Special Section:
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The Best Lack All Conviction: Biomedical Ethics, Professionalism, and Social Responsibility

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The best lack all conviction, while the worst
Are full of passionate intensity.
—W. B. Yeats, "The Second Coming"

[W]e are seized by spasms of genuine moral awareness, but we are as pliant as aspens in our capacity to accommodate to the prevailing rhythms of the world we inhabit.
—Robert Coles, "On Moral Conduct," *The Call of Stories*

Robert Coles' sentiment characterizes well the moral tenor of medical education today. Indeed, medical educators are frequently "seized by spasms of genuine moral awareness," as they try to cope with the massive social and economic problems that face medical schools and teaching hospitals. The perception among educators that we currently fail to adequately teach several core aspects of doctoring, including professional values and behavior, constitutes one such spasm.[1,2,3,4,5,6,7,8,9,10,11,12] In this case, the proposed remedy has generated considerable enthusiasm, but whether the "core competencies" curriculum will make a difference, or simply "accommodate to the prevailing rhythms of the world we inhabit," remains to be seen.

The socialization process that occurs during medical training conflicts with, and tends to diminish, many of the attributes and values usually associated with good doctoring—for example, compassion, reflectivity, curiosity, altruism, self-effacement, and social responsibility.[13,14,15,16,17,18,19] Although these characteristics are often reinforced by the explicit curriculum in medical schools, the tacit learning that trainees receive in the hospital and institutional setting promotes other, and often conflicting, personal attributes—such as detachment, entitlement, wariness, cynicism, an ethic of technique, and a moral myopia about the needs of patients beyond one's immediate field of vision. Thus, paradoxically, the explicit values of professionalism become countercultural in the professional environment.

We have argued elsewhere (in our own spasm of moral awareness) that the failure of medical education to focus on producing good doctors, rather than simply on producing good technicians, is an ethical failure.[20,21] Moreover, the introduction and development of biomedical ethics teaching in medical schools over the last 30 years has not significantly ameliorated this failure. Biomedical ethics presupposes the practitioner's character and motivation and concerns itself with how doctoring ought to be carried out within a utilitarian or

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duty-based philosophical system. Medical students, house officers, and practicing physicians report that they receive little, if any, explicit training in professionalism, and many believe that they become less humanistic and more cynical as their education progresses.

In this paper we narrow the focus to analyze a single, but important, aspect of doctoring, the social role of physicians—that is, the moral responsibility of physicians as physicians toward the community in which they live. Our thesis is that the nonreflective professionalism engendered by today's medical education is especially deficient in this respect. It is quite common for students and young physicians to attest to some traditional professional values; for example, they might earnestly argue that physicians have a fiduciary responsibility to champion their patients' immediate and local interests. However, at the same time they are unlikely to consider putting themselves at risk for their patients or advocating social change to help their patients or their community. These acts are considered supererogatory—not part of the basic doctoring package.

In the next section, we critique contemporary biomedical ethics curricula and focus, in particular, on the miniscule role that social justice plays in the academic experience of medical students and residents. We also touch briefly on the role of altruism and justice in traditional concepts of professional virtue. Is it reasonable to claim that doctors have a social responsibility that goes beyond good patient care? We argue that it is, particularly in light of the medical-school application process, which, as we will describe, demands substantial evidence of volunteerism and social responsibility as important prerequisites for admission and, therefore, by the legal doctrine of detrimental reliance, quite clearly represents altruistic social engagement as intrinsic to doctoring. Finally, we consider the possibility of changing medical education to make it more consistent with professional virtue, especially with regard to the physician's role in society, and recommend several possible curricular improvements.

Biomedical Ethics

Critique of Ethics Teaching

At present, the standard model for biomedical ethics curricula is an uneasy hybrid between a principlist conceptual approach to ethics and case-based teaching practice. By "principlist" we mean philosophical bioethics based on a set of midlevel principles, as explicated and popularized by Beauchamp and Childress.[22,23] The usual list of principles includes respect for autonomy, nonmaleficence, beneficence, and justice; in variations of the list, additional principles might be added (e.g., sanctity of life) or two entries combined (e.g., nonmaleficence and beneficence becoming welfare). These concepts are considered foundational in practice, although in theory they must be derived from, or justified by, an underlying metaethical theory, such as deontology or consequentialism. An important insight of biomedical ethics is that abstract theory doesn't often matter very much at the decisionmaking level. By simply accepting the midlevel principles, teasing out their implications, deriving appropriate rules, and applying the rules, one can accomplish the functional end of ethics. Thus, given that medicine is an eminently practical profession, the way to teach physicians to use ethics is analogous to providing a set of practice guidelines.

