Special Section:
Praxis: Ethical Issues in Medical Education and Training

Lessons from a Bygone Medical Ethics Program

ANONYMOUS

Ethicists in American medical schools feel increasingly discouraged these days. In the 1960s, 1970s, and 1980s, society's enthusiasm for teaching about medical ethics flourished as new medical technologies posed new ethical perplexities. Americans eagerly sought ethics advice and looked to medical schools to provide it. As the sites where many of the new technologies were developed and future physicians were trained, medical schools were the logical place for medical ethicists to work and teach. A few schools recognized society's need and instituted explicit medical ethics teaching—allocating funds, hiring ethicists, creating departments, and trumpeting their accomplishments. But most schools responded to the need with indifference or even hostility. They distrusted outside "experts" and feared a zealous reform movement aimed at the character or practices of modern medicine.[1] Yet even those schools were forced to create ethics programs to meet powerful accreditation requirements adopted around 1990. Complying reluctantly, these schools allocated few personnel and minimal budgets. The resulting programs struggled.

The severe budget cuts beginning at all American medical schools in the mid 1990s threatened the very survival of these struggling programs. Many schools instituted resource-based budgeting, by which every program must pay its way. Predictably, medical ethics programs had difficulty complying. Although they undoubtedly prevented expensive lawsuits against medical schools and teaching hospitals, these programs rarely received direct payment for their services, such as clinical ethics consultations or institutional review board participation. As a result, medical schools have steadily cut ethics budgets while trying to maintain full ethics programs. Many schools now hire inexperienced junior faculty at low pay, impose burdensome teaching loads, recruit ill-prepared nonethicists to help teach, and depend on research grants to defray ethics teaching costs. No wonder ethicists feel discouraged.

Like most others, my medical school has always reacted to medical ethics teaching with indifference at best. When I negotiated my job years ago, I did not perceive that attitude. School officials agreed to allow me to create an unofficial ethics program on my own time with the unspoken proviso (which I did not realize until long afterward) that the program would cost the school nothing. When I arrived, I eagerly set about planning a first-rate ethics program. I envisioned rigorous, cutting-edge research, exciting teaching on headline-

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making issues, and clinically useful committee work and bedside consultations. I identified a few like-minded colleagues to help, initiated a state-of-the-art ethics committee at the teaching hospital's invitation, taught medical-ethics electives for students, arranged special guest lectures and conferences for the entire school, and helped write school policies with ethical implications. I believed medical ethics would eventually prove its worth even to the skeptics, receive its rightful moral and material support from the school, and take its place in the pantheon of basic medical disciplines.

Over the years, however, I learned that the school lacked the will to create more than the appearance of a substantive ethics program. School officials expressed the importance of medical ethics and touted my program to the outside world but gave little significant support. Even when accrediting bodies set their ethics teaching requirements, the school complied halfheartedly. School officials assigned me to teach the new required ethics course and promised resources that they never delivered. Even in prosperous years they allocated little curriculum time and no space, operating budget, clerical staff, or faculty. The school seemed always to dismiss medical ethics as knowledge that students and physicians could learn on their own without formal teaching.

The demise of this course and my whole program was predictable. A program unsupported and barely scraping by in good times cannot survive in bad times. When severe budgetary crises arose at my medical school several years ago and exacted a terrible toll, I finally had to admit defeat and close the program.

Of course, I am disappointed. Yet the experience taught me ten important lessons.[2] I describe them here, with the hope that other medical ethicists might benefit.

Lessons about the Self

Lesson 1: Strive for Excellence in the Important Things

As I already suggested, for years my medical school provided no official ethics teaching. The school believed that technical competence automatically yields ethical practice. But the school had to comply when accrediting bodies passed those ethics teaching requirements in the mid 1990s. At that time school officials assigned me to create and direct a new ethics course for students. These officials offered almost no resources to accomplish the task and urged the least effort necessary to meet the requirements. But conscience would not allow me to deliver a minimal effort. I believed such an effort would foster among students a disdain for the discipline of ethics, achieve little actual ethics learning, and reflect badly on me.

