

Training Doctors for Professionalism:

Some Lessons from Teaching Clinical Medical Ethics

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Abstract

Medical professionalism encourages physicians to place their patients' interests above self-interest. In recent years, many medical organizations, including the American Board of Internal Medicine (ABIM), Association of American Medical Colleges (AAMC), and the American Medical Association (AMA), have developed initiatives to strengthen medical professionalism. By emphasizing professionalism, supporters of these initiatives hope that medicine and physicians may recapture professional autonomy, decrease public criticism of medicine and physicians, and help physicians regain the moral high ground in the unending struggle with payers, both public and private. One crucial question facing medical educators is whether the concepts of professionalism can be taught to medical students and residents. This paper draws upon the author's thirty years of experience in teaching clinical medical ethics to provide guidance on how to teach the concepts of professionalism to students and residents.

Key Words: Professionalism, medical ethics, physician-patient relationship.

Introduction

ALTHOUGH DISAGREEMENTS PERSIST among experts as to which aspects of medical practice are captured by the term "medical professionalism," in recent years there has nevertheless been widespread agreement within academic medicine that it is essential to teach about medical professionalism to medical students and residents. Before considering whether lessons learned from teaching clinical medical ethics during the past thirty years may be applicable to teaching about medical professionalism, it would be useful to ask why medical professionalism has become the shared theme of many professional groups, such as the American Med-

ical Association (AMA), Association of American Medical Colleges (AAMC) and American Board of Internal Medicine (ABIM), which are not always in accord. There is no simple answer to explain why medical professionalism has rapidly emerged as a unifier for a desperately fragmented profession, but Wynia and colleagues recently suggested (1) that medical professionalism, which in their view consists of "devotion to service, profession of values, and negotiation within society . . .," serves as a bulwark for medicine against two other forces competing to control medicine — market-driven and government-controlled health care.

Papers presented at the 15th Mount Sinai School of Medicine Ethics Conference, "Understanding Professionalism and Its Implications for Medical Education," suggested some of the following reasons to explain the contemporary importance of medical professionalism: (a) it may help physicians (perhaps in alliance with patients) to recapture some degree of autonomy, at least decisional autonomy; (b) it may help to break the cycle of public distrust and disrespect for physicians and medicine; (c) it may help physicians and medicine gain the high moral ground in their ongoing struggle with payers,

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whether such payers be managed care organizations or government; and finally, (d) it may actually contribute to improving the process and outcome of patient care. My own view is that the political, economic, social and clinical struggles to recapture or at least retain important elements of doctor and patient autonomy are being fought on the battlefield of medical professionalism.

Even if there were widespread agreement on the desirability of teaching medical professionalism, some might question whether we as a profession are capable of teaching it. Such skeptics might raise the following two questions:

- Is it possible to teach the elements of professionalism? For example, the American Board of Internal Medicine has identified seven negative behaviors as being violations of professionalism: abuse of power, arrogance, greed, misrepresentation, impairment, lack of conscientiousness, and conflict of interest (2). The Accreditation Council for Graduate Medical Education (ACGME) has identified positive aspects of professionalism, including respect, regard, integrity, and responsiveness to patients and society that supercede self-interest (3). Many of the elements identified by ABIM and by ACGME relate to innate character traits and the virtue of individuals; this raises the ancient issue of whether character and virtue can be taught. (See below in section entitled “What should be taught?”).
- Can you teach the values of medical professionalism without changing the internal culture of academic health centers and the entire health system? While many subscribe to the view that professional values are transmitted to physicians by a combination of didactic teaching and role-model mentoring, others including Dr. Ken Ludmerer (4) — and Samuel Bloom (5) — at this conference believe that the development of professional values is influenced by the values inherent in the entire health system.

Ludmerer recently wrote:

“...[S]tudies over the past four decades have documented the profound impact of the entire institutional environment of the academic health center on shaping the attitudes, values, beliefs, modes of thought, and be-

havior of medical students Formal coursework and mentoring represent only two of the many factors that affect the development of attitudes. An unfriendly institutional culture can easily undermine the well-intentioned efforts of those trying to impart professionalism by means of the curriculum The greatest challenge in proving the teaching of professionalism is to modify the internal culture of the academic health center so that it better reinforces the values that medical educators wish to impart. At present this represents no small task for the managed care revolution has caused medical schools and teaching hospitals to become much less friendly to patients and students than they were even a few years ago.”

