Taking Medical Ethics Seriously
Report and recommendations to the Clinical Curriculum Subcommittee
Submitted November 9, 2004

Executive Summary

A. The current curriculum is reviewed and noted are course offerings in the first three years of medical school
B. There is a need to integrate ethics into the curriculum with additional content in the first two years and expansion of ethics teaching in a systematic way in the clinical years
C. There are 5 recommended strategies for implementation
    1. A formal introduction to clinical ethics and moral decision making during the orientation period just prior to the beginning of the third year with the introduction of the "ethics workup" as a systematic approach to clinical ethical decision making
    2. Provide an ethical focus of attention in the medical record at BMC and affiliated hospitals where BUSM students learn
    3. At the clinical clerkship level:
        a. Students will include an "Ethics Concerns" section in the written medical evaluation of patients seen.
        b. Clinical Departments should be encouraged to organize ethics conferences on a regular basis for students house staff and faculty
        c. Faculty Development: Each department should appoint a senior faculty person who will be the mentor and leader in the department for medical ethical teaching. The medical School in conjunction with the residency programs will support faculty attendance at intensive ethics courses. New faculty should be recruited with an interest or expertise in medical ethics. Seminars should be instituted at BMC for faculty in the content and teaching of medical ethics
        d. There should be a "course director" or coordinator of the ethics educational initiative and this course director should chair a permanent interdisciplinary Ethics Curriculum Subcommittee of the Medical Education Committee. The Medical Education Committee will appoint members of this committee and the chair. This committee will monitor and support ethics education at BUSM.
    4. There should be a new integrated longitudinal course during the third year: "On Doctoring: Becoming a Physician". This course would meet for two hourly sessions integrated into the clinical years. It would include seminars and some large group presentations addressing ethical issues, cultural, religious and spiritual issues, the physician patient relationship, the process of reflective thinking and there review of the personal awareness dimension of becoming a physician as it related to patient care and the educational process.

5. The development of a fourth year Clinical Ethics Elective in association with BUSM and BMC's Ethics Consult Service

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I. The Committee's Charge: Dr. Benjamin Siegel asked Dr. Alfred Tauber to chair a committee to make recommendations to the Clinical Curriculum Subcommittee, whose mandate is to formulate curricular reform in the third and fourth years of medical education at BUSM. Specifically, this ethics group was to:

1) Explore how ethics is taught in the clinical years and review what students are exposed to in the preclinical years;
2) Make recommendations for an ethics curriculum integrated into the clinical years;
3) Suggest resources necessary for faculty and curriculum development to sustain these educational efforts.

The Committee notes that while its focus is the third and fourth years of medical school, the first two years comprise the period in which basic medical ethics are introduced, so the committee's survey included an evaluation of the entire medical ethics curriculum at BUSM.

II. Committee Members: Alfred Tauber, M.D. Chairman, Michael Grodin, M.D., Michael Paasche-Orlow, M.D., and Benjamin Siegel, M.D. ex *officio.*

These faculty were complemented by four students: Peter Everett (fourth year), Lisa Stutius (fourth year), Eva Chou (third year), and Joshua Weissman (second year).

III. Current Status of Medical Ethics Education at BUSM

The first year is the focus of medical ethics education at BUSM. In *Essentials of Public Health* (Dr. Michael Grodin, course director), 22 hours are devoted to a wide array of topics in medical ethics, health care law, and human rights. Because the faculty is principally drawn from the health law staff of the School of Public Health, the curriculum reflects their principle interests. Although general ethics principles are taught, the emphasis of the course is on the regulation of medical practice, which includes the rights of patients in regards to malpractice, informed consent, confidentiality and privacy, reproductive rights, the right to refuse treatment, death and organ transplantation. Despite the high competence of the faculty and the relevance of these topics, the curriculum spends little time on formal medical ethics, i.e., the principles approach or more general moral theory instruction. While some would regard this as a short-coming, our ethics course, in stressing health care law and human rights has, in a sense re-formulated "medical ethics" to encompass these areas as part of moral theory. *Integrated Problems* (Dr. Adrianne Rogers, course director), meets approximately once every week. While most of the cases discussed have some ethical concerns, about half are heavily weighted with moral issues. These cases have learning objectives that address these moral issues (e.g., premature infants, the role of religion). Students report that these discussions are often tedious and since they are not tested on the material, the ethics is usually heavily subordinated to learning the pathophysiology. *Introduction to Clinical Medicine* (Dr. Stanfield, course director) has no specific ethics component, although ethics instruction seems to be implicit in discussions of such topics as sexual history-taking, drug/tobacco screening, domestic violence screening, cross-cultural medicine and the like.

In the second year, ethics is covered only as case discussions in two courses continued from the first year, *Integrated Problems* and *Introduction to Clinical Medicine.*

In the third year, the clinical rotations have varying emphasis on ethics training. It appears that Obstetrics-Gynecology, through the influence of Dr. Dick Brown, and Pediatrics, as a result of the efforts of Dr. Benjamin Siegel, make the best sustained effort at having students address moral issues. Drs. Brown and Siegel have adopted a case-by-case approach, which, while not formally structured, attunes students to the ethical dimension of clinical care. In Ob-GYN not all BUSM students are exposed to these teaching experiences while in Pediatrics all students are exposed to an introduction to ethical decision-making, the "ethics workup" and a seminar discussion of cases identifying an ethical dilemma in the practice of Pediatrics. . In the Department of Medicine, 2 clinical problem cases, of 30, are explicitly ethical in nature: end-of life and terminating the doctor-patient relationship.

The fourth year has no dedicated ethics education. Electives in *Medical Ethics* (Dr. Grodin) and *Philosophy of Medicine* (Dr. Tauber) attract few students.

The Academies of Advisors Program is planning to participate in ethics education at BUSM. The Academies were introduced in the Spring of 2003 and consist of six groups of five faculty advisors and 25 students. Under the direction of Dean Phyllis Carr, a more structured program focused on ethics issues is being developed to supplement more formal teaching in medical ethics and professionalism. How the Academies may be expanded; how faculty will be trained to lead such discussions of moral interest; how, indeed, will enough new faculty be recruited to maintain the program as successive classes are added, remain open questions.

IV. The Committee's General Orientation

The Committee concluded that ethics training at BUSM in the clinical years was deficient. Without a formal structure – educational goals and a means to achieve them – the education of students remained *ad hoc* and incomplete. While recent Medical School Graduation Questionnaire surveys by the AAMC suggest that BUSM fourth year students feel reasonably well trained in this area, such self-reporting appraisals are difficult to evaluate, at best. The Committee noted that both Harvard and Tufts are implementing revision in medical ethics training. Harvard's program is still evolving, but Tufts is about to inaugurate a school-wide program in bioethics, which includes a salaried Program Director, who will be responsible for implementing the overall curriculum and overseeing a Faculty Development Program. The resources allocated to this effort are significant: In the clinical years, a core faculty will be developed for each of the five specialty areas (medicine, surgery, ob-gyn, psychiatry, and pediatrics) for each affiliated hospital (five). Clinical-based training efforts will require a Bioethics Coordinator and Program Liaison Person at each hospital to oversee monthly scheduled bioethics presentations. A list of topics is being developed. Without going into detail, the Tufts program is noteworthy for its commitment to identify a core ethics faculty of twenty-five clinicians (for five hospitals) and eighteen faculty for teaching pre-clinical ethics. In informal discussions, it seems as if the Harvard effort is proportionately even greater.