In ethics one attends to principles and procedures, rather than worrying about theories; in therapeutics, one adheres to a treatment algorithm without evaluating the basic science underlying its adoption. The standard model presupposes that the discipline of biomedical ethics is philosophically and rationally based, generalizable, and extrinsic to medicine.

In our experience, teaching based on the standard model conveys three relevant messages to medical trainees. First, the purpose of medical ethics, so to speak, is to protect individuals from each other and from institutions—from being ignored or subjugated by others. Respect for personal liberty ("autonomy," to use Kant's expression) is usually couched in terms of individual rights. In the United States, ethics serves to ensure that medical interactions and interventions do not abridge rights; for example, that clinicians don't compromise the rights of their patients, HMOs or hospitals don't infringe on the rights of healthcare providers, and so forth. The focus of this approach is on individuals with little attention paid to moral claims of the collective.

The second lesson students learn is that ethical questions or issues generally arise only in situations where there is conflict between parties or values. When no conflict exists, the texture of decision and behavior is determined, according to this view, by purely technical or "medical" considerations (i.e., based solely on value-neutral data). That doctoring is ineluctably infused with values is ignored. The conflict model also teaches (lesson three) that the law is the most practical guide to analyzing ethical matters. Legal systems are designed to avert or, failing that, resolve conflicts; thus, because ethics deals with the same problems, jurisprudence provides an efficient model for solving them. Moreover, law has the advantage of being a publicly accessible (and enforceable) code that prescribes and proscribes actions. Under this model, turning to law is seen as taking the work out of ethics.

Students tend to accept the standard model and to develop these conceptions, despite the fact that their teachers almost universally tell them not to do so.[24,25,26,27] Whereas educators introduce principlist ethics as the "basic science" of morality in medicine, they continually emphasize that ethical quandaries in medicine are highly case specific and cannot actually be "solved" by applying the principles and methods being taught. This is analogous to teaching an elaborate physiological model based on the idea that peptic ulcers are caused by hyperacidity and stress, while concomitantly reminding students that ulcers are actually caused by *Helicobacter pylori* infection and, therefore, the theory doesn't work. This paradox of "principlist, but case based" leads to the uneasy hybrid we referred to. To capture the case-specific nature of ethics in medicine, educators supplement principlism in various ways; for example, they might introduce virtue theory, casuistry, or narrative ethics as alternate or supplementary models. Additionally, they often stress the interpersonal aspects of conflict resolution (e.g., communication skills, negotiation, and consensus building).[28] Nonetheless, mirroring their reductionistic approach to basic sciences, students tend to view the moral concepts they learn (e.g., autonomy, informed consent, decisionmaking capacity, advance directives) as the core subject matter of ethics, and its range of quandaries as largely confined to conflicts of rights.

Yet, in most medical situations and with most patients, no such quandary, conflict, or moral puzzle occurs. Values inherent in day-to-day medical practice generally escape notice because, despite the premise of television programs like *ER*, medical practice is not a series of quandaries challenging the skills of a

physician as casuist; rather it is an ongoing, often boring, series of interactions that appear to be morally easy, insignificant, and plain. Consequently, students find that medical ethics, as they understand it, fails to enrich the texture of their practice.

Ignoring the Call to Justice

In the classic list of core ethical principles, justice is almost always mentioned last and takes up the rear in more significant ways as well. Whereas autonomy, beneficence, and nonmaleficence are thought to apply to every dyadic, physician-patient relationship, justice is a moral norm that gains importance as the numbers affected by a decision grow. So long as the most important medical relationship involves only two people, the role of justice seems attenuated. Medical education tends to consider the dyadic relationship as primary, hence to ignore the importance of justice in relation to autonomy, beneficence, and nonmaleficence. This tendency is unfortunate both because even the so-called dyadic relationship is broader than typically visualized and because so much of importance in health promotion and disease prevention occurs at the societal level.