So, I tried to create as worthwhile an experience for students as possible. I included important, practical topics covered explicitly nowhere else, such as attending dying patients and managed-care conflicts. I recruited expert speakers (some from outside the university), used varied large-group presentation formats, and arranged small-group discussions. Unfortunately, the lack of resources doomed the effort. Exhausted after several years, I had to stop and the course died. Nonetheless, I take pride that I strove for excellence and gave my best effort. A few such accomplishments, key to my sense of right purpose

and well done, now give me precious, lasting satisfaction. I am thankful I did not compromise quality for expediency on something so important to me.

Lesson 2: Life Is Zero-Sum

In other words, time and energy spent one way cannot be spent another. Increased time and other resources rarely accompany increased service demands these days. Many people simplistically believe that, to do more with the same resources, one can always cut inefficiencies. My school's officials tend to think that way. After I had given the school an unofficial ethics program for several years early in my career and before the specific ethics-teaching requirements arose, one official asked me to create an official, comprehensive ethics program for the school. He offered me free reign and a director's title (but little else). Young and energetic at the time, I agreed. I knew the value of such programs and welcomed the challenge of building one from nothing. But I soon learned that he expected me to teach students, residents, fellows, faculty, and community physicians and to provide services such as clinical consultations and ethics-related committee work—all on top of my other duties to the school. Still, I tried hard to satisfy his expectations. At first, I sacrificed precious research and off-hours time to give ethics lectures or conduct consultations. Time and energy seemed limitless. But eventually I wore out as age revealed my limits.

That experience taught me that life's zero-sum nature imposes the hard responsibility of using limited time and energy wisely. Since then I have adopted several strategies to ensure caution in deciding about new commitments. For example, I no longer describe my workweek as just my fixed 60%-time commitments (which gives people the impression that I am available for the other 40%.) Rather, I explain to requesters that all of my commitments—teaching, research, administration, and others, fixed or not—already take up about 60 hours a week, or a 150%-time workweek, and I must carefully consider any new commitment. I also make no major commitment immediately. I insist on enough time—at least overnight—to weigh the commitment's costs and benefits. I may consult confidants and mentors and may even ask superiors to suggest comparable, current commitments I should discard to make room for the new one. I also zealously guard my personal renewal time as a necessity, not an indulgence.

Lesson 3. Strive to Become Your Best You

This lesson involves two critical tasks: assessing your true potential and working to fulfill it. The expectations of bosses, colleagues, family, or others can easily derail efforts to fulfill one's true potential. Many people consume themselves in fulfilling others' expectations and thereby neglect their own goals and true potential. Anticipating the judgment of his earthly life in the next world, the eighteenth-century rabbi Zusya once said, "They will not ask me, 'Why were you not Moses?' They will ask me, 'Why were you not yourself?'"[3] Zusya was warning us not to lose sight of our true potential and hence our most important personal goals.

Fulfilling one's true potential, once identified, requires setting appropriate goals and exerting the self-discipline to accomplish them. Feeling vulnerable as

an assistant professor, I thought my academic superiors controlled my future. Whatever they asked, I did—special lectures, the hospital ethics committee chairmanship, clinical ethics consultations, new courses, special symposia. But when the medical school denied my first application for promotion, I realized that my frenetic service for others counted little and had actually crowded out the research I originally intended to do and needed for professional advancement.

Having lost track of my talents and professional goals, I vowed to regain my focus. Although I owed the school some service for my salary, I decided not to compromise my most important goals and to take full responsibility for pursuing them. I learned to say no to many demands that would not advance those goals. Of course, many time-allocation decisions still threaten my resolve. But keeping my goals clearly in sight and pursuing them some every day has enabled me to regain my sense of self.

Lessons about Institutions

Lesson 4: Real Change Almost Always Begins at the Top

Two points argue the validity of this lesson. First, the top officials personify an institution and alone authenticate its actions to the outside world. And second, these officials command the internal knowledge and muscle to make the institution work for their purposes.