To appraise BUSM's standing in ethics education, the Committee considered the character of medical ethics education in the United States and other Anglo countries (England, Canada, and Australia) by literature reviews and polling of its collective professional experience. Summary conclusion: National standards have not been established and the commitment to ethics education varies greatly. There are no prescribed medical curricula in the United States, and, indeed, there is little guidance from AAMC regarding training in medical ethics. [1]

Students and faculty freely discussed their own concerns about the "hidden curricula" of professionalism; the limits of faculty involvement in third year teaching; the severe time constraints on achieving the cognitive goals of clinical training and the concern that ethics and other humanistic/social science matters would dilute the apparent primary process of medical education. These issues acutely pointed to the large scope of the Committee's task in identifying core issues in ethics training of medical students and the lack of an accepted approach, much less a specific agenda. Part of the problem identified by several members was the difficulty of defining 1) content, 2) the process of pursuing ethical behavior in the clinic, and 3) the virtue or character of the ideal physician. These matters are hotly debated nationally, and the Committee reflected some heterogeneity on how central medical ethics should be in medical education. We believe the debate refers to the very character of physician identity educators wish to develop. To initiate ethics education reform at BUSM, basic decisions about the nature of bioethics training must be made. The next sections address this general matter, which are followed by specific recommendations.

V. Background: Whither Medical Ethics Education?

The Committee concurred on a general point: The powerful tool of scientific objectivity has to be balanced against other humane resources that allow doctors truly to hear their patients, assess their values, and respect them. This requires support of an ethos of care that balances science with empathy. If we seek a more comprehensive humane medicine, some measure of success may be detected in the active interest taken by the medical community in

regards to ethics and humanities (Pellegrino and McElhinney 1982). On the national scale, moral issues now receive active attention, evident by the increased frequency of discussions, forums, research, and literature on ethics. While some cynics might well argue that this new-found attention is due to risk management and the high cost of defensive medicine, taking patient rights seriously as both a legal and social concern has undoubtedly forced the medical community to become more sensitive to an ethical domain it too long ignored. (The moral sensitivity of the profession largely remained limited to the doctor-patient relationship, so while medical ethicists focused on the micro level of patient care, the larger issues of distributive justice and human rights remained as a subordinate concern.)

The rationale for ethics training in medical school rests on the general desire to offset the professionalization of physicians as technocrats. Howard Spiro is particularly forthright in his characterization:

> During medical education, we first teach the students science, and then we teach them detachment. To these barriers of human understanding, they later add the armor of pride and the fortress of a desk between themselves and their patients....Students begin their medical education with a cargo of empathy, but we teach them to see themselves as experts, to fix what is damaged, and to "rule-out" disease in their field. (Spiro, 1993, pp. 8-9)

Because medical students are assumed to enter medicine at least in part in answer to an empathic call, the teaching of ethics aims to restore, or perhaps rejuvenate, the casualty of professional training, namely lost empathy.[2]

Mentorship raises the specter of what has been called the "hidden curriculum" of medical school (Wear 1998; Goldie 2000). Formal ethics instruction can only play a limited role in the student's ethical growth, for the lessons of the hidden curriculum are powerful and always present. Role models must be particularly cognizant of their immense impact on students' beliefs and conduct, as empirical research has amply shown that students are more deeply influenced by the behavior of role models than by the material presented in course work (Glick 1993; Goldie 2000). This suggests that the target of medical ethics training should include senior physicians as well as students.

So the question looms: How to reawaken the compassion that inspired (at least in part) students to become doctors in the first place? Those who advocate teaching the humanities argue that the potential gains include "increased care for persons," "increased self-critical attitude" on the part of the physician, "increased capacity for personal growth," "enhancement of patient autonomy," a better understanding of "norms of professional conduct," and finally, "contribution to public policy debates," all due to a heightened humane awareness hopefully achieved through a curriculum devoted to enhancing such qualities (Pellegrino and Thomasma 1981, p. 73-4). To buttress these claims, there are suggestions that clinical performance is linked to moral judgment. Doctors who possess more developed moral reasoning skills may be more competent in the clinic (Sheehan et al, 1980), and this moral awareness has been declared to be correlated with moral education (Harvan 1993, p.361). The optimistic conclusion of such studies promotes the view that education fosters morality, which in turn develops more effective physicians. These views are not universally supported, and indeed, the Committee reserved its collective judgment on this matter.

The debate takes this basic pattern: Critics hold that if the medical school curriculum must include liberal arts, not enough time will be left for science. Already, the traditional four year course of study is often thought inadequate to prepare students for the highly technical and scientific demands of medicine in the twenty-first century. This position is countered with the

observation that ethical reasoning skills figure prominently in the clinical decision-making process, and its relevance is determined by the value assigned by the supporting elements of professional appraisal (Pellegrino and McElhinney 1982, pp. 34-5). Yet a dearth of proper evaluation methods plagues what is already a confused issue (Goldie 2000). [3]

Finally, and most basically, many contend that ethics and moral views are 'caught' not 'taught'. In other words, students have acquired their values by the time they reach medical school through family life, church, and societal interaction. Consequently, formal teaching will be unable to modify these pre-established beliefs (Pellegrino and McElhinney 1982, p. 35). Following this line of reasoning, critics of humanities education in medical school almost scoff at the notion that such course work will have a salutary effect on physician behavior. They maintain that compassion and empathy spring forth from the child's earliest socialization and is supported or altered by the vast cultural influences of a society that may or may not foster such precepts. Even the most ambitious humanistic education cannot alone promote increased moral self-consciousness (Roochnik 1987). The greatest barrier to student development in this area is what has been called medical student "foreclosure of feeling" (Cody 1978, p. 46). Though a well-structured and comprehensive humanities program may be designed to offset this potent force, it seems unlikely that students will themselves become more humane simply by being educated in medical humanities, or even ethics. Role modeling and mentoring of medical students by supervising faculty at the bedside or in the clinics may make a difference.

VI. Seeking Balanced Objectives

The spectrum of opinion concerning ethics education thus falls between two poles: On the one hand, those who advocate curricular reform to increase ethics education argue that supplementing the traditional program with formal humanities and ethics course work will mold a new generation of physicians, infused with enhanced moral sensitivity (Kopelman 1995). They argue that the training (or lack thereof) received in medical school shapes the physician as he or she continues through professional practice, and thus the myopic focus on technical skills and scientific expertise minimizes those personal qualities such as compassion and empathy, which play a major role in patient treatment. Given the current concern for compassionate care and heightened ethical awareness of patient autonomy, ethics education is no longer optional, but has become a necessary component of medical education (Guttentag 1960; Culver et al 1985; Layman 1996, p. 150). And considering the increasing moral challenges facing technological advances in medicine, the ethical challenges will become increasingly more convoluted (Johnson 1983, p.7).