In the reductionistic academic world, students learn that questions like "What is fair?" and "How should these resources be distributed?" fall outside the sphere of medical practice or are only relevant to a small subset of practice situations. First, the clinical relevance of ethics is stressed by making a distinction between "ethics at the bedside" (autonomy, beneficence, and nonmaleficence) and allocation of resources or the right to healthcare (equity or distributive justice). The latter is introduced and discussed but considered beyond the physician's scope of practice, although, of course, as a knowledgeable citizen, he or she should be interested in remedying inequities in social justice. Moreover, a desire to apply considerations of justice in clinical care is considered unprofessional. The good doctor ought always to work in the best interests of his or her individual suffering patient and to disregard the competing claims of others—in other words, no rationing at the bedside.

The first difficulty with the narrow focus on individuals in a doctor-patient relationship is that it distorts who an individual is in our society. Each of us is embedded in a complex matrix of relationships—family, friends, coworkers, churches, community—and this situatedness means that what happens to one of us has genuine implications for others. Justice plays a role in evaluating the effects of any patient's healthcare on those related others. Dyads are a convenient fiction in medical training, but a fiction that distorts young physicians' understanding of the values inherent in their work.

The second problem with the myopic model of dyadic relationships is that it distorts the importance of social issues in medicine. Much of health promotion and disease prevention is about groups. Access to care is not a problem that can be meaningfully addressed by individuals. But to develop thoughtful positions on these problems, students need to have substantial knowledge about specific social issues (e.g., unemployment, poverty, healthcare financing). The typical biomedical ethics course provides neither enough time nor appropriate faculty to cultivate students' understanding of such topics. Moreover, addressing justice-based positions on real cases may be perceived (often rightly) as taking "political" stands, a step that students are often reluctant to take. Further,

students may want to confine their consideration of justice to microallocation choices—for example, which patient should get the last bed in the ICU? Or should a bad habit like cigarette smoking count against a patient receiving scarce resources or expensive procedures?

In fact, part of the tacit learning that occurs throughout medical education is the view that students and residents cannot—and perhaps even ought not—have any appreciable effect on social change or the policymaking process. This can be viewed as a learned-helplessness model in which it is easier to throw up one's hands in frustration than to take practical steps to influence the process. Students often have little or no experience with public policy and probably are only infrequently offered encouragement on such topics. Nonetheless, we should add that, despite severe constraints on their time, some students do become active in issues of social justice in healthcare.[29] Encouraging and rewarding such behavior is one obvious contribution that faculty can make. As we discuss later, standardizing such reinforcement into the curriculum would be a significant step toward addressing these issues in schools where they have previously received too little emphasis.

Our conclusion is that the principle of justice has little or no influence on the student's developing professional identity. As long as the language of philosophical ethics is used to understand and justify medical morality, it would appear that there is no moral requirement for physicians to be socially engaged, and it is to that issue we turn.

Professionalism and Social Engagement

Are altruism and social activism appropriate topics for medical education to address? Is a commitment to social justice part of the package of good doctoring or simply an aspect of good citizenship that is unrelated to professionalism? We may admire doctors who work in free clinics or engage in public-policy debates, but do these activities make them better doctors or simply better people? One might agree that today's medical schools do an inadequate job in conveying the core values of doctoring, but at the same time argue that failure to nourish trainees' *social* responsibility is not part of *that* problem; in fact, social responsibility as such is, at most, a peripheral feature of good doctoring. If we want to reactivate medical virtue, according to this argument, we should focus on less controversial characteristics, like compassion, fidelity, and courage.

To respond to this position, we need to distinguish two quite different versions of what social responsibility in medicine might mean. In the first version, a commitment to the health of the community as a whole is an intrinsic part of medical professionalism; that is, in some sense, every physician ought to accept as one of his or her goals the improvement of health and welfare for all. In this view, the neighborhood or the community or the state might be considered a *patient*. Of course, obligations to individual sick persons are important, but considerations of the common good are related, equally important, parallel, and nonderivative.