My own observations, based on my work as an attending physician at an academic medical center, reinforce Ludmerer’s concerns. Recently, I supervised a particularly empathetic and compassionate resident who had admitted ten complex patients in the previous twelve hours, and was tired, irritable, and overwhelmed by her clinical responsibilities. I tried to serve as her teacher and mentor but found myself having less time to teach because I was forced to document patient records so that I could protect myself against possible legal cases of fraud and abuse. Also, many of the patients we care for in our health system are uninsured and, therefore, are often “neglected” medically between acute in-patient hospitalizations. Further, the teaching hospital I work at faces serious financial constraints, some of which have required the firing of nurses and other patient-care personnel, thereby adding new tasks to those of the already overworked residents. As Ludmerer suggests, it is not easy to model and teach medical professionalism in such a system, a commercial atmosphere which he says (4) “. . . does little to validate the altruism and idealism that students typically bring with them to the study of medicine.”

Can the Teaching of Medical Ethics Provide Any Guidance for Developing Teaching of Medical Professionalism?

Cautionary Observations

Although medical ethics has been taught in most American medical schools since the 1970s, there is little data to document whether

such ethics training has been successful in improving patient care or patient outcomes, whether the doctor-patient relationship has been strengthened, or whether improvements have occurred in the way medical decisions are reached. Very few studies, if any, have examined the impact on the quality of patient care of teaching medical ethics or of medical ethics in general. For example, one major study showed that despite medical ethics' preoccupation for thirty years with end-of-life issues, the care dying patients receive in American hospitals is inadequate both clinically, because it fails to provide sufficient pain medication and ethically, because it fails to respect the wishes of dying patients (6). Professor Leon Kass, one of the founders of the American bioethics movement, recently commented critically about the achievements of bioethics (7): "Though originally intended to improve our deeds, the practice of ethics, if truth be told, has at best improved our speech." As we move forward to develop and implement a national effort to teach medical professionalism, one lesson to be learned from teaching medical ethics relates to the failure of medical ethics to document its achievements. This suggests that in developing teaching in medical professionalism, it is essential to specify the goals of such new teaching, to demonstrate how such teaching improves the process and outcome of patient care, and to develop from the outset methods to evaluate its impact on students (8).

Positive Guidance

Based on my experience from teaching medical ethics for thirty years, I suggest that any new teaching program (for example, a program in medical professionalism) answers the five questions noted in Table 1.

I will discuss these five questions primarily in terms of clinical medical ethics and will provide tentative answers that I have arrived at with my colleagues, Edmund Pellegrino and Peter Singer (9). Whether our observa-

tions about clinical medical ethics also apply to the teaching of medical professionalism is a question I will leave for those with greater expertise than mine in the field of medical professionalism.

1. Why teach clinical medical ethics?

There are three important reasons for teaching clinical medical ethics:

- To provide students with essential and practical knowledge about issues that arise frequently when caring for patients and with which students must be familiar in order to provide good care. Such issues include, but are not limited to, informed consent, truth-telling, confidentiality, human subject protection in research trials, and end-of-life care.
- To encourage students to build upon this foundation of clinical medical ethics through life-long learning.
- To introduce students to the central importance of the physician-patient relationship and the ways in which communication occurs and decisions are reached within this relationship.

The fundamental justification for teaching clinical medical ethics (or for that matter, any medical school or residency subject) is based on its contribution to the care of patients. Therefore, the principal goal of teaching clinical ethics is to improve the quality of patient care in terms of both the process and outcome of care. If young physicians are equipped with the skills required to reach ethical decisions regarding patients, their patients will be protected from violations of their dignity. This means that in educating young physicians emphasis must be placed not only on the ethics of the actual decision but also on the ethics of the decision-making process. The skills of ethical analysis are part of the competence-set of young physicians and are a necessary complement to the physicians' knowledge base and competence in the scientific and technical aspects of clinical medicine.

Many of the reasons offered for teaching clinical medical ethics could also be applied to teaching professionalism.