Those in the middle of the spectrum question whether educational reform is the correct way to encourage more empathy, and if so, how success might be measured. Is medical school an inappropriate setting in which to attempt basic reform of the profession? Is increased empathy even the proper goal? Some believe that if ethics is to be incorporated in the curriculum at all, it belongs in undergraduate education, instilling the value of such thinking at the time pre-medical scientific studies are initiated. (Such suggestions seem to beg the point: Even if undergraduates do receive ethics training before entering medical school, it is still necessary that they apply this knowledge to medical practice, which is best accomplished with medical ethics course work. On this line of reasoning, ethical reasoning skills must be coupled to clinical skills, and thus any conjunction of ethics education with clinical training must be done during medical school, not undergraduate studies [Pellegrino and McElhinney 1982, p. 36].)

Finally, those critics most extreme in their opposition argue that the entire venture is unfounded. From this point of view, ethics training is not an essential part of medicine, and thus moral philosophy or medical humanities, more broadly, should not be included in medical education. Richard Landau argues that the aim of the current medical curriculum is to foster objectivity and dispassion, not empathy, in students (Landau 1993). This detachment appropriately provides them with the skills required to deal with patients and their diseases. From the first encounter with the cadaver in the anatomy laboratory, the student is introduced to the stark realities of the clinic, a radically altered life from that previously known. This entirely new perspective, where humans are reduced to a scientific scrutiny is the foundation of modern medicine and cannot be compromised. Indeed, emotional detachment is a value to be encouraged, in order to make sensible, objective choices. The ability to shut out personal and subjective feelings functions as a potent psychic defense mechanism, allowing physicians to cope with the traumatic aspects of medical care (Landau 1993; Cody 1978, p. 54). Desensitization is thus both practical and effective.

Proper scientific evaluation and diagnosis call for objectivity, and according to this calculus, empathy interferes with professional conduct. This attitude has a long and distinguished heritage, one that competes with the humanistic image of the doctor: According to this view, medicine as a science requires that the physician-scientist must remove himself from the complexities of emotional attachment in order to achieve optimal objectivity. While compassionate involvement that requires a different kind of psychological commitment may be worthy in another setting, on this positivist orientation, medicine is governed by a different ethos.

The Committee balanced these various points of view and concluded that Landau's perspective is myopic in the extreme. Medical competence calls for different faculties. Differing circumstances demand varying degrees of empathy and detachment, and no final prescription is possible beyond calling for both as required. Yet the ethos of contemporary medicine is dominated by the positivist attitude, and while empathy receives a nod of encouragement, there is little doubt which attitude dominates. Medical ethics remains a distant cousin to other disciplines taught in medical schools, and as an educational enterprise, it remains ancillary. Plainly, to trade precious resources (curriculum time and faculty effort) from basic or clinical sciences to teach ethics, which is poorly supported by outside agencies and foundations, is simply cost ineffective, whether measured by accountants or by the academic establishment committed to bioscience.

Rather than promoting an extensive free-standing humanities curriculum as some would favor, the Committee sought a path that would ensure greater attention to training in medical ethics *within* the current structure of BUSM's clinical training. The medical environment is more complex than a modified laboratory, where the rules of cold detachment operate. On the other hand, the bedside cannot become a scene of operatic drama. Instead, physicians function in an arena where emotional demands must be controlled and yet also acknowledged. Ideally, the physician will be caring and compassionate, and at the same time objective and scientific. No small demand, and one that calls for individuals with abilities extending from one end of the subjective spectrum to the other. The question looms as to how such abilities may be effectively promoted. If the root of the problem is physician ignorance, education could indeed be the answer. Yet any attempt at curricular reform is plagued by simplistic optimism and naiveté. It does not address the greater problem of the established mentality of the physician which is systematically passed from generation to generation through

medical education and that throughout the 20th century was guided by a positivist mentality (Carlton 1978, p. 4). The reforms sought cannot be the product of a simple directive by those who seek a more comprehensive moral education. Despite new directives from various medical education governing boards, the failure to adequately address ethics education or more comprehensively consider moral issues continues to plague clinical practice despite repeated calls for reform over the past three decades (Carlton 1978, p.171). With these provisos, the Committee recognizes that the complex contending interests at hand must be balanced.

VII. Curricular Reform

A. Goals and Methods of Ethical Training at BUSM

Putting aside medical humanities writ large, the Committee concurred that ethics education is easily defended at each educational level. With 58% of all US medical schools undergoing major curricular reform in 2001 (Barzansky and Etzel 2001), re-thinking on this matter seems opportune. The typical mantra cites the steady and powerful advances of medical technology which have spawned new ethical dilemmas, and educators would be derelict to disregard the need for ethics in the curriculum, since students cannot be expected to be prepared to face the difficult predicaments of professional practice. Learning from the example of senior staff, though essential, as already noted, is no longer regarded as a sufficient means of ethics training (Johnson 1983, p. 5). The budding physician must be encouraged to question the decisions of his or her superiors, who in turn must be able to justify the chosen course of action. Despite this consensus about teaching ethics, the actual details are hotly disputed, since the purpose, content, teaching methods, and means to measure the success of ethics education are each contested and extensively debated. [4]

A pluralistic society exposes students to numerous viewpoints and they must be able to think critically about them in order to achieve the widely accepted goal of cultivating compassion and moral sensitivity. Although students enter medical school with a well-established set of values and moral sensitivities, it can hardly be assumed that these necessarily will be consonant with those values that foster humane care or are consistent with the values of their patients. In liberal society, diverse moral beliefs contend with each other, and while the law sets minimum standards and might adjudicate some common practice, in the nether world of inter-personal relations and life-directing decisions, no prescribed moral code necessarily prevails. Indeed, the law predominantly sets 'negative' rights and because of its jurisdictional character, it cannot serve as the basis of moral codes, albeit judges are often guided by community standards. Based on this tenet, ethics education and behaviors designed to foster moral sensitivity must complement medical jurisprudence. Because ethics is a formal philosophical discipline which fosters the examination of fundamental moral presumptions, ethics training putatively allows students to critically reflect upon their own values, a vital skill in the fair consideration and treatment of patients whose personal values may not coincide with those of the physician. Accordingly, the first priority of ethics education is to provide students the opportunity to actively scrutinize their own moral assumptions, something which they may have never previously done. This hopefully leads to moral growth and the opportunity to fully assimilate one's passively attained beliefs (Pellegrino and McElhinney 1982, p. 36). The point is to develop a critical attitude in regards to ethics, just as in the clinical sciences.