The strong version of this belief is embodied in public health, social medicine, and population medicine. Public health practitioners sometimes use the state's police power to enact measures that compromise individual rights (e.g., the right to be left alone, the right to privacy) in order to achieve better health

for all. Mainstream physicians typically see themselves as advocates for individual patients, who speak up for their patients' interests when they conflict with restrictive state programs or agencies. However, some commentators believe that the managed-care revolution, which has imposed explicit "third party" obligations on physicians, may push the center of gravity in the profession toward a more universal acceptance of population-based ethics.[30,31,32,33]

A second version of social responsibility in medicine arises as a function of caring for individual patients. There are two variants. The first focuses on sick and suffering persons *in* the community. As ill persons they certainly have a claim on *their* physicians' time. But in the real world, economic and social inequities prevent or inhibit many of them from access to medical care. Everyone agrees that doctors ought to care for *their* patients to the best of their ability, but what about sick persons who have no doctor? It would seem that physicians must have an obligation to facilitate or provide at least some free care to those who need it. The other variant of this patient-based view of social responsibility is based on the biopsychosocial model of health and illness.[34] To understand patients' illnesses, we need to appreciate the economic, social, and cultural context in which they arise. Likewise, to treat them effectively, we often need to design and implement social interventions.

Both versions of social responsibility have played a role in the history of medicine, although the patient-based form is predominant. In consequence, the "good" physician has generally been expected to assume some civic responsibilities. First, there was a tradition that physicians spend a portion of their professional life caring for patients who were unable to pay for their services. This might be a weekly clinic in the local hospital, or it might entail writing off the charges of certain office patients. A late manifestation of pro bono medical care was the free-clinic movement of the 1960s and 1970s, staffed primarily by volunteer physicians. The ascendancy of Medicare and Medicaid, along with the ethos of specialization, dealt an almost lethal blow to this sense of professional obligation. However, the tradition is still manifest in the AMA Code (9.065), which specifies:

> Each physician has an obligation to share in providing care to the indigent. . . . All physicians should work to ensure that the needs of the poor in their communities are met. . . . Caring for the poor should be a regular part of the physician's practice schedule.[35]

In addition to providing free medical care, many American physicians of the early to mid twentieth century promoted and participated in a wide array of public-health activities. For example, community physicians played a major role in the mass polio-immunization campaigns of the early 1950s. Finally, physicians in small towns and rural areas in the United States were often viewed as civic leaders whose influence was felt in education, welfare, and other not-strictly-medical arenas. In summary, it is fair to say that there is a long tradition of social responsibility in the medical profession.[36]

Professionalism Redux

The concept of professionalism has its roots in virtue theory. In 1803 Thomas Percival was the first to present a comprehensive code of behavior for phy-

sicians explicitly grounded in, or justified by, a consideration of virtue. Percival developed a broad, virtue-and-duty-based system of professional conduct, drawing extensively on David Hume's theory of moral sentiment as it was reflected in John Gregory's lectures on medical ethics.[37] In the first chapter of *Medical Ethics*, Percival enjoins physicians to "unite tenderness with steadiness" in caring for patients.[38] Under "steadiness" Percival includes the intellectual virtue of objectivity or reason, along with moral virtue of courage or fortitude. By "tenderness" he means humanity, compassion, fellow feeling, and sympathy. Percival did not limit his analysis to duties to patients and colleagues but also included a consideration of the physician's duties to the community. Since Percival's time, medical virtue theorists have tended to expand the role of altruism and justice and list them among the primary qualities, like fidelity, compassion, *phronesis*, fortitude, temperance, integrity, and self-effacement.[39,40,41]

In recent decades, this virtue-based professional ethic received relatively little attention in medical education because it was associated with negative features like paternalism and an exclusive guild mentality. The old ethics' inability to deal with contemporary issues of patient rights, allocation, and conflicts of interest led in the 1960s to the development of principle-based biomedical ethics, which insisted that physicians be held to universal, rather than profession-based, rules and duties. Thus, Percival and his progeny were allocated to a purely historical role, and their work was considered more a set of rules for membership in a club than a real moral tradition. Medical schools might devote a lecture or two to the qualities of a "good" doctor, but this was, as we indicated earlier, not considered the meat of ethics.

