see studies by J. Kabat-Zinn, M. Linehan and others), there is a scant literature on cultivating mindfulness in physicians (Connelly, 1999; Epstein, 1999, 2001, 2003a, 2003b; Schmidt, 2004; Shapiro & Schwartz, 1998, 2000; Fitzgerald, 1999) – that will be the focus of this chapter.

ETHICAL CHOICES IN CLINICAL PRACTICE

Clinicians face hundreds of decisions each day. Although clinical evidence can guide management of illness, evidence cannot take into account all
relevant elements of each patient’s individual context (Epstein, Alper, & Quill, 2004). Patients’ values and cultural backgrounds, the urgency and severity of illness and their prior experiences with health care determine which issues the patient brings to the physician’s attention. As a physician, my values, expectations and experiences also affect the clinical encounter; these factors affect how well I know and trust the patient, my interpretation of the patient’s verbal and non-verbal communication, and my own level of comfort with the clinical scenario. I make moment-to-moment decisions about which issues I attend to and the degree to which I invite each patient to participate in each decision. In addition, the values of numerous third parties are often tied up in clinical relationships: family members, friends, insurers, administrators and other health care professionals. Each of these factors contributes to the clinical context. I must rely on practical wisdom and judgment; generalizations, rules and principles may frame some of the issues, but often are of limited usefulness in actually choosing a course of action.

Each of these actions has an ethical dimension. Until recently, discussions of ethics have tended to focus on dilemmas of how to act in the face of extraordinary circumstances or on attitudes toward advances in medical technology. The tools to resolve those dilemmas depend on the application of a detached critical morality (Varela et al., 1991). However, this view of ethics has little to do with the small decisions that form the basis of the day-to-day practice of medicine. These issues rarely rise to the level of a well-demarcated “dilemma.” Komesaroff (1995, p. 64) describes these micro-ethical questions as more pervasive and more “finely textured.” They involve negotiating several possible courses of action, and are embedded in relationships. Each task within each clinical encounter – information transfer, emotional engagement, performing surgery, reviewing charts – has an ethical component; physicians make moment-to-moment decisions about how much information to provide, how emotionally engaged to become and limits of their own capacities (Hundert, Hafferty, & Christakis, 1996; Komesaroff, 1995). Komesaroff (1995, p. 68) defines micro-ethics as “what happens in every interaction between every doctor and every patient”; this ethics is “closer to wisdom than reason” and “closer to understanding what is good” than to “adjudicating particular situations.”

As a clinician, I feel that it is important to ground this discussion in real cases and real questions that would arise in daily practice and how clinicians, including me, respond to those situations. Thus, in preparation for writing this chapter, I started with a list of some “what should I do?”
questions that arose during the course of a full day of clinical practice:

- In which order should I return the 10 telephone messages on my desk?
- When do I stop gathering information about the patient’s concern and move on to recommending treatment?
- Should I ask a colleague to take on one of my responsibilities when I am exhausted?
- Do I take the time to remove the patient’s socks to examine his feet even though it is unlikely that I will discover anything new?
- What do I say to an anxious patient during a genital exam?
- What tone of voice should I use when presenting recommendations to make sure that they are understood but also not to seem forceful or coercive?
- When is it time to bring a medical encounter to a close?
- How should I regard the recommendations of a colleague who is often too sure of himself?
- What do I say to a patient when specialists disagree about the likely diagnosis?
- How should I respond to a patient’s racist comment?
- What should I do or say to gain a patient’s trust (or even whether to try)?
- How convincingly should I write an application for disability when I am not sure I believe the patient?
- To what degree should I communicate irreducible uncertainty to patients, knowing that it may reduce patients’ trust? (Suchman, 2005)
- To what degree should I let my patients know of my own limitations and anxieties?
- How much should I care about this patient who does not seem to care much about him-/herself?

The issues listed above – and this is a very incomplete and biased list – have two faces: each simultaneously requires a practical solution to an immediate problem and the formation of trusting relationships characterized by mutual understanding, respect and presence (Frank, 1989; Rogers, 1958; Havens, 1986). The separation between the practical solution and the development of trust, though, is artificial. Trust is essential to clinical practice. Trust is related to improved continuity of care (Safran, Montgomery, Chang, Murphy, & Rogers, 2001) and better health outcomes (Bindman et al., 1995). Regardless of the physician’s efforts to balance power and expertise, it is impossible for patients to acquire all relevant knowledge and skills to participate as fully as both might wish in each clinical decision; thus, some
element of trust is always necessary. Trust is won in a series of clinical acts and contacts in which, through my actions, I convince the patient of my competence, caring, interest, integrity and perseverance. Similarly, I try to build my trust in the patient through understanding the world through his or her eyes and then trying to understand how that worldview results in actions that otherwise might make little sense. Borrell-Carrió (2000) describes how even the choice to smile on greeting a patient regardless of the clinician’s feelings of liking or dislike for the patient opens the door to a relationship in which the patient feels that the clinician is making the effort to listen, understand and demonstrate respect. Establishing trust is an ethical act, as it benefits the patient and the relationship. Using very distinct arguments, Candib (1995) from a feminist perspective and Drane (1995) from a virtue ethics perspective suggest that relational virtues – truthfulness, respect, friendliness, caring and accessibility – need to accompany the ethical mandates of beneficence and patient autonomy.

Trust, though, is insufficient without mutual understanding. However, establishing mutual understanding is complicated by dissimilarities among the culture, language and values of clinician and patient. These subtle misunderstandings often result in disparities in care (Cooper et al., 2003; Balsa & McGuire, 2003; van Ryn, 2002). For example, by virtue of differing cultural norms in the expression of pain or other symptoms, I may misinterpret the severity and impact of an illness, and lead to either over- or under-treatment. Even the unconscious choices regarding which issues I direct my attention to can also be viewed as ethical choices with clinical ramifications. Although most clinicians would be horrified to think that they make clinical decisions on the basis of race and ethnicity, psychological and epidemiologic data indicate otherwise (Fiscella, Franks, Gold, & Clancy, 2000). Similarly, a patient can mistake a well-intentioned physician’s actions as an attempt to distance or deceive. A mindful clinician should be aware of their own contribution to these inequities and act accordingly. This micro-ethical awareness of the presence or absence of mutual understanding requires the capacity for moment-to-moment self-monitoring.

Micro-ethical decisions are usually identified and dealt with tacitly (Polanyi, 1983), by habit. They depend on tacit knowledge – the kind of knowledge one uses to ride a bicycle through heavy traffic – it is second nature but very hard to put into words. Experienced clinicians use their tacit knowledge when we say that a patient “looks sick” without explicitly being able to describe what contributes to our impressions. These judgments then influence the decision, for example, to spend a few extra minutes with this patient at the expense of delaying the next patient. Because of the overwhelming
number of these judgments, clinicians typically have limited awareness even of whether a judgment has been made, much less why. Furthermore, these are not discrete dichotomous decisions but rather a flow of overlapping events that co-occur and mutually influence each other. It is impossible to attend to all of these events, though. Physicians must exercise some degree of selective awareness in order to respond to the flow of these moment-to-moment decisions.

Tacit knowledge is stored in the minds of clinicians as complex sets of interlocking decision rules, or scripts (Schmidt et al., 1990). Educational psychologists have demonstrated that master clinicians can gain access to and enact these scripts on the basis of even small amounts of clinical information (Bordage 1994, 1999). Thus, the febrile child who is judged to “look sick” enacts in me a set of actions that might include blood tests, antibiotics and perhaps hospitalization. Similarly, mental health professionals are adept at reading a patient’s level of depression and anxiety after only a few moments, and experienced neurologists often have a set of provisional diagnoses by the time the patient has stood up and taken a few steps. If the clinician’s scripts are appropriately elaborated and nuanced, enacting them is likely to result in correct clinical actions (Brailovsky, Charlin, Beausoleil, Cote, & Van, 2001). However, use of low-level (“knee-jerk”) decision rules can lead to errors in diagnostic judgment by oversimplifying a clinical situation, by ignoring disconfirming data or through premature closure before all the data have been adequately synthesized (Borrell-Carrió & Epstein, 2004; Woolf et al., 2005). Just as these scripts can apply to the management of a febrile child, they also apply to the development of relationships and understanding patient requests. Clinicians, though, may not even realize that a decision is being made. We have demonstrated, for example, that if a patient requests an advertised prescription medication, the physician is very likely to prescribe it regardless of whether it is clinically indicated (Kravitz et al., 2005); presumably, some physicians prescribe as a result of laziness – taking the path of least resistance, whereas, in others, the request activates one of several “depression prescribing” scripts that may have gone unexamined.

Furthermore, tacit knowledge is often acquired tacitly, via the “informal curriculum” (Hafferty & Franks, 1994) – the socialization of students in the process of becoming physicians. Students learn, for example, to refer to patients by their diagnosis, to ignore psychosocial information and to demonstrate obedience while ignoring actions that are at odds with their own values (Caldicott & Faber-Langendoen, 2005). Students often learn these rules of conduct only from observing their peers, and, painfully, by violating
them and experiencing censure. However, these implicit rules of conduct become ethical norms that are rarely articulated in such a way that they can be examined and critiqued.

In addition to the dichotomy between tacit and explicit knowledge, Polanyi (1983) also distinguishes propositional from personal knowledge. Propositional knowledge is easily communicated, as it consists of data (“facts”) that are independent of one’s own personal experience. Personal knowledge, in contrast, is acquired idiosyncratically, and often within the context of a relationship. Spouses’ knowledge of each others’ tone of voice, physicians’ knowledge of the meaning of a phone call from a patient, identifying a friable blood vessel and recognition of changes in a patient’s clinical course, all involve elements of personal knowledge. Personal knowledge of the patient-as-person can facilitate those patient-centered responses in clinicians, with the caveat that personal knowledge, if unexamined, can be the source of stereotyping and bias. Ethical practice, therefore, depends on both principles and wisdom, and both personal and propositional knowledge.

**PROFESSIONAL COMPETENCE, PROFESSIONAL EXCELLENCE AND MICRO-ETHICAL PRACTICE**

Professional competence is “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2002). Health education organizations and licensing bodies (Accreditation Council for Graduate Medical Education, 2000; Association of American Medical Colleges, 1998) have adopted similar definitions of competence that go beyond a foundation of clinical skills and scientific knowledge. Competence also includes the ability to form healing relationships, communicate effectively with patients and colleagues and adopt a “professional” role (Epstein & Hundert, 2002). Part of that role is empathy, compassion and presence (Larson & Yao, 2005). “Professionalism,” though, is a set of habits and judgments, not merely another set of aspirations and commitments (Project of the ABIM Foundation, 2002); it is more impermanent and context-dependent than otherwise. Although some professional lapses are the result of egregious intentional behavior, most are the result of a mindless disconnect between intention and action. Habits of mind including attentiveness, critical curiosity (Fitzgerald, 1999), presence and self-awareness, are key features of a mature professional.
The following examples show different aspects of the overlap between professional competence, micro-ethics and mindfulness (or the lack thereof). There are several examples; the domain of micro-ethical practice is kaleidoscopic. All are based on real patients; where permission to publish the vignette could not be obtained, the details are sufficiently altered to render them unidentifiable.

**Attentiveness and Ignoring the Obvious**

A 50 year old man who recently had cystoscopic surgery for bladder cancer, and who had a urinary catheter removed the previous day, now has diminished urinary flow and abdominal pain that brought him to the emergency room. Initially (mis)diagnosed as dehydration, physicians administer fluids. When there is no response to treatment, fluids are increased. The nursing staff reported that he had a “comfortable” night, when reports from him and his wife indicated that he was in relentless pain. A resident, realizing the error the next day, inserted a catheter but not before the patient developed a fever due to a urinary tract infection as a result of the untreated urinary retention.

There are several instances of clinical error and moral failure in this case. The initial diagnostic error made is perhaps understandable, given the chaotic and pressured environment in the emergency room. But the perpetuation of the error, despite mounting disconfirming evidence, speaks to a level of mindlessness that seems incomprehensible given that the clinicians involved were all licensed, English-speaking, board-certified physicians who easily could distinguish the symptoms of urinary retention from dehydration. It is likely that one factor was that the patient was regarded as a category – a fixed “entity” – which then conditioned the clinicians to selectively attend to confirming data and ignore that which was inconsistent with the diagnosis. The clinicians violated an ethic of patient-centeredness.

The nurse’s actions also had an ethical dimension. Assuming that the nurse had entered the patient’s room and witnessed his distress, and also recognized a certain level of neglect or mismanagement, she would face an ethical dilemma – either to protect herself and her physician colleagues to maintain homeostasis of the social system within which she was working, or challenge them in order to provide better patient care. But, more likely, she, too, was operating under the same delusion, not questioning the category to which he had been assigned. The ability to reframe and reconsider the original formulation required a level of attentiveness, curiosity, individual responsibility and caring that all of the clinicians perhaps tacitly assumed were the responsibility of someone else. A letter to the medical director of the hospital was answered several weeks later with a form letter, indicating...
that perhaps the system itself suffered from lack of ability to self-monitor and self-correct.

Curiosity and Avoiding Premature Closure in the Face of Complexity

A 38 year old woman has been previously diagnosed with fibromyalgia, interstitial cystitis, chronic fatigue syndrome and irritable bowel syndrome, all “functional” conditions for which no clear cause can be identified, and for which there is no definitive diagnostic test. She has frustrated physicians in the past with her multiple irresolvable physical concerns. She has a history of alcohol abuse and prior sexual abuse, both common among patients who have multiple medically unexplained symptoms and “functional” somatic syndromes. An orthopedist notes abnormalities on her X-rays that suggest inflammation. All of her blood tests are normal. She is referred to a rheumatologist who starts her on a series of medications of increasing toxicity for a presumed systemic inflammatory arthritis. The patient is convinced that is the source of her pain. She notes initial responses, and then the effect of each medication wanes. The rheumatologist is not sure that the risks of the medications are balanced by the transient benefits and is vigilant for evidence that favors stopping the medications.

In this situation, the clinician must maintain two or more competing theories about the patient’s condition. Fibromyalgia is a controversial condition because its presence can never be disproved – there is no diagnostic test, only a cluster of symptoms. Furthermore, the patient’s inflammatory condition has no name; it does not conform to any of the known rheumatologic syndromes yet the patient has an abnormal X-ray. Rather than closing the question by assigning a definitive diagnosis, this clinician maintains an agnostic position or, better, he maintains two competing theories simultaneously (James, 1975). There are multiple potential models; the choice of one of the several explanatory theories may have more to do with the antecedents and particulars of a situation rather than a general rule that would apply to all (McWhinney, 1989; Plsek, 2001). At this point, the clinician may have no guidance as to which to choose: the rheumatologic-inflammatory disease explanation, the abuse-survivor–psychological explanation or the as-yet-undefined complex chronic disease explanation. Leaving the doors open allows a multi-pronged exploration and consideration of trials of multiple treatment options. This capacity for mental flexibility, patience and presence that depends on tolerating anxiety and uncertainty might be considered fundamental to the character of a master clinician.

The patient and the clinician, though, might both feel more anxious by having to face this level of ambiguity, providing pressure toward premature closure – in this case, narrowing of a range of possibilities to a single diagnosis that is considered more definitive than it may be in actuality. The
result would be a forced choice. However, reducing a complex system to an oversimplified one has more than philosophical significance; it can lead the clinician not to explore other viable explanations, ignore disconfirming data and utilize treatments of dubious risk–benefit ratios. The physician enacts the virtue of flexibility and presence in the face of anxiety and uncertainty.

Self-Awareness, Clinical Gaze and Patient-as-Person

A kind, bright and very engaging African American woman – a minister’s wife – has diabetes. Despite having had a foot infection which nearly required amputation, heart-to-heart conversations, providing literature and engaging her in educational programs, the patient seems never to understand how and what to eat. She places her health in God’s hands, a view endorsed by her husband. Her white physician is familiar with literature that suggests that African Americans tend to be less trustful of physicians than their white counterparts (Cooper et al., 2003); she (the physician) also recognizes her own tendency to stereotype, and to possibly overcompensate for her own biases. After trying yet again to explain the need to follow a diabetic diet, she stops and asks the patient what her goals for treatment might be, and how she (the physician) might help her reach those goals. At that point, the patient mentions that an aunt died of diabetes after having had a number of amputations and dialysis, and that she (the patient) had come to realize that, in addition to her minister, physicians might also be agents of, or messengers from, God; the medications she previously feared were reframed as having been blessed. The physician, an atheist, although feeling uncomfortable being thrust into a priestly role, accepts the patient’s belief system as a marker of trust and understanding.

This capacity for mental flexibility, patience and presence that depends on tolerating anxiety and uncertainty might be considered fundamental to the character of a master clinician. In this situation, the physician was frustrated in her attempts to manage her chronic diseases and to narrow the sociocultural distance between practitioner and patient. Personal beliefs and stereotypes entered into the picture. No one could argue with the physician’s adherence to recommended treatment guidelines. Although the physician has done all the right things, she had not, until the visit mentioned above, made the transition from viewing the patient as a clinical case to relating to the patient as a person. The pathologizing clinical gaze, as described by Foucault (1994), is a personal stance on the part of the clinician that reinforces the social roles of physician and patient, and considers patients’ subjective experience only inasmuch as it is interpreted by the physician. Communication, in this case, was technically correct but did not result in an effective healing relationship in which the patient felt understood, respected and honored (Zoppi & Epstein, 2002; Candib, 1995). In contrast, the physician’s later patient-centered (or as might be preferred
here, person-centered) stance allows the humanness of the patient to take precedence over the problem to be solved (McWhinney, 1997); it is an approach that emphasizes knowing the patient as a person and not just knowing about the patient. Later, that approach provided one avenue toward finding common ground in dealing with a previously intractable problem. The clinician was able to make conscious her view of the patient-as-disease and made the ethical choice to see the patient-as-person.

Beginner’s Mind, Presence and Respect

In the hospital, a senior physician witnesses rude treatment by a senior colleague directed toward a mutual patient known to be reluctant to follow medical advice. The physician is aware of his impulse to recoil and avoid his colleague, and also his own frustration with the same patient. He realizes that he has almost given up on the patient, and neglected to suggest another blood test to monitor his condition. He also took the opportunity to mention to the colleague later in the day how frustrating it was to try to help this patient, and perhaps they could collaborate on a plan. Implicitly, by empathizing, he was hoping to find a way to tolerate caring for a patient both found difficult, and also an avenue for helping his colleague treat the patient with respect.

It is only human to want to distance from or react defensively to emotionally charged situations. Confronting a colleague respectfully about such a sensitive issue involves some degree of self-awareness of one’s motivations lest the interaction be viewed as moral one-upmanship. There are also hierarchical issues in medicine that may make such confrontations much more risky for trainees and relatively junior physicians in comparison to their more senior colleagues. While, in theory, the physician’s actions are considered correct by most students and professionals, medical students describing their reactions to having witnessed similar situations often respond that, although they know the correct actions, they also knew that they would be punished for pointing out faults of a senior physician (Ginsburg, Regehr, & Lingard, 2003).

Presence and Avoidance

A 19-year-old woman in active labor now insists on a cesarean section even though the labor is progressing well and there is no medical indication for cesarean section. She is restless and screams with contractions. Her husband occasionally chuckles when she becomes insistent. Her attending physician is tired; it is 3 am Saturday morning. He has explained to her the reasons why a cesarean section would involve more danger than benefit. He also knows that, if she is uncontrollably restless and pushing against an incompletely dilated cervix, it will cause the cervix to swell, and possibly delay delivery.
She is calmer when the physician is there; her husband has no noticeable calming effect on her. The physician is wanted at home; his daughter has a soccer game the next morning which he was hoping to attend. He is aware that he is annoyed at the patient; he thinks, “Why can’t she use the techniques she was taught in her birthing classes in order to self-regulate and manage her own distress?” Normally, he would leave much of the management of labor to the nurses, residents and family members and arrive when delivery was nearing. He mentions that he is needed upstairs to see another patient. But that patient could conceivably wait.

In a technical sense, this physician’s presence was not needed on a moment-to-moment basis. There are numerous cognitive alibis he could employ to justify leaving the patient, while the underlying reason of not wanting to deal with an emotionally intense situation in which his usual level of control is not possible. Many of these reasons make sense, at least on the surface. But, simply being there appears to have a therapeutic effect, even though it is an uncomfortable situation for him. This ethical choice depends on the particulars of this situation in this moment; for other women in labor, his presence might not be so important. Compassionate presence is only possible to the degree that the physician recognizes his own feelings and makes choices to serve the patient at the expense of heightening his own fatigue.

**Awareness of Non-Cognitive Factors in Decision-Making**

A man comes into the office requesting a throat culture for possible strep infection. The physician notes his temptation to just get the strep test; it would be a fast and easy visit, and would likely be negative. However, he chooses not to accept the man’s request at face value, and, rather, engages the patient in a long discussion in which he explained that the test was likely not indicated, and that, if it were positive, would likely be a false positive – it might indicate that he is a chronic strep carrier (which is normally not treated) and not truly infected.

Another patient, a 48-year-old woman, is feeling despondent and mentions that she has seen a television advertisement for Paxil®, and wonders if the medication might help. She has chosen to leave her job rather than move with her company to another state. She displays few symptoms of major depression, for which medication might be indicated. Her physician prescribes the medication, and considers that fulfill the patient request might strengthen the physician-patient relationship. When asked later if he would consider this appropriate care if he were auditing a chart of a trainee under his supervision, he says “doubtful.”

Clinician behavior in the face of patient requests indicates that the physician often does not act as the “learned intermediary” as has been suggested by those in favor of direct-to-consumer advertising of prescription drugs. In a recent study (Kravitz et al., 2005), we trained actors to two clinical
conditions – major depression and adjustment disorder – and sent them, with physicians’ prior consent, into the offices of 152 primary care physicians in three US cities. For each role, there were three request conditions. In two of these, the patient made a request for a medication; the patient either mentioned a direct-to-consumer advertisement for Paxil® (a prescription antidepressant) or a TV show about depression. The third group made no request. Physician prescribing increased from a baseline rate of 10% for the adjustment disordered patients in the control condition to 55% if the patient mentioned Paxil®. The indications for antidepressants for adjustment disorder are questionable. Clinician focus groups revealed a rich network of rationalizations for their actions, such as gaining the patient’s trust, using the request as evidence for depression and considering the risks of overprescribing less egregious than underprescribing. This contrasted with a general assessment that prescribing for the non-depressed patient was not appropriate. Clinicians also “remembered” incorrectly; few admitted having been influenced by the patient request. In contrast, physicians who do challenge patient requests are “rewarded” with longer visits, in which lengthy explanations may still result in an unsatisfied patient, and increased physician anxiety and self-doubt. This lowered “hedonic tone,” if not examined and understood, may be a driving force toward taking a path of lesser resistance and creating a cognitive alibi to justify the physician’s actions (Borrell-Carrió & Epstein, 2004).

**Global Self-Deception**

A psychiatrist, highly regarded in the community as a “physician’s physician,” was known for his helpfulness to men who were struggling with their sexual identity. When it became known that he incorporated touching and stimulating patients’ genitals as part of his “therapy,” it became apparent that he had constructed a careful rationale – that his providing stimulation helped them understand and focus better on the conflicts for which they were seeking help.

If this were an otherwise sociopathic, exploitative or clinically incompetent physician, these events may have confirmed an emerging picture of someone who should never have practiced medicine. The illustrative components of this case, though, are that even otherwise excellent, virtuous clinicians can create rationalizations for actions that otherwise would be considered reprehensible – often those actions pit the physician’s own needs (in this case, perhaps, a need for intimacy or to explore his own ambivalent sexuality) against the interests of the patient. Accepting gifts from or investing in the
pharmaceutical industry may be a lesser example of the same principle; physicians typically find rationales and minimize the influences that such relationships can have on their clinical actions.