If we reject the notion that ethics education should indoctrinate students, what should we accept as a more proper goal? In general, a reasonable aspiration is "to develop physicians' values, social perspectives, and interpersonal skills for the practice of medicine" (Miles et al

1989, p. 705). In addition to these general aims, a chief priority of ethics education is to provide practical decision-making skills to be used in the clinic (Miles et al 1989; Goldie 2000). Thus, ethics education should provide physicians with the following specific competencies:

1) an awareness of the humanistic and ethical aspects of medical careers;
2) the capability to evaluate and affirm their own personal and moral commitments;
3) a proper foundation of philosophical, social and legal knowledge;
4) the ability to use the aforementioned knowledge in clinical reasoning;
5) the interpersonal skills necessary to apply this insight, knowledge and reasoning to humane clinical care.

The basic objective is to hone the practical ability of moral reasoning for the clinical setting so that the physician will be aware of not only the fundamental ethical concepts governing care, but also the dynamic of physician and patient values determining what and how care is administered (Pellegrino and Thomasma 1981; Goldie 2000). Of these fundamental skills, the ones that should be emphasized during the didactic lectures of the first year and then actively taught in the introduction to clinical skills include (Culver et al, 1985):

1) The ability to identify the basic moral aspects of medical practice. This includes the routine explanation of risk, ascertaining whether the patient understands the risk, and the validity of the consent given.
2) The ability to obtain a valid consent or a valid refusal of treatment is fundamental to patient autonomy. To know the basis of consent and what constitutes adequate information, the ability to appropriately communicate such information, and the ability to distinguish persuasion from coercion are critical moral (albeit interpersonal) skills.
3) The ability to determine the competency of patients to give consent or refusal of therapy. Students must understand that competency is a murky area where legal and psychiatric determinations are at play. Standards should be reviewed.
4) Knowledge of how to proceed if a patient is only partially competent or incompetent to consent or refuse treatment, i.e., understanding the clinical (psychiatric) and legal (administrative) procedures for dealing with a compromised patient.
5) Knowledge of how to proceed if a patient refuses treatment. The issues of health care proxy and the valid appointment of such an individual must be understood as legal matters.
6) The ability to know when it is morally justified to withhold information from a patient or breach confidentiality. Although these are rare problems, physicians in understanding justification of breaking normal practice are concomitantly aware of routine standards.
7) Knowledge of the moral aspects of the care of patients with poor prognosis or who are terminally ill. This vast area requires training in a) effective interaction skills, b) the propriety of sharing of such information (confidentiality issues), c) determining when it is morally justified to forego or discontinue treatment, and d) defining the role of "Do Not Resuscitate" orders.
8) Above all, students should have the competency to engage in empathic collaborative discussions with patients, and their loved ones, and together, make decisions based upon patients values/cultural/ spiritual belief systems and being consistent with the best scientific practice of medicine and the values of the physician.

B. Taking Ethics Seriously at BUSM

The Committee deliberated as to how to best follow the "middle path." It concluded that if the BUSM faculty seriously sought a change in medical education that will augment training in medical ethics, then an enhanced value must be assigned to those behaviors that 1) express the moral concerns of care and 2) enhance the communication between patients and their care givers. While the Committee recognizes the competing points of view regarding how this might be achieved, we recommend that curricular reform be addressed towards developing the particular skill of obtaining an ethics evaluation as a *routine* part of the medical evaluation. The topics of particular interest, e.g., end of life, informed consent, privacy, etc. will undoubtedly arise as instances of student experience. Instead of developing a curriculum to cover such topics again (they are already addressed in the first year), the Committee recommends that the groundwork of being comfortable with basic ethical principles and a systematic basis for making such an evaluation become the focus of ethics training in the third year. To that end, an addition to patient evaluations is suggested:

To place medical ethics more firmly into medical practice the Committee recommends that medical ethics be made an explicit focus of attention in the medical record. A separate section of the medical chart, one integral to clinical evaluations and on-going progress notes, should be devised to articulate both the obvious and less apparent ethical issues pertinent to each patient. This so-called Ethical Concerns section is designed to proactively identify such problems and thereby raise these issues as part of routine evaluation and care (Tauber 2001; 2002).

The Committee emphasizes that the proposal made here is not 'radical' in any sense. The ethical issues addressed in evaluating a patient's social history and psychological state, as well as identifying value-laden decision-making are already important elements in patient evaluations. In a sense, we are advocating a re-organization plan. So, as a reform of data gathering and organization, what is already *implicit* will become *explicit*. In systematizing the ethical concerns of patient care, the student will have the benefit of an easily learned schema, which will prove invaluable in future practice, as well as an aid for the more immediate demands of Board exams.

The medical record not only depicts health care, but it also has a role in structuring that care and the logic implicit therein. In its narrative, the chart identifies clinical problems, the efforts to diagnose illness, and finally, records therapeutic interventions. But it also proscribes the ways each of these processes are performed. In short, the record reflects the structure of medical thought. And, perhaps less obviously, it also expresses the values embedded in clinical practice.[5]

The medical record again needs revision. Ostensibly, the chart identifies all the clinical issues at hand, assesses each individually, and then integrates these to ensure that the patient receives thorough care. But the aspiration of integrated, comprehensive care remains, and as a true mirror, the medical chart remains piecemeal, and more telling perhaps, incomplete, clearly revealing lingering frustrations facing patients and their health care providers. As a true mirror of health care, the medical chart reveals a remarkable absence of attention to medical ethics, except in the case of crisis management.

But medical ethics is more than crisis decision-making, for implicit to virtually all medical interventions is a complex array of choices based on individual and cultural values. The kinds of care, the integration of diverse belief systems, the attention to the psychological reaction to illness are each representative of a vast universe of moral reckoning — moral in the sense that values are exercised as choices are made. In short, medicine's moral accounting must factor all those values that determine clinical decisions. On this view, medicine's scientific ethos is only

one element of this calculus. Religious beliefs, personal histories, psychologies, and social mores also carry weight in this calculation.

The conspicuous absence of medical ethics in the record of clinical encounters is baffling given the current global interest in making medicine's moral commitments explicit. To design repair, we propose an addition to the medical record: In the admission note, and thereafter in progress notes and in the discharge summary, we propose that a section called *Ethical Concerns* be inserted. 'Ethical' in this instance encompasses all those matters related to the value-based decisions which are constantly made when caring for a patient. What options are exercised and how they are implemented are more than technical decisions. Clinical decision-making must be integrated within broad social and psychological concerns. These decisions require physician guidance, and the doctor in turn, to negotiate effectively, should be aware of his or her own value system that either may be in harmony or in conflict with those of the patient. Self-reflection and empathy thus become important moral faculties in addressing the myriad challenges that appear in the exercise of effective care.

An *Ethical Concerns* section of the medical record would provide for a synthesis of personal, social, and ethical issues related to patient care. There, physicians would self-consciously address problems which range from decision making in crisis to the mundane details of support for the ill during the hospital stay and after discharge. In making deliberate efforts to identify such questions, the doctor effectively addresses those concerns often closest to the patient's own experience of illness. More than a scientific and legal document, the medical record might then become a more comprehensive construction of a person's illness.