The current movement to identify and teach core competencies of doctoring resurrects the old concept of professional ethics.[42,43,44] It does so, generally, by claiming that there are certain duties shared by all doctors and, specifically, by including among them a number of moral duties to patients and to the community. A close look at the section on medical professionalism in the AAMC Core Curriculum for graduate medical education illustrates the new emphasis on social responsibility and engagement. This document indicates an overall goal of producing physicians who are "altruistic" and "accountable." Altruism includes the requirement that residents "must use their influence to improve the health of the communities where they live and practice," and they must "understand the roles that physicians can play in meeting the healthcare needs of the poor, in addressing health inequities that exist between different populations in the society, and in promoting the general health of the public."[45] To accomplish these goals, the document lists 11 curricular objectives, including, "Residents should be able to serve as the patient's advocate . . . to provide care to all, regardless of ability to pay; and to know about community healthcare needs and resources."[46]

We should note, however, that the listed objectives identify cognitive or volitional states rather than indicating specific behaviors. In other words, even though social responsibility is being presented as an intrinsic (and teachable) component of professionalism, educators remain reluctant to specify precisely *how* to implement this component. The core curriculum is clear that residents must *know* about community problems and *be able to* serve as an advocate, but action based on this knowledge appears, at least at this stage, to remain supererogatory.

Truth in Advertising

An important part of the medical-school application process is an attempt to assess an applicant's motivation and character. There is no secret about this. In fact, it is well known that applicants are expected to assemble a portfolio of experiences and activities that demonstrate their commitment to traditional values of the medical profession. Hence, this portfolio should also include substantial evidence of altruistic and socially responsible behaviors, such as volunteering significant amounts of time to crisis hotlines, emergency rooms, ambulance services, tutoring programs, and so forth. In consequence, MCAT application essays almost always includes declarations of concern for others and a vocation to foster the good within society—to fit, in short, with the "virtuous" type of the good doctor, who is selfless, courageous, and an advocate for those less fortunate. They also recount the applicant's knowledge and experience with social issues. For example, recent essays reviewed by the authors indicate awareness of "the role economics plays in health and access to healthcare," the importance of "social as well as physical health," and the determinative role that "social context plays in caregiving."

We realize that sophisticated students well understand what admission committees want and are prepared to give it to them, but unless we adopt the cynical view that the process is a farce and applicants hypocrites, we must necessarily assume that most of these young people enter medical school with a genuine concern for the community of patients and the belief that altruistic and socially responsible qualities are important qualities in their chosen profession. Certainly, medical schools represent the profession in that way. Thus, it is not surprising that students develop cognitive dissonance when they find themselves in an environment that is in many respects unsupportive of, or even hostile to, altruism, compassion, and social awareness.

There is a strong argument to be made that the students, by holding themselves out to medical schools as socially concerned, become morally obligated to continue to act on those concerns. Detrimental reliance is a longstanding doctrine in equity law, which holds that when one party notoriously advertises himself as possessing certain characteristics, or being able to provide certain services, and others reasonably rely on those representations, the party becomes obligated to perform as tacitly promised. Medical schools judge applicants' premedical records of public service in an attempt to appraise their altruism and commitment to others' welfare, and prospective students participate in such activities in an attempt to convince medical schools that they have the "right stuff." Relying on these representations, schools admit some students rather than others. We believe that, by the fundamental moral intuition underlying the equitable doctrine of detrimental reliance, entering students have assumed an obligation to continue to behave in socially responsible ways because they represented themselves as socially responsible; and medical schools have assumed an obligation to provide a culture of altruism and social engagement for their students and to provide occasions in which the students can manifest these attitudes.

Toward a Culture of Social Engagement

It is perhaps unfair to criticize ethics education for failing to enhance medical professionalism, or encourage social responsibility, because these were never

its goals. Nevertheless, the term "medical ethics" implies that the subject matter concerns the way doctors ought to behave. When we tell laypeople that we teach medical ethics, they often respond with statements like "Good! It's about time." Or, alternatively, they relate anecdotes about insensitive or inappropriate physician behavior, apparently under the impression that "medical ethics" is designed to prevent such behavior. Thus, the biomedical ethics curriculum as it has developed may itself constitute a form of detrimental reliance: as ethics has entered the formal medical curriculum, professionals and nonprofessionals alike might reasonably expect that the ethical dimension of doctoring is, in a broad sense, "covered." In fact, as we have shown, only a narrow aspect of professional ethics is usually addressed.

In this analysis we do not want to discount the value of "doctoring" courses (e.g., communication skills, patient interviewing, and the physician-patient relationship), which have become increasingly common in medical education; or "softer" humanities courses, like literature, film, and cultural or religious studies, which enliven the curriculum in a minority of institutions. Nonetheless, they are insufficient. The teaching of medical professionalism in general, and its social dimension in particular, has languished, despite the development of a strong ethical commitment to patient rights and shared decisionmaking.