A long-time top administrator at my medical school resolutely resisted supporting an official ethics program. Nothing could change his mind—not special lectures and symposia on "hot" ethics topics, nor written plans detailing expected program benefits, nor urgings from visiting ethics experts, nor appeals from prominent local businessmen, nor unfavorable comparisons of our school to nearby medical schools with vibrant ethics programs. Never openly hostile, this administrator quietly stifled institutional support for a program. He ignored requests for internal funding and blocked access to external donors. At the same time he promoted flashier, far more expensive high-tech programs, such as organ transplantation. No ethics program could take root against such top-down resistance.

Lesson 5: Most Institutions Act More Like Nervous Systems Than Hearts

People react differently as individuals than they do as groups. In particular, certain sensitivities (such as compassion) that many people demonstrate as individuals rarely surface from institutions. Medical schools act like most other institutions. Perhaps the constant crises besetting medical schools desensitize them to anything but their own pain. Only its relief seems to motivate them. The resulting constant pressures and demoralizing environment extinguish many courtesies and kindnesses that make human life tolerable. Thus, today's medical schools act more like nervous systems than hearts. As a colleague says, "Schools do not love you back."

At the very outset of my career, my medical school and its teaching hospital faced a scandal involving patient deaths. With both institutions hurt by lawsuits and bad publicity, the medical staff president invited me to form an ethics committee to prevent such problems in the future. I accepted, believing that the

committee would demonstrate the benefits of a clinically relevant medical ethics program. That committee provided exemplary service over many years: organizing seminars for faculty, students, and staff; updating obsolete hospital policies on brain death, patient refusal of care, and withdrawal of life support; and conducting hundreds of bedside consultations to the appreciation of patients, families, and staff. Yet as the original scandal faded in institutional memory, both the school and the hospital took less and less interest in the committee's work. Both institutions appointed ever-more junior administrators to the committee, declined my requests for a small operating budget, and consulted the committee less and less on ethics-related matters.

One day a patient's family misunderstood a bedside ethics consultation as usurping care duties from doctors and nurses and "playing God." The family complained to the hospital's administration. Stung by the complaint, the hospital director, the hospital lawyer, and the medical school lawyer convened an immediate ethics committee meeting. Without considering the merits of the complaint or acknowledging the many prior ethics consultations that had successfully handled sensitive issues without complaint, the hospital administrator chastised the committee and placed it under the hospital lawyer's control. Many members (including me) felt repudiated and soon resigned. Since then, the committee has lost much of its ability to promote patient interests independently and often acts as merely a risk-management tool.

Lesson 6: Where Their Treasure Is, There Will Their Hearts Be Also[4]

In other words, commitment precedes passion, or cost precedes value. "Treasure" in a medical school includes time, personal prestige, and money. The early challenge of creating from nothing an ethics program at our medical school intrigued me. With the help of a few supportive colleagues, I committed myself to that goal, devoted significant time to it, and created an initial, unofficial program of noncredit classes, guest lectures, journal clubs, and public seminars. I believe that my initial commitment to create the program sparked my later passion to see it succeed. That passion fueled my efforts through future trying times.

Unfortunately, as the reader now knows, officials at our school lacked that commitment and hence that passion. One dean openly disdained formal ethics training. Students reported that he would proudly announce on the first day of class that our medical school offered no ethics course and that clinicians would teach students the ethics they needed to practice medicine. Thus, the dean not only withheld his prestige from any formal ethics training, he actually used his prestige to undermine attempts to provide it. A later dean, who favored some ethics training, tried to institute it without funding or staffing. He also allocated to it too few hours and at the least desirable times in the curriculum—at the end of the second year (when students cannot bear classes anymore) and at the end of the fourth year (when students have already mentally graduated). Having committed no significant funds, time, or other resources, this dean had no investment to protect. So, in hard times, faculty attrition and shrinking budgets made ethics teaching a quick casualty. The students concluded that, because the school did not seem to value formal ethics training, they need not either. How different their attitude might have been had the deans committed prestige and resources to the effort.