Because the medical record is a narrative of a particular sort (Hunter 1994), it tells a story of disease. So what is included in that story formulates, structures, and thereby interprets. Standardized along prescribed lines, the medical chart may be perused quickly by anyone conversant with current practice. Such a document displays information uniformly, and (perhaps more subtly) the logic and ethos underlying practice — how care is thought of and ultimately delivered. But the record is more than a *reflection* of practice and thought, it is also a *determinant* of what kind of care is given, because the record functions in structuring clinical thinking. Doctors are trained to fulfill the template of the record's divisions and sub-divisions, to obtain data relevant to the particular problems that require attention, as well as to address unsuspected disease. If questions are not asked, answers cannot be given. If tests are not performed, the best intentioned scrutiny will not suffice. Similarly, if inquiry is not made into the welfare and support of a patient, the physician will not identify potential or present problems. And while there is an increasing sensitivity to gleaning such insight in the clinical interview, there is as yet no formal place in which to situate such information. By specifically addressing the moral concerns of the patient as part of the medical encounter, students will have a straight-forward means by which such matters may be considered. We regard this addition as an effective vehicle to make ethics a more central concern of doctors-in-training.

To have a section in the medical chart devoted to such concerns serves to highlight the physician's awareness of the moral dimension of care and foster its development. By demanding that the busy physician attend to this dimension of his patient, ethics will be given appropriate standing for attending to concerns of the ill that too often are bypassed or forgotten.

C. The Ethics Work-up

'Ethics' refers to the deliberations, character, and justifications concerning all those matters related to the value-based decisions which are constantly made when caring for a patient.

Broadly speaking, there are two domains where value judgments are prominently at work: The first concerns the implementation of knowledge: After applying the scientific and technological tools of clinical medicine, the question looms, What should be done for a patient in the context of the personal and social contexts of the illness? (Note, the use of 'illness' as opposed to 'disease;' the latter is a biomedical designation for pathologically defined dysfunction, while 'illness' refers to the entire constellation and experience of a person being sick.) The second arena is defined by the emotional, social, spiritual, and cognitive elements that are at play in the patient's experience of illness. How do physicians, beyond the exercise of their clinical science, participate in a personal drama? These draw upon their empathy to address the myriad challenges that appear in the exercise of effective care. These issues, as crucial as they might be, are rarely voiced in the medical record and thus remain conspicuously muted.

What might an "ethical work-up" section of the medical record entail? Should a series of specific questions be asked or a prescribed format followed? What, indeed, are the limits of such an inquiry? or better, How comprehensively should one attempt to address such concerns? Where should it appear? Clearly, different patients have different requirements and different questions dominate different clinical settings. But no matter what the particularities of any given case may be, a self-conscious consideration of the patient's values must be considered; and, no less important, the doctor's self-awareness of the values guiding his or her own choices and actions also must be understood. Defining the value structure of both the patient and student/physician, and making it explicit, provides the basis by which the clinical encounter remains a consensual and cooperative effort. Because the 'moral space' is constructed by a complex confluence of values, sometimes in perfect alignment, and sometimes not, an ethical work-up must enunciate and ultimately encompass the values of the patient *and* the values of the clinician in the setting in which he or she operates. In other words, there is an on-going negotiation as to what *can* be done, what *should* be done, and *who* decides those choices for each patient (Pellegrino and Thomasma 1981). We recommend making this deliberation explicit — articulating the basic ethics which will guide and inform clinical decision-making.

Under this scheme, doctors/students not only would fully explain therapeutic options to their patients, but in doing so, the underlying ethical norms and the meta-ethical assumptions (on what basis is one value picked over another) by which medical opinions are arrived at become apparent. To determine mutually agreed upon therapeutic goals, the physician must be aware that the decision is an adjudication of perspectives, where embedded values often silently determine what is seen, what is believed, and what is advised. The point of the exercise is to deliberately address potential conflicts of value *before* they arise, and, as in any negotiation, to understand both points of view.

Surprisingly, scant attention has been given to formulating a comprehensive "ethics work-up," although both general guidance (Lo 1995), as well as specific protocols have been devised for certain problems, such as palliative care (Lo, Quill, and Tulsky 1999; Karlawish, Quill, and Meier, 1999). This is due in part to the competing systems of medical ethics (e.g., axiomatic, consequentialist, consensual, or pragmatic ethics [Murphy, Butzow, and Suarez-Murias 1997, pp. 23ff.]), the sheer complexity of the issues involved, and the restrictions imposed by the particularities of individual cases. Nevertheless, a four-fold practical approach has been devised (Table 1), which offers an orderly review of the ethical issues in any case (Jonsen, Siegler, and Winslade [1998] offers case illustrations of this approach). (While other schemas have been proposed [e.g., Myser, Kerridge, and Mitchell 1995], we believe this simpler version is superior.)

Table 1: Four-fold Ethics Evaluation (adapted from Jonsen, Siegler, and Winslade [1998])

1. **Medical Indications**: Define clinical problems, goals of treatment, probabilities of success, and plans for therapeutic failure; delineate cost/benefit ratios of care.
2. **Patient Preferences**: Maintain patient's right to choose by determining preferences for care; assess competence of patient and ability to cooperate with medical treatment; if incompetent, is there health-care proxy or Advance Directives?
3. **Quality of Life**: Specify prospects, with or without treatment, of patient's recovery; define physical, mental, and social consequences of treatment success; explore plans for care in event of treatment failure.
4. **Contextual Features**: Clarify family or provider issues that may influence clinical decisions, including allocation of resources, financial restraints, and religious or cultural factors; describe possible legal implications of treatment decisions, e.g., clinical research or teaching; establish the scope of confidentiality.

Table 2 outlines a deliberative procedure for arriving at the patient's moral profile and an ethical decision within this format (Thomasma 1978).

Table 2: Presentation of Ethical Decision-making (adapted from Thomasma 1978)

Step 1 Identify the significant human factors in the case. Demographics (age, occupation, education, family status, home setting, etc.), behavior history (psychiatric history, criminal record, substance abuse), religious and political attitudes relevant to health and medical care.
Step 2 Explicitly define related value factors (medical, professional, or human) present for the patient, health care professional and other relevant persons involved in the case.
Step 3 Delineate all ethical choices and major value conflicts.
Step 4 Set priorities for values which are in conflict and give reasons for holding a position.
Step 5 Identify the criteria by which a decision is made, considering underlying ethical norms and meta-ethical assumptions (How was *this* decision, based on *that* value, moral?)
Step 6 Critique the assumptions underlying the decision made in step 5 and present the final opinion and strategy for dealing with the moral issues identified.