In this context, the AAMC- and ACGME-sponsored movement to develop curricula in the core competencies of doctoring, including professionalism, is a breath of fresh air. But will it be possible to transform this breath into something more substantial than air? In a recent editorial, Peter Rothman summarized the problem as follows: "Lofty phrases generally do not change customary ways of doing things."[47] Among the strategies he identifies for producing physicians who are more socially involved, he stipulates that (a) professional and board-certifying organizations require, rather than recommend, standards of behavior, including community service, and (b) medical school and residency curricula be designed to "inculcate social skills." It is not unreasonable to expect the AAMC and ACGME, along with medical schools and other professional organizations, to flesh out their current recommendations with an escalating series of carrot-and-stick (especially stick) requirements over the next few years.

In the remainder of this paper, we want to imagine the characteristics of a curriculum that might achieve the ethos we seek. We need to begin, of course, with the hospital and institutional cultures that currently exist. As we have argued elsewhere, rapid economic and structural change has stimulated widespread dissatisfaction and disillusionment, especially in academic medical centers, a situation that suggests now is a good time to intervene; that is, try to bridge the gap between tacit and explicit values. To accomplish this, we would need to alter the dynamic of medical education, and move the center of curricular gravity, as sketched in the following dichotomies:

- Minimize ethics as quandary solver; maximize ethics as character builder.
- Minimize the exclusive role of analytic philosophy and law; maximize the use of other humanities and social sciences, such as history, literature, film, religious studies, women's studies, sociology, cultural anthropology, and public policy.

- Minimize attention to the structure and process of reasoning; maximize attention to communication, group process, negotiation, consensus building, and self-understanding.
- Minimize the gulf between preclinical and clinical teaching; maximize the number and type of learning activities that can be utilized in either setting.
- Minimize students' feelings of ignorance and impotence in the face of social problems; maximize their social awareness and sense of mastery.
- Minimize the brutalizing affects of hierarchy and bureaucracy in the classroom and clinic; maximize collaboration and teamwork.
- Minimize student cynicism; maximize optimism and hope.

To summarize, we envision a professionalism curriculum that subverts many elements of today's hospital and institutional cultures in the hope of transforming those cultures by enhancing medical professionalism. In our view, the now-traditional rights-based ethics course is only one component. However, the curriculum we visualize does not necessarily include a series of courses or experiences labeled "ethics." Rather, professionalism ought to be framed as a dimension of every aspect of medical education, the only proviso being that additional social and humanities-based experiences become part of the educational culture.

We suggest that the curriculum would need to develop four interrelated themes and strands of experience throughout the educational process: (1) personal reflection and reflective practice; (2) narrative competence; (3) strong role model engagement and interaction; and (4) community service. In the following paragraphs, we comment on some of the programs and considerations that might help in reaching this goal.

Reflective Practice

The first prerequisite for developing an ethos of social responsibility is to provide a safe venue for students to share experiences and enhance personal awareness. A number of thoughtful commentators have stressed the need for physicians to better understand their own beliefs, feelings, attitudes, and response patterns.[48,49,50,51,52,53,54,55] One of the earliest proponents of this view was the British psychiatrist Michael Balint, who focused attention of the therapeutic power of the physician-patient interaction with his aphorism "The doctor is the drug."[56] Balint encouraged physicians to meet regularly in small groups to discuss their difficulties with patients and their personal reactions to patients. We know that physicians tend to avoid emotions, to identify them as negative, and often to confuse knowledge of a feeling with the experience of that feeling. Physicians are particularly vulnerable to feelings of anxiety, loneliness, frustration, anger, depression, and helplessness when caring for chronically, seriously, and terminally ill patients.[57] The common technique of changing feelings into "affects" leads physicians to trivialize and sanitize emotion, including their own responses, and thereby to distance themselves from their patients.[58] The more physicians try to reverse this process by developing an understanding of their own beliefs, attitudes, and feelings, the more likely they will be able to connect with, and respond to, their patients' experience.