**MINDFUL PRACTICE**

Mindfulness is a concept borrowed from Buddhist psychology, first described 2,500 years ago (De Bary, 1972; Kabat-Zinn, 1994). Buddhist psychology asserts that people – including healers – have relationships with others that mirror one’s relationship with one’s own inner world. Inquisitiveness, healing intention (Schmidt, 2004), acceptance and kindness all start with the self and then can be directed toward others. These qualities depend on insight, which in turn depends on the ability and willingness to observe with equanimity to see things as they are rather than how one would have them be. When practicing mindfully, clinicians are curious, engaged, present in the moment, seemingly undistracted and able to be calm even if they are doing several things at once. Closely monitoring their own cognitive and emotional processes, they can practice with clarity, integrity and compassion.

The concept of *mindful practice* (Epstein, 1999) also draws on diverse philosophical traditions that discuss the importance of personal subjective experience (Dewey, 1958; James, 1975; Polanyi, 1974) as well as more contemporary formulations of the structure of professional knowledge (Eraut, 1994; Friere, 1998), learning (Schön, 1983, 1987), development (Gilligan, 1993; Kohlberg, 1969) and intelligence (Gardner, 1993). More than an occasional flash of insight (Balint, 1957), or a structured reflective activity, mindfulness is a state of mind that permits insight, presence and reflection. Mindfulness is a habit of relating to the world. The ability to understand the patient’s needs, and not confusing those needs with one’s own, enhances clinicians’ ability to express compassion and caring in terms that are meaningful to patients (Goldstein, 1994; Candib, 1995; Noddings, 1984). Mindfulness is not restricted to the socioemotional sphere; one can practice surgery, read a radiograph and examine a skin lesion mindfully. Mindfulness is a state that many good clinicians experience on a daily basis but often they do not have words to describe it. It has much in common with a state of “flow” (Csikszentmihalyi, 1991) described by high-performing athletes and musicians (Gallwey, 1997).

In the preceding sections, I discussed several ways in which professional excellence is based on knowledge of and respect for the patient as a person, with values and needs. This is neither simple nor straightforward. Physicians
may not notice the need to look at the ethical dimensions of a particular situation. If they do, they may find that a patient may not have expressed explicit opinions or clearly formulated values prior to any discussion with a physician; these values and meaning may emerge through discussion and deliberation (Suchman & Matthews, 1988a). Ideally, this may be a reflective process in which synergistic mutual influence leads to increasing clarity. However, the illusion of partnership may cloud the patient’s values when they do not comport with those of the clinician. Physicians’ power and privilege can silence patients’ expressions of their needs and values, confuse the patient so that he or she is unsure of his or her values, or persuade the patient to express values that may not be meaningful or important. On the other hand, there is a competing tendency to underinfluence patients and withhold recommendations, more passively acceding to patients’ requests (or demands) in the name of patient autonomy (Quill & Brody, 1996). Because the potential for influence is large, in my view, clinicians have an ethical obligation to be able to distinguish between the patient’s values and needs and their own, and to be aware of the ways in which their social position interferes with understanding the patient and his or her needs.

Four qualities characterize mindful practitioners: attentive observation, critical curiosity, beginner’s mind and presence (Epstein, 1999) (Table 1). Attentive observation is often instantaneous and impressionistic. A patient’s limp can easily be ignored by a physician who sets the agenda of the visit to discuss the patient’s hypertension and diabetes. The limp may indicate claudication due to a blockage of an artery to the leg; this is not even a problem in another category of illness but it is directly related to the areas of the clinician’s concern. Fitzgerald (Fitzgerald, 1999) describes a case in which a resident presented a patient as “BKA times 2” indicating that the patient had had two below-the-knee amputations. On rounds, the attending physician observed two feet, 10 toes (there was only one patient in the bed).

### Table 1. Characteristics of Mindful Practice.

- Active observation of oneself, the patient, and the problem – including peripheral vision and preattentive processing.
- Critical curiosity, including the courage to see the world as it is rather than as one would have it be.
- Beginner’s mind – willingness to examine and set aside categories and prejudices, and humility to tolerate awareness of one’s areas of incompetence.
- Presence – a purposeful willingness to simply being there, undistracted, and focusing on the task at hand, regardless of pleasant or unpleasant thoughts or feelings.
In fact, there had been a transcription error from the prior discharge summary (DKA [diabetic keto-acidosis] was mistaken as BKA) and the resident assumed it to be true to the degree that he did not even notice the presence of feet. The previous case of urinary obstruction mistaken as dehydration also exemplifies this tendency to ignore the obvious when the category is taken too literally, too concretely, as in the following example:

A patient of mine was thought by a specialist to have adrenal insufficiency on the basis of low blood pressure and hyperpigmentation of the skin; the clinician included in written progress notes and the discharge summary “rule out adrenal insufficiency” even after it was pointed out that the patient’s hyperpigmentation was a suntan which ended at the sleeve line.

Attentive observation also applies to what was not present but might be expected; on one occasion, George Engel, a clinician known for his skills of observation, commented on the absence of evidence of family in a patient’s room – no cards, no flowers, no articles of clothing – when no one else present saw that there was something missing.

Attentively observant clinicians “observe the observer while observing the observed” (Epstein, 1999). Metaprocessing (Eraut, 1994) – thinking about thinking, feeling about feelings – includes being aware of the process of noticing as well as what was noticed and the process of evaluating values. One use of metaprocessing is to become aware of “pre-attentive processing” – the automatic mental activity that allows the clinician to sort data and choose what to attend to within moments of meeting a patient before processing the objective and subjective data to support it. So, the neurologist who, on meeting the patient, “knows” that the patient has Parkinson’s disease before she can list the features that she observed, is making use of pre-attentive processing (Austin, 1998). The brain rapidly scans a wide array of perceptions, detects conspicuous features and relegates some information to the background, all before the content of the perception is analyzed. Clinical skills, such as palpating the abdomen, involve tacit knowledge and pre-attentive processing; often tactile sensations become fully scrutinized only when something seems aberrant. But also judgments about the patient occur during this phase. If the patient is obese, perhaps the clinician thinks of diabetes but also may regard the patient as lazy, non-compliant and less likely to change, and therefore less deserving of the clinician’s attention. Consider the following example:

A medical student is in the operating room assisting a urologist who is removing the lymph nodes surrounding both kidneys in a young patient with cancer. After dissecting the left kidney, the surgeon is working on the right side with the left kidney out of his field of vision. The medical student notes that the left kidney is turning blue; he notifies
the surgeon but the surgeon dismisses the concern without looking. Several minutes later, the student mentions it again, now that the kidney is a dusky purple. The surgeon tries unsuccessfully to untwist the kidney, and calls in a vascular surgeon to repair the damaged artery to the kidney. After the surgery, the surgeon mentions an “unavoidable complication” to the family; the patient’s kidney function was temporarily affected but recovered.

This surgeon’s response to an error that initially might have been avoidable was compounded by discounting (and demeaning) an informed observer, denial and rationalization. This response led to consequences that were more serious than they would have been had the surgeon been more mindful. The surgeon did not only rationalize an error, but likely convinced himself that it was unavoidable. The dichotomy between what is remembered and what occurred is often shocking when clinicians view videotapes of their clinical practice; inevitably, there are behaviors that are plainly evident that we would have sworn we would never exhibit. Unfortunately, there was no videotape, only memories, leaving the clinician free to distort what actually occurred and delude himself that the story told was the story experienced at the time. In-the-moment self-awareness helps the clinician respond to the deluge of micro-ethical choices by making mid-course corrections to repair faulty communication and diagnostic errors. One of the limitations of organized reflection groups – which can otherwise be helpful and potentially transformative for clinicians – is that the patient is already gone, and actions during the encounter have already exerted their influence.

Being attentive involves training the mind to ask: “If there were data that I ignored, what might it be?” “How might my prior knowledge of this patient affect my ability to perceive what is going on with him today?” or “Is there an ethical issue embedded in this situation?” An important consideration is being aware of who else is in the room (literally and metaphorically); it is striking how often clinicians ignore family members present in the hospital room. Attention to one’s own physiological and psychological state makes it possible to say to oneself, “I am feeling exhausted; I should review the patient’s history again in my mind before assuming that I have all the information that I need.” Or, asking oneself, “Is this what the patient meant, or are these my assumptions and values speaking?”

The second characteristic, critical curiosity, is manifest when clinicians approach suffering rather than pushing it away and approach surprise with concerned interest. The critically curious clinician resists the tendency to create interpersonal distance or generate simple but inadequate responses in the face of complexity. They avoid the tendency to change the topic when they encounter awkward moments (Epstein et al., 1998). Critical curiosity
implies the kind of hospitality described in Rumi’s poem at the beginning of the chapter. Hospitality in response to “difficult” patients and seeming unsolvable problems can sometimes make the difficult patient seem not so difficult. He or she acquires a human face rather than being merely a problem to be managed.

A mother brings her daughter for an HIV test. Her daughter, age 22, previously hospitalized for a psychotic illness, is functioning reasonably well and holding a job. They discussed a recent consensual sexual encounter that the daughter had with a man she just met and had not seen since. The daughter’s manner is naive and disarmingly disclosing; she had learned nothing from this encounter. The likelihood of future injudicious sexual behavior is high. It is relatively easy to provide information about HIV prevention, explain and obtain the HIV test, and advise her to use better judgment. However, I completely failed at understanding her sexual needs and behavior. I could not imagine having that little insight and judgment – she did not even like the person who was her partner that time; it was sad and painful for me to grasp.

Had I not realized that my own sadness and pessimism about her ability to change impeded my ability to explore further her ability to make better choices, I might not have been able to proceed. Upon recognizing this, I asked the mother to leave the room to ascertain whether the patient had any personal questions or concerns, and that what she was saying reflected her own values and not those which she assumed to please others.

The third characteristic, beginner’s mind, refers to the capacity to see a familiar situation with new eyes. It involves the ability to hold multiple perspectives simultaneously, to avoid premature closure.

A mentally retarded man, in excellent health for his 70 years, is under his younger sister’s care. Periodically, she makes “urgent” telephone calls requesting to speak with me, usually about trivial matters, such as changing the brand of non-prescription vitamin pills. I am tempted, on receiving yet another message, to think that this is yet another inappropriate request.

But, I think, could this situation be different? Or better, can I permit it to be different this time? Can I adopt a more agnostic frame of mind – that this could be an appropriate request or an inappropriate one – pending further confirmation? Could it reflect her anxiety about caring for her brother, and might I be the only support she has in this process? How can I respond with flexibility yet not waste time? What would let me know?

Presence refers to a purposeful willingness to simply being there, undistracted and focusing on the task at hand, regardless of pleasant or unpleasant thoughts or feelings. Presence implies that there is a relationship between the knower and the known – “connected knowing” of ideas, people or things (Belenky et al., 1997). It suggests a view that knowledge, information and
theories, in part, are part of the person who is using them such that a purely objective view is not possible. Taking this view implies that all clinical activity occurs in the context of relationships (Tresolini & Pew-Fetzer Task Force, 1994) that sometimes can transcend professional roles. Patients describing this “connexional” dimension (Suchman & Matthews, 1988b) say that “he (or she) was really there for me.” They refer to times when physicians called them just to see how they were getting on, when they felt listened to, when the physician spent enough time, and when physicians helped patients make difficult decisions. In that way, the presence of the physician can have a direct effect on healing and well-being. Sometimes judicious self-disclosure (Candib, 1987) or thinking out loud (Epstein, 2003b) contribute to the feeling of presence. When clinicians are fully present, patients report that perceived time exceeds elapsed time (Zoppi, 1994; Dugdale, Epstein, & Pantilat, 1999). Patient satisfaction, interestingly, is more closely related to perceived rather than elapsed time; the difference between the two may serve as one proxy measure of presence.

Mindful practice is not a state that is achieved. Rather, it is a habit of mind that, with vigilance, single-mindedness of purpose, and effort, leads the clinician closer to an asymptote of awareness in each situation, but never quite achieves it. Being mindful requires the judicious use of attention and presence both of which are limited by cognitive capacity. The clinician must be mindful of his or her own capacity to be mindful; it is only natural to withdraw attention momentarily when experiencing cognitive overload and anxiety. Aware of the particulars of each relationship and situation, the mindful practitioner has “radar” for when these situations evince an ethical issue or a matter of character. However, because each situation involves different cognitive and emotional challenges, learning from any one situation is only partially helpful in the resolution of future ones; the effort is ongoing and constant. Just as a musician learns scales and pieces of increasing difficulty but still finds challenges in each new piece, the clinician can develop habits of mindfulness and apply those habits to an increasing number of situations. Conversely, claims that the clinician has achieved a new level of practice may be illusory and deceptive, – it may invite a certain type of arrogance that then closes the door to continued learning – so-called “spiritual materialism” (Trungpa, 1987).

Professional character, in this sense, is not an enduring quality of an individual; it is re-invented with each clinical act. Even the sense of self – who I am and what I believe – is thought by cognitive scientists to be impermanent. Cognitive science research (Varela et al., 1991; Damasio, 1999) suggests that a subjective sense of continuity of self “depends on the
recurrent formation (and dissipation) of cooperative neural activity across various regions of the brain” (Kurak, 2003). Although these patterns lend a sense of continuity of self – I am this or that type of person – these patterns are not necessarily substantive. Rather, they may be dependent on how we construct ourselves through memories of prior experiences and concurrent sensory input. Two centuries ago, Kant suggested a similar view when he proposed that the sense of “I” might be no different from other thoughts that one might have – in flux and impermanent (Kant, 1781). These lessons from philosophy and cognitive science are concordant with the Buddhist concept of “dependent co-origination” which suggests not only that external events are impermanent, but also that the state of consciousness itself comes into being on a moment-to-moment basis. Using an analogy of a movie, Kurak (2003) suggests that not only does the movie change plot and characters, but the screen and the viewer themselves appear and disappear with each frame. The implication of this view is that ethics depends on the ability to recognize and respond to the flow of consciousness, awareness and reactions in oneself in order for “character” to emerge in each moment. It also implies that character (ethics) is an emergent property not only of an individual in isolation but rather of the individual in relation to the situation at hand; one’s character can shine in certain situations and be obscured in others. The Buddhist view modifies the Aristotelian view that there might be a more general fundamental disposition to do good that underlies ethical actions.

FOSTERING MINDFULNESS

Although caring, attentiveness, avoiding premature closure and humane care are self-evident virtues, why are they not uniformly practiced by medical practitioners? The first reason is failure of curiosity. The culture of medical training rewards being correct (Johnson, Levenkron, Suchman, & Manchester, 1988), and discounts imagination and creative thinking (Coulehan & Williams, 2001). Subjective data are discounted; a patient with back pain is taken more seriously if an MRI scan shows a protruding disk, and a patient with flank pain is relieved of stigma when the urinalysis demonstrates blood. This is true even though clinicians know better – radiologic abnormalities are poorly correlated with reported symptoms. Suffering is intrinsically subjective, as is healing and compassion.

Delusion – “the tendency of the mind to seek premature closure … that quality of mind that imposes a definition on things and then mistakes the
definition for the actual experience” (Epstein, 1995) – is antithetical to mindful practice. Signs of delusion are beliefs in spite of disconfirming evidence, conflating self-interest (such as keeping on time) with the patient’s interest (assuming that the patient is also in a rush without actually asking), overconcreteness and unexamined emotions. Overconcreteness is often embedded in the language of medicine – the diagnosis (a category) is often confused with the patient (a person).

Unexamined emotions can lead the physician to conflate his or her own emotional reactions with qualities of the patient him- or herself. A patient who does not take prescribed medication often provokes anger in physicians. But the physician’s anger does not diminish the patient’s suffering. Cynicism and defeat, and, when chronic, burnout, place a dark lens between the physician’s observing eye and the patient’s experience; nothing can help, nothing makes a difference, so why try? Listening, in that situation, seems only to bring on more burdens for the physician. Entitlement is learned through having paid dues in a punitive medical education system (McKegney, 1989); arrogance is learned during the pursuit of excellence or the effort of maintaining the illusion of excellence. Regarding others with contempt, and not feeling a need to learn or change, is antithetical to curiosity and adopting a beginner’s mind. Arrogance places the clinician in a position of inflexibility, in which changes of perspective become increasingly distasteful and threatening.

If mindful practice is desirable, the selection and training of physicians is another set of micro-ethical acts. Medical school admissions criteria are ethical decisions; admissions committees decide what kind of persons we want as our doctors. One could imagine an admissions process that judged applicants’ ability to be attentive and curious, for example. Choosing medical trainees on the basis of their ability to be supple, adaptable and self-correcting would be a change from current policy in most schools.

Mindful practice is developed in relationships – between teacher and learner, learner and patient – and by encouraging learners to learn from and care for themselves. Apprenticeship models of training allow for the ongoing modeling, close observation, reflection and feedback over time that can lead to mindfulness and identify error and delusion. Some medical schools have partially returned to an apprenticeship model having witnessed the decline of strong bonds between faculty and students. Ideally, the master-mentor acts as a steward to encourage growth so that the trainee will eventually supersede the teachers’ clinical skill. Unfortunately, training in ethics, mindfulness and humanities are often abstracted from the day-to-day work
of medical training (Campo, 2005). An apprenticeship model might help bridge theoretical knowledge and ethical practice.

Clinical teachers can create expectations for mindfulness by asking trainees not only to observe the patient but also to observe their own thoughts and feelings when approaching the patient. This can be facilitated through review of videotaped encounters but, ultimately, trainees learn to self-monitor in real life – “I am feeling angry … or distant … or annoyed” – so that the trainee can learn to accommodate to the interior landscape as well as the external context. This moment-to-moment self-awareness can be developed by doing meditation, but it is unrealistic to expect all medical trainees and clinicians to meditate for half hour everyday. However, the intention to be self-aware, and small actions taken toward that end, may be sufficient, in the same way that a clinician who smiles at a patient he has just met is communicating openness and interest in accommodation to the patient’s needs.

Mindful practice is cultivated by using reflective questions – questions to which the teacher does not know the answer and startle the student’s self-concept. Reflective questions are designed not to edify but rather to invite doubt and ambiguity, so that students can shake free of misconceptions and discover their own answers. For example, commonly, clinical data gathering is conditioned by the expected diagnosis. In a patient with fatigue, expecting a “viral syndrome,” a resident might “forget” to ask about sleep disturbances, feelings of worthlessness and other symptoms of depression. A question to a student such as “What are you assuming about this patient that might not be true?” can provoke curiosity in an open-ended way, and may improve diagnostic thinking. These questions should promote critical curiosity, in contrast to “what am I thinking” questions. It is not the answer that is important – in fact; many reflective questions have no answers. Rather, the question should disrupt habitual and rigid patterns of thought and behavior to allow a familiar situation to be seen in a new way. A clinical preceptor can comment on small gestures that often go unnoticed in daily practice, such as how nods of the head convey interest or not, or how the clinician acknowledges an error to a patient. Listening for the unexpected involves the ability to find surprise in the ordinary actions of daily work, and to listen to oneself and others without naming what is heard until it has been understood. Teachers should ask “What did you observe?” “In what ways were you surprised?” “How did you respond to the feeling of surprise?” “What interfered with your observations?” and also, “If there were relevant data that you ignored, what might they be?” The goal is to help students internalize a habit of self-questioning (Table 2).
Categorization and premature closure are the two ways clinicians react in an attempt to manage ambiguity and uncertainty, but these are not necessarily the most effective ways. Comfort with uncertainty may be difficult to teach directly, but can be modeled. When a clinician teacher is in error, or when the situation is unclear, thinking out loud can help make explicit the kind of mental flexibility, backtracking and reformulation that characterize the excellent practice of an imperfect art.

Mindfulness can be assessed. We have used peer assessments to measure some of the intangible qualities that make good clinicians (Dannefer et al., 2005). The processes of assessing one’s peers and receiving feedback both invite reflection. We have observed a subtle but palpable change in the way that students interact, with the knowledge that their peers are watching attentively. Their comments reflect some healthy discomfort with the process but overall it is viewed as positive and sometimes transformative. Analysis of medical errors can identify lapses in mindfulness; a recent study indicated that the most common individual causes of error were premature closure, faulty contextual assumptions, faulty perception, misattributions and inappropriate use of heuristics (Graber, Franklin, & Gordon, 2005). Brown and Ryan (2003) have validated a scale that measures mindfulness and can be applied clinically; future studies can correlate communication skills, medical errors and teamwork with these measures. This is an area that deserves more focused work.

Mindfulness can apply to systems just as it can to individuals. Weick and Sutcliffe (2001) have proposed that mindful systems are the key to success in “high-reliability organizations” – those in which errors can have disastrous consequences, such as in aviation or trauma units. The organizational structure and management can foster the development of a “collective character” – for example, in medical settings, which may translate as a

Table 2. Habits of Self-questioning: Reflective Questions.

- How might my prior experiences affect my actions with this patient?
- What am I assuming about this patient that might not be true?
- What surprised me about this patient? How did I respond?
- What interfered with my ability to observe, be attentive or be respectful with this patient?
- How could I be more present with and available to this patient?
- Were there any points at which I wanted to end the visit prematurely?
- If there were relevant data that I ignored, what might they be?
- What would a trusted peer say about the way I managed this situation?
- Were there any points at which I felt judgmental about the patient – in a positive or negative way?
- Is there an ethical issue embedded in this situation?
culture of safety, respect and resilience. They cite several qualities analogous to those of mindful practitioners: transparency, reluctance to oversimplify, and listening for useful data that may come from unexpected sources.

SUMMARY AND CONCLUSIONS

During one 4-hour clinic session, I saw 11 patients, including three described below:

A schizophrenic patient, 51 years old, requiring high doses of medication to keep her out of the hospital, called the office wanting to speak with her primary physician about assisted reproductive technology. She has a boyfriend, and has never had children. She is in the midst of menopause. A message is left for the physician explaining the problem.

A patient with multiple documented kidney stones is requesting narcotic pain medications. He has difficulty controlling his own narcotic use, having gone through a week’s worth of pills in 1–2 days on several occasions in the past. He has missed appointments with specialists who may be able to provide tangible help. He is disabled and lacks transportation to the office.

A patient with worsening gait says that he doesn’t care when offered a referral to a neurologist, and the neurologist reported that the patient came for a consultation “against his better judgment.” Later, after diagnosis of a brain tumor, the same patient is declining rapidly despite radiation treatments – he cannot walk or swallow, and is incontinent. Yet, he insists on continuing the treatments.

These situations raise two kinds of ethical issues. The first involves what to do? Which course of action is correct? Is this the right balance of patient requests and physician responsibilities? Is it wrong to deny the patient’s request for assisted reproductive technology? Is it acceptable to prescribe narcotics to a patient with known kidney stones and a history of opioid abuse? How hard should a clinician push for follow up even if a patient indicates indifference? Should I let a dying patient persist with ineffective and potentially harmful treatment?

The second set of issues includes questions about the physician’s willingness and ability to understand him- or herself in the context of this clinical scenario: Have I attempted to understand and respond to the patient’s suffering? Have I examined my own biases, feelings and values that might be affecting my clinical judgment? Have I attempted to see the patient’s human face, not just the problem being presented? These latter virtues are translated into simple acts – returning the phone call, writing a referral letter, phoning the radiation oncologist, seeing the situation from a new angle, maintaining a relationship while refusing a request, doing a home visit,
insisting that the patient reconsider treatment that will only increase suffering and not delay death.

In sum, the development of professional character involves developing micro-ethical competence; this, in turn requires three factors to be present—self-awareness, interpersonal skills and healing intention (Schmidt, 2004). Self-awareness can be learned and interpersonal skills can be taught, whereas those with healing intention must be first identified and selected during the medical school admissions process, and then inspired and motivated to maintain those virtues in the face of conflict, ambiguity and despair. One definition of professionalism is “taking the patient’s socks off to examine his feet” (D. Klass personal communication 2004). This implies doing the right thing even though potentially unpleasant, inconvenient and easy for both patient and physician to forget. It is a small act; its presence or absence would hardly be noticed. This attitude of mind that predisposes to moment-to-moment mindfulness is difficult to sustain in stressful situations, requiring constant vigilance and self-observation. Mindfulness is the will, equanimity and compassion to welcome and honor each patient, even if he is one of the “crowd of sorrows, who violently sweep your house empty of its furniture” (Rumi, 1995, p. 109).