Lessons about Working in Institutions

Lesson 7: You Can Bargain Best before You Start

This lesson is obvious to me in retrospect. But I was inexperienced and overconfident as I applied to this school for my first job. When my future superiors readily agreed to my starting an ethics program, I assumed that they were making an enthusiastic commitment to it and that they understood the program would require some future resources from them. Lulled by their expressed interest and my own optimism, I did not conduct crucial due diligence. I failed to analyze critically what my future superiors said (and did not say), to plan for long-term resource needs, to quiz past and present employees about the reliability of the school's follow-through, to consult experienced ethics colleagues elsewhere about the job, and to insist on all agreements in writing. Since then, I have learned that even when they start with good intentions, people change, forget, misunderstand, or come to disagree over time. I have also learned that signing a contract, moving across country, and beginning to draw a salary and to enjoy fringe benefits nearly extinguish an employee's bargaining power. In short, evaluating a job prospect requires anticipating future problems carefully and negotiating hard in order to solve as many of them as possible beforehand.

Lesson 8: Insist on What You Need

Don't compromise on necessities. You have may have to live with your compromises for a long time.

My experience suggests that a stable, credible medical ethics program has five elements that must not be compromised:

(1) A professional faculty. A credible ethics program requires an expertly trained, professional faculty hired into the program. Medical ethics is a scholarly discipline with its own literature, concepts, logic, and perspectives. Core faculty must command an expert knowledge of the field. (I suggest the equivalent of at least a Master's level ethics education.) Core faculty must also set their priorities to maintain the program through difficulties or inconveniences. Though often helpful, volunteers from outside rarely command the necessary expertise and may not set their priorities to see critical tasks through.

(2) Sufficient numbers of core faculty. "One equals zero" is mathematical nonsense but administrative truth. As I learned, one person trying mostly alone to build a program or to move a large, inertial institution eventually exhausts himself and dissipates his efforts. For that reason, I believe a medical ethics program requires three or four core faculty to share the workload, spur one another's creativity, celebrate triumphs, and console about disappointments. Such a program also requires adequate support staff.

(3) A dedicated budget including "hard dollar" faculty salaries. The arduous, time-consuming teaching and service duties of a medical ethics program demand "hard dollar" funding. Grantors do not fund such ongoing programmatic duties. And faculty must not be expected to

siphon time off funded research to perform them. Additionally, schools must resist filling ethics jobs solely with part-time clinicians just because they can earn clinical income. Although clinical involvement helps orient a program to everyday issues of delivery, direct patient care entails hidden time costs and can interfere with ethics duties.

(4) Protected research time. To stay curious and current, faculty must conduct research. Yet ethics research is often hard to fund, and the most innovative research is even more so. For that reason medical schools should protect some research time—on average, 20 hours per week in large, uninterrupted blocks—for their ethics faculty.

(5) Defined goals and constituencies. The many service requests from multiple constituencies can easily overwhelm a medical ethics program. Thus, the faculty should track requests and the effort required to service them. Additionally, school officials should help the faculty define their main goals and primary constituencies. Together, program faculty and school officials should map progress toward these goals, review it periodically, and make changes as needs dictate.

In sum, medical ethics programs may be low-budget, but they are not no-budget. Real programs require real resources.

Lesson 9: Forgive Your Enemies, but Remember Who They Are[5]

For me, this was the hardest lesson of all. Despite our best intentions, enmity can arise over differences in values, goals, or style. Friends overcome those differences to create healthy, mutually nurturing relationships. Enemies do not.

I now must view as enemies the few people who intentionally and repeatedly did me more harm than good. Still, I believe that identifying enemies hinges less on assessing outcomes (which can be unintentional) and more on discerning intentions. Enemies *intend* to benefit themselves even at the expense of others.