Implicit to this exercise is fact gathering, obtaining the clinical and psycho-sociological data, which is already routine, or should be. The key modification lies in taking these facts and not only examining them in the accepted fashion — principally within the pathophysiological context — but to place the deliberative process on a coordinate system that includes not only the patient's values, but also the student's. Thus the ethics work-up is directed toward understanding not only the patient's needs, resources, and values, but to coordinate these elements with the student's efforts, themselves directed by a set of values and priorities, both personal and institutional. The self-reflective elements of the ethics work-up make this portion of the clinical portrait different in kind from the rest of the chart, which is oriented from the examining doctor towards the patient. In the *Ethical Concerns* section, a true dialogue is embraced.

The Committee is not formally proposing details of an *Ethical Concerns Section*, but given the outline in Tables 1 and 2, certain elements should be included and the following seven-step process (modified and combined from the approaches discussed by Fletcher and Moseley 2003 and formatted according to Table 2) might serve as a starting template for the student ethical evaluation. Note, the first three Steps are devised as 8 broad questions and serve to gather data

for the moral evaluation; steps 4-6 frame the ethical evaluation proper (with its decision-making process) with another four broad questions; the last step is implementation and re-evaluation.

Table 3 Seven Step Ethics Evaluation (or 12 Basic Questions of an Ethics Work-up)

Step 1 Patient assessment

1. What are the patient's relevant contextual issues?

a. demographic facts
b. life situation and life style
c. family relationships, noting both supportive and weak or abusive relationships
d. setting of care: home or institution
e. socioeconomic facts
f. language spoken and English proficiency
g. cultural factors that would particularly encumber comprehension of biomedicine
h. religion, especially in terms of support needs

2. Is the patient capable of decision-making?

a. competence – legal issues, mental status
b. documenting diminished of fluctuating capacity if existing
c. prospects for enhancing capacity

Step 2 Explicitly define relevant value factors

3. What are the patient's preferences? (in terms of)

a. Understanding of condition
b. Views on quality of life
c. Values relevant to treatment decision-making
d. Current wished for treatment
e. Advance directives (including DNR)
f. Any reasons for seeking treatment regarded as medically inappropriate or refusing treatment regarded as medically indicated

4. What are the needs of the patient as a person?

a. Psychic suffering and possible interventions for relief
b. Interpersonal dynamics
c. Resources and strategies for helping the patient cope
d. Adequacy of home environment for care of the patient
e. Preparation for dying or long-term disability

5. What are the preferences of family or surrogate decision-makers?

a. competence of the surrogate
b. knowledge of the patient's preferences
c. opinions on quality of life and best interests of the patient
d. reasons for seeking treatment regarded as medically inappropriate or refusing treatment regarded as medically indicated

6. Are there interests other than, and potentially competing with, those of the patient?

a. Interests of the family (e.g., concerns about burdens of caring for the patient, disagreements with the patient's preferences)
b. Interests of a fetus
c. Scarce resources and competition for their use
d. Interests of hospital staff

e. Interests of the hospital (e.g., malpractice, economic incentives)

7. What is the nature of the relationships between

a. clinicians and patient/family

b. attending physicians and other hospital staff, i.e., consultants, nurses and house staff?

c. patient and family or surrogates?

8. Have all the parties involved in the case had an opportunity to be heard?

Step 3 Delineate all ethical choices and major value conflicts.

9. How is the moral problem being framed by the patient , family, and care givers?

a. Should the ethical question be re-formulated?

b. Identify and rank the range of moral considerations.

c. Are there relevant institutional policies pertaining to the case?

Step 4 Set priorities for values which are in conflict and give reasons for holding a position.

10. What are the goals of treatment and long-term care/prognosis of the patient?

a. Consider alternative goals and interventions in terms of patient choices

Step 5 Identify the criteria by which a decision is made.

11. Has a consensus been reached, and if so, how?

a. If not, what are the next steps for resolution?

b. What are the ethical and judicial standards and guidelines for resolving the moral problem(s) of the case?

c.. Consider underlying ethical norms and meta-ethical assumptions (How was *this* decision, based on *that* value, moral?)

Step 6 Summarize the final opinion and strategy for dealing with the moral issues identified.

12. In the critique of the moral deliberation, what are the assumptions underlying the decision made in step 5?

Step 7 Implement and then re-evaluate to determine the effects(s) of any actions or decisions.

A likely question, given that medical practice already addresses the psycho-social setting of the patient's experience of illness, is why this modification in record-keeping is required. Simply stated, the clinical priorities as a function of the wider life concerns of the patient are rarely described. Perfunctory notes about marriage status and employment constitute an acceptable social history, and only ancillary psychiatric or social worker narratives provide a more comprehensive picture of the patient in the home setting. We propose deliberately addressing this aspect of care by compelling the student to define the moral space within which she administers care. In so doing, medical ethics will be firmly placed in the chart and thereby powerfully direct, and self-consciously justify her mode of professional behavior.

Most cases require little or no ethical reflection (Lo and Schroeder 1981). For those facing end of life decisions, resuscitation, living wills, autopsy requests, and health care proxy are already routine and are, by and large, in place to be enacted; their formal adoption for every patient remains. The dramatic settings of transplantation, in vitro fertilization, abortion, and the

like, hardly need comment here, since the ethical concerns of such decision-making are integral to these clinical encounters. The 'extremes' of the medical spectrum are not our primary concern, for what needs attention is the more ordinary case, where determination of choices must be made in the context of a patient's values that are not easily articulated, and are frequently overlooked. In one report, almost one in seven patients suffered a moral dilemma unrecognized by the ward team (ibid.). While much depends on the patient population examined and the moral "index" adopted, we suspect further study will reveal this figure as conservative. [6]

VIII. Summary Recommendations

A. Implementation

1) During the transition period between second and third year, students will be given intensive instruction in the ethics work-up. Since BUSM already has organized a week-long orientation to the clinical experience, such an addition should be easily incorporated. The ethics syllabus will include relevant papers, explanatory narratives, and perhaps most importantly, several cases for discussion. We imagine that these cases will range from routine matters (e.g. obtaining a DNR order) to more dramatic illustrations. Reference to materials covered in the first year will be made. In this regard, the Committee strongly urges that consideration be made to increasing the number of hours devoted to the foundations of medical ethics. Specifically, more time should be devoted to general moral theories and the principles governing the evaluation of applied ethics.

2) During *each* clinical clerkship of the third year, students will be expected to include the *Ethical Concerns* section in their written evaluations. These should be critiqued by clinical faculty on a regular basis. In this regard, the Committee is concerned that faculty may be ill-equipped to supervise such write-ups. Attention thus must be made towards increasing faculty development in ethics training (see below).

3) A regular ethics conference should be instituted in the major clinical departments, which students must attend. The rationale for such conferences is to enhance the profile of medical ethics in the clinical service and to focus faculty attention on these matters as a more routine part of medical practice.

