

Teaching Medical Ethics in Internal Medicine Residencies

Technologic advances, the medical malpractice crisis, and changes in health care reimbursement pose ethical quandaries for the practicing physician every day. Should the demented patient be kept alive with tube feedings, antibiotics, and mechanical ventilators? How defensively must the prudent physician practice? Does the private practitioner have a duty to care for indigent patients? To resolve these questions, practitioners must understand medical ethics. Medical ethics teaching should have an important place in residents' preparation for practice. This teaching can sensitize residents to ethical issues in patient care, improve their ability to analyze those issues, and help them make sound management decisions. Yet residency directors who want such teaching in their programs may feel ill-prepared to plan and implement a medical ethics curriculum. This chapter reviews recent events in medical education that have emphasized the importance of medical ethics teaching, outlines the rationale for this teaching, proposes topics for inclusion in a medical ethics curriculum, and suggests ways to train faculty and teach medical ethics to residents.

THE CHANGING CLIMATE FOR MEDICAL ETHICS TEACHING

Until the early 1980s, many program directors believed teaching medical ethics was unnecessary or even counterproductive to resident education. Directors thought three years was barely enough time for residents to master the many technologies of internal medicine; medical ethics teaching would merely usurp valuable time from traditional technical education.²⁰ Some directors doubted that medical ethics could be taught or could have much impact on resident behavior.³⁷ Others felt that experienced clinicians could teach medical ethics adequately in the course of conducting good patient care.

Those attitudes began to change with two recent events. In 1983 a special American Board of Internal Medicine (ABIM) subcommittee issued a statement that excellence in practice requires the internist to meet high standards of humanistic behavior. This subcommittee identified integrity, respect, and compassion as humanistic qualities essential for clinical competence. The subcommittee also concluded that the cognitive aspects of ethics should be taught, that residents can be sensitized to their own values and their patients' values, and that "established personality traits and behavior can be modified."³⁷ Furthermore, the subcommittee endorsed ABIM's attempts to assess humanistic qualities in candidates for board certification. The subcommittee urged ABIM to continue ethics questions on the certification examination and to advise program directors about standards and methods for assessing humanistic qualities in residents.^{22,37}

In 1984, the Association of American Medical Colleges published "Physicians for the Twenty-First Century: The General Professional Education of the Physician Report" (GPEP Report). Though specifically addressing premedical college and medical school education, the GPEP Report had clear expectations of ethics and values training in residency. The report stated: "Ethical sensitivity and moral integrity, combined with equanimity, humility, and self-knowledge, are quintessential qualities of all physicians."³⁶ Residency education must nurture those qualities in residents because residents are particularly susceptible to cynicism and

depression. Residents need medical ethics teaching to help counteract the stresses of overwork and feelings of inadequacy as well as to bolster residents' ethical and humanistic development.

WHY ETHICS SHOULD BE TAUGHT DURING INTERNAL MEDICINE RESIDENCIES

Teaching medical ethics in internal medicine residencies is justified for several reasons. First, residents must learn to recognize the full range of ethical issues that pervade medicine. (A medical ethics issue is any conflict of values concerning patient care.) Journal articles proliferate on withdrawal of life support, assessment of patient competence, refusal of recommended treatment, and decision-making for incompetent patients, and physicians now recognize these topics as ethical issues (Perkins, HS: unpublished data). Yet many important but less dramatic issues often go unrecognized. Should physicians order unnecessary tests at patients' insistence? Should physicians inform patients about clinical mistakes? Must physicians treat noncompliant patients? Clouser sees medicine as a conceptual ghetto: a highly educated community with similar training, language, and goals, but impoverished of other world views.²¹ This idea may explain why many ethical issues escape physicians. Physicians may simply not recognize values different from their own. Ethics teaching sensitizes physicians to the different values patients may have and to the conflicts of values that create medical ethics issues. For example, one study demonstrated that interaction with a physician-ethicist on medicine ward rounds at a teaching hospital more than quadrupled the number of patients whom residents recognized as posing significant ethical problems.³⁰