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REFERENCES


CHAPTER 8

LEARNING AND TEACHING IN PROFESSIONAL CHARACTER DEVELOPMENT

Karen V. Mann

ABSTRACT

Fostering the development of professional character in student physicians remains the most essential, yet challenging and sometimes elusive goal of those in medical education. Current understandings and contemporary approaches to learning and teaching can provide perspectives that may inform our thinking. In this chapter, learning with and from others is explored along with approaches that form the foundation for the development of professional character that integrates moral conduct into professional practice. The implications for both teaching and learning and the importance of the learning environment are discussed. Education as a moral endeavor and values-based practice is emphasized.

INTRODUCTION

You cannot ‘make’ a doctor whose practice is intelligent; you can only seek to cultivate one (Fish & Coles, 2005, p. 60).

As previous chapters in this volume have addressed, our goal is to explore the growth of professionalism in physician and health professions
education. This goal has concerned medical educators for almost a century (Enarson & Burg, 1992). However, notwithstanding the many reports that have addressed the attributes required of a professional (American Board of Medical Examiners, 2002; Medical School Objectives Writing Group, 1999), and the means by which they may be developed, there remains an unresolved assumption: for these attributes to be integrated into action the professional must have developed a moral sensitivity, motivation and conduct to undergird, frame, and guide his or her actions and judgments.

The question for us as educators appears to concern how we can facilitate the development of the desired attributes of a professional. Yet, as we explore further, the fundamental question becomes: how can the foundation for moral conduct be laid, and what is the role of the individual teacher, the institution and the profession in facilitating that development, or as Hafferty describes it, “moral enculturation” into the profession? (Hafferty & Franks, 1994)

To consider what contemporary approaches to education and learning may have to offer us in this fundamental endeavor, it is necessary to step back from the discussion to ask, in an educational sense, “What is the history of education in the professions” – or “How did we get to where we are?” Such questions allow us to explore the cultural history of teaching and learning, and to see that influence in our current context. They allow us to consider the challenges and tensions in the preparation of physicians, and to examine our roles as teachers, and the nature of the endeavor in which we are involved.

This chapter will begin by examining these questions briefly. In the section on “Professional Values in Teaching and Learning,” we will examine the challenges of preparing physicians, against the evolution of teaching and learning that have occurred in the profession and the role of values in teaching and learning. In the remainder of the chapter, we will explore how we might understand ourselves and our learners better. In the section on “Contemporary Approaches to Learning and Teaching,” we will review selected contemporary approaches to learning that can inform our educational work. Lastly, we will consider the implications for us as teachers, and for the institutional and professional contexts of which we are a part.

PROFESSIONAL VALUES IN TEACHING AND LEARNING

Recently, a fundamental shift in the discourse of medical education has begun, reflecting important changes in thinking. First, the vision of physician
education is broadening from a focus solely on teaching to include both the teacher and the learner. Second, there is increasing regard for the role of the learner in the education process. Education that is learner-centered places the student at the heart of the educational process; it focuses on the teacher not as the transmitter, but as the facilitator of the learner’s acquisition of the knowledge, skills, values, and attitudes that will prepare them adequately for their life work. In medical education, this life work will be in a profession whose basic tenets include service to others, and the responsibility of conducting themselves in a morally appropriate way in situations of complexity and uncertainty. As professionals, learners will require courage, judgment, and self-knowledge as well as the prodigious amount of discipline-specific knowledge and skill that characterize these professions.

Such changes challenge long-standing and deeply held beliefs about learning in the professions. Many of these beliefs and assumptions are implicit and rarely articulated and discussed. Instead, their existence is demonstrated in their incorporation into the ways that teaching is conducted, the development of curricula and objectives, and the assessment of learning achievements. In any aspect of our lives, as teachers, community members, professionals, and persons, our attitudes, beliefs, and values significantly and continually affect the decisions we make, the understandings we develop, and the actions we take (de Cossart & Fish, 2005). This effect occurs with or without our conscious awareness. These beliefs and assumptions are particularly critical when we approach the area of developing character. Physician education is more than learning the “what and how” doctors do. It is about learning to be a physician.

Let us examine briefly some of the beliefs and assumptions that underlie the practice of medicine. The strong and essential scientific basis of medicine accompanies a belief that the world is knowable, that knowledge is objective, and can be discovered. The scientific approach also emphasizes understanding of general principles and information that are context-free and thus applicable across many situations. Over the last two to three decades, the scientific bases of medicine and health care have been accorded new emphasis under the rubric of evidence-based medicine (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 1997). Evidence-based medicine has been an important demonstration of a commitment to the improvement of health care, through providing care that is shown to be effective, thus utilizing resources wisely, while maximizing benefits to health and minimizing harm.

The history of education in medicine and the health professions is also revealing. From its earliest days, medicine was learned through apprenticeship. The apprentice studied with the master and learned, through observation,
practice, and experience, to practice as the master did – that is, to replicate and take on the role of the master, and to make it the learner’s own. As medical education progressed and evolved, curricula became more defined and standardized in keeping with the cosmic advances in scientific understanding. Emphasis has grown steadily on the knowledge, as well as particular skills, that all student physicians must acquire. Many teachers of medicine today have experienced their physician education as described above – that is, learning to do and know what is required, and learning to apply knowledge and skills appropriately. All of these changes have occurred against a background that assumes the presence of strong moral character and desirable personal attributes in both learners and teachers.

In deeply significant ways, these two important cultural histories of medicine and medical education have gradually separated physicians from their roles as educators. First, the emphasis on science, and the huge advances made and ongoing in this area, have increasingly emphasized the knowledge required, and separated that knowledge from personal growth. As the ability to intervene effectively in the health problems of persons has steadily increased, the requirement for skills has grown concomitantly. The complex, demanding, and uncertain environments of medical care today have added to the emphasis on appropriate knowledge and skills, and on evidence of their performance. Together, these influences are reflected in an approach to preparing physicians that some would describe as more resembling training, than education. And, while we may eschew the idea that we are providing vocational training in the preparation of professionals, both our activities and our discourse sometimes belie our dismissal. For example, at least in North America, we frequently speak of those in postgraduate education as “trainees.” We also speak of “delivering” education, which to some suggests a product, rather than engagement in a process that involves both ourselves as teachers and the learners (Fish & Coles, 2005).

It is useful to consider the differences between education and training as guiding philosophies in the preparation of physicians and the tensions these differences create. Education aims to help learners to gain understanding, “by constructing and reconstructing meaning for themselves, and/or by inquiring critically from a range of perspectives into events from their practice in order to illuminate and thus improve it” (Fish & Coles, 2005, p. 65). In contrast, training focuses on the learning of knowledge, skills, procedures, and responses, without the necessity of reference to the context of the society in which they occur, or the values that underlie the actions. Education is about understanding and choices of how to use one’s knowledge and skills in the wider setting. The need to demonstrate that physicians are competent
to provide safe, effective care, combined with accountability on the part of educators, have encouraged specific definition of learning outcomes. In this process, abilities such as communication and interpersonal interaction and even professionalism itself have also been defined as a set of skills to be mastered. The importance of these skills is clear, along with evidence that they can be learned, and more importantly, that they have an effect on patient care. However, in regarding them as skills, we risk equating the acquisition of the appropriate behaviors with understanding and professional growth. Important discussions are beginning in this area, regarding the assessment of such integrative professional competencies/capabilities (Van der Vleuten & Schuwirth, 2005).

A natural extension of the definition of specific outcomes and specific behaviors and skills is the view that as educators, our job is to teach them, and that achievement of the objectives indicates our success. Further, we may come to regard our own teaching as a set of skills that is separable from context, values, and the environment. Simply stated, we may come to think less about ourselves as being teachers, and more about teaching as something that we do.

In fact, just as physician practice is perceived as values-based and a moral practice, education too is a professional practice. Educational practice is organic and evolving, and informed by many fields – including psychology, philosophy, sociology, anthropology, among others. Contemporary educational approaches have arisen both from these related fields, and from new understandings gained from practice. In this ongoing evolution and growth, the theory and practice of education are intimately and inseparably connected.

In addition to the tensions between education and training, professional education today also encounters another tension: the dilemma of what kind of professional we wish to develop.

Schön (1983, 2002) was among the first to describe professional practice as a complex set of practices and knowledge, developed to address messy, confusing problems in the “swampy lowland” of professional practice. In contrast to what Schön called the “high, hard ground,” where problems can be solved through the application of formal theory and knowledge, problems in the lowland are confusing and defy technical solution. In Schön’s view, the irony of the situation was that the problems of greatest concern to individuals and society are those in the “swamp.” Schön went on to describe two divergent approaches to professional practice, which he termed the “technical rational” and the “professional artistry” approaches. Each approach reflects a set of values and an orientation to practice. These two approaches are compared in Table 1.
The technical rational perspective views practice as a set of clear-cut routines and skills that can be efficiently utilized. Those who support this view of practice value the idea that such an approach minimizes error and maximizes the reliability of competent, safe care provided. Those who support the professional artistry view recognize the central importance of knowledge and skill but hold that professional practice cannot be reduced to

**Table 1. Two Views of Professional Practice.**

<table>
<thead>
<tr>
<th>The Technical Rational (TR) View</th>
<th>The Professional Artistry (PA) View</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows rules, laws, routines, and prescriptions</td>
<td>Starts where rules fade, sees patterns, uses frameworks</td>
</tr>
<tr>
<td>Uses diagnosis, analysis</td>
<td>Uses interpretation/appreciation</td>
</tr>
<tr>
<td>Wants efficient systems</td>
<td>Wants creativity and room to be wrong</td>
</tr>
<tr>
<td>Sees knowledge as graspable, permanent</td>
<td>Knowledge is temporary, dynamic, problematic</td>
</tr>
<tr>
<td>Theory is applied to practice</td>
<td>Theory emerges from practice</td>
</tr>
<tr>
<td>Visible performance is central</td>
<td>There is more to it than surface features</td>
</tr>
<tr>
<td>Setting out and testing for competency is vital</td>
<td>There is more to it than the sum of the parts</td>
</tr>
<tr>
<td>Technical expertise is all</td>
<td>Professional judgment counts</td>
</tr>
<tr>
<td>Sees professional activities as masterable</td>
<td>Sees mystery at the heart of professional activities</td>
</tr>
<tr>
<td>Emphasizes the known</td>
<td>Embraces uncertainty</td>
</tr>
<tr>
<td>Standards must be fixed</td>
<td>That which is most easily fixed and measurable is also often trivial – professionals should be trusted</td>
</tr>
<tr>
<td>Standards are measurable and must be controlled</td>
<td></td>
</tr>
<tr>
<td>Emphasizes assessment, IPR, inspection, accreditation</td>
<td>Emphasizes investigation, reflection, deliberation</td>
</tr>
<tr>
<td>Change must be managed from outside</td>
<td>Professionals can develop from inside</td>
</tr>
<tr>
<td>Quality is really about the quantity of that which is easily measurable</td>
<td>Quality comes from deepening insight into one’s values, priorities, actions</td>
</tr>
<tr>
<td>Technical accountability</td>
<td>Professional answerability</td>
</tr>
<tr>
<td>This is training</td>
<td>This is education</td>
</tr>
<tr>
<td>It takes the instrumental view</td>
<td>It sees education as intrinsically worthwhile</td>
</tr>
</tbody>
</table>

*Source*: Reproduced with permission from Fish and Coles (1998).
routines or procedures. They see those skills are embedded in a broader context. They believe that the indeterminate zones of practice – uncertainty, uniqueness, and value conflicts – lie outside the realm of the technical rational solutions. They view practice instead as a continuous process of framing problems in complex situations and using practical wisdom and professional judgment to address the problems, guided by moral principles. In exploring the notion of developing moral character, the second, more holistic view may offer a more congruent approach.

De Cossart and Fish (2005) describe the tensions that exist between facilitating the development of the safe competent practitioner, and the thinking moral physician. They also develop the notion of values, and how they guide our practice, both as physicians and as educators. As they note:

Values are those abiding and long-cherished views which we have as individuals – but do not necessarily share – about what counts as enduringly worthwhile and important. Our professional values determine how we consistently see the world in which we engage in professional practice. They shape what we prioritize in our professional life and how we conduct ourselves in both clinical and educational settings. That conduct reveals our values to our colleagues, patients and learners. The term ‘conduct’ here refers to the acknowledgement that beneath our visible behavior lie moral and ethical dimensions (p. 21).

Fish and Coles (1998) have depicted the role of values in our practice, using an iceberg analogy (Fig. 1). Values serve to motivate us, and to influence our behavior significantly. They are the foundation for our beliefs, attitudes, and expectations, all of which underlie the tip of the iceberg, our actions and experience.

Values have great significance in teaching and learning in clinical settings. Teachers, whether they are aware of it or not, are models of professional values, a discussion to which we shall return in a subsequent section of this paper. This means that the teacher/physician is under constant scrutiny and his or her conduct will be interpreted differently by patients, teachers, learners, and staff. Learners particularly, who are working and learning with the teacher, are exposed first-hand to actions and values that may or may not agree with their own (de Cossart & Fish, 2005; Coulehan & Williams, 2001).

Teachers are not the only models of professional values; however, learners also model their values. Their values too, may be more evident in how they conduct themselves than in what they say. The opportunity for the learner to explore their personal values is critical to the development of the professional whose behavior is guided by moral principles.

Sometimes, the values we believe we hold are not evident in our actions. Argyris and Schö̈n (1974) described the difference between “what we say” and “what we do” as the difference between our espoused theory and theory.
in use. Similarly, we can think about the difference between our espoused values (what we say we value), and our values in use (the values revealed in what we actually do). Clearly, conflicts can arise, particularly in settings where the nature of the system does not allow us to act in keeping with our values. That kind of conflict, rather than being dismissed or set aside, can provide an opportunity to look more closely at our values, and why we are experiencing the dissonance we feel.

Turning now to educational values, our educational values are also very clearly shown in our educational actions. De Cossart and Fish (2005, pp. 48–49) present professional values that might guide surgical education. While values, like skills, cannot be totally context-free, some of these values are relevant to our discussion, and are presented below:

- The practice of education is a moral enterprise, not a technical one.
- The cultivation in the learner of moral awareness is central to education for the professions.
- Teachers and learners need to examine their own professional and personal values in order to respond to the competing demands and ethical dilemmas of practice (both educational and health care).
• The establishment of a learning partnership between teacher and learner is a vital basis for educational practice.
• Conversation (dialogue) in teaching and learning is important: in that it enables learners to make educational meaning for themselves out of their experiences and their teachers’ offerings and enables teachers to ensure the appropriateness of that “meaning making.”
• Establishing an environment that is safe for the patient and nurturing of the learner (within which the learner can be challenged educationally) is vital to education.
• Reflection and deliberation provide important means of developing both educational understanding and clinical thinking.
• Self-directed learning and self-assessment are important as ultimate goals for autonomy.
• Professionals engage in lifelong learning and continuous professional development.

This statement of values provides an opportunity for us as teachers to consider our own personal values, and a basis for us to consider how the values we hold may affect learning and teaching.

CONTEMPORARY APPROACHES TO LEARNING AND TEACHING

Educational practice then is clearly about values and more than just knowing how to do educational things (having the skills of teaching) (de Cossart & Fish, 2005). This perspective helps us to consider our roles as teachers more deeply, and to reflect on our underlying values and how they guide our teaching and learning. If we are to think differently of ourselves as teachers, how can contemporary approaches to learning and to education help us to enact our broader view and values? There are many approaches that can assist and inform our enhancing and facilitating the professional development of our learners. Some of these represent actual theories of learning. These include constructivism, social learning theory, self-determination theory, situated learning, and informal learning. Another body of knowledge that can inform us arises from the educational approaches that follow from these theoretical perspectives. In particular, we will explore critical literacy, reflection and reflective practice, and professional and pedagogical caring.

Despite their different perspectives on how learning occurs, the reader will find some areas in which these approaches overlap. These areas of
congruence allow us to see that certain approaches may have value from a number of perspectives. The approaches will be presented first, and their commonalities and implications for teaching will be discussed later.

The Contributions of Learning Theory

Constructivism
As educators our goal is not to transmit knowledge and “fill up empty pitchers,” but to stimulate creative, critical thinking, exploration of different perspectives, and of the foundations of good practice. This stimulation and facilitation of learners as they develop their understanding of the world is part of an approach to learning called constructivism (Merriam & Caffarella, 1999). In this view, learning is the process of constructing meaning and making sense of experience based on our past experience. Teaching and learning are about enabling the learner to build or construct understanding, or working with the learner to build a shared understanding. Teaching is also about both learners and teachers uncovering their existing knowledge and understanding and thinking critically about what they need to learn. A constructivist approach to teaching and learning enables the learner to challenge and to see things differently. In this context, learning is about the development of moral conduct that is nurtured and developed through good teaching. This is a very different activity than trying to inculcate behaviors in learners without their understanding. Constructivism provides an essential background for considering both the contributions of learning theory and other contemporary approaches.

SOCIAL COGNITIVE THEORY

A hallmark of professionalism has been the professional’s right and responsibility of autonomy and self-regulation. Accordingly, professional education has traditionally focused on the individual learner. The responsibility to learn and the assessment of achievements have been at the individual level. This approach has been appropriate, given the accountability of individuals to provide appropriate competent care. While the individual learner is still central to the education of professionals, there is ample evidence from both cognitive and social psychology that learning is a social process: we learn from and with others and from the environment (Salomon & Perkins, 1998).

Some of these perspectives are particularly germane to our understanding of learning in all its forms. One of the major voices in this field is Albert
Bandura, who described such learning as social cognitive theory (SCT) (1986) formerly called social learning theory (1977). SCT incorporates both behavioral theory and cognitive psychology. We recognize the behavioral influence in elements such as the use of feedback, rewards, and disincentives. However, SCT goes beyond the idea that the environment shapes behavior and posits that all responses are mediated by our cognition. Some principles of this approach are helpful.

- Individuals are constantly interacting with their environment. Bandura (1986) termed this a reciprocal dynamic interaction, occurring continually among the person, the environment, and the person’s behavior. Each of these elements is constantly being influenced and influencing others. This means that our learners are actively “in” the environment, and not passively receiving and responding to the actions of others, or to the environmental influences.

- Individuals have certain inherent basic capabilities. These include (a) the ability to symbolize experience and hold it in our memory for future use, (b) forethought capability – the ability to use experience as a guide and motivator, (c) the ability to learn vicariously or by observation, and (d) self-reflective and self-regulatory capabilities, which are the capabilities to reflect on and evaluate one’s own actions, and to set goals, and monitor one’s progress toward them (Kaufman, Mann, & Jennett, 2000).

- Individuals learn through experience and feedback, and feedback is essential to learning.

- Individuals’ actions are affected by their self-efficacy, i.e., their perception of their ability to carry out a particular task or activity. Self-efficacy determines the difficulty of tasks chosen, the goals set, and time that individuals will persevere.

Two elements of this approach merit further explication to explain their relevance to us as teachers and learners. These are learning through observation, or role modeling, and self-efficacy.

**Learning Through Observation**

One of the strongest influences on our learning in our environment is the persons with whom we work and live. We learn powerfully from observing others and the actions they take, and from the outcomes of those actions for them. It is helpful to explore how this learning may inform our educational thinking. The literature in medical education has focused attention on this under the rubric of role modeling.
Role Modeling

Learning from role models is a time-honored means of learning how to be a professional: junior colleagues have identified the persons whose abilities and attributes they admired and have worked to emulate those qualities and behaviors. Role models are part of learning across society, regardless of profession or role. In all aspects of our life, we can think of people whom we admired greatly and who have influenced us in our development.

Both implicitly and explicitly, we have relied heavily on role modeling as a teaching and learning strategy. In recent years, however, several factors have focused closer attention on role modeling. First, various educational bodies have identified that the “role” of the physician is not a unitary one: in one example, (CanMEDS, 2000) beside the central medical expert role, physician roles including communicator, collaborator, manager, health advocate, scholar, and professional have been identified. Second, role models exert a strong influence on career choice (Wright, Wong, & Newill, 1997).

A third factor in raising our awareness of role modeling has been our understanding of how learning occurs. As noted above, we know from SCT that vicarious learning occurs powerfully through observation of others. We also know from situated learning (Lave & Wenger, 1991) and cultural learning (Rogoff, 2003) that as learners become gradually immersed and increasingly part of the profession, they learn to participate in the professional culture from listening to, and participating in the “talk” of that community. In the context of learning about becoming part of the profession, members of the professional community are very influential role models.

Role models are often part of the “hidden curriculum,” which represents those aspects of the curriculum that are not identified as part of the formal and informal curriculum. The hidden curriculum is conveyed in language, institutional policies, assessment strategies, and resource allocations; through these channels, and the persons who enact them, powerful messages are transmitted about the values of the profession (Hafferty & Franks, 1994). Several studies have shown the influence of these factors, often most clearly transmitted by role models. Thiedke, Blue, Chessman, Keller, and Mallin (2004) gathered students’ observations of community-based physicians’ behavior during a community placement. The instrument used was developed based on previous responses provided by students to a request to provide specific examples of positive and negative behaviors. Five themes emerged from the observations as follows: professional demeanor with the patient, communication style with the patient, view of responsibility to the patient, use of time with patients, and financial considerations of the patient.
The students gave the highest rating to aspects of the physicians’ demeanor with patients (4.7/5); the lowest ratings were given to the physician’s view of his or her role (3.39/5). The latter theme concerned the physician’s view of whether they had any responsibility to the patient beyond the immediate purpose of the office visit.

Role models are not confined to faculty in medicine or to faculty in general. Models in medical education may come from other health professionals, more senior students, peers, residents, and the institution itself. Senior models themselves continue to look for models, and sometimes find them among their junior colleagues. These various models present a wide range of behaviors, for example, communication skills, from varied perspectives. They model them in different ways, across multiple contexts; and, they model for an increasingly diverse group of learners, who may interpret what they see quite differently, based on their own background and experience.

Such variety of models and approaches means that being a silent role model is not always sufficient. To examine and develop one’s own set of professional values, learners need an opportunity to understand what is being modeled, and what the model intended or was thinking. For learners to understand what is being modeled, role models must be articulate, exploring, and explaining their reasoning or actions, so that students can reflect on what they have seen. Being articulate is not without risk; however, if models articulate their reasoning strongly, it may be difficult for learners to question. Reflecting openly with other peers and learners can also be risky, as it opens the individual to criticism and comment. Yet, the most effective learning comes when learners can question and reflect on the model’s approach, allowing them to compare what they have seen with their own developing understanding and values.

Effective role modeling is multi-factorial. It involves superior teaching skills, expert clinical skills, and personal attributes. It involves demonstrated attitudes, such as enthusiasm, respect, enjoyment, and balance of professional and personal lives. There are also barriers to effective role modeling, including lack of time, and personal reserve or inflexibility. Being conscious of oneself as a role model appears to be essential.

**Self-Efficacy**

Another significant influence in how we learn and change is found in the perceptions that we have of our ability to govern our lives. This sense of personal agency, self-efficacy, is developed through interactions with our
environment. In today’s complex and demanding world, these beliefs about efficacy enter into every sphere of functioning; they shape the development of our professional work and personal growth and well-being. In the enactment of moral and ethical conduct in complex professional situations, beliefs in personal efficacy are important (Bandura, 1995).