Additionally, students' ethical development may be hindered by their responses to certain everyday learning situations. These include conflicts between the

requirements of medical education and those of good patient care, assignments that entail responsibility exceeding the student's capabilities, and personal involvement in substandard care.[59] Once again, the opportunity to discuss, analyze, critique, and sometimes repair these experiences enables students to find their own voices and may eventually empower them to use their voices effectively. "The practice of always keeping quiet is a failure in the process of learning to care."[60]

This need for a venue to discuss trainee experience should be addressed throughout the four years of medical school, as well as in graduate medical education. This venue may stand alone, as in regular Balint group meetings, or be included in a more extensive curriculum on physician personal awareness that features other materials and methodologies concerned with physician beliefs and attitudes, feelings and emotional responses in patient care, challenging clinical situations, and physician self-care. As we discuss later, reflective writing and journaling may supplement small group discussion.[61]

Role-Model-Based Practice

Traditionally, professional development in medicine was based on apprenticeship-type relationships with a wide array of role-model physicians. These ranged from junior (next step up) to senior exemplars, and from task-specific (e.g., "My resident knows how to handle families") to broad models of doctoring.[62] Much deserved attention has been given to the impact of managed care on academic medicine and, in particular, on student exposure to senior clinicians. As profit margins on reimbursement have diminished and government support for medical education has declined, the demand on physicians' time and energy to see more patients more efficiently has grown. One of the most odious consequences has been a decrease in the time available for teaching and mentoring students and residents. Learning clinical skills is a slow process that requires repeated practice under supervision. Learning professionalism is an even slower process by which trainees come to understand the context and meaning of clinical skills and develop a professional identity. If teachers fail to exhibit the values of doctoring because they view themselves as technicians, or because they are nonreflective about their professionalism, trainees learn to become like them. Thus, in today's hospital culture, role models often tend to exhibit quantitative (not much time to spend) and qualitative (not much value to give) deficiencies.

What trainees need is time and humanism. Wright and his colleagues found that the attributes significantly associated with being a good clinical role model included spending more than 25% of one's time teaching, being available to the team 25 or more hours per week while serving as the attending physician, emphasis on the importance of the doctor-patient relationship, and commitment to teaching the psychosocial aspects of medicine.[63] Any attempt to create a new culture of medical professionalism has to begin by addressing the need for more engaged and humanistic attending physicians. This is not a problem we are able to address here, but in the following paragraphs we propose to build on the student's exposure to good clinical role models by adding two additional types of role models, narrative mentors and social engagement mentors.

Narrative Competence

Medical practice is structured around narrative, and much of medical knowledge is narrative knowledge.[64,65] Medicine bursts with anecdotes, cases, and stories. Medical practice begins with listening to the patient's story; it then employs narrative and its many devices to help understand the patient in his or her community; and to heal or relieve suffering.[66,67,68,69,70,71,72,73] It is amazing that in this presumed narrative-rich environment, students experience devaluation of the "subjective" and learn to objectify their patients. The narrative medicine movement is a way of reframing much of the knowledge and skills of good doctoring under the aegis of language, culture, and story. Rita Charon defines narrative competence as "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others."[74] She identifies four sets of professional relationships in which narrative competence is required—physician and patient, physician and self, physician and colleagues, physician and society—virtually the same as the areas identified in furtherance of reflective practice. Students may enhance their repertoire of social role models by exposure to narratives of real and fictional physicians; and they may increase their understanding of their own developing professional identities by writing about their experiences.

Reading the doctors, good and bad. The curriculum should include opportunities for students to read and analyze biographical narratives of contemporary and historical physicians whose professional lives reflect an ethic of service. For example, historical role models might include Albert Schweitzer, Walter Reed, and Elizabeth Blackwell, as well as many other less well known physicians. Contemporary stories of physicians committed to serving the public interest might range from Paul Farmer[75] to David Kessler to Timothy Quill. These provide vicarious role models against whom students can test their own self-constructions. Although it may appear that reading stories about good doctors is unlikely to substitute for or resist the more powerful effect of actual physician role models in the clinical setting, there is an important difference between the living role model and the narrated one: written narratives, especially autobiographical ones, include expressions of interiority seldom available in the flesh. Reading the work of, say Kate Scannell,[76] or Abraham Verghese,[77] or Robert Coles,[78] a student gains access not just to the outward behavior and explicit advice of the physician but the more nuanced and often ambiguous accretion of material: the doubts, questions, and shifts that go to make up a narrated character and, we suggest, a professional ethos.