Second, residents must learn a sound framework for resolving ethical issues. The framework provided by medical ethics teaching rests on the primacy of the physician's loyalty to patients' wishes and interests. Physician intuition and feelings are insufficient to manage such issues. Alcoholics and drug addicts may repulse the resident, but his or her feelings do not justify denying these people full medical care. Medical ethics examines clinical decisions for their assumptions, logic, and implications. Furthermore, ethics teaching requires more than demonstrations of good patient care. Actions can be ambiguous. The resident may not understand that the attending physician stops the vegetative patient's respirator not to save money for the hospital but to comply with the patient's presumed wishes. Ethics teaching emphasizes the importance of stating reasons to justify actions and understanding how those reasons derive from a comprehensive ethical framework.

Third, medical ethics teaching can have its greatest impact during residency because those are professionally formative years. For the first time in their careers, residents must take responsibility for patients' medical care. Residents must learn decision-making under circumstances of incomplete knowledge, predictive uncertainty, and their own and patients' high expectations. This weighty responsibility often daunts residents, and their anxiety will prompt them to adopt whichever problem-solving methods appear useful. As one such method, medical ethics can prove itself useful to residents in conducting patient care.^{29,32} In addition, medical ethics can shape practice habits most during residency because residents' habits are not yet ingrained.

WHAT RESIDENTS SHOULD KNOW ABOUT MEDICAL ETHICS

In July 1983, the DeCamp Foundation invited the nation's leading medical ethicists to a conference to define a core curriculum in medical ethics. They identified seven fundamental ethical skills that every resident should know:²⁷

1. **Know the moral aspects of medical practice.** The resident should realize that medical practice requires choices based on values. Because such value-laden choices determine how physicians will treat patients, medicine has a distinct moral dimension. Sometimes values conflict, and residents must be able to recognize those conflicts and resolve them in ways that promote patients' interests. Patients' wishes are usually the best indicators of patients' interests. A lung cancer patient requests full cardiopulmonary resuscitation despite the resident's recommendation against it. The resident sees resuscitation merely as wasting valuable medical resources and prolonging the patient's suffering. The patient, however, wants more time with his family. The resident should recognize the conflict between his values and the patient's and resolve it by honoring the patient's wishes.
2. **Know how to obtain informed, voluntary consent.** The resident should clearly understand that the fundamental purpose of informed consent is to facilitate the patient's informed participation in decisions about his own care, not to protect the physician or the hospital. The resident should also know the ethical (and often legal) standard of disclosure—what a reasonable patient would want to know in such circumstances—and be able to communicate medical information in language the patient can understand. For example, most patients want to know important side effects of medication. Thus, before starting clonidine for hypertension, the resident should inform a young man about possible fatigue and impotence.

Proper consent must also be voluntary, i.e., free from coercive influences causing the patient to choose against his true wishes. When patients' decisions appear illogical, the resident should probe for possible coercive influences. The resident recommends adding nifedepine to a Medicare patient's antihypertensive regimen. Agreeable at first, the patient refuses after the resident explains the high cost. The resident probes and discovers the patient is afraid he cannot afford nifedepine on his pension. The resident asks the social service department to apply to Medicare for drug reimbursement and then the patient agrees to take nifedepine.

3. **Know what to do if a patient refuses recommended treatment.** The resident ordinarily should honor patient refusals of treatment if probing reveals no misunderstanding or coercive factors influencing the patient's judgment. A man with bilateral lower extremity weakness from a midthoracic spinal stenosis refuses recommended decompressive surgery. The neurology resident probes for the reasons behind the patient's refusal. The patient says he understands the doctors have good intentions in recommending surgery, but he does not want to risk becoming more disabled from the surgery. Without compelling evidence that misunderstandings or coercion influence the patient, the physicians correctly choose to honor the man's refusal.