Perceived self-efficacy refers to the beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments (Bandura, 1997). Self-efficacy perceptions are not the same as self-concept or self-esteem. Self-concept is a more composite view of oneself, thought to be formed through both direct experience and the evaluation by significant others (Bandura, 1997). Self-efficacy perceptions are more specific to tasks and contexts. Self-efficacy concerns our judgments of personal capability; self-esteem is concerned with our judgment of self-worth. However, self-efficacy may contribute to both self-concept and self-esteem. Self-efficacy is an important basis for enactment of knowledge, skills, attitudes, and moral behavior.

Self-efficacy perceptions are developed in four main ways:

- **Experience**: The most powerful and effective influence on self-efficacy is experience. While self-efficacy is generally a fairly stable perception, experience of success can alter these perceptions.
- **Vicarious learning**: Less effective in fostering self-efficacy, but still influential in the development of self-efficacy perceptions, is learning through the observation of others’ behavior. We can compare ourselves to those others, observe how the behavior can be successfully carried out, and make judgments about our own ability accordingly.
- **Encouragement and exhortation**: Encouragement influences perceptions of self-efficacy; however, such encouragement is less effective than either personal experience or observation.
- **Physiological state**: Individuals also judge their self-efficacy concerning a particular task based on their state of arousal, e.g., whether they feel nervous or confident as they approach the task.

Experience is the most powerful factor in building and increasing self-efficacy perceptions. Helping individuals to develop self-efficacy requires that they experience the relevant tasks directly. A plethora of studies in the literatures of psychology, education, and health education have shown that interventions to increase self-efficacy lead to changes in individuals’ behavior. More importantly, there is evidence that perceptions of self-efficacy are related to the difficulty and level of tasks they take on, the effort expended, and their persistence at them even in the face of obstacles (Bandura, 1977; Zimmerman, 1995).
Perhaps most relevant about the concept of self-efficacy is its relation to self-motivation and self-direction. In part, self-efficacy is developed through external influences; these external influences are important in the incentive they provide and in the information they provide the learner about his or her competence. Especially, early in one’s acquisition of new skills or ways of conduct, these influences are important (Bandura, 1986). As skill develops, motivation becomes more intrinsic and the rewards come not only from the rewards the behavior brings, but also from the behavior itself.

Self-efficacy perceptions are particularly important to self-direction and to lifelong learning and professional development. The more capable people believe themselves to be, the more challenging the goals they set for themselves. Moreover, efficacy also influences the evaluative reaction that people have to their own performances. Teachers have an important role in fostering self-efficacy, both through helping students to have appropriate experience and reflect on the information it gives them about their competence, and also through setting standards at which learners can feel efficacious and capable.

**SELF-DETERMINATION THEORY**

Other authors have explored the ideas of self-direction and self-regulation of behavior, and the development of autonomy. Self-determination theory (Deci & Ryan, 1985; Williams, Saizow, & Ryan, 1999) describes the development of autonomous motivation, and suggests that the environment is very important in supporting the inherent intrinsic motivation toward human growth. In relation to professional character development, the learning environment plays an influential role.

According to Williams and Deci (1998), the key to learners developing autonomous motivation is the provision of “autonomy support.” As they note, “autonomy support describes an interpersonal orientation in which persons in positions of authority (e.g., physicians and/or educators) take the perspectives of others into account, provide relevant information and opportunities for choice and encourage others to accept more responsibility for their own behaviour” (Williams & Deci, 1998, p. 303). In medical education, autonomy support involves an interpersonal approach to pedagogy that leaves medical students feeling more understood and more involved in an educational partnership. Although autonomy support has much in common with humanistic and student-centered education, the authors argue that behaviors integral to autonomy support concern providing choices about...
how to behave, the information necessary to make wise choices, meaningful rationales for suggested behaviors, acknowledgment of feelings about behavior options and encouragement to choose and to persist.

Deci and Ryan (1985) make a clear distinction between controlled motivation, where rewards are external and may not be in accordance with the learners’ goals, and autonomous motivation, which implies volition and choice. They also note that autonomy is not interchangeable with independence from teachers; it does not imply teachers who are distant and withholding. Rather, autonomy-supportive teachers hold meaningful dialogues with students, listen as well as provide factual information and advice, and suspend judgment while soliciting opinions and concerns of students. Such teachers may hold high standards, set times, make recommendations, and give honest feedback just as their colleagues who are less supportive of student autonomy; however, they do these things in an understanding, encouraging, non-judgmental style, rather than a demanding or critical style.

Studies of the conduct of autonomy-supportive teachers found that they listened more, resisted giving solutions, supported students’ intrinsic motivation, were less directive and asked more questions about what students wanted to do (Williams, Saizow, & Ryan, 1999). These authors also report a two-year longitudinal study of 72 second year medical students enrolled in an interview course with 18 instructors, in which the students’ autonomous motivation for learning, valuing of psychological aspects of care and feelings of competence in interviewing patients were assessed at the beginning and end of the course. The results indicated that students who viewed their teachers as more supportive of autonomy, themselves became more autonomously motivated over the course. This motivation was associated with the development of stronger psychological values and self-perception of greater competence in interviewing (Williams & Deci, 1996). In these authors’ view, autonomy-supportive climates seem to help students become more humanistic. While humanism is not synonymous with strong moral character, the ability to see and participate in the humanistic aspects of decisions is likely to influence professional development in the direction of personal growth and self-knowledge.

The learner-oriented teaching (LOT) model (ten Cate, Snell, Mann, & Vermunt, 2004) is based on a model of learning developed by Vermunt (1995). It approaches the development of autonomy and self-direction, looking at three dimensions of development: the cognitive, the affective, and the metacognitive. On each of these dimensions, the teacher helps the learner to negotiate three stages: total teacher guidance, shared guidance involving both teacher and student, and lastly, total student self-direction.
SITUATED LEARNING

Apprenticeship is a familiar and pervasive method of learning in medical education. It is founded in the established tradition of learners entering the practice setting, as apprentices. Learners have the opportunity to learn skills and acquire knowledge in the situations where they are used and to understand that context. They also learn the content and process of professional practice. As experience increases, learners build and extend understanding. In the terms of cognitive psychology, learning is said to occur through the development of schemas. This apprenticeship experience allows learners to build and change their existing schemas, through which they understand and make sense of the world. Learning in the context of practice connects what is learned to “where, when, how, and with whom” it is learned. Much of what is learned about being a physician is most effectively learned in the practice setting, where the learner can see how knowledge and skills are applied to the solution of authentic problems. Further, the knowledge and resources to solve such problems is often only present in the situation. In addition to knowledge and skills, the learner also acquires values, attitudes, and ways of thinking and being.

Situated learning (Lave & Wenger, 1991, 2002) is related to apprenticeship, but enlarges this concept considerably. Situated learning takes the perspective that much of what we learn is not separable from the context in which it is learned. In situated learning, this is limited neither to the individual context of the learner’s knowledge, experience, and background, nor to the particular problem of which the knowledge is part. It also includes the learning environment and of the community of practice that comprises it.

Situated learning describes a process where learners build new understandings, through gradual participation in the community of which they are becoming a part. They do this in several ways. As learners, they begin at the edge or periphery of the community, where because of their status as learners, they have what is called “legitimate peripheral participation” (Lave & Wenger, 1991, 2002). We would recognize this in the students who are placed in a clinical rotation, or residents beginning postgraduate education. As they gain experience, learners become more involved in the community. They gradually participate in more of the community’s work, and they move from the periphery toward the center of the community. Learners increasingly take on responsibility for the work of the community, in this case, the care of patients. One of the ways that learners gather knowledge and understanding is by participating in the “talk” of the community. They learn
both “to talk,” and “from talk.” The former of these, for example, talking aloud with more senior members of the community, as well as peers, helps learners to build new understandings. It also allows other members of the community (i.e., teachers) to learn from the learners’ thoughts and to check the appropriateness of what they are learning. Learning “from talk” exposes the learners to the language that is used in the course of work. This may be seen in interactions with patients and colleagues and the institution. Language is a powerful determinant of and demonstration of values. Through participating in the community, not only do the learners acquire knowledge about professional practices; the practices themselves are also changed (Rogoff, 2003). A key element of participation in the community is the opportunity to see and participate in the framing of problems, and to understand how knowledge in a discipline is structured.

Most health professionals are accustomed to more traditional apprenticeships as part of their educational preparation. In the “situated learning” conception of apprenticeships, learners are actively engaged with the community and the opportunity to develop an understanding of the values that guide the community. As teachers we are challenged to think beyond learning passively from observation and modeling, to approaches that involve the learner in the community, and that help the learner to build rich schemas from which to construct their understanding.

Situated learning fits well with the principle that unites many innovations in medical education and other curricula: learning can occur best in the context of practice. Apprenticeship and situated learning rely heavily on learning from the experts in the community. A commonly observed characteristic of experts is that they possess more knowledge than they can tell. They have a rich array of knowledge and expertise that they bring to their work, and when asked, they may have great difficulty articulating it. This kind of knowledge is described as tacit knowledge (Sternberg & Horvath, 1999). In addition to its important role in expertise, tacit knowledge is also important because many values and attitudes are also conveyed tacitly. Further, when learners observe the actions of their teachers, they may not be able to understand why certain actions are taken, because of the tacit knowledge that underlies them. Learning in this manner is powerful and enduring.

**INFORMAL LEARNING**

Tacit knowledge and tacit learning have in common the idea of not knowing all of what we know or have learned. The notion of tacit or implicit learning
has been debated and explored in the cognitive psychology literature. Recently, discussion and research have focused on the broader topic of informal learning in the workplace (Eraut, 2000, 2004). Eraut has developed a typology of informal learning that includes implicit learning, or “the acquisition of knowledge independently of conscious attempts to learn and in the absence of explicit knowledge about what was learned” (Reber, 1995). Implicit learning may be occurring even when we are aware of learning explicitly. Implicit learning involves accumulated learning over a series of episodes; when we encounter a new event, we may connect it immediately to our past experiences and it fits into or reinforces that pattern. It also influences our future behavior, as it acts as a kind of background that predisposes us to certain presuppositions and stances or expectations about the way things are (Eraut, 2004).

Informal learning is largely invisible and taken for granted; we may not even recognize it as learning. As Eraut (2004) describes it, it is implicit, unintended, opportunistic, unstructured, and largely occurs in the absence of a teacher. Cultural knowledge is acquired in large part informally, through participation in the activities of the community or workplace; much of it is so “taken for granted” that we are unaware of its influence on our behavior. Eraut also argues that relationships are critical in the workplace, and that the emotional dimension of professional work is much more significant than normally recognized. In a typology of what is learned informally in the workplace, Eraut includes task performance, role performance, awareness and understanding, personal development, teamwork, academic knowledge and skills, decision making, problem solving, and judgment. In each of these categories, values and moral predispositions are learned.

In medical education, Coulehan and Williams (2001) have described a form of informal learning that they have called “tacit learning.” They include in tacit learning all those aspects of the curriculum and the socialization process that instill professional values and a sense of professional identity, but do so without explicitly articulating those issues. Tacit learning arises from both the “hidden curriculum” (Hafferty & Franks, 1994) and the “informal curriculum” (Hundert, Hafferty, & Christakis, 1996). It occurs both during and outside of formal educational activities.

As Coulehan and Williams (2001) note, tacit learning is often more powerful than explicit learning, as it relates to “doing rather than saying,” and because it is reinforced frequently, and therefore tends to be well learned. An example of this may be seen in the work of Stern (1998) who studied the teaching of values in clinical medical education. In comparing the recommended with the taught curriculum, Stern noted that the recommended
global and local curricula explicitly valued the importance of service and interprofessional respect. However, his study revealed that these values were actually taught “in reverse” as interprofessional disrespect, and as the burden of service. Such discrepancies are puzzling to students and can create conflict between explicit and implicit learning (Feudtner, Christakis, & Christakis, 1994).

Coulehan and Williams (2001) argue that tacit learning favors the development of three traits that can be in conflict with the values of caring and moral growth. They are detachment, entitlement, and non-reflective professionalism. Detachment encourages the discounting of emotions and affective aspects of work, focusing on the cognitive and technical aspects. This focus may actually result in the “atrophy” of one’s emotional skills to a kind of emotional numbness. Entitlement represents the response to the intensity of medical education; learners view their long-hours, and stressful work and study requirements as a kind of “paying their dues” that entitles them to high personal and material returns.

The third characteristic that may be acquired as a response to informal learning and the accompanying emotional conflict is that of non-reflective professionalism, which Coulehan and Williams (2001) believe is the most frequent outcome. Non-reflective professionalism describes the development of physicians who believe that their behavior is guided by one set of espoused values, yet who are relatively unaware that their actions reflect a different set of actions and beliefs. There appear to be three ways in which the conflict between values that are espoused and those that are learned is resolved. These are through conflating values, deflating values, and thirdly, by maintaining values.

In conflating values, students and young physicians begin to believe that the best expression of the explicit value is through behavior that reflects the tacit values. For example, they may come to believe that being objective and detached is the best way to care for a patient. Learners also respond by deflating values, that is, changing their conception of the ideal physician to fit their lived experience. In this situation, they discard the traditional virtues, and may become cynical, and focus on the technical aspect of their work, without accepting wider responsibility for their patients. There remains a third means of coping, that some students display and that is through maintaining their values. These students seem to have a “natural immunity” to the forces that undermine their moral development (Coulehan & Williams, 2001). The building and strengthening of natural immunity will be discussed in our consideration of the implications for our teaching and learning.
The theoretical approaches of constructivism, social learning theory, self-determination theory, situated learning and informal learning have in common certain perspectives on learning. First, they all view the learner as actively participating in the learning environment through both observation and experience. Second, they all highlight the importance of learners’ experience as a means of understanding and learning the profession which they are entering. Experience also plays a role in students’ development of perceptions of self-efficacy, and of their motivation to behave in ways that support human growth and move toward valued goals. Third, they all see the educational enterprise as a process rather than a product. The process is one of increased understanding, skill, experience, and involvement. Fourthly, the process involves the teacher and learner in a partnership, where both teacher and learner interact and share in the construction of understanding. Let us turn now to certain educational approaches which may further inform our thinking. Three approaches have been selected because of their particular relevance to the development of professional character. These are critical literacy, reflective practice, and professional and pedagogical caring.

Critical Literacy

Critical literacy is an approach to understanding learning found in the field of general education. Critical literacy views the world as a text, which is to be read and understood. It is “a way of looking at written visual and spoken texts to question the attitudes, values and beliefs that lie beneath the surface.” (www.discover.tased.edu.au/english/critlit.htm). Critical literacy is the ability to read the world as text, to understand it, and to be sensitive to the factors that may determine the situations and events we encounter. Many occurrences in our learning environments and professional education curricula are both unquestioned and taken for granted. Indeed, although critical thinking has been emphasized as a skill required by all professionals, its application has largely focused on critical approaches to problem solving and to the examination of evidence and information. Even in those situations that encourage a holistic view of the patient and the deliberate and considered use of clinical judgment, to decide “what is best for this patient at this time in this situation,” reflection on the factors that surround and include the physician–patient relationship is often overlooked, or given limited attention. Critical literacy extends even beyond the patient–physician relationship, to consideration and awareness of interactions with the health care team and the health care system, and it incorporates the influences of wider societal values and expectations.
When we consider the application of this concept to professional education, critical literacy includes

- looking at the meaning within texts (situations and relationship);
- questioning the ways in which texts (the situations) have been constructed;
- providing opportunities to consider attitudes and values;
- providing opportunities to take social action; and
- emphasizing multiple interpretations of texts (because people interpret texts in light of their own values and beliefs, texts will have different meanings to different people).

An important aspect of critical literacy concerns its connection to social accountability. Social accountability is emerging as an explicit element of the mission of professional education (World Health Organization, 1995; Health Canada, 2001). It describes the shared contract between the medical school and society, and that academic medical centers and the educational programs within them will work toward social equity and change, particularly in the health of the population. Critical literacy provides an approach through which health professionals can develop the understanding and motivation to act in a socially accountable manner.

There are four main tenets of critical literacy. A brief definition is given for each, along with the kinds of questions that are raised:

1. *Disrupting the commonplace.* This involves taking a critical stance on the “taken for granted,” in relation to such matters as how people are positioned in the system or curriculum, and analyzing the contribution of language to the support or disruption of the status quo. This is important in medical education, because we need to understand the history and philosophy of medicine. Wear and Castellani (2000) raise such questions as: Who are we? How did we arrive in this situation? Why do we practice in a particular way? What disciplines does medicine draw from? Which disciplines are not included?

2. *Interrogating multiple viewpoints.* This includes the process of individuals reflecting on experience both from their own viewpoints and from the experience of others. Questions are raised such as: Whose voices are heard, and whose are not? What differences exist? In medical education, we ask ourselves such questions as: Whom do we serve? Who is not served? What does it feel like to be sick? What does it feel like to be a tired – burned out doctor (Wear & Castellani, 2000)?

3. *Focusing on sociopolitical issues.* Critical literacy considers power relationships, sociopolitical systems, and language as being interwoven with
education. Understanding the systems in which we live allows the opportunity to challenge inequities. In medical education, students might question, for example: Who decided that physicians should perform some tasks, and not others? Who benefits from the current arrangement? What is the relationship between the level of education and power? Between the level of education and remuneration? What implications do these relationships have for health (Wear & Castellani, 2000)?

4. Taking action and focusing on social justice. Critical literacy encourages practitioners to engage in regular praxis, reflecting on their work, and acting on the reflection to improve it. In medical education, this has significance in that it encourages reflection on language and power in our work and how language is used. Does it create barriers and distance?

Wear and Castellani (2000) have written a seminal paper on the development of professionalism. These authors argue that medical students have little opportunity to engage with bodies of knowledge that are not gained through bioscientific/empirical methods. They observe that these other bodies of knowledge, such as philosophy, sociology, and literature, are often those where compassion, communication, and social responsibility are addressed. They further assert that to educate physicians who develop professionalism throughout their education and their careers requires a curriculum and processes that support it. They speak particularly of the need to promote in our learners the development of a sociological consciousness, interdisciplinary thinking and understanding of the economic and political dimensions of health care. Without these, broader frames of interpretation and understanding, conduct, and orientation implied in the four tenets of critical literacy would be beyond the scope of students’ learning. What is required is that medical curricula include and value critical thinking about oneself, the medical profession and society. As Wear and Castellani (2000) state, “Students need tools not only to address the pathophysiology of an illness itself but also to deal astutely with language and communication, knowledgeably with biases in decision making (their own and their patients’), politically with how services are accessed, ethically with moral ambiguities in medicine and empathetically with the experience of illness across differences in race, gender and class” (p. 603).

The work of Beagan (2003) provides an informative example of the importance of critical literacy, and of attention to the ways in which it is gained. Beagan reports a study of students’ reaction to and learning from a formal curriculum offering developed to engage students in understanding issues of social relations and of the role of physicians in contemporary
society. Students about to experience the course were compared through survey responses and interview with a group three years later, who had experienced the course. To summarize the findings briefly, both students before the course, and those that had been exposed shared certain perceptions: they believed that medical practitioners were neutral in terms of their social characteristics. Further, they believed that it was desirable to be “gender-blind,” “color-blind,” and “class-blind,” arguing that these characteristics did not and should not matter. Beagan found that social and cultural group membership affected perceptions more than the course, and students from racialized minorities and lower socio-economic classes believed that such factors affected their experience as medical students. When students did see difference, they perceived it often as “disadvantage” of other groups.

One of the common themes that Beagan (2003) describes is the idea that “it’s just not an issue.” Students perceived that there was little time to practice medicine in a culturally or socially sensitive way. They saw the standard of clinical practice as that of treating everyone neutrally, and objectively, as if they were “classless, raceless, and genderless.” What was learned in the course did not seem relevant to the course of care. Beagan argues that curriculum must help students to become “situated practitioners to be critically aware of their own social location, their own emotions and their own impacts on the situation” (p. 613).

Wear (1998) in reflecting on the significance of the white coat in medical education, also highlights the role of critical literacy. She describes this ritual as one which is intended to support the values of professionalism; however, multiple meanings are embedded in the wearing of the white coat. She speaks of critical literacy directly, when she notes that students must recognize how differently patients and non-physician caregivers may “read” their white coats and what these readings mean to the kind of care they give, or think they give.

While it is recognized that moral education does not begin with the entry into professional education, it undoubtedly continues during that process, and these elements upon which morality is built, are worthy of our attention, as teachers. As Hafferty and Franks (1994) note, medical educators increasingly understand professional education to be a process of moral enculturation, of taking the values, attitudes, character, and identity of the chosen profession (and, implicitly, of the “good” professional) as one’s own.

Reflection and Reflective Practice

A second approach which has increasingly appeared in the professional education literature is that of reflection and the development of reflective
practitioners (Schön, 1983). Of many definitions of reflection, two are helpful to frame the discussion of its role in the development of professional character. According to Moon (1999, p. 10), “Reflection is a basic mental process with either a purpose, an outcome, or both, applied in situations in which material is unstructured or uncertain and where there is no obvious solution.” In the context of learning, Boud, Keogh, and Walker (1985) state: “Reflection in the context of learning is a generic term for those activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations.” Both definitions have implications for the development of professional character; the situations in which values and beliefs are explored and developed are frequently complex, and without a single or clear best response. However, in Boud’s definition, we also see the potential for using the exploration of experience as a vehicle for understanding personal and professional growth. Epstein and Hundert (2002, p. 226) underline the importance of reflection as an aspect of professional competence, when they write “Competence depends upon habits of mind, including attentiveness, critical curiosity, self-awareness and presence. Competence is developmental, impermanent, and context-dependent.”

Reflective practice and reflection have not rested easily in the evidence-driven, bustling environments of current-day health care. Clear definitions of reflective practice and its purposes are lacking. Evidence of its effects on learning and on practice is also lacking. Further, the perception still exists for some that reflective activities are subjective, thus leading to reinforcing current understandings rather than to building new understandings, growth, and change. As well, most professionals would characterize themselves as already engaging in reflection periodically, making the introduction of this concept to professional education seem redundant.

Generally speaking, it is possible both theoretically and empirically, to identify different levels of reflection that range from our thinking and acting on an everyday basis in response to our environments, to specific reflection on incidents or events, to development of understanding through interpretation (personal experience and that of others), and lastly, to reflecting on how we reflect (von Manen, 1991). Development of the deeper levels of reflection appears necessary to harness the engine of learning that reflection can provide.

Several models of reflection have gained credence in the literature. Kolb (1984) described a four-phase learning cycle (concrete experience, reflection and observation, abstract conceptualization, and active experimentation) in which reflection is a key step in learning from concrete experience. That model still informs the development of some professional curricula. While the model is helpful in focusing on learning from experience, and on
reflection as a fundamental element in the learning process, it does not specifically attend to the affective elements of learning. The model is important in that it presents the learning process as non-linear and iterative; suggesting that learning from experience is individual to the learner and dependent on the learner’s unique blend of past experience and existing knowledge, skills, and understanding. It also describes reflection and experience as constantly mutually informing each other.

The model of reflection posed by Boud et al. (1985) has also been significant in the broader educational literature. This model is particularly informative because it highlights the affective nature of learning from experience, an essential aspect of the development of professional character. Specifically, the model takes the learner back to the experience, to examine both the positive and negative feelings that accompanied it, allowing the learner to reflect and re-evaluate the experience.

The cycle concludes with the learner having new perspectives on the experience and a readiness for application of these perspectives in future experience. This model too, highlights reflection as an iterative process (see Fig. 2).

Perhaps the most familiar to those in professional and physician education is Schön’s model of the reflective practitioner (1983). Schön described the professional as having a combination of formal knowledge, experience, and theory, all combined in the individual’s explicit and implicit knowledge and skills in framing and addressing the “messy, indeterminate” problems of practice. Schön described this ability as the individual’s “knowing-in-action.” In this iterative model of learning through reflection and experience,
the professional engages in two types of reflection when his or her “knowing-in-action” is surprised or challenged in the course of practice. The first type of reflection is “reflection-in-action,” in which the professional thinks on his/her feet, to evaluate the situation, to generate possible courses of action, and to evaluate the most beneficial of those to pursue. The second type of reflection, “reflection-on-action,” occurs following the event, during which the professional is able to return to the event, and consider systematically what learning has emerged from it, or what learning might be required. New learning is incorporated into the individual’s knowing-in-action, in an iterative cycle of learning from experience.

