MEDICAL EDUCATION
**Commemorative Issue: Professional Ethics and Instructional Success**
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I shall take up 2 interwoven questions in these pages. First, what goals should medical ethics teachers be trying to achieve in their work with medical students? And second, what measures are appropriate in determining whether those sought-after outcomes have been achieved? I want to consider 6 ends-in-view that should inform the work we do with medical students and to sketch how we might gauge our success with these objectives.

I should perhaps begin by saying something about how I came to these problems. I have lived in Honolulu for more than 20 years, teaching "ethics in health care" in many different settings. Unlike most places on the planet, Hawaii has no majority population. We are all minorities here. Caucasians like myself represent only about a third of the population. The rest are Japanese Americans, Chinese, Filipinos, Hawaiians, Samoans, Koreans, Puerto Ricans, Native Americans, Portuguese, African Americans, and many others.

My students have taught me to be cautious about assuming consensus, for the moralities they bring with them into medical education are strikingly diverse. I regularly tell them about a 25-year-old Samoan patient who had a tumor in his leg. It had metastasized and death could not be prevented. It is well known in Hawaii that Samoans acknowledge a far greater deference to familial authority than most Westerners accept. So the relatives were gathered near the hospital bed for a meeting. The physician recommended amputation to prolong the young man's life for perhaps a few additional months. The father, who was also the chief, promptly approved the procedure and the young man nodded. But later on, alone now in pre-op, the patient tells the surgeon that he does not want to live out his last weeks as an amputee. Even more, he does not want his father, the chief, to know he has questioned his judgment. For the young man, the social consequences of disclosure would be worse than amputation.

I ask my students, "What should a good doctor do?" For the Samoans in my class, the question is a no-brainer. Take the leg off. Why are we talking about this? Caucasians find some way to backtrack, telling the father a story, if necessary, but absolutely not performing the surgery. Asians and Pacific Islanders are split. Some side with the Caucasians, but others honor the chief's decision either because the young man should be treated under Samoan rules or out of a sense of filial respect. It gradually becomes clear to the class that there is no consensus; that—

collectively—they do not know what a good doctor should do in that circumstance. This acknowledgment is the beginning of wisdom.

I recount this story here because what is true of Hawaii is becoming true in most places. Pluralism, as the political philosopher John Rawls tells us, has become a permanent feature of the human condition, not likely to fade away[1]. The representative peoples in my medical ethics class need to be able to bracket somehow the personal moralities they bring with them into the profession. They need to open themselves to the possibility that, in becoming physicians, they may have to learn new and different ways of understanding their obligations.

As ethics teachers in medical schools, we have the advantage of working with good students who want to become good doctors. They can be shown, first, that there are troubling ethical dilemmas in medicine that they do not know how to negotiate and, second, that it is important that the profession honor some reasonable shared ethical commitment. If we are to teach professional ethics in health care, it must be our first objective to help students make room for the probability that the moral principles that have served them and their families well over the years may be inadequate to the task of providing 21st century physicians with sound ethical guidance. Vexing ethical dilemmas—like the case of the Samoan—are effective in getting students' attention. And that attention is the most dramatic evidence that this initial goal has been achieved.

It is useful to conceive the most important task of ethics teachers as, in part, the creation of an intellectual space within which persons from different cultures and backgrounds can reach responsible judgments on the obligations of physicians. One way to begin this task is to help students distinguish between their own personal values—what they happen to care about—and the core values of the profession—what a good physician ought to care about.

Dilemmas in professional ethics flow either from conflicts between core values, necessitating some kind of rule for establishing priority, or from ambiguity in a core value, necessitating what we philosophers call "disambiguation." The classical debate about medical paternalism involved the conflict between the competing values of beneficence and respect for patient choice. The problem of physician-assisted suicide illustrates ambiguity in a core value. Although we accept that physicians should never harm their patients, can there be situations in which death is a benefit rather than a harm? What should medicine mean by "harm"? The core values approach mirrors in pedagogy the creative process that can give rise to professional codes of ethics. Both medical students and the profession to which they aspire need to articulate the profession's distinctive values and, in the context of carefully chosen cases, disambiguate and prioritize these values in the process of reaching consensus about what good physicians should do. In the classroom, both the values and their prioritization are constantly in play and are the products of facilitated discussion.