4. **Know what to do about incompetent patients.** The resident should know how to identify incompetent patients and how to secure valid consents to treat these patients. Incompetence means the inability to understand information relevant to a decision, deliberate about options logically, make a choice consistent with one's own values, and communicate that choice. Simply refusing recommended therapy does not by itself prove incompetence. (Patients, such as the man with spinal stenosis, may validly refuse recommended therapy because it violates their personal values.) The vegetative, the comatose, and the severely demented are the clearest examples of incompetent patients: they meet all four conditions in the definition of incompetence.

After having identified an incompetent patient, the resident should ensure that the patient has a suitable proxy who knows the patient well and can make decisions promoting the patient's wishes or interests. A severely demented Alzheimer's patient is admitted to the hospital for a urinary tract infection. The patient has no family. While treating the infection, the resident approaches the patient's best friend and longtime neighbor to be his guardian, and the friend agrees. Guardianship will officially designate the friend as the decision-maker for the patient in the future. The resident asks the social service department to initiate the guardianship proceedings.

5. **Know when it is morally justified to withhold information.** The resident may understand that professional tradition has allowed the physician great discretion to withhold from patients information that might harm them. The law calls this doctrine "therapeutic privilege." Yet the resident must understand that patients need medical information to make important life decisions, and that this information rarely harms patients. Physicians can almost never justify withholding important medical information from patients. Claiming the patient would lose hope and faith, the family asks the resident not to tell a very religious, elderly woman her cancer diagnosis. Without more convincing evidence of severe harm to the patient, the resident correctly insists he must disclose the diagnosis.
6. **Know when breaching confidentiality is justified.** The resident must understand that maximum therapeutic benefit often depends on the physician's duty to maintain confidentiality. If a patient cannot expect the physician to keep sensitive information confidential, the patient may hesitate to request medical help or to disclose information that may be necessary for accurate diagnosis and effective treatment. Yet this duty is not absolute. The law specifies three exceptions to the physician's duty to keep confidentiality: (1) reporting communicable diseases, child abuse, elder abuse, and gunshot wounds; (2) testifying in court; and (3) disclosing serious danger the patient poses to specific others. The first two exceptions are self-explanatory, but the third requires clarification by example. The Tarasoff case in California involved a rejected lover who confided to his therapist that he intended to kill his former girlfriend. Although the therapist notified the police and the police detained the patient briefly, they eventually released him for insufficient proof that he would commit murder. The patient then killed the girl, and her parents sued the therapist for not warning the victim. The

California Supreme Court ruled in favor of the parents by declaring: “The (patient’s) protective privilege ends when the public peril begins...”¹

7. **Know how to manage patients with poor prognoses.** The resident must know how terminal care differs from curative care. When terminal care is indicated, the resident must be able to focus on physical comfort, avoid excessive monitoring, and attend to the patient’s emotional needs. Meeting those needs sometimes requires special staff effort and modifications in hospital routine. A young woman’s surgical, radiation therapy, and chemotherapy treatments for breast cancer have failed, and her physicians conclude she is dying. The patient requests comfort care and permission to see her preschool children. The resident stops all laboratory tests and monitoring of vital signs. He writes a no-resuscitation order. He also persuades hospital administration to make an exception to normal policy to allow the children to visit their mother in her room.

After the DeCamp conference had defined the seven ethical skills above, the federal government and private insurance companies introduced strong cost containment measures, including reimbursement by diagnosis-related groups. These measures justify an eighth ethical skill every resident should know:

8. **Know how to manage medical resources wisely.** The resident must learn to use medical resources only when they will benefit patients.

On the one hand, the resident should adhere to cost containment measures by not wasting resources. The technologic imperative—the tendency for physicians to overuse technologies because they exist—has considerable power over residents and other young physicians. Lacking confidence in his or her own clinical judgment, the resident often relies too heavily on technology to reassure himself. Most patients with congestive heart failure can be adequately diagnosed and treated on the basis of history, physical examination, and chest x-ray. Few patients require expensive echocardiographic studies or multiple gated scans. The resident should resist the temptation to order such tests routinely.