Moon (1999) has synthesized and analyzed the multiple perspectives on reflection in professional development. To those approaches above, Moon adds that reflection can help to move the learner from surface to deep learning. This involves the learner not only making meaning of experience, but also integrating that experience into what is currently known, understood, and valued.

Common to all approaches to reflection is the belief that (a) individuals learn from experience, (b) this learning happens effectively when experience is critically and carefully revisited and re-examined, (c) affective elements of experience are also critical to learning, and (d) this process can form an ongoing source of professional development and lifelong learning.

Studies of reflection have also identified that it can occur in anticipation of experience, and may therefore involve both looking forward and back. Studies of excellent teachers revealed that they used reflection both in planning and in review of their teaching (Pinsky, Monson, & Irby, 1998). Of the health professions, nursing has the largest literature on reflection and education for reflective practice. Medical education is also increasingly engaging with this approach as it seeks to develop fully actualized professionals, whose conduct is competent, thoughtful, and morally based.

Boud and Walker (2002) thoughtfully explore the challenge of context in introducing reflective practice into professional education. They note the risks of “recipe-following,” reflection without learning, intellectualizing reflection, inappropriate disclosure, uncritical acceptance of experience, and asking learners and teachers to reflect in a non-reflective environment. They emphasize the importance of the total cultural, social, and political environment in which reflection occurs and determines appropriate goals foci and learning. These authors see the learning context as the most important influence on reflection and learning.

Frankford, Patterson, and Konrad (2000) suggested that practice communities and organizations increasingly will be recognized as agents of
professional socialization. They propose that lifelong learning and commitment to medical professionalism could be fostered in organizations that institutionalize processes of collective reflection. They assert that such institutions will be collegial, experiential, and promote reflective, lifelong learning.

Frankford’s work extends the notion of individual reflection to reflection that is collective, occurring in groups such as the teams that increasingly characterize the context of medicine. They suggest that students and practitioners must learn the skills of reflection-in-action, and reflection-on-action as group processes. In this process, also the individual reflection feeds into group learning and group learning feeds back into individual learning. They argue that through such processes, social values are brought to bear on individual encounters. It seems logical to suggest that in this context, individuals can also explore and understand their own moral values as they relate to those of the community.

Professional and Pedagogical Caring

Professional and pedagogical caring are frequently considered within the rubric of moral education. Pedagogical caring as an educational approach has developed specifically in response to the recognized need to address the professional development of health professionals. Many earlier approaches to address professionalism and humanism have appeared to be “tagged on” to the curriculum, rather than a deliberate, integral part of it. Professional caring may be a vehicle that allows the integration of the scientific and humanistic aspects of professional practice; it aims to contribute to a better balance in education between scientific caring (ideas and objects) and caring for living things (self and others) (Noddings, 1992).

Caring is a complex notion that combines cognition, affect, and behavior. It is an important element for our consideration because it is closely intertwined with attributes such as altruism, humanism, compassion, empathy, and integrity. There are several frameworks for considering caring, one of which is that of Bebeau, Rest, and Narvaez (1999). Reflecting on research in moral education, both in the school system, and in professional education, they propose a four-part framework for development of moral literacy. The elements are:

- **Moral sensitivity: interpreting the situation.** This is the awareness that our actions affect other people. It also includes being aware of different lines of action and how they could affect the parties concerned, including the self.
- **Moral judgment: judging which action is morally right or wrong.** Asking oneself which of the available lines of action is more morally justified.
• **Moral motivation**: Prioritizing moral values over other personal values.
• **Moral character**: Having the strength of your convictions, having courage, persisting, overcoming distractions, having implementing skills, and ego strength. *Van Hooft (1996)* further links caring and moral action, asserting that actions in situations of moral difficulty or practical quandary are an expression of what is cared about most deeply.

The idea underlying professional and pedagogical caring is that interactions between teachers and learners involve attitudes, behaviors, and actions that are grounded in the moral respect of both self and others (*Cavanaugh, 2002*). Further, caring is not a one-way interaction; caring and respect must characterize the actions of both teacher and learner. Caring may be seen as the context within which teaching and learning interactions occur. The profession and literature of nursing education have a longer history with the principle of caring than does medical education; nursing regards caring as a core value in teacher–learner relationships, on the assumption that, if students are to develop professional caring ability, they must be cared for in their environment, and that a trusting, caring environment is essential for students to learn to think critically.

Some evidence exists that, among student nurses, the perceptions of the learning environment contribute modestly but independently to the ability to care, as measured by student caring ability scores, even when the influence of previous experience is removed (*Simmons & Cavanaugh, 1996*). Further, a longitudinal follow-up after graduation of nurse participants in the earlier study suggested that the influence persists into professional practice. Caring ability scores as a student nurse were significantly correlated with those as a graduate, and the relationship with school climate scores remained significant (*Simmons & Cavanaugh, 2000*).

The evidence about caring in medical education is less clear; however, studies of medical students that have repeatedly revealed widespread perceptions of psychological abuse (*Kassebaum & Cutler, 1998; Mangus, Hawkins, & Miller, 1998*), and pedagogical approaches that have not been caring, but rather have taught students that they are on their own, need to be tough, and should not expect to be cared for (*Branch, 2000*). Further, an Israeli study by *Carmel and Glick (1996)* looked at the attributes of what they termed compassionate – empathic physicians and the socio-organizational factors that may enhance or inhibit this behavior pattern. The physician group labeled as compassionate and empathetic were younger, and demonstrated more pro-social and fewer stereotypical attitudes toward patients than those who were not classified as such. However, both groups
were identical in their rank ordering of the importance of attributes that “make a good physician,” and that “are important for promotion in the hospital.” While empathic behavior was considered the most important attribute for being a good physician, it was ranked the least important for being promoted. This study suggests clearly that the organizational policies and practices relatively undervalued the characteristics of teachers that would contribute to moral development.

Robins, Gruppen, Alexander, Fantone, and Davis (1997) developed a measure of the learning environment for use with medical students that incorporated predominantly humanistic aspects, and related those to satisfaction. The strongest predictor for the entire group was an item that reflected caring on the part of faculty, the perception that medical education was important for faculty.

Branch (2000) reports that both men and women medical students naturally approach the ethical aspects of their relationships with patients through a framework of caring. He frames caring within a moral orientation, in which ethical behavior results from a framework of moral reasoning, moral sensitivity, moral motivation, and moral character (Bebeau et al., 1999). He suggests that caring is demonstrated in both receptivity (listening with empathy and compassion) and responsibility (translating those feelings into actions that serve patient needs). Branch (2000, p. 128) further suggests that students arrive at their professional education with receptivity, but “unfortunately we find that medical education beats students’ ability and willingness to care right out of them.” He suggests three important educational approaches: preserving receptivity, taking responsibility, and creating a caring environment.

Of several pedagogical approaches to facilitate the development of caring, role modeling is acknowledged as one of the most powerful. However, it is acknowledged that it is important for learners to see desirable characteristics modeled. It is difficult for students to retain compassion when what they see are practices based on competition, economic concerns, and misuse of authority (Stephenson, Higgs, & Sugarman, 2001). Teachers require both development to become aware of themselves as models of moral conduct, and support to do so in situations that do not always support that behavior. Leadership is required at the top institutional and professional levels, and rewards for exemplary performance are needed.

Some studies have attempted to look at elements of professional and pedagogical caring in the learning environment. Arnold, Blank, Race, and Cipparrone (1998) analyzed a 14-item questionnaire completed by both medical students and residents, based on their observations and experiences.
Three underlying factors were identified: excellent role models (placing needs of patients first), honor/integrity, and altruism/respect.

Senior students, faculty, residents, and other health professional responded to a survey that questioned the degree to which student physicians were able to acquire specific “non-cognitive attributes” through their undergraduate (MD) educational program (Mann, Ruedy, Millar, & Andreou, 2005). Five factors explained 65% of the variance in responses: teamwork and inter-professional skills, duty and responsibility, communication and interpersonal skills, professionalism and values, and trustworthiness and ethical behavior. Five of 25 items received a rating of >4 out of 5. These were “acts with honesty and integrity” (4.25); “displays compassion and empathy in patient care” (4.04); “demonstrates a commitment to lifelong learning” (4.03); “acts in a trustworthy and truthful manner” (4.02); and “interacts effectively with patients and families” (4.01). The lowest rating for all groups was given to the item “balances personal and professional life” (3.19). This study speaks to the learning environment as a whole, but also provides information on the degree to which certain behaviors are valued and demonstrated.

The three approaches discussed, critical literacy, reflective practice, and professional caring, share certain important underlying principles. These include the need to develop a fundamental understanding or literacy that enables learners to read and understand the complex environments of the profession, their relationships and of health care delivery. They also underline the importance to learning of the opportunity to reflect on one’s experience as a means of integrating it into one’s personal values and knowledge. Third, they emphasize the necessity of a trusting, caring environment, in which learners can see and understand the moral elements of behavior, and enact these in their daily conduct.

**IMPLICATIONS FOR TEACHING AND LEARNING**

In the previous sections, we have explored the importance of values in professional education, and some selected understandings of learning and educational approaches that may inform our thinking. What do these approaches tell us, and how can they guide us in the enterprise of moral education? In this section of the chapter, we will consider how they may inform us in our educational work.

The implications are presented in seven groups: designing the curriculum, building self-efficacy and autonomy, developing critical literacy, developing
reflective practice, seeing ourselves as role models, building a learning environment to support moral growth, and returning to our values.

**Designing the Curriculum**

- Development of the curriculum extends beyond the creation of a document that describes the objectives, content, teaching, and assessment methods of the program. The curriculum design is a reflection of the values of the institution and the teachers within it. Design of the curriculum is the creation of the context and process for the development of moral character. The design must therefore be informed by an explicit exploration of the professional and educational values which underlie it.
- The curriculum is important both in content and in the process of how it is delivered. Learners need the opportunity for active engagement in learning, and for opportunities to participate. Opportunities to question and reflect on one’s own practice are essential to active engagement and participation.

**Building Self-Efficacy and Autonomy**

- The development of self-efficacy in addressing moral and ethical aspects of practice and incorporating them into practice requires more than ability at ethical reasoning. Learners need opportunities to practice, and experience this integration, at whatever level of challenge they can manage. As teachers, we can help to guide learners to experiences that are at their level of learning, and to build on that experience toward more challenging situations.
- Autonomy and self-direction do not imply independence from teachers. In fact, these attributes are nurtured through behaviors that are supportive and allow students the opportunity to challenge themselves and to develop the motivation to conduct themselves in a moral way.

**Developing Critical Literacy**

- The curriculum has an important role in facilitating learners to develop an understanding of issues such as power, and the importance of multiple viewpoints, in such a way that the commonplace is questioned and the patients’ needs are served. Deliberate effort is required to expose students to experiences that will provide these opportunities to learn, and to facilitate their reflection on, and integration of these experiences into their developing professional understanding.
• The challenge for us as educators is twofold: to help students to look at themselves and their own biases, ideas, and attitudes, and to help them to understand difference and the impact of difference on the experience of being a physician and a patient (Beagan, 2003).

**Developing Reflective Practice**

• Reflection is the engine that drives and the vehicle for turning experience into learning. To be effective in promoting learning, reflection needs to be systematic and focused. The clinical learning environment is one where reflection and reflective practice need support to flourish and become a part of learning. Clearly, it is neither possible nor desirable to reflect on “everything”; however, both planned and unexpected experience offer opportunities for learning. As teachers, our support and participation and openness to critical reflection are important to the learner, through both providing a model for the process, and the opportunity to experience it directly. Boud and Middleton (2002) have alerted us to the challenges of context in promoting reflection in professional education. Together with learners, we can set appropriate goals and foci for reflection and avoid the intellectualizing and ritualizing of this important process and vehicle for professional development. We need also to be cognizant of the values expressed in the environment, either explicitly or implicitly through the hidden curriculum.

• Reflection is not intended to be a solitary activity, in which there is the risk and possibility of reinforcing one’s own views and actions. Reflective activities may involve groups of learners, learners and teachers together, and other members of the institution as well. These are important fora for examining values, standards, and professional norms. Institutional structures are required to allow for collaborative reflective professional practice.

**Seeing Ourselves as Role Models**

• Role modeling includes all aspects of professional practice, including thinking skills, technical skills, interactive skills, values, and personal attributes. It is occurring continuously, with or without our conscious awareness. It is important to try to make one’s actions and thinking explicit, and to be open and willing to reflect on those actions with learners. Learners have many models from whom to learn, and we can facilitate their learning through peers, more senior learners, and other health professionals. A necessary ingredient is our awareness of ourselves as models and of the powerful potential teaching strategy role modeling provides.
Wear (1998) highlights our impact as role models in the following statement:

Our teaching behaviors are some of the clearest signals we send to students about what a professional is and does. The way we listen to and look at students, the way we talk to them, how accessible we are to them, what we expect of them and how we make our expectations known, how we respond to their accomplishments and failures, whether and how we share our own shortcomings and uncertainties with them – these signs are thick in the air at all levels of medical training, and students certainly breath them in. (p. 734)

- Teachers require support to be effective role models. The institutional and practice environment may be busy, complex, and rewarding a range of behaviors, some of which are less desirable than others. In order that teachers behave consistently in ways that demonstrate the best in moral conduct, they require both support and reward for exemplary performance. Further, teachers will require ongoing development themselves, to appreciate their power as moral agents and as role models.

**Building a Learning Environment to Support Moral Growth**

- Without exception, the theoretical understandings and educational approaches in this chapter share a common theme: the critical importance of the learning environment in promoting the moral growth and the development of professional character. The learning environment is the context for this learning, both formally and informally. The environment is also the venue where learning about ethical, social, and cultural issues, and the opportunity to develop reflective skills are situated. Lastly, and of utmost importance, the learning environment frames the relationships between learners and teachers and their shared experience.

- As teachers we have the opportunity to engage in a partnership with learners that has at its base a mutual respect and regard for each other. This “mini”-learning environment can allow us to explore and reflect together on the learner’s experience and on shared experiences. That sharing and reflecting can promote moral growth for learners and continued commitment on our part as teachers to the affective and ethical and moral aspects of our work.

- There are opportunities for us as teachers to understand and support the development of natural immunity to those influences that may inhibit moral growth. Some factors that contribute will be individual, e.g., the commitment to religious beliefs, previous experience, or opportunity to test one’s values and resolve conflicts. However, other factors relate to the
clinical environment and the climate it provides for learning. Our responsibility involves attempting to integrate moral attributes into our actions and this can be done best in a safe environment that encourages reflection and learning from experience.

- With learners, and as faculty, we have opportunities to explore those influences that may be contributing to a conflict between those traditional values that are important in the development of moral character, and the sometimes opposing values that learners observe and learn from the environment. To do this effectively may require systematic reflection, and openness to factors that may lie in the non-scientific aspects of professional practice, including the emotional aspects of practice. It is also important for us to recognize that these values are not attributable only to individuals, but to larger environmental influences as well.

- The learning environment is a model of the institutional and educational values. The members of that environment enact those values. Much of our behavior is “taken for granted.” However, to bring about awareness and promote change, the commonplace must be questioned, and we have opportunities to consider how we both reflect and create those values.

- The learning environment is not the sole responsibility of teachers and learners: the influence of the institution and its values exerts a pervasive effect on the context in which professional character is developed, and our everyday lived experience and interactions occur.

Returning to Our Values

- Perhaps the most important implication for us as teachers is the awareness of how values underlie the choices we make and the actions we take. Our values are an expression of our most deeply cherished ideals. Participating with learners in their development as professionals enables us as teachers to examine and reaffirm our own values and the ways in which we demonstrate them. Indeed, the opportunity to go on learning and developing professionally throughout one’s career offers rewards for teachers and learners alike.

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CHAPTER 9
THE MEDICAL-SOCIAL EDUCATION COMPACT AND THE MEDICAL LEARNER

David J. Doukas

ABSTRACT
Recent accreditation standards have changed for all US and Canadian medical schools and residency programs. Newly mandated knowledge, skills, behavior, and attitudes required of the learner to become a medical professional are permeated with professionalism and associated curricular themes. The art of medicine now emphasizes humanistic skills, ethical precepts, and principle-based values. To this end, this chapter calls for enhanced learner collaboration with educators, as well as a required longitudinal ethics curriculum and medical apprenticeship for all phases of medical education. These efforts can thereby result in greater moral reflection on professionalism and its successful assimilation into clinical practice.

INTRODUCTION
An important part of the development of the physician is the insight into how science and art must be balanced in patient care (Wear & Castellani, 2000).
For the past century and a half, much emphasis has been placed on the value of science in clinical care. While technology is indeed a wondrous and beneficial aspect of science, oftentimes the required humanistic and ethical aspects of care are potentially marginalized in the clinician’s mind. So, too, has this effort-based balance of power been taught to both medical students and house officers. The purpose of this chapter is to look forward beyond this imbalance to a future time of equanimity between the art and science of medicine. The main thrust of this effort will examine the educational setting of physician development, and offer an educational approach that is intended to promote the balance of the art and science of medicine.

ETHICS-IN-EVOLUTION

During the past four decades, a concept and discipline of scholarship known as bioethics emerged. Bioethics made inroads into medical curricula slowly over its first decade. By its initial construct based on “Autonomy, Beneficence, and Justice,” principalism held the pedagogical high ground in medical training. Penetration of bioethics teaching has consisted mostly of didactic lectures with some small group teaching (Lehmann, Kasoff, Koch, & Federman, 2004). Over time, though, it was realized that there was more to ethics in facilitating the moral development of the new physician. Over the years, ethics education has broadened its educational palette to include virtue ethics, care ethics, narrative ethics, medical humanities efforts in art and literature, standardized patients, and observational evaluations (to name just a few permutations).

During these same 40 years of bioethics’ development, the contemporaneous setting of United States health care included fee-for-service care in which greed and avarice adversely affected medicine. In response to these abuses, managed care then flourished (with its complex moral morass of positive and negative enticements and penalties). With managed care, attendant conflicts of interest arose, as well as an evident paucity of self-effacement (Pellegrino & Thomasma, 1993). Added to these ethical challenges was the widespread injustice of over 40 million Americans lacking medical care. The current delicate balance of self-interest and self-effacement is a compelling aspect of medicine that highlights the need for ethics and professionalism education. Besides managed care, the lure of profit in private pay and concierge medicine are currently rampant. The problematic nature of these forms of health care pit the physician’s own gain against the patient’s betterment. The social aspect of medicine has been far too
confused with a guild-like practice promoting self-interest. When combined with the scientific advances over the past 50 years in diagnostic (and quite lucrative) testing, the technological imperative became an irresistible engine of physician ordering and reimbursement. Such self-interest was particularly noteworthy in physician ownership of laboratories, pharmacies, CT and MRI scans as well as in the mundane ordering of bench labs in their offices with attendant profit margins.

Professionalism’s recent emphasis, then, can be seen as a natural progression of medicine reasserting itself. This autonomy of the profession was not to be promoted in a guild-like unionization thrust. Rather, professionalism’s resurgence can be seen as a refreshing rejection of the “moral rust” effects of a guild mentality. The emphasis of professionalism in the literature is an embracing of our collective social role in a societal covenant (Veatch, 1981; Pellegrino & Thomasma, 1993). This emphasis is also recognized as a somber responsibility of self-regulation and the freely entered obligation of each of its members in serving the “other” – i.e., the patient. Therefore, rejection of self-interest is a cornerstone of this recent professionalism movement. Greed is supposed to be checked at the metaphorical door – in the case of medicine, at the portal of medical education.

Besides these changes in the medical system, notorious contemporary events have precipitated medical professionalism’s resurgence. Past abuse of the vulnerable in society by physicians have galvanized public opinion that such transgressions must be redressed. Infamous moments in medical history such as the Tuskegee, Willowbrook, and the Radiation Experiment abuses are important touchstones that help galvanize the need for education in medical ethics and humanism (Rothman, 1991; Jonsen, 1998).

One powerful catalyst in medicine’s self-examination of its moral charge was the Institute of Medicine (IOM) report on error, “To Err is Human,” and its description of how error contributes to the deaths of untold scores of thousands per year in the United States (Kohn, Corrigan, & Donaldson, 1999). A two-pronged etiology seemed to be the culprit: lack of sleep in physicians-in-training, and lack of professional knowledge, skills, and conduct. Within a short period of time of the IOM report, professionalism became the new buzzword in the medical literature. The impact of this new aspect of medical literature was twofold; clearly, practicing physicians needed to be much more accountable in their knowledge and conduct. The response was to increase local and national accountability and databases on physician misconduct and liability. Moreover, all new physicians (in both medical school and residency training programs) would need to have professionalism made part of their training (Doukas, 2003).
But, weren’t all physicians trained to be professionals? Well, yes and no – insomuch as there has long been an “informal curriculum” embedded in medical training. This informal (or hidden) curriculum promulgates institutional values, mores, and behaviors that were deemed acceptable and appropriate (Coulehan & Williams, 2001). This hidden curriculum is passed from attending physicians to fellows, along to house officers and to medical students. The hidden curriculum teaches both knowledge and behavior, and it does so without formal review, acknowledgement, or accountability.

If there appears to be a flaw in the construct of the informal curriculum, it is because this system has also helped nurture, or at least tolerate, an adverse side of medicine with a rudderless moral course, e.g., calling patients “GOMERS” (“Get Out of My Emergency Room”), having attending physicians throwing instruments in the operating room, and performing the charade of “slow codes” on dying patients who had wished to be resuscitated (Coulehan & Williams, 2001; Patenaude, Niyonsenga, & Fafard, 2003). These examples have not been the shining moments of medical ethics and professionalism. Between the evident lack of a professional atmosphere in which to learn, and a relative paucity of curricular contact hours on humanistic, ethical, and professional aspects of health care in medical training, redress of the medical education of the physician was inevitable. Further, ambiguity of what different persons and groups call “professionalism” has lead to ambiguity, and a lack of coherence as to how it can and should be taught (Swick, Szenas, Danoff, & Whitcomb, 1999).

THE MEDICAL EDUCATION REFORM IMPERATIVE

One would hope that in an ideal world, the profession of medicine, through its constituent schools and residency programs would have a desire and means to teach and evaluate the art of medicine. However, with the overwhelming emphasis on technology and scientific advances, medical education has been notably bereft of humanism, ethics, and professionalism until recent bioethics curricular efforts.

The variation of the Golden Rule “He who has the gold, rules” is an apt one, and brings hope to teaching the art of medicine. The changes currently underway in medical education are wed to the fact that non-compliance could be potentially disastrous, due to monetary and accreditation review. In fact, these changes have the potential to be the greatest since the educational review and reform of all US medical schools by Abraham Flexner nearly a century ago (Flexner, 1910).
The Accreditation Council for Graduate Medical Education (ACGME) put forward a set of new benchmarks for evaluating the adequacy of North American house staff programs. Their periodic site reviews determine the adequacy of residency and ACGME-accredited fellowship programs that earn both accreditation as well as federal monetary support. ACGME introduced the new standards, termed the General Competencies in 1999 (http://www.acgme.org/outcome/comp/compFull.asp). It has been observed that over 60% of the content articulated in the General Competencies comprises aspects pertaining to humanism, ethics, and professionalism (Doukas, 2003). Together these six competencies require outcomes-based skills that are measurable. House officers must learn these skills – or else. The “or else” here is potential loss of federal funding. For any program director who may scoff at this potential funding revocation, the reader is commended to recall the several prestigious schools that lost ACGME accreditation (and funding) when ACGME’s 80 h work rules were instituted, and ignored. Hubris is not a satisfactory response to meeting the accreditation standards of the ACGME. All North American residency programs must adhere to these standards.