4) A new longitudinal integrated third year course meeting for two hours sessions during specific times in the third year: "*On Doctoring: Becoming a Physician*" would be established. This course would consist, mostly, of a seminar series with two faculty and groups of 10 students each, but there could be some large group (lecture) presentations. The faculty members and students could be the same as in the previous Academy groups. These faculty and students in the seminar groups have had a prior relationship with each other each other over the previous two years of medical school. Faculty members would encourage a supportive and nurturing atmosphere for exploration of the content issues of the seminar as articulated in a syllabus to be developed. The course content would include ethics (as a major content area), cultural/religious/spiritual issues in the patient/family/physician relationship. It would explore issues of personal awareness, all aspects of the patient/physician relationship, and the issues associated with the professional development of the medical student becoming a physician. The seminar would include the discussion of specific student experiences during the clerkship and include at least one written reflective essay by students (would could be discussed in the seminar) as well as significant and important experiences students have had while in the clinical years. The faculty would be the members of the Academy of Advisors, as these faculty members

were chosen as excellent senior teachers. The Clinical Curriculum Subcommittee would support this course and would appoint a course director and members of the supervising faculty committee to oversee this course. This course would be a formal part of the curriculum during the third year, continuing to address the mission of the Academy of Advisors during the first two years of medical School.

5) A fourth year Clinical Ethics Clerkship elective should be offered in tandem with a vitalized Ethics Consult Service. This might be coordinated with the elective already offered in Medical Ethics (Dr. Grodin).

6) To successfully implement an *Ethical Concerns* section in the medical record, cooperation and coordination between BMC and BUSM is required. The Committee notes that the Ethics Committee of BMC has recently changed leadership. We strongly urge that the BUSM Curriculum Committee work in tandem with the BMC Ethics Committee to foster inter-disciplinary activities around medical ethics in the clinical setting. (Attendance of BUSM faculty at the BMC Ethics Committee meeting would facilitate such interaction.)

7)Resources – both financial and time allocations -- must ultimately be coupled to clinical duties in order to foster faculty development and active participation in the arena of bioethics education.

8) Ethics education for fourth year students should include a continuation of the ethics work-up on clinical rotations and participation in ethics conferences. In addition, preparation for the National Board exam that includes Professionalism and Ethics should enlist formal instruction in the particular skills that will be tested.

9) Special ethics seminars should be encouraged and supported in various clinical departments and smaller clinical units which have hitherto shown particular interest in ethics, e.g., intensive care units, Pediatrics, HIV, Hematology-Oncology, Family Medicine, Geriatrics, Psychiatry, and Obstetrics-Gynecology.

10) With new regulations requiring that ethics be actively taught in residency training programs, the various pedagogic ethics activities for students should be coordinated with those implemented for post-graduate training. Considering the importance of residents as student mentors, the integration of student education with residency training is imperative.

B. Faculty Development

While there appears to be wide-spread interest among BUSM faculty in medical ethics, only a small group are professionally trained. [7] Although recruitment of present faculty to actively participate in ethics education is likely, a more concerted effort in developing professional expertise is required. The Committee recommends,

1) Recruitment of clinical faculty with expertise in medical ethics be given a high priority;
2) Subsidize BUSM clinical faculty to attend intensive ethics courses (e.g. the Georgetown summer course);
3) Institute on-going faculty seminars in medical ethics;
4) Appoint a 'course director' with support staff to supervise and coordinate ethics education at BUSM.
5) An interdisciplinary Ethics Curriculum Committee (i.e., a sub-committee of the Curriculum Committee) should be responsible for monitoring and, when appropriate, recommending revision of the ethics curriculum.

C. Further Study

Given the Committee's specific recommendations, we acknowledge that any curricular reform will be difficult to evaluate. After all, of what benefit is adding ethics to the curriculum if educators have no way to determine success and thus improve their programs? Several problems are glaringly evident: First, because of the numerous and ambiguous purposes of ethics education, it is difficult to devise any dependable measure of success. In order to assess progress, specific goals must be identified; which are appropriate? Second, since the basic structure of moral development has already taken place prior to a student's entrance to medical school, how can discernment be made as to the extent medical ethics education has modified or expanded moral reasoning, and whether success, or lack thereof, is due to the curriculum or other factors embedded in the medical culture? Third, which test best measures development? The widely used Defining Issues Test is based on the moral development theories of Kohlberg, which, if anything, measure an ethics at odds with the moral sensitivity sought for health care givers (Gilligan 1982; Baier 1987, 1994). Fourth, the impact of ethics education may not surface until many years have passed, for ethical sensitivity may develop with growing maturity. One final point: many options for the evaluation of ethics education exist, such as tests, interviews, simulations and peer review, and it may be necessary to employ more than one approach to determine accurate assessments of moral sensitivity (Layman 1996, p. 156). Because of the ambiguities of educational results, we encourage the Curriculum Committee to sponsor outcome studies in this area.

D. Conclusion

By adopting these recommendations to invigorate student training in medical ethics, we believe BUSM would become a leader in ethics education. We recognize that administrative approval to change current procedure in the medical chart requires thorough study and hospital-wide implementation, but the Committee regards such an effort as integral to modifying the culture of practice. In short, we appreciate that to inaugurate an *Ethical Concerns* section in the medical record will have far-reaching effects in re-positioning the importance of medical ethics in the care of patients. We regard this as a salutary result.

Footnotes

1. In recent surveys of US medical schools, at least 39 different topics are covered, and only six content areas were taught in a majority of schools: informed consent (85%), health care delivery (75%), confidentiality and privacy (67%), quality of life/futility/provision of treatment (67%), death and dying (66%), and euthanasia and physician assisted suicide (60%) (DuBois and Burkemper 2002). Of the 1,191 ethics readings used by US medical schools, only 8 are used by more than six schools, and no reading is used by more than ten schools, which dramatically illustrates that there is no consensus on the relevant literature! (ibid.). But these statistics only reflect a portion of the deep imbroglio about medical education in this area.

2. Consider one recent study reporting the results of interviews of approximately 630 medical students at the sophomore and senior levels. Among the seven areas of ethical considerations, students had most often witnessed "ethical breaches in the area of professional norms," a category which consists of the perceived ethical norms to which physicians must adhere (Bissonette et al 1995). The students did not characterize these violations as clinically serious,

yet they did believe that the patient involved was not given proper "care, sensitivity, and respect." Interestingly, sophomores were found more likely to report regard for patients as a central ethical issue, which only confirms the general impression that as the professionalization process progresses, sensitivity towards patients decreases (Self 1993), and that this results from standards learned from mentors, inasmuch as medical faculty, instead of serving as role models of moral behavior are too often cited as exhibiting insensitivity (Bissonette et al 1995).

3. Little progress has been made in evaluating the claims made by education reformers. Though standardized vignette exams (Savulescu 1999) and Kohlberg-based tools (a schema that tracks the sequentially sophisticated stages of moral reasoning [Kohlberg 1984]) have been utilized (Sheehan et al, 1980), the goal of making students "more humane" is not easily quantified, and the goals of such education have not been clearly defined (Pellegrino and McElhinney 1982, pp. 37-8). Although some studies suggest that even a relatively short amount of time in ethics-oriented course work favorably influences moral reasoning (e.g., Sulmasy et al 1990), a more concerted effort on the teaching wards is probably more effective (Carmel and Bernstein 1986). In any case, training ethical sensitivity remains an unresolved issue (Arnold, Povar, and Howell 1987; Self et al 1989; Goldie 2000).