On the other hand, the resident should realize that cost containment measures can set physician and hospital interests against patient interests. The resident must never allow these measures to compromise important patient interests. Residents must be sure patients get the medical attention and resources they require. The family of an elderly demented woman controls her Social Security checks but has failed to pay several months’ rent to the nursing home where she lives. When the patient is hospitalized for pneumonia, the nursing home refuses to take her back until the family pays the outstanding bill. The family refuses. When the inpatient days allotted under Medicare run out, the hospital administrator urges the physicians to discharge the patient immediately to the family’s home. The physicians, however, believe that this would seriously compromise the patient’s interests: a family unwilling to use the patient’s Social Security checks to pay her nursing home bills is unlikely to give her adequate care at home. Even though the hospital may suffer a financial loss, the physicians decide to keep the patient hospitalized until proper placement is arranged.

RESOURCES REQUIRED FOR EFFECTIVE MEDICAL ETHICS TEACHING

An effective medical ethics curriculum requires three resources from the department: endorsement, faculty, and funds. The department chair and program director must openly endorse ethics teaching and actively promote it to residents. Non-ethics faculty must reinforce ethics instruction by using ethical concepts in their own clinical teaching.³⁶ Without strong department-wide endorsement for medical ethics teaching, residents will view ethics as unimportant.

Effective medical ethics teaching also requires trained faculty able to devote sufficient time to develop and teach the curriculum. The department should recruit at least three people—a professional ethicist or theologian and two physicians—to serve as medical ethics faculty. The department should commit 20-25 percent of each ethics faculty member's work week to the ethics teaching program. The ethicist must have a strong commitment to medical ethics. He or she should be willing to teach residents on the wards and in the clinics. Many medical schools and hospitals already employ ethicists, and some of these ethicists may be available to the department of medicine on a shared basis. Ideally, the physicians recruited as ethics faculty should command respect as clinicians and also have strong motivation to study medical ethics. These physicians will need formal training in the subject. Medical ethics fellowships, lasting from several months to two years, are available at the following institutions:

- Center for Clinical Medical Ethics, The Pritzker School of Medicine, PO Box 72, The University of Chicago Hospitals, 5841 South Maryland Avenue, Chicago, IL 60637
- The Institute for Medical Humanities, The University of Texas Medical Branch, Galveston, TX 77550.
- The Hastings Center, 255 Elm Road, Briarcliff Manor, NY 10510.
- The Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057.
- The Robert Wood Johnson Clinical Scholars Program, c/o the Robert Wood Johnson Foundation, College Road and US Route 1, PO Box 2316, Princeton, NJ 08543-2316.

The Department of Medicine at the University of Texas Health Science Center at San Antonio offers an intensive, one-month seminar covering the most influential books and articles on medical ethics. This seminar also offers participants the opportunity to conduct in-hospital ethics consultations under supervision. A residency program's ethics faculty should conduct ongoing research about medical ethics and publish their results. The department chair should assure the ethics faculty that their teaching and research will receive proper recognition in promotion and tenure decisions. Assessment of that work should include consultation with comparable ethics faculties at other medical schools or hospitals.

Effective medical ethics teaching uses the following forums: teaching conferences, teaching rounds, ethics consultations, and participation on appropriate committees. First, four to six departmental teaching conferences per year should focus on ethical issues. The conferences

might include medical grand rounds, morbidity and mortality conferences, and house staff conferences. Almost all medical ethicists recommend that these conferences address specific cases to demonstrate to residents the importance of ethics to actual patient care. Conferences use the ethics faculty's time efficiently, but one-hour, case-oriented conferences provide little time to develop a basic theoretical framework for understanding ethical issues. Thus, residents may sometimes feel the solutions are arbitrary.

Second, ethics teaching rounds should occur on the oncology wards, in the intensive care units, and in other patient care areas where ethical issues arise frequently. These rounds should require residents to present cases posing ethical issues. In this way, residents will gain experience at identifying and articulating ethical issues. These rounds otherwise share the advantages and disadvantages of teaching conferences.