The six competencies of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice cover a gamut of moral and conduct domains deemed by ACGME to be intrinsic to the healer’s role. These competencies require knowledge, skill acquisition, behavior, and demonstrated attitudes for all evolving medical professionals. The obvious emphasis of these competencies is that a humane, ethical, and professional physician must attain those requisite areas of mastery of information, proficiency of skills, and humanistic comportment such that patient-centered care is paramount.

The six competencies have knowledge requirements in biological, clinical, and psychosocial aspects of care. Additionally, physicians must master procedures for their area of care and understand evidence-based medicine and how to access the latest evolving medical information (e.g. Information Technology mastery). These areas of knowledge are obvious for the contemporary medical learner. However, there is much more to learn.

Residents must learn how to construct a therapeutic relationship with a patient, collect information from a patient, collate it effectively, work with patients in negotiating treatment plans, and work with other health professionals. These humanistic areas of knowledge are fundamental to serving the patient in the clinical encounter. In the ethical/professional realm, the resident must learn about moral concepts of respect, beneficence, compassion, self-effacement, prudence, and justice.
Skills must likewise be developed regarding physician–patient–family communication in forging a productive collaboration, with decision making based on an analysis of patient preferences, with the nurturing of collegial relationships and an understanding of scientific evidence in considering viable alternatives. Further, interpersonal skills relating to listening, conveying verbal and non-verbal communication as well as respect for diversity must be mastered.

Most importantly, these skills must then be translated into behaviors and attitudes that convey a proficiency of both knowledge and skills. As a resident works with patients, family, residents, staff, and others, they need to impart a sense of humanistic skills evidencing their moral, ethical, and professional demeanor.

What is ACGME asking residency programs to teach and assess in their educational charge? Does the resident act in a humane fashion to the patient, to their family, to the health care team, to consultants, etc.? Do ethical precepts form a basis of interaction with these persons? Does the resident maintain a professional demeanor in conduct, while also promoting excellence of patient care through competence and caring?

The ACGME has thrown this weighty moral gauntlet in the form of the General Competencies as a challenge to each and every residency program. Each program now must translate how the general competencies can and should be applied to their residents. The ACGME has been very forthcoming and helpful in providing articles, timelines of implementation, as well as means by which to teach and assess these competencies (the “Educational Toolbox”) (http://www.acgme.org/outcome/assess/toolbox.asp; ACGME, 2000; Lynch, Surdyk, & Eiser, 2004). Additionally, web-based resources exist to help such as the American Society for Bioethics and Humanities (ASBH) Task Force for Graduate Medical Education in Ethics and Humanities (http://www.asbh.org/Doukas/index.html). This web-posted project allows for program directors to compare peer-reviewed efforts from a variety of North American residencies that have been scrutinized for meeting the goals and objectives of the General Competencies. Further, a model curriculum in Ethics and Humanities on how to address ACGME educational goals and suggested means to assess them has been web posted as well by the ASBH Task Force (http://www.asbh.org/Doukas/classmodproj.html).

To help strengthen the ACGME mandate, another relevant and powerful educational player has also entered the teaching ring. The Liaison Committee for Medical Education (LCME), which is responsible for medical school accreditation, has likewise “tethered” medical student teaching such that the M.D. degree holder is to be prepared for General Competency
training (http://www.lcme.org/standard.htm). While less detailed than its ACGME counterpart, its efforts promote medical education integration of the art of medicine. This “belt and suspenders” approach reinforces the concept that learning humane, ethical, and professional aspects of patient care is a life-long educational journey. As addressed elsewhere by the author, this effort is less rigid than that of ACGME, but no less compulsory for all medical schools in their accreditation (Doukas, 2006). Graduating students are expected to have an ethical and humanistic foundation that will enable them to be ready for General Competency training in residency. When the mandates of LCME and ACGME are coupled, the change in medical education effort is potentially tremendous, as the shift is far and away toward the art of medicine. This balance is something not seen in contemporary medicine for a century.

CONVERTING THE COVERT TO THE OVERT

The ACGME and LCME requirements for humane, ethical, and professional education for residents and medical students have an Achilles Heel. While the medical accreditation organizations have been fairly transparent in their required educational mandates to medical schools and residency programs, there is an opaque quality to the educational endeavor. Medical learning institutions, as a rule, do not make their requirements, ongoing efforts, or means of assessment known to the medical learners.

It is laudable to have a programmatic thrust for all medical learners in the humane art of being a physician. However, how can we truly hold the learner accountable for those covert objectives when the medical students and residents are not aware of them? Granted, many programs and schools may mention the importance of humanistic behavior, knowledge of medical ethics, and a need for professional conduct. These areas of study may even merit the articulation of learning objectives on ethics or communication skills for the medical learner in medical school and residency programs. These efforts may be helpful, but are not quite sufficient.

Another approach is an appeal for educational transparency in medicine (Doukas, 2006). One can argue that a learner cannot sufficiently learn when he or she is an unwitting participant in a silent contract. How can a resident or medical student strive toward the goals of the General Competencies when they are not informed of their importance to them and (very importantly) to their institution in their accreditation? Further, the translation of this covert educational mandate into an overt set of goals and objectives for
the medical learner can then enable him or her to aspire to meet these goals. This task allows for the learner to understand the relevance of this vital aspect of the art of medicine and appropriately balance it with the scientific learning objectives. A comparison may be made to informed consent in patient care. A patient has little hope to attain goals in a medical circumstance when the agenda, goals, and means to carry them out are not made clear to him/her. So, too, there is little hope to attain these goals for the medical learner.

The “educational informed consent” would thereby necessitate a values clarification of the educational institution to the learner. The learner needs to be informed why the art of medicine helps one to be a better physician, and to put this in perspective of achieving optimal patient-centered care. Moreover, the learner needs to understand how the residency program as a medical-education unit is subject to evaluation, review, and redress for not meeting these goals of humane, ethical, and professional care.

The medical learner next needs to acknowledge that they understand the goals of the art of medicine. Often, we ask patients, “What is your understanding of this therapy or intervention?” We need, then, to see what value medical students and residents attribute to this aspect of medicine. This process would facilitate greater discussion among the educational players, particularly those who are too ready to accept or reject these efforts without reflection and moral inquiry. Lastly, as a participant of these educational efforts required in medical school and residency, the medical learner ultimately needs to accept the moral charge of the LCME and ACGME regarding the General Competencies – but how?

A MEANS TO AN END

The educational changes that are ahead make the means of implementation an important part of achieving the end result. ACGME has been quite thorough in disclosing what is educationally required, the educational means to achieve success, and supporting normative and empirical publications for its rationale (Doukas, 2003). It has made its timeline abundantly clear to residency programs regarding the General Competencies (http://www.acgme.org/outcome/project/timeline/TIMELINE_index_frame.htm). If humanism, ethics, and professionalism are to be incorporated, though, the learner needs to be part of the process.

The proposed next iterative phase in medical pedagogy, then, is the construction of the Medical-Social Education Compact. The Medical-Social
Education Compact is an agreement between pedagogical stakeholders that identifies the goals and objectives of medical education, with pointed emphasis on the humane aspects of clinical care. As noted in Fig. 1, the Medical-Social Educational Compact is a three-level organizational teaching model, founded on the values, goals, and accreditation standards of the LCME and ACGME, which in turn are responsible for articulating and enforcing these standards on medical schools and residency programs, respectively. With humane, ethical, and professional aspects of care coming to the educational fore, these two organizations wield great influence in shaping all future US and Canadian physicians.

![Diagram of the Medical-Social Education Compact](image-url)
Two decades ago, Robert Veatch put forward the concept of a three-tiered covenant upon which medicine could be structured \cite{Veatch1981}. The basis of this covenant was an openly professed set of duties and obligations of the practice of medicine, the individual physician, and the individual patient, as well as society. The concept is helpful in education as well. The organizational structure of medical education is entrusted to medical schools and residency programs with administrative oversight by LCME and ACGME. These programs are, in turn, entrusted with teaching the principles of knowledge and practice to enable the student and resident to evolve into a professional.

Both LCME and ACGME should serve as a conduit in representing medical education to society at large, as they are accountable for those programs that they accredit. Setting social standards that represent society’s medical needs is an important part of that process. This is why an increased sensitivity to social responsibility and justice, with greater interaction between the medical profession and society is necessary, thus requiring societal input and reflection.

Further, one can argue that ACGME and LCGME should have community involvement in its consideration and review of its educational standards. Those who receive the care (the recipients of these outcomes) deserve to have their voices be part of the compact. This construct is not unlike having community members on ethics committees to facilitate understanding and help with oversight.

The real thrust of this compact is how two new standards (those of ACGME and LCME) are then implemented at the teaching level. As noted above, institutions often have educational goals and objectives about ethics or professionalism that are never clear to the medical learners. The Medical-Social Education Compact sets out to articulate in its dialogue between learners and their teachers what it is they are required to learn, how they will learn it, and how they will be assessed that they understand it and put it into action.

**THE EDUCATIONAL CODE OF PROFESSIONALISM**

The cornerstone of the compact is the Educational Code of Professionalism \cite{Doukas2006}. A model code is illustrated in Fig. 2.

The Educational Code of Professionalism is intended to be a content and process-based statement by each constituent residency program and medical school in accepting its charge in teaching both the science and art of
I will strive for excellence in acquiring, maintaining, and displaying those areas of biomedical, social, and humanistic knowledge, skill, and behavior that enable me to care for my patient.

I commit myself to the ethical principles and virtues of medicine. I will maintain a therapeutic and ethically sound interpersonal relationship with my patient and, as permitted by my patient, with the patient’s family. I will hold information confidential as ethically and legally prescribed. I will be respectful of my patient and acknowledge the values and preferences of my patient in making health care decisions. I will be honest in my interactions and thereby facilitate the informed consent of my patient, including allowing my patient to withhold or withdraw treatment.

I will be a compassionate practitioner who will be caring in demeanor. I will be respectful of my patient in delivering health education, and of the options in improving health, or palliating discomfort. I will be respectful and sensitive to my patient’s culture, belief systems, age, gender, and disabilities in their care. I will endeavor to address the total medical needs of my patient and appreciate the effects that social and cultural circumstances have on health care.

I will use medical information and investigations in a prudent and evidence-based manner when treating my patient. I will endeavor to apply knowledge systematically gained from the care of many patients and apply it to the patient before me, as well as in teaching other medical professionals. I will practice cost-effective care to treat my patient and I understand that my patient and I are part of a larger health care system. I will strive to be prudent in allocating resources in a way that does not compromise quality of care to my patient.

I will be my patient’s advocate in their receiving quality care and help negotiate the complex system of health care. I will be an agent of change for my patient’s betterment, and work effectively with other health professionals and managers to improve the health care of my patient. I will exhibit ethically sound business practices and demonstrate integrity in the care of my patient. I will not allow self-interest to jeopardize the care of my patient.

I will be entrusted to maintain all of these precepts and I will not condone their violation in my conduct or by other health professionals or those in training.

Fig. 2. An Educational Code of Professionalism. Source: Reprinted with permission from Doukas (2006).

medicine to its learners, as it understands its role within the General Competencies educational framework. The rationale for the proposed Educational Code of Professionalism is to engage teachers and learners in the educational setting in constructing a common set of goals for the art and science of medicine. The author has previously developed a set of common educational themes for medical school and residency to clarify the educational goals required by the LCME and ACGME (Doukas, 2006). Hence, the model put forward in Fig. 1 is intended to serve only as a framework of how such a code might ultimately look, rather than serve as a ready-made end itself.
The Educational Code of Professionalism should spur the professional actualization process by requiring engagement by the stakeholders. The focus of this code is patient-centered, which assumes that education programs already have student-oriented codes of conduct or honor codes. The process of formulating a code would entail gathering educational leaders and learners (however they wish to gather, whether by a direct or representative process), and then discuss how they would meet the mandated pedagogical goals of outcome as required by LCME and ACGME. A code of this nature calls on stakeholders to articulate a joint vision for how the ethical evolution of the learner can and should take place (Cohn & Lie, 2002). It is intended to be a means by which to assess whether the goals of humanistic, ethical, and professional knowledge and conduct are adequately taught and evaluated – rather than solely by periodic accreditation site visits.

The formulation and maintenance of the Educational Code of Professionalism, and the compact that are built upon it, are both predicated on invested stakeholders. Educational programs and learners both have much to gain by joining forces to articulate their educational goals and setting program objectives and assessment criteria to measure whether these goals are being met. Accountability in this domain would help compel educational administrators to assess their logistical, temporal, and monetary efforts regarding the art of medicine and their success toward meeting accreditation requirements.

One could argue that the future of the profession of medicine is being safeguarded through the efforts of ACGME and LCME. The amount of effort put toward meeting the mandate of humanistic, ethical, and professional medical knowledge and conduct will determine how successful our profession will meet the outcomes sought in practicing the art of medicine. The Code and Compact, then, serve to frame expectations of what medical schools and residency programs must do. It makes these requirements transparent to medical students and residents. And, as opposed to being a tacked-on oath with no moral weight, it makes clear the moral mandate of both teacher and pupil to articulate how these goals will be met (Veatch, 2002). Such conversation should occur programmatically, with the specific learners and teachers involved (rather than at a city, state, or federal level). Each school or program will have its own agenda, means, and methods of teaching humanism, ethics, and professionalism.

The most important aspect of this process is the shared decision making for each institution in constructing its own Code (and Compact) with their relevant accreditation body. This negotiation requires open communication, teaching, and learning, and power sharing over the art of medicine. The
resultant “informed consent” holds the learner as a stakeholder who will be vested with appropriate authority in the moral development of its school or program. This collaboration requires involving students in the identification of conjoined learning objectives in ethics and humanities with their teachers. This process would be a fuller, participatory means to the required end of review and accreditation by ACGME and LCME. Moreover, the outcome would be the fulfillment of a moral mandate: to teach every student to be humane, ethical, and professional.

Students and/or residents and their teachers would need to agree on the meaning of the accreditation standards and their jointly elucidated goals and objectives in meeting those standards. Agreement could then be reached on the areas of knowledge that would be learned. Likewise, analytic skills and behavioral skills would be agreed upon in ethical analysis and humanistic behavior. Most importantly, endpoints of demonstrated behavior need to be discussed and openly agreed upon. This process of Code formulation allows for a common language and set of expectations that allows for the forging of the large educational Compact. The Medical-Social Education Compact thereby lays out what it expects of the teacher and the learner in a way that can be satisfied, evaluated, and measured against the accreditation standards as well as their own Educational Code of Professionalism.

Such a structure is a far cry from the current status of top-down learning objectives and extremely limited student/resident investment. The Educational Code of Professionalism that is agreed upon allows for a foundation of future ongoing trust. This trust is a prerequisite for the Medical-Social Education Compact. The actualization of the compact is a three-pronged triad of knowledge, analytic skill building, and observed behavior.

Must such a process be done? Obviously, no, it does not. However, given the mandatory nature of the new emphasis on the art of medicine, a prudent course would be to allow the learners to come to the table to voice their own perspectives and allow them the ability, as pupils, to hold their teachers, institutions, and residency programs accountable. Acknowledging that learners are stakeholders is critical to a covenant of trust in education. This act alone empowers the learner and allows for open discussion and negotiation on how the learner is to evolve into a doctor.

Humanism, ethics, and professionalism may not be the obvious areas of teaching emphasis for the preclinical medical student. As any teacher of a clinical clerk or resident knows, these learners have a dawning realization that all of their education is for naught if not for humane and ethical care, performed with professional skill. The Education Code of Professionalism
requires input from all phases of medical education to capture relevant themes on learning the art of medicine. As shown in Fig. 2, the Code might best begin with what it is to the professional – a profession of those things deemed most essential in knowledge and humanistic skills. The professional is nothing without such professing, accompanied by a body of knowledge and skills, a common code, self-regulation, and a sense of a social covenant (Pellegrino, 2002). The code would then delineate how the ethical principles and virtues of medicine are of value to the care of patients (Doukas, 2006). This section purposely captures the sense of both duty and character that is requisite in the physician as required by LCME and ACGME.

The code should set out to describe how the learner relates to patients and their families, proclaim how respect for persons applies itself to information, and describe how consent and refusal are valued. Such concepts are required in ACGME and LCME accreditation, and are often described in ethics courses. This Code needs to reinforce for all education stakeholders: “This is part of your real world.” Binding oneself to the Code converts the esoteric concepts of ethics into a promise of care. The Code could then describe aspects of character, such as compassion and sensitivity, with regard to the holistic needs of the patient. Prudence could be similarly emphasized along with justice, patient advocacy, and self-effacement. The virtue of integrity could also be appealed to regarding ethical conduct in business practice. The conclusion of this code should call for a commitment to all of its articulated principles and concepts of character, and introduce the professional aspect of self-regulation. Non-adherence should require some sort of redress for those who violate the precepts that all have freely taken on in their professional lives.

The illustrated code, as mentioned above, is intended only to serve as an ethical guidepost. Each medical school and residency program must decide how it will address the ACGME and LCME professionalism mandates. As a set of mandates, though, they must be addressed. The code allows for each school or program to state how they will implement its educational vision. Further, it allows students and residents to see what is expected of them.

As noted previously, a majority of the language within the ACGME General Competencies stresses ethics and character of one form or another (Doukas, 2003). This code allows for the learner to appreciate and take on the responsibility of grasping how the art of medicine facilitates the humane, and in turn, the scientific practice of care. Any educational program can craft a similar vision and make it as general or detailed as they wish. To close the educational circle in medical-education accreditation, we need to
scrutinize the intended end result. ACGME, in particular, sees the broad vision of the General Competencies as required for the outcomes it is intending – humane, ethical, and professional conduct and care.

The medical schools and residency programs may be well intended in their effort here, but who is to say their judgment on outcomes is valid or objective? ACGME does go to great lengths to describe evaluation of learners. While these efforts to put forward an assessment framework are laudable, they are not without challenges in implementation and validity that could prove problematic in generating outcomes data pertaining to the ethics or professionalism of learners (Arnold, 2002; Veloski, Fields, Boex, & Blank, 2005).

Ultimately, the programs and schools are responsible for designing the details and implementing them, then measuring outcomes. The feedback of implementation and outcome can and will provide data for ACGME and LCME about practical obstacles to any of their educational objectives. The current situation stops here, though.

Learners are the key to assessment. Students and residents are currently not effectively part of the evaluative, and more importantly, responsibility infrastructure. The Medical-Social Education Compact would not only allow but also require, medical student and resident involvement in curricular design, implementation, and assessment. Yet, such a power shift may be a bit of a jolt for educational programs. Nevertheless, learners need to be heard in the educational system as the recipients of mandated knowledge and skills. Students are well positioned to provide real world data regarding the effectiveness of ethics and professionalism educational efforts.

Broad program objectives written by course directors who claim that the art of medicine is “shot through their efforts” may be found wanting by the learner. Claims of education efforts must be balanced by learner assessment of the validity of the goals and outcomes. Medical students and residents are fully capable to voice their own perspectives of ethics in action. They can provide candor and guidance on what educational efforts succeed or fail. Similarly, they can provide valuable information as to which of their colleagues professionally, clinically, or ethically succeed or fail. Such evaluation is likewise critical of their teachers.

The Medical-Social Education Compact’s strength is in its contractual obligations that flow in the three-tiered structure of accreditation organizations, learning institutions, and learners. The feedback between accreditation organizations and learning institution already exists. Expectations of teaching-professional conduct, humanistic behavior, and medical ethics has been broadly laid out by ACGME and LCME. ACGME has been even more detailed in framing how programs can respond to the mandate.
CONTINUOUS HUMANISM, ETHICS, AND PROFESSIONALISM EDUCATION

Setting out educational goals using an Educational Code of Professionalism helps set the agenda in forging a Medical-Social Education Compact. The Compact would then exist between the accreditation bodies, education programs, and learners who then implement the code and set parameters of accountability. The next critical step of humanism, ethics, and professionalism education is a pragmatic response that lends itself to any medical-education setting. The art of medicine should not be educationally sequestered away. The least effective means of instilling humanism, ethics, and professionalism in medical students is during the preclinical phase of education, and in discrete small aliquots (Musick, 2000; Roberts, Green Hammond, Geppert, & Warner, 2004; Benbassat & Baumal, 2004).

The relevance of the art of medicine is revealed when patients are cared for by the medical learner, and when the message is delivered longitudinally over time. Yes, some knowledge needs to be imparted prior to patient contact. However, the need to know the art of medicine will be reduced in the learner’s mind if he or she does not see how it fits in their long-term development or relates to patient care. As it stands, a principlism-based preclinical educational approach to medical ethics, coupled with essentials of communication skills are a fairly common commodity in medical education. While not discounting this helpful start, it does not comprise the fuller context of teaching the art of medicine.

What is missing? Peer into the literature and one can quickly see what is considered lacking. Commentators have called for the inclusion of virtue ethics, narrative ethics, casuistry, care ethics, social justice, and medical humanities (including art, literature, etc.) (Pellegrino, 2002; Doukas, 2003; Wear, 2000). The paucity of a broad-based curriculum in the art of medical practice makes the current emphasis on outcomes problematic. Outcomes are predicated on knowing what needs knowing, and using this knowledge to analyze real world problems to an effective end. Additionally, learners then are expected to take on those attitudes that enable the appropriate behaviors to fulfill the outcomes goals.

Therefore, the next phase of enabling humanism, ethics, and professionalism in medical education is to implement a program that embraces all phases of education. This effort would be across all four years of medical school, as well as all years of house staff education. Such a programmatic pedagogical thrust has added value, given the increased stakes of LCME
and ACGME educational accreditation (along with all of their monetary-side benefits).

This goal of infusing education with humanism, ethics, and professionalism need not be costly or at the expense of other educational goals and course work. It does require a shift of academic value for the art of medicine by academic educators and administrators. The art of medicine, in all of its forms, should not – and if it ever is to be valued – cannot be consigned to “orphan topic” status in medical education (Misch, 2002). Any longitudinal program in Humanism, Ethics, and Professionalism, must have academic, logistical, and grading parity with any other basic science or clinical educational experiences. Yielding time for such a program would convey this parity, with prestige, monetary support, and logistical support as necessary pre-conditions. The content of this change can build upon the strengths of medical ethics and professionalism that already exist. The components that most urgently requires redress are in the areas of character development, social agency of the physician, and analytic skills for ethical and humanistic dilemmas.

The final form of any program will depend on the Code/Compact structure of the institution or program, as well as the faculty strengths present. Humanism, Ethics, and Professionalism programs would likely start with preclinical medical school education addressing deontology, virtue, and narrative ethics, while also emphasizing case analysis in small group seminars and moral reflection during preceptorships. Upon first contact with patients (preferably as soon as the first semester of the first year), keeping a journal and discussing preceptor interaction facilitates greater introspection. Further, these efforts can be enhanced with medical humanities efforts in art, literature, history, sociology, and anthropology. Clinical year efforts should be case-based (either while rounding or when in a small group setting), using actual interactions of students with patients as catalysts for discussing humanistic skills, ethics, and professional conduct. Standardized patient encounters and use of patient simulation centers can further assist these efforts. The fourth year could also have a “capstone” intensive course, such as that offered at the University of Pennsylvania. This 40 h course would run for one calendar week, and blend brief didactics and extended case discussions. This format is even more compelling for the emergent MD as the graduation date approaches (along with the start of residency). Electives in such areas as law and bioethics, primary-care ethics, and medical humanities can be offered throughout the four-year period, as school schedules allows.
Residents can incorporate didactics on the art of medicine in Core Conferences, as well as currently established Grand Rounds series. However, for reflection, additional seminars and case-based conferences are a natural extension of this effort. For both medical schools and residencies, a requirement to observe learner–patient interactions should be incorporated for evaluation as well as other methods mentioned by ACGME such as peer, instructor and 360 degree evaluations.

