

Alpert Medical School Teaches Clinical Ethics

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There are as many methods of *teaching* medical ethics as there are of *doing* medical ethics. Despite some degree of standardization across other disciplines within the science of medicine both in the material to be taught and the methods of teaching (pedagogy), clinical ethics education is largely a “home-grown” product in most medical schools. National organizations like the American Society of Bioethics and Humanities have ethics education interest groups but have not developed formal curricula in these areas. Within the house of Medicine, similarly, professional organizations have published ethics guidelines and manuals but these are usually specialty or sub-specialty specific with little attempt or success in identifying and publishing common standards or methods of imparting these professional ethics to students.

Often, medical ethics education is attached to or incorporated into courses that teach general professionalism in the context of teaching the skills of medical interviewing or physical examination. For example, some boundary issues and standards of professional behavior might be appended to teaching about taking a sexual history or specific physical exam maneuvers. In these schools, ethics education is seen as part of the process of professionalization with the hope that professional ethics will be absorbed and then adopted by the students before they get to their more comprehensive clinical training. (Of course, once their clinical rotations get started, they are at risk of being more forcefully swayed into other approaches by the “hidden” curriculum¹ that they pick up informally from colleagues, more senior medical students, house officers, faculty and others who work in health care.)

In some schools, ethics education is taught by philosophers who are more observers of the medical profession than practitioners of it. A particularly complicated or challenging situation that is originally based in an actual case is presented, and then the details of the case are twisted like a Rubik’s cube with a series of “what-if” questions in an attempt to glean the underlying ethical principle in the case.

Many but not all medical schools do teach medical ethics using the approach of “principlism” developed by Beauchamp and Childress and first presented in their book *Principles of Biomedical Ethics* originally published in 1979.² Most clinical medical students are able to recite “the big 4” principles of Autonomy, Beneficence, Non-maleficence and Justice while making the mistake of thinking these 4 are presented

as a hierarchy (with autonomy at the top), that this approach can help one decide what to do and that there are only four principles to remember.

METHODS OF MEDICAL ETHICS

There are actually many different ways of “doing” medical ethics.³ A relatively simple approach is to use **virtue ethics** and simply ask, “What would a good doctor do?” when faced with an ethically complicated situation. While running the risk of circularity and begging the question of “what makes a good doctor,” this approach is often surprisingly useful. We all have had or have heard about physicians who behave in exemplary (or less than exemplary) ways and some model of ideal behavior is usually close at hand. Another approach is to use **casuistry** or case-based ethics. Like the philosophers mentioned above, this approach starts with the presentation of a case and proceeds with a discussion intending to identify the “best” approach to the situation. Cases that are similar or different in ethically relevant ways are then examined in an effort to identify the aspects of the case that are most ethically relevant while also looking for underlying ethics tenets that are strong enough to stand up in different but similar situations. The hope is that by deciding the best course in this case, the practitioner will have also identified a strategy that will be a useful guide in other ethically similar cases in the future.

The tools of **feminist ethics** can be used to attend to those whose interests are often discounted. **Communitarian ethics** seeks the approach that results in the best outcome for the community (which contrasts with the (mistaken?) approach often taken which allows *individual autonomy* to assume a dominant role in directing behavior).⁴

While many approaches to medical ethics ask the question from the physician’s or practitioner’s perspective, at Brown we tend to lean more heavily on a technique called deliberative bioethics.

DELIBERATIVE BIOETHICS

Now more than ever, the practice of medicine has become a “team sport,” so the question for the physician is less “what should I do?” and more “What should *we* do?” and that “we” entails the involvement of others.

In a paternalistic model of care delivery, the “we” is the patient and the physician: Using paternalism the physician decides what is best for the patient. As such, the question “What should we do?” is actually “What should I do to (and for) you, the patient?” In a hierarchical practice environment, the physician may consider and then decide on the best approach and inform the rest of the team what has been decided. In this way, akin to medical paternalism, “What *should* we do?” becomes simply “What *will* we do?” as the physician uses authority to direct the team’s actions.

Using a model of shared decision-making, this “What should we do?” seeks to incorporate the values of the patient *as understood by the patient* in an effort to attain a philosophically rich, autonomy-respecting model of shared decision-making by incorporating medical facts, medical science and practical wisdom *and* both patient’s and physician’s goals and values.

Similarly, the approach of **deliberative bioethics** rests on the premise that the “best” approach from an ethics standard is the one that seeks to maximize the goals and values of all of those involved. Included would be conversation about the worthiness and prioritization of conflicting motivations which may be intrapersonal or interpersonal. This approach mirrors shared decision-making between physician and patient.