The dialogue in a successful class can therefore mirror the ethical progress of the medical profession. For as the bioethics literature matures, it becomes possible to distinguish between what might be called "consensus issues," about which a broadly accepted, well-founded professional judgment has been formed, and "knife-edge issues," about which responsible professional judgments either fall on both sides or are sparse. It seems to be a fact of contemporary life that the publicity surrounding a dilemma in medical ethics is greatest at the time the troubling cases first appear and professional opinions are poorly informed. In the United States, cases of newborns with duodenal atresia and Down syndrome (e.g., the Baby Doe case) exemplify this. Now, dozens of articles and years later, there is broad and responsible consensus on the dimensions of the obligation to treat such infants. But the media do not cover the evolution of informed opinion as they publicize the first cases that precipitated the debate.

The glaring disparity between the prominent initial dramas and the slow and largely invisible emergence of professional consensus has perhaps led members of the public and even some scholars to opine that ethical questions are inherently resistant to responsible answers. But this is not so, and it is possible to ascertain, at any time, the conventional ethical wisdom of the profession. Several elements enter into this determination. First, there are consensus documents that regularly appear in medicine. While these are a key source, the positions found within them have to be consistent with the medical ethics literature—the second source. Where a topic has been well-explored, the relevant arguments developed and assessed, it is sometimes clear that, at least for now, the issue is settled. In the United States, for example, there is effective consensus on the nature of and need for informed consent, most cases of withdrawal and withholding of life support, and the use of patients as research subjects.

Accordingly, a second instructional objective would be to expose students systematically to the main elements of the profession's current sense of its ethical responsibility. Ideally, students would also be able to distinguish between knife-edge issues (e.g., medical futility) and consensus issues (e.g., refusals of blood by adult Jehovah's Witnesses). This objective is easy to assess: exposed to a case for which a professional consensus exists, and to practical options, students should be able to pick out the professionally favored course of action, if ethics education has succeeded.

There is an element of the profession's ethical consensus that is both critical to the student (and to the profession) but separate from understanding the favored principles that specify a physician's clearest responsibilities. For in addition to the broadly accepted ethical standards in medicine, there are the considerations and arguments that have been advanced in support of those standards. The authority of the profession's standards is not a function of bare acceptance but rather (one hopes) a function of the good reasons there are for endorsing them. For medical ethics, like all medical knowledge, must rest upon solid reasoning. An understanding of the profession's standards is incomplete unless a third objective is achieved: that

students will be able to grasp the essential relationship between the privileged status that the consensus principles should enjoy and the soundness of the arguments given in support of them. In my experience, student understanding can be assessed by means of research papers or class presentations, perhaps done as a group. The available literature is reviewed and the main arguments laid out, thoroughly and fairly. Students can explore both knife-edge and consensus issues and the task itself can mirror the social process that can give rise to a profession's distinctive ethic.

As one who teaches and works in medical ethics, however, I sometimes find myself setting out the consensus view, spelling out the arguments that have persuaded the profession, but then going on to criticize those same arguments. As a philosopher, I am trained to identify and expose arguments that are weak or flawed or inconsistent with other accepted justifications. For example, although the conventional wisdom is that physicians should breach confidentiality when necessary to protect identifiable, seriously endangered third parties, I have argued that that precept is mistaken. I talk about my reasons for challenging the consensus view and why a different position, supported by less obviously flawed arguments, should be favored. In setting out such a critique, I want students to see how medical ethics is, as it were, "in play." I want students to appreciate the possibility of change and to understand the professionally supported ways of bringing that about. My physician colleagues tell me that medicine's technical knowledge has a half-life of 7 years. Something similar is (or at least should be) true for medicine's ethical knowledge.

When we speak of technical competence in medicine, what typically springs to mind has mainly to do with the extent of the practitioner's knowledge base and his or her skills in differential diagnosis and treatment. But there is ethical competence as well. Physicians should, for example, be able to spot potential ethical problems before they become unmanageable: the doctor treating the 25-year-old Samoan should have talked with him privately before discussing options with the family. There is much to be learned about how to conduct a family case conference. We know the mistakes that clinicians make and can teach simple ways of avoiding them. Doctors should be able to retrieve information about ethics, discern and assess the arguments that are set out in those resources, and manage sensitive issues in the clinical setting.