THE MEDICAL APPRENTICESHIP

Another aspect of medical education is perhaps the most important one, cultivating the art of medicine. This teaching model was the means by which the art of medicine survived until the nineteenth century – that of the medical apprenticeship. While mentorship generally has been lauded in medical literature as a valuable educational tool, apprenticeship is a binding together of pupil to teacher in order to pass on knowledge, skills, and practice (Rose, Rukstalis, & Schuckit, 2005; Kenny, Mann, & MacLeod, 2003). Medical learners could benefit greatly from a longitudinal apprenticeship. For medical students, this interaction would begin on day one and continue periodically for four years. For residents, this interaction would be sustained through each year of residency. Apprenticeship allows for the valued triad of observation of the teacher, interaction with him or her, and role modeling of behaviors (Coulehan & Williams, 2001; Johnson, 2000). The apprenticeship stimulates moral reflection on what it means to be a physician, allowing for an integration of knowledge, analysis, and demonstrated behavior. The apprenticeship would begin slowly with the medical student or resident. The learner would be paired with a physician–teacher whose responsibility would be to teach, interact, and observe the learner over the entire four years of medical school (or the entire residency program). This format is different from the emergent “Doctoring” courses in many medical schools (Kalet, Krackov, & Rey, 2002). These current efforts concentrate their timing during the first two years of medical school, but then stop. They tend to concentrate on medical knowledge and skills needed for the clinical years, but less so on humanistic and ethical aspects of care.

The proposed apprenticeship would, instead be enduring, comprehensive, and as part of its design, inclusive of aspects of ethics and humanism that are currently lacking. It would require that both preclinical and clinical realms of medical education cede curriculum time to allow for the apprenticeship relationship to bond, grow, and flourish. This goal is not educationally easy
for medical schools. It would mean setting aside half or whole days periodically for contact and education by medical students to work with patients and the physician–teacher over four years.

The building of such a relationship is based on mutual expectations. The learner expects to be taught the science and art of medicine, skills of the real world, and the role modeling of attitudes and behaviors by the physician-teacher that allow for scientific and humanistic growth (Misch, 2002). The learner is expected to be attentive and industrious, willing to learn new knowledge and skills, and to then demonstrate evolving attitudes and behaviors. The expectations of mutual-education goals set forth the initial promise of this covenant between pupil and teacher. Ongoing time and interaction allow for growth of the trust between the parties. Such a covenant allows for flexibility within each pedagogical dyad regarding execution, yet the overarching education expectations of the Medical-Social Education Compact set out the framework for ongoing development. Such a relationship can be constructed with physician-teachers both inside and outside the medical school setting. In the residency setting, both residency faculty and those who are not part of the residency teaching program can be physician-teachers. As in medical school, the time spent together would be structured to maximize interaction, knowledge and skill building, and most importantly, assessment of observed attitudes and behavior.

The interactions would begin with observation of the physician-teacher and patients with shadowing intended to facilitate both knowledge/skill development and role modeling (Gracey et al., 2005). The next phase of the relationship would be to allow for observed patient care, or attendant precepting. This form of role modeling would be valuable for outpatient clinical education, but also for inpatient practice (Kirkpatrick, Nash, & Duffy, 2005; Hatem, 2003). This allows for the learner to take the lead in facilitating the interaction with the patient, and the responsibility of eliciting a sound history and physical. The physician-teacher can then guide, teach, and role model with his or her own interaction style, so the learner can dynamically adjust the physician-patient encounter. This educational process deserves special attention (and curricular time) as it allows for directive feedback, while the learner is best able to make adjustments. Waiting to discuss interactions until after they occur makes redress or remediation more artificial. This dynamic interaction allows for directive education and role modeling, which can maximize both pedagogical and patient care benefit.

The latter stages of this apprenticeship could then be structured in the more classical precepting model. In this model, the student or resident first
sees the patient, examines the patient, assesses the medical and humanistic needs of the patient and presents this information to the physician-teacher. The Socratic questioning by the teacher allows for filling gaps of both the science and the art of medicine, with follow up by personal contact by the teacher, with learner observation.

Additionally, the learner can participate in the physician-teacher’s involvement in service activities to the educational and lay community. This participation lays a foundation of practicing the social agency that is professed by the medical profession. All learners are expected to give of themselves educationally, as their physician-teachers have done for them. Medical students and residents learn because the educational system and society allows us to, through the social covenant of medical professionalism (Pellegrino, 2002). Learner involvement in community-based medical volunteering and education-based service activities thereby sets the future stage of learner participation as a future professional.

DISCUSSION

These evolutionary changes are not without their challenges. The idea of bringing all educational stakeholders to conversation, much less consensus is not part of current ethics and humanities education. Nevertheless, it is necessary to discuss the programmatic goals and assessment that will ultimately make accreditation tenable. Not addressing the education plan and the means of assessment will likely lead to student and resident confusion as to why so much time is spent on ethics and humanism, thereby breeding disdain and resentment.

Regarding the longitudinal timeline of teaching the art of medicine, time-based turf battles in medical school curricula are stories of legend. Meanwhile, in residency programs, there is a practical time-based concern. The 80 h work week was mandated by ACGME to reduce fatigue and error. All curricular demands of the residency must be confined to this time restriction each week. So, for both medical school and residency one can easily imagine the refrain “we just don’t have time for an apprenticeship or for that matter a curriculum in humanism, ethics, and professionalism.” Such a response does not hold water anymore. As the art of medicine is now a part of LCME and ACGME accreditation, this vital aspect of training must be incorporated. The more thorny questions will revolve about what aspects of current education should be consolidated or jettisoned due to a lack of outcome data to support their continued presence.
The other major critique to these efforts globally, as well as to the apprenticeship model, questions who would be the teachers and physician-teachers that are necessary for its success. After all, not all schools and residency programs have developed or implemented ethics coursework or other educational sessions. While many schools and programs have faculty with interests in ethics (e.g., some with advanced degrees in bioethics, and some who serve as ethics committee chair for their institution), there may be little consolidation of these efforts into a cohesive program. This disarray is likely due to the lack of effort, time, and ability given the money and politics of the institution.

However, LCME and ACGME have changed the stakes by adding financial repercussions if the ethical/professional aspects of the General Competencies are not fulfilled. Resistant educators and administrators will soon have no choice but to gather the troops and make plans. They will need to ascertain who has ethics and humanities backgrounds and then consolidate them logistically into a working education program for this effort. This educational endeavor will require release time, money for course personnel support, and most importantly, the pedagogical mandate to have a place at the educational table in medical schools and residency programs.

The personnel to teach can be gathered from ethics and doctoring courses, ethics committees, and mentorship programs that currently exist. Recruitment (with negotiated time and financial relationships) can be sought from institutional or local departments of Philosophy, Sociology, Public Health, Law, etc. Other teachers could be recruited externally or internally trained – via masters or PhD level degrees paid for by existing tuition remission programs.

Physician-teachers can be trained by the scholars and teachers recruited or trained above. The emphasis here would be on selecting physicians with excellent interpersonal skills who enjoy teaching students and residents (Neufeld, 1998). Intensive or immersion courses (tightly targeted and time-focused) could then facilitate pedagogical skills, while videotaping of physician-teacher interactions with reviews by learners can improve skills in practice.

An important aspect to the art of medicine is to acknowledge the need for pedagogical equanimity with the rest of medical education. Excellence in education in humanism, ethics, and professionalism should be rewarded. Teachers who provide this education with outstanding outcomes data to demonstrate effectiveness deserve the granting of tenure and other commensurate rewards at their academic institutions (Shrank, Reed, & Jernstedt, 2004). While these teachers are not necessarily generating new
indirect funds through grant writing, do they not also deserve financial stability and security for their educational and scholarly proficiency, and the maintenance of accreditation (with all of its financial consequences)? Only this level of reward will achieve the sea change of facilitating this educational evolution.

Fig. 3. Summary of Proposed Medical Education Venues in Ethics.
This chapter argues that an inclusive approach for all educational stakeholders is the optimal manner to respond to the humanistic, ethical, and professional education requirements for medical schools and residency programs. Figure 3 summarizes the structure of this response, based on the foundation of the Educational Code of Professionalism to facilitate the forging of the Medical-Social Compact at each educational site (medical school or residency program). The knowledge, skills, and attitudes/behaviors that are required of all physicians would be instilled in the depicted venues, while the role modeling and interaction strengths of apprenticeship would occur in parallel to these efforts. The future of medicine is depending on its past: both on the balance of art and science, and the means to learning through apprenticeship.

CONCLUSIONS

The integration of humanism, ethics, and professionalism will be a dynamic and vexing issue for the next 5–10 years of medical education. Cognitive dissonance of assigning worth according to old standards versus new educational requirements will likely confuse many residency directors or medical school deans. The cautionary tale lies with those residency program directors who said, “I don’t have to adhere to eighty hour work rules of the ACGME.” These programs lost accreditation (and tens of millions of dollars) and had to re-establish themselves after months of redress to regain it.

The art of medicine was the foundation of medical care for over 2000 years. Our over-reliance on the science of medicine has left the medical field with great challenges of reincorporating this art. The art was never lost, but it has been neglected. We are now presented with an opportunity to reintegrate ethics and humanism on a broad scale to medical education. Our effort should focus our commitment to teaching the medical learner the balance of art and science in medicine. Importantly, we should aspire that all of our students and residents are humane, ethical, and professional not because our accreditation depends on it, but because it is the right thing to do.

REFERENCES


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CHAPTER 10
SEARCHING FOR DOCTOR GOOD: VIRTUES FOR THE TWENTY-FIRST CENTURY

Nuala Kenny

ABSTRACT

The resurgence of interest in professionalism necessarily focuses us on the moral core of medicine and the character of the good doctor. While medical education reform projects aimed at educating for professionalism are replete with lists of laudable virtues necessary for the doctor, we have made little progress in mapping those character traits, values and behaviors to admission procedures, curricular reform and faculty development. If educating for professionalism is to be effective, medicine must re-claim the moral core of professionalism and identify clearly the fundamental traits, values and virtues necessary for good medical practice in the twenty-first century.

INTRODUCTION

For most of us, images of the good doctor come to mind easily. From our own personal experience of a kind family doctor or an efficient and caring response to trauma or witnessing the faithful attendance on a dying mother,
we all have stories that vividly portray the virtues of medicine. Reflecting on doctors we have known may also summon sharp and painful images of bad doctoring: the insensitive reporting of bad news, the arrogant failure to listen to deep-seated worry or the devastating consequences of unacknowledged incompetence. Our judgments of these experiences are not simply personal judgments about individual personalities. They say something about doctoring and the character of a profession. In them there is some common thread of expectation about how doctors should act.

Personal experiences of medicine tell us something about good doctors. Society’s images of the good doctor, as portrayed in art and literature, provide us with an understanding of what remains the same and what changes over time. In the early twentieth century, George Bernard Shaw’s *The Doctor’s Dilemma* and Sinclair Lewis’ *Arrowsmith* captured an image of the demanding nature of medicine, commitment to advancing medical science and the moral gravity of the doctors. By 1969, as dazzling medical advances created paradigm-shifting discoveries, Marcus Welby, the wise, competent, always available family physician had become a cultural icon. He epitomized scientific and clinical competence and caring as he delivered babies, set fractures and comforted the dying.

A shift in imagery occurs in popular culture with the 1970 appearance of the irreverent, wise-cracking, but clinically exemplary, Hawkeye Pierce of MASH. His personal vices, understood as coping mechanisms amidst the horrors of war, are in sharp contrast to a fierce commitment and loyalty to patients. In the 2004 TV appearance of the rude, arrogant, sexist, but brilliant, diagnostician Dr. House, we see a doctor who violates every ethical precept regarding respect for patients and peers. He is tolerated because of his diagnostic acumen. A more radical departure in the image of the doctor is presented in the cosmetic plastic surgeons of Nip/Tuck. They make a fortune using medical science and technology for high-priced cosmetology. They are the anti-heroes of traditional medicine but represent a vision of medicine as business with no moral core. Do these recent depictions tell us something about what modern doctoring has become or are they warnings of what it might become?

In this volume, we have explored the historical importance of virtue and professional character in medicine, the resurgence of interest in professionalism, and the actual and potential role of medical education in shaping character. Some, like Pellegrino, McCullough and Rhodes, and Smith have argued strongly for the essential importance of professional character. Others, like Veatch, believe it dangerous or unnecessary in modern practice. It is over a decade since Pellegrino issued a call for a restoration of virtue ethics
in medicine (Pellegrino, 1995). While medical education reform projects are replete with lists of laudable qualities of the doctor, we have not made any real progress in mapping those to admission procedures or educational initiatives. If the resurgence of interest in educating for professionalism is to be effective, it must re-claim the moral core of professionalism. If the character of the doctor is still important, we need to identify more clearly the fundamental and enduring traits, values and virtues necessary for good medical practice. We will need more reflection and scholarly work on those traits, values and virtues necessary for good practice in the changing context of society and culture as well as the significant shifts in medical practice. If the character of the physician is still important and medical education can and does influence the development of professional character, we must clarify the values and virtues needed for good medical practice in the twenty-first century.

PROFESSIONAL CHARACTER AND THE CONTEXT OF MEDICINE

Hippocratic medicine has changed profoundly over its 2,500 year history as it has become increasingly scientific, technological, commercialized and commodified (Starr, 1982; Relman, 1992). Patients have changed in many ways as well. There is less deference to authority (Haug, 1976), an expectation of choice, and widespread access to previously unavailable medical and scientific information (Markus, 2001). Paradoxically, it has remained the same in some deep way at the encounter of doctor and patient – the place where Pellegrino tells us the essence of medicine is discovered (Pellegrino & Thomasma, 1981).

Medical education has undergone constant curriculum and pedagogical ‘reform’ in order to keep up with these changes (Christakis, 1995). All the attention to organizing curricula and changing formats from didactic teaching to small group and problem-based learning has been important in helping learners manage information. It has been characterized by astute observers of medicine and medical education as essentially

A history of reform without change, of repeated modifications of the medical school curriculum that alter very slightly, or not at all, the experience of the critical participants, the students and the teachers (Bloom, 1998).

Insights from psychology, sociology and education increasingly identify medical education as a process of moral enculturation, of learning not just
specialized knowledge and technical skills but those values and attitudes that make for the good doctor (Hafferty & Franks, 1994). Medical education has been inattentive to the shaping of values and attitudes that occurs in the formation of new doctors. The dominance of science in the curriculum, the failure to attend to the importance of role models and the ‘hidden curriculum’ of values, compounded by modern bioethics’ focus on dilemmas, have all tended to minimize the actual shaping of values and attitudes that occurs during medical education. There is a growing awareness of the paradox of a rhetoric of altruism, compassion, empathy and evidence-based medicine (EBM) in medical education with the reality of an environment fostering detachment, self-interest and technological dependence (Coulehan & Williams, 2003). The students hear the call for patient-centered care but are told repeatedly of their superiority and learn of their power. They are exhorted to the centrality of the doctor–patient relationship but spend soul-numbing hours in book learning. Calls for medical education to deliver on its rhetoric have become increasingly explicit and demanding (Wear & Bicker, 2000).

Role models are key to learning the real values of medicine because “the values and behaviors that individual physicians demonstrate in their daily interactions with patients and their families, and with physicians and other professional colleagues, become the foundation on which medical professionalism rests” (Swick, 2000, p. 613). In all of the attempts at medical education reform, the importance of faculty as role models for learning the values and attitudes of good medical practice has been neglected (Kenny, Mann, & MacLeod, 2003). Despite our enthusiasm for evidence-based practice, as Bebeau (2006) has reminded us, there is little empirical evidence regarding the impact of role models.

There is ample evidence that there is a morale crisis in contemporary medicine:

The medical profession today is affected by a siege mentality ... like the occupants of a citadel about to fall into the hands of hostile force. They are divided, dispirited and tempted to defect. Worst of all, physicians are becoming convinced that traditional sources of the profession’s credibility and its moral commitments have no survival value in today’s competitive climate (Pellegrino & Thomasma, 1993, p. 39).

Carl Elliott (2006) has vividly portrayed this disillusionment in medicine. His chapter describing the disappointment of many doctors in finding medical practice just a job without any moral core conjures up the Peggy Lee feelings captured in the lament “Is that all there is?” These same demoralized and disillusioned practitioners are the role models for tomorrow’s physicians. What values and attitudes are they modeling?
THE CENTRALITY OF VIRTUE AND CHARACTER

Pellegrino (2006) reminds us of the importance of character and virtue in the Hippocratic tradition of medicine. Even doctors who know little about that tradition are imbued with an understanding of its essence: the integration of empirical science and technical skill with a public moral commitment to the patient’s welfare. The nature of the relationship between the knowledgeable and powerful physician and the vulnerable patient requires this core moral commitment to use the power of medicine for the patient’s welfare (Jonsen, 2000). The ethic of this early moral commitment focused intently on the doctor as a moral agent – as a person of good character. It emphasized the personal integrity of the physician because of their power and privilege, the inherent uncertainty in the emerging medical science and the reality that doctors make their living from the sick and dependent.

The focus on individual character shifts with the development of the notion of a medicine as a profession. McCullough (2006) identifies the history of professional ethics as built on three elements: a solid conceptual foundation of scientific and technical competence, commitment to patient welfare and the profession as a public trust. Thomas Percival, charged with mediating conflicts that had erupted between physicians of different schools of medical science, wrote the first code of medical ethics, Medical Ethics or A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons (Percival, 1803). This code, the template for the code of ethics for both the American and Canadian Medical Associations, shifted the focus of physician ethics from personal character to a highly organized professional standard of conduct. These codes were “a decisive and revolutionary break with the British conception of character-based medical morality” (Baker, Caplan, Emanuel, & Latham, 1999, pp. 20–21).

While commitment to the patient’s welfare and medicine as a public trust were essential, the moral work of medicine became focused on the provision of scientific judgments and technical competence. What really counted as good medicine was an understanding of diseases, their causes, signs, symptoms, prognoses and treatments, and applying this understanding in the assessment and management of each individual patient. This scientific paradigm was reinforced when debates about the appropriateness of using anesthesia generated a new view of professional responsibility based on a “calculus of suffering,” i.e., formally judging the benefits and risks of a medical intervention (Pernick, 1985). There emerged a belief that objective scientific evidence would direct what was for the patient’s welfare; the character of the doctor was not as important as his science. By the twentieth
century, however, medical advances such as the portable ventilator, cardiac resuscitation, immunology, organ transplantation and the new genetics presented unprecedented issues for doctors in determining a patient’s best interest. Scientific evidence did not direct to one obvious choice for the patient, but rather to many possible options, each with potential benefit and risk. At the same time, decisions regarding the patient’s welfare were no longer understood to be the purview of the doctor alone. Emerging in the 1960s, modern bioethics rejected what was seen, and often was, paternalism on the part of doctors and focused on patient rights and autonomy in decision making. In fact, the original philosophers engaged in bioethics teaching in health professional education rejected the notion that character was a legitimate object of ethics education. They assumed that character was already set on admission to professional schools and that privileging any set of virtues or character traits was unacceptable. Clearly, personal character is well developed by admission to medical school. The admissions process is crucial. However, the values, attitudes and behaviors necessary for good doctoring are learned in medical school and residency.

Bioethics’ practical focus on dilemma solving moved medicine and medical education even further away from reflections on the character of the doctor and the virtues needed for the practice of medicine in a world enthralled by medical science and technology. So, we moved from “trust your doctor to know what is in your best interest” to “find the doctor with the best scientific and technical skill” and from there to “the doctor’s job is to bring you the best science and technical skill and you will decide what is in your best interest.” The doctor’s job is to know the science and to be technically proficient; patients become consumers. While these changes have been occurring, there has emerged a deep concern about the goals of medicine (Callahan, 1996, 1987). The development of enhancement technologies; the use of medical science for purposes quite different from the historical concepts of alleviation of suffering and promotion of health; and the medicalization of many aspects of life have fueled debates regarding the very possibility of a moral core to medicine with inherent goals (Veatch, 2001). For many, medicine has become a business like any other (Relman, 1992). Physicians are losing patients’ trust because of worries regarding financial conflict of interest in new systems of funding and delivery that present real conflicts to physicians’ commitment to the best interest of the patient (Khushf, 1998; Mechanic, 1996, 1998). Some question the very possibility of a fiduciary relationship of trust – the is historically central notion of commitment to the patient’s welfare – in market-oriented medicine where “buyer beware” is the rule (Rodwin, 1995).
So, while attention to professional character has been moved to the background in medical education, and assumptions about scientific evidence and patient autonomy have been seen as forces justifying that exclusion, the current state of medicine provides compelling evidence that the notion of a profession with its moral core, requiring the cultivation of certain character traits, seems to provide a remedy for the disillusionment and dissatisfaction of doctors and patients alike.

THE RESURGENCE OF INTEREST IN PROFESSIONALISM

The word ‘professional’ has lost its essential meaning. It is used today to mean a job well done and focuses on technical competency. The historical concept of profession is much richer and demanding. It contains three essential elements: competence, altruism/beneficence/commitment to the welfare of the person served and an understanding of medicine as a public trust (McCullough, 1999).

The current interest in educating for professionalism is based on at least three empirically based observations about North American medicine: deficiencies in clinical decision making or judgment, the failure of physician’s to meet patient expectations in communication, continuity of care, availability and advocacy, and studies demonstrating that medical education does not, in fact, support those values traditionally associated with medical virtue (Coulehan & Williams, 2003). Each of the three essential elements of professionalism appears to be far less than the ideal. For many, the resurgence of interest in educating for professionalism provides a unique opportunity for a critical educative endeavor, important for the profession itself, not just future doctors. It is a way to reclaim the moral core of medicine. For others, the emphasis on medical professionalism is a worrying call for a return to an elitism that emphasizes the power and authority of medicine over other health professionals. For still others, professionalism is a nostalgic notion belonging to another era because medicine has become a job like any other.

Medical education seems to have accepted educating for professionalism as the antidote for the ills of medicine. A number of key issues can be seen in the various professional education projects:

- a rhetoric of almost limitless virtues and qualities;
- difficulty in identifying a meaningful core set of values and virtues;
• differences between those who root the notions of professionalism in foundational philosophical concepts and those who believe they need to be created with input from medical students; and
• differences regarding the need for more in-depth theoretical work on professionalism versus the need for more practical action and behavior-based curriculum and evaluation.

All of these issues require further attention. Here, I want to focus on the question of identifying core values and attitudes. The enthusiasm for generating long lists of values, attitudes and character traits can be seen in a sample of major initiatives which includes: physicians should be altruistic, knowledgeable, skillful and dutiful (Association of American Medical Colleges, 1998); should practice with “honesty, integrity, maintenance of confidentiality … and respect for patients, patients’ families, other students, and other health professionals” (Liaison Committee on Medical Education, 2002); “… have respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession, and a commitment to excellence and on-going professional development”; and practice “altruism, duty, excellence, honor and integrity, accountability, and respect for others” (Accreditation Council for Graduate Medical Education and the American Board of Medical Specialists, 2000). If we reviewed more projects, we should see these qualities and many more besides.

There is concern with the abstract and vague nature of these lists (Wear & Nixon, 2002). A special issue of The American Journal of Bioethics called for a pause in the enthusiasm for professional education precisely because of concerns with

... the professionalism discourse and how the specialized language of the academic medicine disciplines has defined, organized, contained, and made seemingly immutable a group of attitudes, values, and behaviors subsumed under the label “professional” or “professionalism” (Wear & Kuczewski, 2004, pp. 1–2).

The longer and vaguer the lists, the less likely they can be incorporated meaningfully into educational strategies. Some definitional clarity and consistency is needed desperately.

To complicate matters, the ACGME sees ‘professionalism’ as just one of the competencies of the modern doctor along with patient care, medical knowledge, practice-based learning, interpersonal skills and systems-based practice. This is quite a different view from one that understands the concept of profession as definitive containing those essential elements: competence, commitment to the patient’s welfare (beneficence) and an understanding of
medicine as a public trust (McCullough, 1999) from which competencies should be derived.