4. For instance, should neutrality be embraced or a particular moral orientation adopted? Indeed, some have argued that it is impossible for teachers and students to remain neutral in this endeavor. Yet, the "neutral" goal of teaching ethics without expecting students to become more ethical and thereby embrace a moral perspective is fundamentally contradictory (Kopelman 1999, p. 1309). Instead of efforts to remain impartial and avoid discussion about values, which are unavoidably present even in the choice of the material and cases presented, teachers should be willing to recognize and discuss these values (ibid.), acknowledging that to teach any one moral standing as superior to others already assumes a set of values, which in turn must be scrutinized (Goldie 2000). The exercise is directed towards developing a sensitivity to the ethical domain, not to impose a moral order on another.

Regarding method, should ethics be taught in general or in specific terms? Among the "content areas" suggested are "ethical theory and humanities," "professional ethos," "multidisciplinary issues," "patient autonomy and clinical dilemmas," "student physicians," "academic medicine," and "social issues" (Miles et al 1989; Goldie 2000) The latter area, which includes social justice, is often eschewed as too politically-charged, although BMC's commitment to distributive justice offers a natural framework for such education. Another contending issue is to what extent the "Principles" (Beauchamp and Childress 2001) approach should be taught at the expense of its various critiques, such as feminist (Wolf 1996). Considering that most residency training governing boards require competence in understanding the Principles approach to medical ethics is a strong incentive to focus on this 'mantra' at the expense of a more comprehensive education.

The content of ethics courses may vary depending on the area of medicine, the perceived purpose or founding philosophy, and the specific approach adopted, e.g., principalism (autonomy, beneficence, etc.), decision theory (analyzing decision-making process as a model to provide the skills for investigation and resolution of moral dilemmas), or "topics" (clinical moral problems, e.g., professional codes of ethics, human experimentation, informed consent, resuscitation status, withholding of information, refusal of treatment, allocation of resources, and confidentiality) (Layman 1996, p. 153). The recent shift toward context-based, specific ethical

training has been challenged; some say that the training should be more generalized, in hopes of providing students with a foundation for recognizing ethical issues.

The next issue faced by educators is that of choosing among the various options of how to effectively integrate ethics in the curriculum. Most agree that ethics should not be taught in one course alone, for this will convey the message that ethics are separate from the day-to-day practice of medicine. The more sensible choice is that of “a single, discrete course and integrated modules across the curriculum” (Layman 1996, p. 154). This method of integration, popular in allied health education, shows students that ethics are not optional, but that they are an essential part of professional medicine. Another popular approach in medical schools is that of offering several courses or seminars supplemented by clinical rotations (ibid.). This practical method allows students to employ the skills learned in the classroom to the real life situations of the clinic. Corresponding to the desire of integrating medical ethics with daily practice is to limit the lecture hall as the setting for ethics education. In its place, small groups, the customary clinical setting and also the easiest place for students to voice their opinions about specific dilemmas, is favored to promote role playing, casuistry, decision analysis, and Socratic questioning (Layman 1996; Johnson 1983; Goldie 2000).

5. Indeed, when the format for keeping medical records was last revised about thirty years ago (Weed 1969), it was largely in response to a new appraisal of how physicians thought about their patients. The problem-oriented medical record was a deliberate attempt to re-organize the chart according to clinical problems. Because of the explosion of medical technology in the 1960s, the patient’s comprehensive health needs risked being lost among the competing interests of one subspecialty perspective or another. The revised chart helped the doctor to identify all the medical issues at hand, assess each individually, and then integrate them to ensure that the patient received comprehensive care. But the aspiration of integrated care remains, resisting even the best-intentioned efforts to address the grievances leveled at a health care system too often seen as dehumanizing.

6. There are compelling moral, as well as administrative rationales for foresight, but significant objections may be raised: The first is “economic” — the economics of time and professional priorities. On this view, physicians are already over-taxed in their commitments and do not have the resources to offer patients the requisite time to obtain the information called for here. The second is a deeper and thus more difficult objection: While physicians may wish to be humane, they by and large function as technocrats and thus are rarely called upon to exercise moral sensitivity. Consequently, the patient in the typical setting does not expect to discuss values and beliefs, and only in the most pressing of circumstances do such deliberations take place.

As for the first concern, the economics of time and commitments divide the professional day by certain expectations and standards of conduct. If students/physicians were expected to devote more professional effort in getting to know their patients, then the time it took to accomplish that objective would be acknowledged as important and factored in. To deny priority to this issue is not only tell-tale evidence of the problem, but an indictment of our health care system. Only in alerting the professional and lay community alike to the short-changing that is obviously occurring, can the profession begin to adopt formal standards that will eventuate in change.

As to the second objection, perhaps more effort devoted to establishing the moral relationship between doctor and patient is unnecessary. Why should the physician move beyond serving as technocrat to a more complete care giver? After all, is not medicine ultimately a

scientific discipline, ever more beholden to technological applications? On this view, technical proficiency is paramount and attention to humane values will come into play only as required, and in a minimal expression. Others on the health care team — nurses, social workers, clergy, administrators, psychiatrists — can deal with ethical complications as they arise. This particular contrasting perspective has already been considered and the Committee regards this issue as so deeply determined by personal values and individual professional self-image, that further elaboration on this aspect of the proposal would be non-contributory. We can only maintain what seems to us a truism:

Medical ethics is more than judicial directives, risk management, and academic debate. It is the very foundation of medicine, the moral substrate upon which clinical care is built. One might see most choices and actions — even the most mundane — as enacting some underlying value system, but such reflection is not ordinarily part of clinical practice. In adopting serious efforts to assure that medical ethics does not become another sub-specialty, but rather flourishes as an integral component of every physician's training, conduct, and practice, the profession must embed moral self-consciousness in the medical record, where an awareness of the importance of deliberate ethical considerations becomes explicit.

7. The selection of faculty to teach medical ethics poses a major problem. Who is equipped with the proper qualifications to impart such important material to future physicians? Furthermore, what are the pertinent qualifications? The greatest challenge in finding the best instructors lies in the few number of people trained to teach this subject. Piecemeal solutions have been offered: the 'competent amateur' and group teaching, the most popular choices. Neither is optimal, nor a third option that calls for an intermingling of faculty from non-medical fields, such as law and theology. The 'solution' is begging for resolute leadership. Until institutional assets are committed to medical ethics, this field, like any other, will only be able to patch together elements that can only approximate the required resources (Layman 1999, p. 155). While BUSM has a strong faculty in health law, the clinical faculty competent to teach medical ethics remains small.

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