Third, ethics consultations are also a key part of ethics teaching. Ethics consultations help residents recognize ethical issues involving their patients, change management in many cases, and boost residents' confidence in their final management plans (Perkins HS: unpublished data). Consultations, however, are quite time-consuming for ethics faculty and may foster in residents an unhealthy reliance on the consultants. Fourth, participation on the hospital ethics committee, the institutional review board, the intensive care units committee, and other committees addressing ethical issues provides an opportunity for ethics faculty to teach other faculty and staff.

Furthermore, effective medical ethics teaching requires adequate financial and material resources. Because almost no outside funding exists for teaching medical ethics, the department should allocate enough funds to cover all reasonable curriculum-related expenses. These expenses might include subscriptions to the *Hastings Center Report*, the *American Journal of Law and Medicine*, and *Law, Medicine & Health Care*; teaching videotapes; Bioethicsline (a computerized literature searching program like Medline); guest speakers; and secretarial help.

The department chair and the residency program director should commit these resources generously—endorsement, faculty, and funds—with the conviction that medical ethics must become a key element of residents' education. Medical ethics teaching enriches and balances residents' technical education by addressing the important human dimension of medicine.

AUTHOR

Harry S. Perkins, MD, Professor, Department of Medicine, University of Texas Medical School at San Antonio

ANNOTATED BIBLIOGRAPHY: MEDICAL ETHICS CONTENT

Books and Monographs

1. Beauchamp TL, Childress JF. "Principles of Biomedical Ethics", Oxford University Press, New York, 1983. This book presents systematically the four fundamental principles of bioethics — autonomy, beneficence, non-maleficence, and justice — and illustrates the application of the principles to actual cases.
2. The Hastings Center. "Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying", Briarcliff Manor, New York: The Hastings Center, 1987. This book summarizes the scholarly literature on the life support decisions, emphasizes prospective planning for them, and specifically discusses decisions about cardiopulmonary resuscitation, nutrition and hydration, antibiotics, and pain relief.
3. Jonsen AR, Siegler M, Winslade WJ. "Clinical Ethics: A Practical Approach to Ethical Issues in Clinical Medicine", MacMillan Publishing Co. Inc., New York, 1986. This handy pocket-sized book presents a framework for analyzing and resolving common medical ethics issues. The framework has four components: medical indications, patient preferences, quality of life judgments, and socioeconomic factors.
4. President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research. "Deciding to Forego Life-Sustaining Treatment", US Government Printing Office, Washington, DC, 1983. In this report, a presidential commission lays down sensible guidelines for making life support decisions based on patients' wishes and interests. The report differentiates decision-making procedures for competent and incompetent patients, and deals extensively with three especially problematic topics: permanently unconscious patients, severely ill newborns, and resuscitation decisions.
5. President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research. "Making Health Care Decisions", US Government Printing Office, Washington, DC, 1982. This commission report identifies personal well-being and self-determination as the two values underlying the informed consent doctrine and considers this doctrine and the "ethical imperative." Thus, health care professionals should ensure patients are properly informed and allowed to participate as much as possible in decisions about their care.
6. Reich WT, Ed. "Encyclopedia of Bioethics", MacMillan Publishing Co., Inc., New York, 1978. Though a little dated, the Encyclopedia remains an important scholarly reference on topics from abortion to zygote banking.

Journal Articles

7. Annas GJ. "Not Saints, But Healers: The Legal Duties of Health Care Professionals in the AIDS Epidemic", Am J Public Health 1988, 78:844-9. Despite established legal duties for physicians to treat in emergencies, to refrain from discriminatory patient care

practices, and to avoid abandonment, professional societies and state legislatures have not uniformly upheld a physician's duty to treat AIDS patients.