2. When to teach clinical medical ethics?

If clinical medical ethics (or professionalism) is essential to medical education and prac-

TABLE 1

Teaching Clinical Medical Ethics to Medical Students and Residents

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1. Why teach?
 2. When to teach?
 3. What should be taught?
 4. How should it be taught?
 5. Who should teach?
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tice, it should not only be taught as a block course (although some basic instruction is required) but it should also be continuously integrated into the young physician's education at all levels of medical school and residency training. Whenever possible, ethics teaching should be coordinated with students' other learning objectives. For example, an ideal time to teach about brain death and the vegetative state would be during a basic science course on neuroanatomy and neurophysiology. Similarly, the introductory anatomy course offers a unique opportunity to deal with issues of death, dying and respect for the dead body. The course on history taking and physical diagnosis is the optimal time to engage students on topics such as the doctor-patient relationship, truth-telling, confidentiality and informed consent.

Whatever foundational instruction is provided in clinical medical ethics during the first two years of medical school must be reinforced during the clinical years. This point was stated eloquently in 1902 by William Osler in a speech to the New York Academy of Medicine (10).

“In what may be called the natural method of teaching, the student begins with the patient, continues with the patient, and ends his study with the patient, using books and lectures as tools, as means to an end For the junior student in medicine and surgery it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself.”

In the contemporary context, clinical teaching about ethics and professionalism is best accomplished by integrating the teaching into each of the students' clinical clerkships. This practice disrupts the pattern of clinical education least, takes advantage of the students' involvement with actual cases, and eliminates the problem of designing a course to cover all the major ethical and professional issues encountered in all major specialties.

3. What should be taught?

Ideally, teaching about clinical medical ethics should include three dimensions: cognitive skills (information and facts); behavioral skills; and character development and virtue.

a. Cognitive skills. Students should be introduced to the literature of clinical ethics, to the research methodologies used in ethics, and

to a practical approach for doing ethical analysis. The specific curriculum should reflect the incidence and prevalence of clinical situations that are encountered in the students' or residents' work. Curriculum design also can be based upon published studies of the epidemiology of ethical dilemmas that are seen in inpatient settings, outpatient setting, or consultation setting. Another approach to curriculum design is to target teaching to meet the perceived needs and preferences of students, which will vary depending on students' and residents' levels of training and specialties (11).

b. Behavioral skills. The assimilation and mastery of cognitive knowledge are not an end in itself for clinicians. To be effective in caring for patients, clinicians must have the behavioral skills that are necessary to put their knowledge to work in everyday clinical encounters. A physician who knows the legal and ethical requirements of writing an order not to resuscitate (DNR) should also be expected to know how and when to initiate discussions about DNR status with patients and families in a thoughtful and sensitive manner. Instruction in the behavioral skills of clinical ethics requires teaching and role modeling by experienced clinicians who can demonstrate the skills in practice. It further requires that students have the opportunity to practice these skills while being supervised by experienced clinicians.

An eloquent argument for integrating cognitive knowledge and behavioral skills is contained in an influential consensus statement (12) which concluded that students should be taught both cognitive knowledge and “interactional abilities to deal successfully with most of the moral issues they confront in their daily practice.”

c. Character development. Ten years ago, in discussing the importance of character development as part of medical ethics teaching, my colleagues and I wrote the following statement, which may apply with equal force to the current goals of teaching medical professionalism (11):

In addition to cognitive knowledge and behavioral skills, some attention must be paid to the affective component of clinical ethics — that is to say, to the kind of person the physician should be as well as the kind of decisions he or she should make. In short, ethics requires that the physician be a person of character, one who can be expected habit-

ually to act in the patient's interests when no one is watching. Trust is essential in the healing relationship. The norms and principles of clinical ethics must in the end be filtered through the person of the physician. The values or principles the physician chooses, the theory of ethics he espouses and the way he interprets the relationship with the patient will shape the ethical decision he makes in a given case. In order for a physician to perform in an ethically defensible way, both procedurally and substantively, some development of his character is essential. This is the most difficult task in clinical ethics.

A statement such as this inevitably raises the question that Plato raised in "The Meno" (13): "Can you tell me Socrates: Can virtue be taught? Or, if not, does it come by practice? Or does it come neither by practice nor by teaching, but do people get it by nature, or in some other way?"

4. How should clinical medical ethics be taught?

At the University of Chicago we emphasize the following six principles (the "Six C's") in teaching clinical medical ethics (Table 2):

I wish to elaborate here on the fifth point — that clinical medical ethics teaching should be clean (i.e., not too complex). Our model for teaching clinical medical ethics includes cognitive training in the fundamentals of ethics, with a core set of lectures on 8–10 important topics; a recommended text that is clinically oriented; and a basic approach to ethical decision making (11). It also provides students with a bibliography of accessible articles and reference materials for further reading. The students are also provided with opportunities to develop behavioral skills in their clinical work ("See one, do one, teach one"). For example, after reading about the core elements of informed consent, a

student observes a skilled clinician negotiating consent with a patient, and the student is then given an opportunity to elicit informed consent while the instructor observes the student-patient interaction.