There is a core to professionalism that students must learn. While most students enter medical school with enthusiasm and commitment to the sick, as Rhodes and Smith (2006) have argued compellingly, they have to learn what commitment to the sick means in the context of medical practice. Medical professionalism is not just what every generation thinks it is! Virtues cannot be cherry-picked to suit the temper of the times. However, the times require explication of the values, attitudes and virtues necessary for competence, commitment to the patient’s welfare (beneficence) and medicine as a public trust, to be expressed within the social and historical context of medical practice.

THE CORE VIRTUES OF MEDICINE

Bioethics has come to dominate our thinking of ethical issues in the health professions. Bioethical rules and principles are helpful for promoting dialog and in negotiating the ethical dilemmas of practice. However, rules and principles do not fully encompass the moral core of professional practice. Understanding the doctor as a moral agent is essential. This is where virtue theory helps us in attempting to identify a set of necessary professional character values, traits and behaviors.

While virtue is not a popular concept in our time, Edmund Pellegrino has educated modern medicine to its classical Aristotelian foundations:

- excellence in traits of character;
- traits oriented to ends and purposes;
- an excellence of reason;
- centered on practical judgment; and

These elements are crucial for they identify virtues as very practical characteristics necessary for practices. They are not saintly, ethereal qualities for the few. Alasdair McIntyre (1984) has described virtues as acquired qualities that are necessary to achieve the good internal to practices and to sustain communities (p. 74). So, virtues are important not just for individual practitioners but also for the profession itself.

From their philosophy of medicine rooted in the phenomenology of the doctor–patient encounter, Pellegrino and Thomasma (1993) have identified the fundamental virtues of medicine as: fidelity to trust, compassion, phronesis (practical wisdom), justice, fortitude, temperance, integrity and
self-effacement. These virtues tend us to excellence in the practice of medicine. Most of the conceptual work in this area has focused on the virtues in the encounter between patient and doctor, and rightly so. However, this encounter is situated within very complex environments today. Those environments need to be taken into account as we attempt to validate virtues for contemporary practice. The central features of medical practice theory include the doctor–patient encounter, the power and limits of medical science and technology, the complexity of the concept of ‘best interest’, practice on teams, and systems of care and funding.

THE DOCTOR–PATIENT ENCOUNTER

Clearly, good clinical practice is more than scientific and technical competence. In emergency departments, hospice, neurosurgery operating rooms and clinics, it is still primarily about an encounter between a doctor and a patient. Therefore, “the healing relationship, itself, provides a phenomenological grounding for professional ethics” (Pellegrino, 1995, p. 266). This is not to say that the relationship, in itself, provides specific answers to all the ethical dilemmas of practice but rather that, in the relationship, we find the need and justification for certain virtues necessary for excellent clinical practice. The nature of illness requires attention to the moral/ethical core of the illness, disability and dying experience. At its deepest and most enduring, the encounter between a patient and a doctor is an encounter between a person in need and a doctor’s promise of help from science and technology. This understanding has been the basis for the fiduciary history of the doctor–patient relationship. It requires an embodiment of Hume’s notion of sympathy, which is the capacity to enter into the experience of others. Patient-centered medicine builds on just such capacity as it focuses on conscious attention to sharing power and reciprocity in the relationship.

Attention to the moral and ethical nature of practice from the patients’ perspective is often lost in the busy and demanding conditions of practice. Yet, as Epstein has reminded us, mindfulness in the encounter is crucial (Epstein, 2006). A health care encounter is a place 0 meaning for patients and their loved ones. Patients are not consumers, rationally making choices at the mall. No matter how knowledgeable or powerful in their personal lives, patients, as patients, are vulnerable. They must be able to trust that their doctor is competent in all areas – clinical, scientific, technical and ethical – and committed to their best interest. This vulnerability is the basis for trust. Physicians must recognize and respond to this vulnerability,
respecting for the uniqueness of each patient and their “illness experience” (Kleinman, 1988). This is quite different from, but complementary to, their objective diagnosis. Some empathic development and fostering of ethical sensitivity (Bebeau, 2006) is essential in medical education if this vulnerability is to be understood.

Patients today come with high expectations of what medicine can do for them; they are demanding with the expectations of a consumer society. After all, this is the generation of high-speed Internet, unlimited choice and belief in the power of science and technology to fix instantly. Some of the vulnerability of patients and their loved ones arises from their trusting too much in what medicine can do. Many patients come with information surfed on the web but with no context for its real meaning and no understanding of what to do with the facts (Markus, 2001). Fidelity to trust requires doctors to assist patients in understanding both the potential and limits of knowledge and evidence.

Patients come from increasingly diverse backgrounds of culture, religion and socio-economic status. Respecting patients in their diversity is crucially important for acting in the patient’s best interest. Medical education has responded by developing programs facilitating cultural competence rather than “cultural humility.” A disturbing Institute of Medicine (2002) study showed that bias, stereotyping and prejudice from health care providers perpetuates health care disparities. Medical education’s focus is usually on individual patients or doctors and not on systems that promote discrimination and inequity. Self-reflection is required for doctor’s to attend respectfully to issues of religion, culture, race and their influence on the illness experience.

There are different styles of relationship between doctors and patients. Some of these differences are related to personality; others to very different conceptions of the patient–doctor encounter, and more from the specialization of practice today. The highly personal context of care has changed in much of medical practice, even in primary care where long-term relationships have been the norm. Walk-in clinics and multi-member practices mean that even primary care physicians may be relative strangers to the patient. Medicine has become highly specialized with a specialty for every organ and system and for investigation as well as patient care. There are some important consequences of these changes: toleration of certain negative attitudes and behaviors from doctors because there are other attributes at stake such as a technical excellence, and disrespectful behavior to medical colleagues, particularly, to primary care practitioners by hospitalized specialists. This fracturing of the profession resulted in insufficient attention to identifying the core virtues of doctoring shared across specialties and sites.
RECOGNIZING THE LIMITS OF MEDICINE

Modern medicine is practiced within a society that has experienced death-defying medical advances. The power and scope of medicine have expanded beyond imagination. Today dead is not dead; effective resuscitation will revive them. Some believe that if you can find the right hospital with the best equipment and the best doctors, a cure is possible for everything. The reality is that much medicine is practiced in uncertainty; humans are mortal; and medical science and technology are limited in achieving all we would hope for from them.

So, clinical judgment – that phronesis or practical wisdom Pellegrino writes of – is central to the practice of medicine. Respecting patients’ choices is important but there are limits to what patients can demand and medicine can deliver. The question of the limits of medicine is complex; it requires doctors to have a balanced understanding of medicine’s potential for good and its risks of harm (Callahan, 1987, 1990). It requires an understanding of what medicine cannot accomplish as different from what might be accomplished, but is ethically questionable. How ought doctors recognize and discuss futility (Rubin, 1995; Schneiderman & Jecker, 1995)? It is clear that “futile, otherwise ineffective or marginally effective treatments are not scientifically or morally defensible” (Pellegrino, 1994, p. 315). Moreover “… it is properly the purview of the physician to judge that an intervention is ineffective in meeting specified goals. If so, then to pursue the intervention would not promote the good of the patient that the physician has sworn to serve” (Sulmasy, 1997). Many do not understand that, for doctors, ‘do no harm’ is not just a negative duty to minimize risk and harm but part of the duty of acting for the patient’s welfare (beneficence) (Sharpe, 1997; Sharpe & Faden, 1998). There are other times when doctors must be advocates for their patients, when it would be easier to claim that there is nothing else that can be done. The burden of obtaining access to limited expertise and arguing for coverage of potential benefits for a patient can be overwhelming. Doctors require wisdom to know when these efforts are required for their patient’s welfare and the courage to work for them.

A very special concern about the limits of medicine is a widespread failure in the recognition of and acceptance of dying on the part of doctors, patients and families. There is abundant evidence that doctors have difficulties in moving from the goals of cure or significant improvement to the goals of palliative care. Despite advances in palliative care and education about dying, there are serious issues in recognizing when hope for cure or more time are futile; when dying is what is happening and we can indeed do harm by medical interventions aimed at cure.
ACTING IN THE PATIENT’S ‘BEST INTEREST’

Doctors’ commitment to the welfare of the sick is central to medicine. However, the patient’s welfare was understood simply in the past. In a historical context, where doctor and patient almost always came from the same religious and cultural background, and the options were few, whatever the doctor ordered was understood to be for the patient’s welfare. The doctor was trusted to judge competently the best intervention for the patient. Acting for the patient’s welfare is still the primary ethical duty of doctors. However, what constitutes the patient’s welfare and who judges it has become complex and contested. There has been a significant shift from the language of patient ‘welfare’ to the use of the superlative in ‘best interest.’ Acting in the patient’s ‘best interest’ does not mean giving them everything they want or could ‘possibly’ benefit from, regardless of risk, but from options judged to bring more potential benefit than harm to this patient. Doctors have a duty to make judgments about which options to include and which to exclude in decisions with patients. Because culturally we associate benefit with “providing the best” and “being aggressive,” patients usually expect (or at least accept) their physicians’ predilection toward performing too many, rather than too few, interventions. This pattern of aggressive diagnosis and treatment also results in economic and social benefits for the physician. It is clear that “non-reflective physicians could see themselves as engaging in patient advocacy while at the same time engaging in self-interest by performing or interpreting the procedures that constituted their expertise” (Coulehan & Williams, 2003, p. 12).

The doctor requires clinical judgment to assess the best evidence of scientifically validated treatments and provide this information to the patient. From these options, the patient and doctor together review and discuss so that the patient’s values regarding which potential effects are benefits for the possible risks and harms inevitable in any intervention direct the choice. Respect for patient autonomy is a relatively new concept in the history of medicine (Katz, 1981). It requires an understanding of ‘best interest’ as first and foremost rooted in empirical evidence. Demands for non-validated interventions are increasing. Some patients come with these demands in the name of autonomy. Doctors must recognize when unnecessary or non-validated care may benefit them financially and keep the patient/customer happy but is incompatible with the obligation to use only good empirical evidence as the basis for decisions. Doctors today must also be wise enough to understand the erosion of good science from commercialization at the laboratory bench and in distorted and biased continuing education. EBM
is a concept that has come into widespread use in the last decade. It refers to the use of research data regarding the effectiveness of an intervention to guide the decision about which interventions to use in clinical practice. It is not ‘cookbook medicine’ but rather, “… the integration of best research evidence with clinical expertise and patient values” (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000, p. 1). This integration is no easy task. It is important to respect intuition and to recognize the ethical and epistemological limits of empirical evidence and the importance of clinical judgment (Tonelli, 1998). The best empirical evidence is a necessary but not sufficient requirement of ethical practice. Here is where that virtue of phronesis or practical wisdom comes to bear. It is that trait that helps us incorporate the scientific judgment with the patient’s good. It helps doctors to respect science and its limits.

**MEDICAL PRACTICE IN HEALTH CARE TEAMS**

While the doctor–patient encounter is understood intimately and occurs often within a fairly private space, most health care is provided within a wider context. Exclusive attention to the virtues of importance in the encounter is inadequate to capture the values and attitudes needed for excellent medical practice in our time. Modern medicine is practiced in teams and in complex systems of delivery and funding. It is also highly remunerative. Unless some attention is given to the virtues needed to ensure that patients’ interests are put before the financial interests of doctors or others, medical education is doomed to prepare future doctors for a lifetime of frustration and ethical distress.

While the doctor–patient encounter is still crucially important, modern medicine is practiced in teams. Both doctors and patients are dependent on the expertise and assistance of many health care professionals to realize the patient’s best interest. Doctors must model and teach about the centrality of the doctor–patient encounter in a way that recognizes its importance but also acknowledges that it is not the only significant relationship for patients and their loved ones. This is a difficult area for a profession that believes strongly in the ultimate responsibility for the patient’s welfare being in the doctor’s hands. The values and attitudes that make for effective participation in teams are often at odds with this sense of ultimate responsibility.

There has been much written about the doctor–nurse relationship that provides insight into health care team dynamics. The nursing literature provides a strong critique of the power imbalance in medicine and the failure
of physicians to understand and respect the role, expertise and moral work of nurses (Stein, Watts, & Howell, 1990; Bradshaw, 1995). Physicians lament a loss of something they call the ‘bedside nurse’ and are critical of changes in the education and increasing autonomy of nurses, even as they are dependent on them for care of their patients. The literature on ethical distress emanating from nurses record their increasingly deep moral concerns regarding the role they are often ‘ordered’ to play in patient care they judge ‘wrong’ or ‘bad’ from their unique perspective. These issues are crucially important for patients because the lack of good working relationships adversely affects care. Nurses are acutely aware of the need to supplement technological developments with care of body, mind and spirit. They lament that doctors seem to have become fixed on interventions to the exclusion of careful interaction and assessment of patient need.

Clearly, there are health care teams that function well as teams. There are wonderful examples from primary care clinics, transplant teams and cancer services, among others. However, successful teams appear to be a function of the personality of the doctor rather than any learned or systemically reinforced role. Doctors have legitimate concerns regarding authority and responsibility. The modern health care team requires new ways of cooperation and collaboration. Changing scopes of practice requires a sharing of power and authority; no easy thing for doctors. It should not be surprising that doctors are not great team players. For, while medicine is practiced in teams, the education and formation of doctors is in silos. There is an emergence of interest in inter-professional education but this will be no easy task (Hall & Weaver, 2001; Humphris & MacLeod, 2002). Medical education must participate meaningfully in these educational initiatives. Faculty must model those values and attitudes that recognize the limits of the doctor’s expertise and acknowledges the expertise of others.

DOCTORS AND PRACTICE IN SYSTEMS OF FUNDING AND DELIVERY

The traditional medical ethic is deeply rooted in the notion of duty to the ‘best interest’ of this particular patient. It derived from a time when diagnosis, treatment and prognosis were the purview of the doctor, and nursing care was provided by the patient’s family. It is still the crucial element in professionalism. Today, realizing the patient’s best interest requires the resources of others and the support of systems of funding and delivery of care.
So, rooted in a long-standing ethical commitment to individuals, it is not surprising that doctors see systems as presenting a conflict of interest for them in their primary or, as some see it, their sole duty to individual patients. If so, what is the doctor’s obligation to the development and management of systems of funding and delivery most compatible with their primary obligation to patients?

Doctors earn their living from the care of vulnerable and dependent individuals. From the first doctor–patient encounter where a fee was paid, it was clear that trust is essential because doctor's can benefit financially at the peril of their patients (Rodwin, 1993). What has always mitigated the conflict is the doctor’s public profession of a commitment to the patient’s welfare, even at the cost of the doctor’s welfare. The conflicts are not eliminated; they are inherent in the nature of the doctor–patient encounter. Historically, physicians were paid directly by patients or not at all. This changed when private insurance, paid for by patients, began to flourish. Medical care at this time was relatively inexpensive and simple. After WWII most countries of the developed world began to provide public coverage of essential or medically necessary health care for their citizens. In the U.S., big business began to offer health insurance as a fringe benefit to evade wage and price controls establishing a link between employment and health insurance that still characterizes U.S. health care (Angell, 1993). Both public and private insurance coverage insulated doctors and patients from costs. The view that doctors have obligations to the ‘best interest’ of this patient, regardless of other considerations, was unquestioned until the late 1970s. Phenomenal medical advances, such as mechanical ventilation, cardio-pulmonary resuscitation, dialysis and organ transplantation, made it apparent that health resources were not infinite. Health systems realized difficulties providing all that medicine could do for all patients. Doctors now find themselves, in situations where they recommend what is in the patient’s best interest and systems cannot or will not provide it. We need to re-assess the values and attitudes necessary for just and fair practice. We need to start with that longstanding issue of doctor’s earnings.

For many, fee for service is a cornerstone of medicine. For others, it encourages unnecessary and inappropriate care. Today, many different types of physician payment have been developed including fee for service – directly paid fee for service paid through indemnification and private (actuarial) insurance or public (social) insurance, salary, capitation, etc. Not much attention has been given to the question of how doctors ought to get paid. Little is known regarding doctors’ experiences of ethical issues with different funding mechanisms. They have identified concerns regarding financial incentives
that erode trust and their own commitment to an ethic of undivided loyalty to patients’ best interest (Sulmasy, Bloche, Mitchell, & Hadley, 2000).

As systems of care developed, doctors became gatekeepers to resources above and beyond their own time and talents. The ‘traditional’ role of gatekeeping for necessary care related to ordering tests, initiating treatments and interventions, and consultations and ordering care. When done with careful clinical judgment regarding evidence, benefits and the limits of medicine, this gate-keeping has little potential for compromising the patient’s welfare.

As medical science and technology became more effective in treating patients, care shifted from homes to the hospital and became a more ‘public’ good than a private transaction between doctor and patient. Today, the vast majority of physician services and virtually all complex sickness care are funded through public or private insurance schemes. Shared risk and resources are at the center of insurance; all systems have limits. In the U.S., the limit is at the point of entry to health care but, once in, patient demands can be extreme. In public systems such as those of Canada, Australia, New Zealand and Western Europe, limits are not on entry but rather on access to certain technologies or services. Physicians are deeply conflicted about their participation in limiting benefits. There is general agreement that, at the bedside, ethical doctors should choose interventions with evidence of benefit; minimize marginally beneficial interventions, inform patients of cost constraints, advocate for the individual patient’s benefit; and work to provide just and fair access to health care. The traits necessary for these aspects of practice need to be the object of careful reflection.

Much of the literature on the ethical issues systems present to doctors comes from the U.S. experience of for-profit managed care systems. It is important to understand doctors’ concerns and conflicts of duty from this perspective. It is equally important to recognize that many physicians operate in publicly funded health care systems. While both public, not-for-profit health care systems and private, for-profit systems share the necessity to limit access to health care resources for individuals because of the almost unlimited potential benefit in modern science and technology, there are some fundamental ethical distinctions between them (Christensen, 1995).

Organizations and systems of care are responsible for many patients. Physicians can become “double agents” in managed care because it modifies the doctor–patient relationship and adds a relationship to the managed care organization itself (Angell, 1993; Shortell et al., 1998). Managed care has developed some practices that directly conflict with the doctor’s duty to the patient interests even as they affect the doctor’s financial interests. Negative gate-keeping uses physician self-interest to limit use of medical
services, especially expensive ones. Positive gate-keeping encourages physicians to increase services for those who can pay and encourages market demand because of the profit motive. It is governed by the ethics of the marketplace, i.e., *caveat emptor* not trust. It is not surprising that in the U.S. there is a crisis of trust concerning doctors and HMOs (Mechanic, 1996).

While most physicians see these limitations as interfering with their obligation to patients, many others are concerned that the power of economic incentives linked with the loss of medicine’s moral core means medicine’s capitulation to market forces and abrogation of the doctor’s duty to advocate for just systems for their patients. Just systems of funding and delivery of care are crucial if patients’ interests are to be well and fairly served. Doctors cannot do this alone. So, while some bemoan any limits on any potential benefit for their patients, others see important issues in the emergence of managed care because

Managed care has made the social *interdependence* of medicine more explicit. Physicians will come to see themselves and their patients in the context of a multiplicity of social values and institutions rather than isolated players (Coulehan & Williams, 2003, p. 15).

A number of key individuals have tried to address the ethical response of physicians to the development of systems of funding and care (Wolf, 1994; Pellegrino, 1995; Morreim, 1995). Pellegrino (1995) calls for an ethic of distributive justice. Rodwin (1993) urges health system economics structured to support medicine’s fiduciary obligations. He recognizes challenges to the fiduciary metaphor but emphasizes that physician and provider accountability can be improved through new ways of thinking. Emanuel and Emanuel (1992) see a new physician accountability incorporating population-based medicine and incentive alignment especially with patient outcomes. McCullough (1999) proposes a new ethic of managed care that of co-fiduciaries of the health of individuals and populations. These new ways of understanding obligations to systems as well as to patients presents doctors with the need to re-assess the traditional elements of commitment to the patients’ best interest and medicine as a public trust.

So, what values and attitudes ought to be developed here? The single duty to the individual patient regardless of cost model of medicine does everything, including “gaming the system” (Morreim, 1995) to advantage this patient. Paradoxically, it endangers other patients and the system itself if everything possible is done. Another view conceives of the doctor’s duty as providing what is best for the patient within the limits of the system; the system itself is not the doctors’ responsibility. Still another view is the “dual-stewardship model” (Minogue, 2000) where doctors must conceive of
duties to patients and to systems. Criticisms of dual stewardship focus on concerns for undermining the patient’s confidence in the doctor’s commitment to their interests, and the justifying of ‘gag clauses’ where patients are not informed of options available outside their system. Developing values and attitudes appropriate for practice in these complex systems require a reaffirmation of the professional elements of competence, altruistic commitment to patient welfare and medicine as a public trust.

CONCLUSION: VIRTUES FOR OUR TIME

If the images of past heroes of medicine and the good doctor are clear; what does the future look like? Can we sketch out the features of the good doctor in the twenty-first century? There are many possibilities. I can provide no clear portrait but rather, hope to suggest that from the many colors, shapes and components of practice in our time, an outline can be defined. This outline will clearly indicate that we are describing a doctor and not a mechanic or merchant. Without those first broad strokes that start a portrait, no image can be created as the background can shift and change. The core features of the doctor as a professional must remain recognizable. The core virtues necessary for contemporary practice become a little clearer.

Fidelity to trust is still central to professional practice. The patient must be able to trust in the doctor’s scientific, clinical and ethical competence. Scientific competence requires an understanding of empirical evidence and its limitations. Clinical competence requires a respectful and empathic interaction with the patient and meticulous attention to the patient’s history, physical examination and illness experience. Phronesis, or practical wisdom, allows the doctor to make a thoughtful judgment of potentially effective interventions for the patient. Ethical competence demands an acceptance that the doctor’s task is to bring evidence and clinical judgment regarding potential benefit and to assist the patient in judging what benefits and risks are acceptable to them. Commitment to the patient’s best interest is still the basis for the patient’s trust. It requires doctors to understand the fundamental complexity in the notion of best interest. While we have moved from self-effacing to altruistic and fiduciary conceptions of this commitment, the central moral and ethical concern remains – the doctor’s personal and financial interests are at stake in every patient encounter. Doctors need to develop courage and fortitude to work for patients’ best interests in a climate where many doctors are simply entrepreneurs. They also need to develop temperance and prudence to recognize the ‘hype’ of medicine and to
resist patient demands for unnecessary or non-validated care. Finally, the profession must re-claim its commitment to medicine as a public trust, not a business. Doctors must engage in the development of just, fair systems of care and funding. These are now crucial elements in the patient’s interest. This will be very difficult as the profession has not attended to the notion of medicine as a public trust. If this care could be agreed upon, then the work of identifying meaningful strategies for curricular reform and faculty development could begin in earnest.

Even if medical education can bring some theoretical order and consistency to the enterprise of professional education, it faces an enormous challenge. For, if excellence in professional practice is learned in the experience of excellent practice, then faculty and other successful practitioners are essential teachers of medicine’s moral core. If they have abandoned that moral core because of fatigue, disillusionment or greed, then medical education’s image of the good doctor becomes a nostalgic portrayal of what was in a simpler time or a cartoon of the folly and naivety of impossible idealists. The disconnect between the rhetoric of professional morality and the reality of entrepreneurial practice in a consumer world will be more sharply and painfully defined.

The promise of educating for professionalism is an issue for the medical profession and its future. It is not just another educational experiment. Despite the masses of web-based information, the power of medical and technologic advances and the consumer mentality of modern life, when individuals are really sick, medically dependent and dying, the character of the doctor matters (Bendapudi, Berry, Frey, Turner Parish, & Rayburn, 2006; Heyland et al., 2006). The challenge for the profession is to recognize this enduring reality and to develop educational, professional and health system structures and practices to preserve and protect it in a changing world.

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