Ethics is about theories of right action and deliberative bioethics requires the participants to present defensible reasons for one action or another. Gutman and Thompson, in discussing deliberative democracy, have stated that “citizens and officials must justify any demands for collective action by giving reasons that can be accepted by those who are bound by the action.”⁵ Similarly, in deliberative bioethics, other members of the medical team and members of the patient’s social circle have a right to the same types of reasons.

Gutman and Thompson have presented four characteristics of ethical reasons that must be present for this approach to succeed.⁶ First the reason must be accessible or comprehensible. Second the reason must be moral, i.e., general and therefore applicable to all in similar situations. Third, the reason must be revisable. The very process of entering into ethical deliberation requires that one is willing to revise one’s position, if presented with an adequately compelling argument. Finally, the reason must be respectful. As Gutman and Thompson state, “much moral disagreement will persist even among good-willed and intelligent people” so entering into deliberative bioethics one accepts the possibility that consensus may not be possible. That said, deliberative bioethics seeks to understand and then balance these types of reasons with the goal of a *shared decision* about the best path forward *together*.

CLINICAL MEDICAL ETHICS EDUCATION AT BROWN

At Brown, clinical ethics education is based on a balance between acquiring the ethics of the profession and the humility required to deliberate ethically with others, whether those others are classmates, patients and their families or other members of a healthcare team. This often requires doing extra work to better understand the perspectives and priorities of others with a goal of *shared decision-making*. As such, students are given an assignment in two of their clinical clerkships to identify and then formally analyze an ethically complex medical situation using assigned templates that encourage use of deliberative ethics.

In our experience with clinical ethics consultations, those involved are often at loggerheads over an intervention with both “sides” pretty sure they are making the right choice and that the others are mistaken. Surprisingly, the facts of the case are often not mutually agreed upon and this lack of a common understanding of the situation may have led to the divergent views on what should or should not happen. Even when the facts are clear to all, goals and values of the participants are often assumed and not adequately explored. Sometimes there is open hostility or disdain for the (assumed) goals of the other side. We have found that stepping back from questions about *interventions* and doing a more formal analysis of *goals* often yields an understanding and appreciation of the other and will frequently allow for respectful shared decision-making moving forward.

In the students’ medicine clerkship, they are asked to complete a 6-step ethics consultation template that mirrors what we use in clinical ethics consultation. In the first step, the facts of the case are presented including biologic, social and psychologic factors. As noted, in actual ethics consultations, what feels like a very complicated ethics dilemma is sometimes simply the result of a failure to communicate. The goal of step 1 is to have a common understanding of the situation before delving into more complicated issues of ethics. In subsequent steps, the student is asked to clarify the pending medical decision and then attempt to crystallize the ethics question. As ethics is often about obligation or permissibility, this may take the form of a “should” or “may” question.

Once the ethics question is posed, there is a conscious attempt to list out those involved in the pending medical decision and subsequent ethics question and then to delineate the needs, preferences, values and obligations related to the decision at hand of each of those involved. Some of these motivations will be readily apparent and some will require some background work. With an eye toward the actual medical decision and knowledge of the motivations of the various “players,” the student is then asked to balance the motivations against each other while also looking for commonalities. This balancing exercise is the crux of the ethics analysis. The final step in the analysis is a “preventive

ethics review" which seeks to learn from the very existence of this ethical dilemma: What could have been done differently in this or a similar case that would have mitigated the ethical tensions?

A slightly different tack is taken in the students' obstetrics and gynecology rotation. In this assignment, the students are also tasked with identifying an ethically complicated medical situation. The obstetrics environment is rich with conflicting motivations and interests and, with minimal prompting, the students present a fascinating array of cases to analyze. Once the case is chosen and presented, the students are asked to simply outline the competing considerations in the case and to put themselves into the role of attending physician and decide what their chosen path would be with supporting reasons for that action. Recognizing that others may well choose differently, they are then asked for the most compelling reasons why one might choose differently. Finally, as James Dwyer has written, there is a great danger in medical ethics in remaining silent⁷ and the students are specifically asked to discuss what harms might ensue if they choose to keep their ethics concerns to themselves in the medical situations they have chosen to analyze.

It is our contention that there are ethical tensions inherently present in every medical encounter⁸ and that physicians (and especially trainees) disregard those tensions at their own and their patients' peril. Attending to their own personal and professional ethics and also actively seeking to understand and incorporate the goals and values of their patients and colleagues into a model of shared decision-making is presented as an important element in their professional development.

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