For years, I trusted people generally to do right by one another. I resisted keeping mental accounts of favors and slights. But experience has taught me to change my approach. I still start new relationships by assuming acquaintances are good people, but I keep a more careful mental account of favors and slights than before. I also watch people's treatment of others under the assumption that a person treats others as he will treat me. I find such informal accounting is the most reliable indicator of what intentions others have and hence whether they are likely to be friends or enemies.

Of course, everyone makes mistakes in relationships. Some mistakes are unintentional; some are big. I try to allow most people one big mistake. I allow certain special people several big mistakes. But when people do me consistent harm without compensatory benefit, I begin to view them as enemies. I then treat them with civility and caution.

Wounds at the hands of enemies can create a festering anger that erodes one's spirit. Forgiveness is essential for healing. Yet forgiveness does not occur automatically or effortlessly. It takes hard work. After the frustrations of dealing with my school over the ethics program and after the disappointment of its closing, I have had to work hard at forgiveness just to regain a healthy perspective. I have not yet completed the task. Progress is slow, and I occa-

sionally backslide. But I have learned that forgiveness can come with conscious effort and sufficient time.

A Lesson about Looking to the Future

Lesson 10: "In My End is My Beginning . . ."

Changed thinking often prompts changed feelings. So, I have taken this motto—attributed to Mary, Queen of Scots—as my perspective on the demise of my ethics program. Although I first considered my ethics program a failure, I have now chosen not to think of it that way. Students learned from the classes, patients benefited from the consultations, and I learned much about myself and about practical, real-world ethics. These accomplishments are important and meaningful to me. The program certainly deserved more success than it received, but its demise has had a positive side: I am free as never before. I must no longer cater to medical-school policies and personalities. I choose when, what, and whom I teach. I can also focus on my research and its rewards. Overall, I am prospering.

I wish I could say as much for ethics programming at my medical school. Scrambling once again to meet those accreditation requirements, the school is patching together another ethics teaching effort. In so doing, the school is repeating some of its earlier mistakes. For example, the school has asked some current faculty, who are too few for the task, have never been involved before, and are not formally trained in ethics, to teach it.

Only accrediting bodies and professional societies can set such schools straight. Accrediting bodies must scrutinize the staffing, curricular content, and funding of medical ethics programs. An important 1994 nationwide survey of programs should be updated and used for critical comparisons across schools.[6] Above all, accrediting bodies must not approve superficial or lackluster programs but demand stable, substantive, high-quality programs. Professional societies in medical ethics also have a role. They must help protect faculty—especially junior faculty—from institutional abuses. These societies should explicitly address career development issues through lectures at meetings and through ongoing, one-on-one mentoring by experienced medical ethicists. Such societies might also initiate on-site evaluation and perhaps certification of programs.

A Final Comment

Lessons from experience form the core of everyday, practical ethics. Many of those lessons, like the ten here, may come at a dear price. For both of these reasons, we, medical ethicists, must consciously share with others the knowledge we have gained. Such lessons from experience may yet prove our most important legacy to the medical ethicists who succeed us.

Notes

1. Clouser KD. Medical ethics: some uses, abuses and limitations. *New England Journal of Medicine* 1975;293:384–7.

2. This list of lessons may trouble some philosophers. It lacks the comprehensiveness and the coherence that Dan Clouser and Bernie Gert want from a principle-based ethics theory. They might call my lessons "chapter headings" (Clouser KD, Gert B. A critique of principlism. *Journal of Medicine and Philosophy* 1990;15:219–36). I concede possible conceptual messiness. Still, experience yields valuable, if messy, lessons.
3. Buber M. *Tales of the Hasidim: The Early Masters*. New York: Schocken Books; 1947:251.
4. Matt. 6:21.
5. Reinhold Niebuhr wrote something similar, but not exactly the same, in: Niebuhr R. *Moral Man and Immoral Society*. New York: Scribner's; 1947:263–4.
6. Society for Health and Human Values. Program directors' survey of medical ethics and humanities programs. 1994.