A fourth objective would therefore be to nurture the development of practical ethical skill. An ethically competent physician doesn't merely have an open mind, a grasp of the profession's conventional ethical wisdom, and a sense of the debates that give rise to that consensus. The ethically competent physician is also capable of doing certain things. Important things. Role-playing can serve as a way of teaching and in assessment.

But now I want to consider what I think is a major oversight—even an error—in what I have just set out. In general, good teachers properly stay focused on their students. And we commonly measure our success by assessing each one of them, as if our teachings were talismans to be bestowed upon each initiate. But this attention

can blind us to a larger and much more important objective. For there is an important sense that, as teachers of medical ethics, our "student" is the medical profession as a whole. Ethics education does its job best not merely when each student acquits himself or herself respectably but, rather, when the class as a whole can model within itself the character of an ethically competent profession. Medicine is one of civilization's great traditions and, as the contemporary moral philosopher Alasdair MacIntyre has shown, to remain vital a tradition must sustain ongoing and vigorous debate about the nature of its distinctive goods and how these are to be realized in the course of practice[2]. While one cannot and should not avoid student-centered teaching, the fifth educational objective calls upon teachers to promote the creation of what can be called an ethically competent profession. Each of the 4 preceding objectives is a prerequisite for this larger one. For unless medicine enjoys a critical mass of what we might call "statespersons," it will be unable to participate coherently in the social organization of health care, unable to chart its own course, and unable to shape its distinctive dedication. The student body needs to be prepared to play a role in the profession's ethical governance.

Though it may seem paradoxical, communities like the medical profession can be measured, in part, by the quality of their disagreements. When divergent voices are clear and cogent, when competing intellectual positions are well-informed and well-reasoned, and when open-mindedness is conjoined with respectful fairness and critical attentiveness, there is hope for progress. Ethics education in medicine can model habits of mind and discourse that can serve the abiding interests of the profession as well as individual professionals.

Success here can be seen in the political character of the profession. How does it sustain its ethical deliberations? How well do practitioners grasp the values implicit in their common work? How effectively are issues defined and settled? It is the sad fate of teachers that the ultimate effects of our work are too often lost in a jumble of concurrent causes and effects at increasing temporal and spatial distances. Nevertheless it is useful to keep our sights on the intellectual health of the profession and the character of its debates as measures of our long-term and collective success.

But there is a sixth and final objective that takes us yet to an even broader level. For the medical profession exists to serve—centrally—the health needs of its community. The relationship between the two expresses something of a social contract: benefits and resources flow directly and indirectly to the profession as its distinctive services are rendered to the community. In this arena, a community is in good order when both of the parties are reasonably satisfied with the balance between the goods they receive and the burdens they are obligated to shoulder. Accordingly, pertinent questions of justice, social values, ethical obligation and public policy will pervade aspects of that transaction and, ironically, physicians will almost inevitably find themselves on both sides of the bargaining table, as providers and, on occasion, as patients.

If, in one context, the ultimate student in a medical ethics course is the medical profession itself, in another the ultimate client is the community as a whole. For a central collective task of the profession is to reach a stable and just accommodation with its community. This has never been easy, not least because of the tendency to act out of personal interest rather than out of professional values: the boundary line between professional associations and trade associations is often blurred. Accordingly, it should be the final objective for those who teach professional ethics in health care to open up the subject of the proper place of medical care in a just society, to pay attention to the standards that should inform "the deal." As bioethicists, we have been fairly successful in moving out of the classroom and into the public sphere, making contributions that can reach broad audiences even as they address pressing social concerns. We can show how medicine can help to craft the social setting within which it is practiced even as we equip its practitioners to work responsibly within that context.

**References**
1. Rawls J. *Political Liberalism*. New York, NY: Columbia University Press; 1995
2. MacIntyre A. *After Virtue*. 2nd ed. South Bend, Ind: Notre Dame University Press; 1984.

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