5. Who should teach clinical medical ethics?

Medical ethics should be taught by those who do it well and who have the capacity to motivate students and residents to improve the quality of their patient-physician interactions and patient outcomes. These teachers could be either practicing physicians who have received training in ethics or bioethicists who have clinical experience. Role-model-teaching physicians are especially important for the following reasons:

- Physicians can teach ethics in the clinical setting by referring to actual clinical cases, as is done in most other effective clinical teaching.
- Physicians are responsible for resolving — rather than just for analyzing — clinical-ethical problems in order to reach good decisions with their patients.
- Physicians also demonstrate ethically appropriate professional attitudes and values to students so that students learn both from the formal teaching of clinical ethics and from their teachers' modeling of ethical behavior and professional conduct.
- Physician-teachers incorporate clinical-ethical considerations into the routine practice and teaching of medicine.

The five questions that have been addressed with respect to teaching clinical ethics should also be considered when developing a teaching and training program in medical professionalism. I suspect that many of the issues addressed about clinical medical ethics would apply also to teaching medical professionalism.

Two Final Thoughts on Teaching Clinical Medical Ethics and Medical Professionalism

Can Character Be Taught?

This ancient question has no easy answer. In my view, medical education and training not only provides students with a new vocabulary and a new knowledge base, but also serves as a

TABLE 2
Principles for Teaching Clinical Ethics
The 6 C's

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1. Clinically based
 2. Cases (real)
 3. Continuous
 4. Coordinated (integrated)
 5. Clean (i.e., simple)
 6. Clinicians as instructors
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moral pilgrimage in which character and attitudes are molded by the experience of caring for sick patients. While most students will change during training, not every student will emerge with a set of character traits that ensures that ethical and professional standards are always maintained. This, in turn, places a heavy burden on those who help select medical students for admission to medical school. Medical school admissions committees do very well, but sadly, there is no gold standard with which to identify with precision those students whose character flaws may prevent them from developing the kind of ethical and professional attitudes that society wants and demands of its physicians. Left to myself, I would always select students based on positive character traits (if I could identify them) before GPAs or MCAT scores, but I acknowledge that such a selection process is an art, not a science (14).

The Fundamental Importance of the Doctor-Patient Relationship

After undergoing trial by fire during the last decade, the doctor-patient relationship in the US has emerged with renewed vitality and a strong endorsement from patients. This is as it should be, since the doctor-patient relationship has always, at all times, served a universal human need (i.e., helping people who turn to medicine for help) and has pursued an unchanging goal (to provide the best help it can within the scientific limits of the times). The ethics and professionalism of the modern physician is not very different from that of the ancient physician who subscribed to the following Hippocratic guidelines (15): “. . . as to diseases make a habit of two things, to help or at least to do no harm.”

Almost 2500 years ago, in a remarkable passage in Book IV of “The Laws,” Plato recognized that good doctor-patient relationships were required to achieve the goals of medicine. Plato described inadequate doctor-patient relationships, what he called “slave medicine,” as follows (16):

“The physician never gives the slave any account of his complaints, nor asks for any; he gives some empiric treatment with an air of knowledge in the brusque fashion of a dictator, and then is off in haste to the next ailing slave . . .”

Plato contrasted this inadequate doctor-patient relationship with what he called the physician-patient relationship for free men, in which (16):

“The physician treats their disease by going into things thoroughly from the beginning in a scientific way and takes the patient and his family into confidence. Thus, he learns something from the patient. He never gives prescriptions until he has won the patient’s trust, and when he has done so, he aims to produce complete restoration to health by persuading the patient to comply.”

The best clinical medicine, Plato tells us, is practiced when the scientific and technical aspects of care are placed in the context of a personal and professional relationship in which the physician strives to win the patient’s support and trust. In this regard, the professional and ethical values described by Plato and those that are expected of the contemporary physicians are remarkably similar. Both are based on a medical relationship with the patient in which the physician’s core ethical and professional values are the foundation of good clinical care.

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