8. Brett AS, McCullough LB. "When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligation", N Engl J Med 1986, 31:347-51. Patients who demand useless or even harmful therapies present a common ethical problem for physicians. These authors propose that the physician has no ethical obligation to fulfill a patient's wish for a particular therapy unless that therapy has potential benefit for the patient.
9. Jonsen AR. "Do No Harm", Ann Intern Med 1978, 88:827-32. Jonsen cites four meanings of the medical maxim "Do no harm": (1) Medicine is a moral enterprise intended to benefit patients; (2) Physicians should exercise due care in attending patients; (3) Patients should ordinarily be allowed to determine which medical risks are acceptable to them; and (4) Patients should be allowed to determine when treatment's harm outweighs its benefits.
10. LaPuma J, Schiedermayer DL, Toulmin S, Miles SH, McAtee JA. "The Standard of Care: A Case Report and Ethical Analysis", Ann Intern Med 1988, 108:121-4. Using a case to illustrate, the authors propose that the standard of care should include technical competence at managing disease, the general legal duty to possess and use the skills of a reasonably well-qualified physician, and the ethical obligation to promote patients' interests.
11. Lo B, Dornbrand L. "Guiding the Hand That Feeds: Caring for the Demented Elderly", N Engl J Med 1984, 311:402-4. The authors state four questions to consider in deciding whether to give tube feedings to the elderly demented: (1) Will the feedings relieve hunger and thirst? (2) Will the feedings prolong life? (3) Will the feedings cause suffering? (4) What psychosocial effects will the feedings have? The decision to withhold tube feedings should be grounded in patients' wishes or interests.
12. Lo B, Jonsen AR. "Ethical Decisions in the Care of a Patient Terminally Ill With Metastatic Cancer", Ann Intern Med 1980, 29:107-11. This article addresses questions physicians often ask about euthanasia. The authors point out the important difference between giving high doses of narcotics to alleviate pain and giving equally high doses to kill the patient.
13. Lidz CW, Appelbaum PS, Meisel A. "Two Models of Implementing Informed Consent", Arch Intern Med 1988, 148: 1385-9. The authors describe two models for implementing informed consent: (1) the event model that involves presenting information to the patient only once shortly before treatment; and (2) the process model that involves giving patients information, discussing it with them, and negotiating about decisions throughout the therapeutic encounter.
14. Lynn J. "Ethical Issues in Caring for Elderly Residents of Nursing Homes", Primary Care 1986, 13:295-306. Institutionalization often deprives the elderly, demented, and

disabled of much control over their lives. Physicians should try to restore some control to these patients by inviting their participation in medical decisions. Furthermore, physicians should steadfastly serve as the patients' advocates despite current pressures to ration resources and to contain costs.

15. Lynn J, Childress JF. "Must Patients Always Be Given Food and Water?", Hast Cen Rep 1983, 13:17-21. Lynn and Childress say that the incompetent patient usually should receive food and water. A few instances, however, justify not giving food and water: (1) whenever feeding cannot improve the patient's nutrition and hydration; (2) whenever the patient would not consider the improved nutrition and hydration beneficial; and (3) whenever the patient would consider the burdens of feeding to outweigh its benefits.
16. Morreim EH. "The MD and the DRG", Hast Cen Rep 1985, 15:30-8. Cost containment programs based on diagnosis related groups (DRGs) threaten to destroy the physician's traditional loyalty to the patient. While affirming the importance of this loyalty, Morreim urges physicians to eliminate wasteful practices.
17. Perkins HS. "Ethics at the End of Life: Practical Principles for Making Resuscitation Decisions", J Gen Intern Med 1986, 1:170-6. This article outlines three principles for making resuscitation decisions: (1) Give cardiopulmonary resuscitation (CPR) unless compelling reasons indicate the patient would not want it; (2) Give no CPR if the patient has refused it; and (3) Give no CPR if it would not serve therapeutic goals the patient would choose.
18. Steinbrook R, Lo B. "Artificial Feedings: Solid Ground, Not Slippery Slope", N Engl J Med 1988, 318:286-90. Arguing from five recent legal cases, the authors propose that nasogastric and intravenous feedings be used only if their benefits for the patient outweigh their burdens. If benefits do not outweigh burdens, the physician may justifiably withhold the feedings.
19. Steinbrook R, Lo B, Tripack J, Dille JW, Volverding PA. "Ethical Dilemmas In Caring for Patients With the Acquired Immunodeficiency Syndrome", Ann Intern Med 1985, 103:787-90. The authors recommend fully aggressive therapy for all AIDS patients who want it unless the patients are terminal and therapy has virtually no prospects for success. The authors also recommend that patients who want to limit their therapy discuss those wishes with their physician and execute advance directives.

BIBLIOGRAPHY: MEDICAL ETHICS EDUCATION

Books and Monographs

20. Bickel J. "Integrating Human Values Teaching Programs Into Medical Students' Clinical Education", American Association of Medical Colleges, Washington, DC, 1986. This survey reveals that human values teaching programs have widely varied objectives.

Common problems for these programs include insufficient funding, general faculty disinterest, and lack of institutional support.

21. Clouser KD. "Teaching Bioethics: Strategies, Problems, and Resources", The Hastings Center, Briarcliff Manor, NY, 1980. Clouser champions medical ethics teaching that develops students' analytical thinking as well as sensitizes them to moral issues.
22. Subcommittee on Evaluation of Humanistic Qualities in the Internist, American Board of Internal Medicine (ABIM), 1985. This monograph identifies and defines three humanistic qualities the ABIM requires of board-certified internists: integrity, respect, and compassion. The monograph also presents strategies for assessing these qualities in residents and emphasizes the importance of assessments based on direct observation.

Journal Articles

23. Arnold RM, Povar GJ, Howell JD. "The Humanities, Humanistic Behavior, and the Humane Physician: A Cautionary Note", Ann Intern Med 1987, 106:313-8. The authors describe humane physicians as possessing technical competence, humanistic attitudes, humanistic behavior, and knowledge of humanistic concepts. To train such humane physicians, the authors favor residencies that teach communication skills and cognitive aspects of medical ethics, medical anthropology, and the other medical humanities.
24. Barnard D. "Residency Ethics Training: A Critique of Current Trends", Arch Intern Med 1988, 148:1836-8. Barnard argues that ethics training during residency should include retreats, discussion groups, and other experiences designed to encourage residents to develop a sound philosophy of practice and to learn good relationship-building skills. In this way residency programs will acknowledge and nurture "the humanness of the residents."
25. Carson RA, Curry RW. "Ethics Teaching On Rounds", J Fam Pract 1980, 11:59-63. Carson and Curry use three cases to illustrate the value of ethics teaching on ward rounds. Ethics teaching facilitates physicians' decision-making by "challenging assumptions, clarifying issues, making distinctions, pointing out deficiencies in reasoning, asking for reasons, and then probing (those reasons) to see whether they withstand scrutiny."
26. Clouser KD. "Medical Ethics: Same Uses, Abuses and Limitations", N Engl J Med 1975, 293:384-7. Clouser claims medical ethics' primary purpose is to structure disputed issues by analyzing concepts, applying relevant principles and precedents, and drawing out implications of actions. He also says medical ethics may not specify one "right" answer for every issue.
27. Culver CM, Clouser KD, Gert B et al. "Basic Curricular Goals in Medical Ethics", N Engl J Med 1985, 312:253-6. At a conference the nation's leading medical ethicists agreed on the following beliefs about teaching ethics in medical schools: (1) Medical ethics cannot change students' basic moral character but helps students give good character "the best behavioral expression;" (2) Medical ethics cannot be taught piecemeal

as students rotate through the clinical specialties; (3) Successful teaching programs may vary considerably; and (4) The content of medical ethics instruction should be “rigorous and precise.”

28. Jonsen AR. “Leadership In Meeting Ethical Challenges”, J Med Educ 1987, 65:95-9. Jonsen notes that most physicians remain quite inarticulate about medical ethics, and a gap separates medical ethics teaching and actual patient care. He urges university medical centers to maintain faithfulness to the suffering patient and to exercise leadership in assuring proper care for all.
29. LaPuma J. “Consultation In Clinical Ethics: Issues and Questions In 27 Cases”, West J Med 1987, 146:633-7. LaPuma reviews one year’s ethics consultations at the University of Chicago hospitals. Of 27 consultations, 18 concerned withholding life support, 3 concerned costs or scarce resources, 3 concerned patient autonomy, and 3 concerned other issues.
30. Lo B, Schroeder SA. “Frequency of Ethical Dilemmas In a Medical Inpatient Service”, Arch Intern Med 1981, 41:1062-4. The percentage of patients recognized by attending physicians and residents as causing significant ethical problems rose from 4 percent to 17 percent when a physician-ethicist attended medicine ward rounds at a teaching hospital.
31. Loewy EH. “Teaching Medical Ethics to Medical Students”, J Med Educ 1986, 61:661-5. Medical ethics requires instruction in order that students learn necessary information about ethics, acquire important analytic skills, and practice these skills under supervision. Loewy favors using patient vignettes and clinically I instructors to teach medical ethics.
32. Pellegrino ED. “Relevance and Utility of Courses in Medical Ethics: A Survey of Physicians’ Perceptions”, JAMA 1985, 253:49-53. Of 1,023 physicians who responded to a mailed questionnaire survey, only 314 (30.7%) had had any ethics courses in college, medical school, or postgraduate education. Yet 82 percent of these 314 reported that these courses helped them identify value conflicts; 79 percent said these courses increased their sensitivity to patients’ needs; and 73 percent said their courses improved their ability to deal openly with ethical issues.
33. Pellegrino ED. “Educating the Humanist Physician: An Ancient Ideal Reconsidered”, JAMA 1974, 227:1288-94. Pellegrino argues that all practicing physicians must be technically competent and compassionate. In addition, some physicians must command a broad humanistic education in order to place medicine in its proper relation to culture and society. Excessively weighted toward the technical for many years, medical curricula should re-emphasize compassion and humanism.
34. Purtilo RB. “Ethics Consultations in the Hospital”, N Engl J Med 1984, 311:983-6. Purtilo raises important procedural questions about an ethicist’s doing clinical consultations: (1) Should the ethicist record his consultation in the medical record? (2) Should the ethicist be paid for the consultation? (3) Should the ethicist have access to the

patient, family, physician, and other informants in the case? and (4) Should the ethicist have a hospital staff appointment?

35. Siegler M. "A Legacy of Osler: Teaching Clinical Ethics At the Bedside", JAMA 1978, 239:951-6. Siegler believes teaching ethics from actual cases at the bedside maximizes personal accountability, reinforces the relationship between technical competence and ethical decisions, involves the entire health care team, and decreases medicine's resistance to ethics instruction. Physicians, assisted by clinically informed philosophers, should take the responsibility for teaching ethics at the bedside.
36. Report on the Working Group on Personal Qualities, Values, and Attitudes. Physicians for the Twenty-First Century. Report of the project panel on the general professional education of the physician and college preparation for medicine. J Med Educ 1984, 59:177-89. This working group identified attitudes a physician should have "to recapture the human spirit in medicine." Medical education, however, often undermines the development of these attitudes. Therefore, the group challenged medical school faculties to: (1) choose students with the potential to develop those attitudes; (2) demonstrate those attitudes to students, and (3) design educational experiences and student evaluations to reinforce those attitudes.
37. Subcommittee on Evaluation of Humanistic Qualities in the Internist, American Board of Internal Medicine (ABIM). "Evaluation of Humanistic Qualities in the Internist", Ann Intern Med 1983, 99:720-4. This article states the purpose of the subcommittee and some of its initial findings. Citation 22 summarizes the subcommittee's final report.
38. Winkenwarder W. "Ethical Dilemmas for House Staff Physicians", JAMA 1985, 254:3454-7. Winkenwarder offers suggestions for managing the ethical issue created by disagreement between attending physicians and residents: (1) recognize the value differences present and discuss them; (2) use consultants or "recognized sages" to help resolve such disagreements; (3) minimize misunderstandings by maximizing communication among the staff; and (4) teach more medical ethics.