A problem with this approach is its perceived reliance on the "great men" version of history in which role models serve the function of practice guidelines; that is, standards that should be followed if you want to be "right." Students and teachers may feel comfortable with this view because it is compatible with the hierarchical structure of medical education, where students are expected to obey (as well as emulate) those ranking above them rather than critiquing their teachings or, worse yet, critiquing the hierarchical system itself in the interest of developing their own values and identity. For example, if Albert Schweitzer is considered a saint whose actions ought to be copied, then students lose interest because sainthood has little narrative drive, and Schweitzer's considerable faults (e.g., his strong paternalism and his lack

of enthusiasm for the benefits of scientific medicine) become impediments to understanding his achievements: "Why should we study that guy? He was nothing but a self-promoting racist and a quack!"[79] However, if Schweitzer were presented in context, perhaps by a variety of selections from his writings (e.g., *Out of My Life and Thought*[80]), students might address the relationship between professionalism and, in this case, the larger question of religious and cultural values. Indeed, the drawbacks of relying on "great men" for narratives may be mitigated by using literature more broadly and having students engage in sustained analysis of varied, and often negative, cultural representations of doctors, as in George Eliot's *Middlemarch*, Henrik Ibsen's *An Enemy of the People*, or the doctor stories of Anton Chekhov and William Carlos Williams.

Viewing cultural representations of doctors. Another way of supplementing the student's exposure to social role models is through video, which has the virtue of being able to bring many different "living and breathing" physician characters into the room, including negative representations that can serve as countermodels against which students may construct their own, presumably more positive, professional identities. "Good," or at least sympathetic, doctors frequently appear in popular medical dramas like *ER* and also in healthcare "reality" shows (e.g., *Trauma: Life in the ER*, *Maternity Ward*, *Code Blue*). Some observers believe that *ER* has for some years played a significant behind-the-scenes role in the socialization of medical students, especially during the preclinical years, when, as O'Connor suggests, "the televised physicians of *ER* may offer students their most vivid glimpse into the practice of medicine."[81] These fictional physicians, he continues, "may be mirrors for students wherein they validate desirable qualities, such as compassion," and many students are likely to use them as "points of reflection in forming a professional identity" as the characters "either reinforce or contradict the influence of real life physicians."[82] One medical student records being inspired by a doctor on *ER* to take social action and organize a bone marrow drive at his medical school.[83]

Speaking and writing one's personal narrative. The entrance essay and, later, the residency essay should not be the only occasions on which medical students are expected to articulate their professional personae. Students should be encouraged to keep journals, and curricular opportunities should be created for them to write about their patients and their personal reactions to patients, colleagues, and teachers.[84] Narrative approaches might also be employed in case conferences and other exercises in which students present verbal narratives that explore their developing professional identities. At Stony Brook, for example, such opportunities arise for third-year students during the obstetrics/gynecology clerkship, when they meet to discuss challenging situations encountered in their work, and during the pediatrics clerkship, when they write papers about similar cases and situations. Frequently, in the discussion of these cases, students express surprise at or disapproval of the unethical or unprofessional behavior of residents or attending physicians, responses they are free to articulate in this venue and, in the case of the obstetrics rotation, to share with their classmates and faculty. There are times when these sessions allow students to verbalize their resistance to the role models offered them and to the institutional structures that make such resistance so difficult. It is here, too, that students may identify ways in which institutional and broader social problems might be addressed.

Community Service

The medical curriculum should include socially relevant *doing* as well as *studying*, as we outlined in the accompanying article. To reiterate, the AMA Code specifies, "A physician shall recognize a responsibility to participate in activities contributing to an improved community."[85] In another section the Code indicates, "A physician shall . . . recognize a responsibility to seek changes in (legal) requirements which are contrary to the best interests of the patient."[86] If these requirements are important manifestations of professionalism, they should be addressed in medical school through a wide array of available social preceptorships, such as HIV education in local high schools, volunteer work in hospices, health services for migrant farm workers, or even work with environmental or other politically active volunteer organizations.

There should also be an expectation that students continue their preclinical social involvement with a social agency or other community-oriented activity. Two currently existing programs, Health Professions Schools in Service to the Nation (HPSISN) and Community-Campus Partnerships for Health (CCPH), serve as models for this type of service learning, in many cases spearheaded by medical students themselves. Two of the primary goals of HPSISN are "to instill an ethic of community service and social responsibility in health professions schools' students and faculty, and to equip future health professionals with community-oriented competencies."[87] We believe that every student should in some way be active in such programs.

In addition to direct action, we believe that students should also have the opportunity to learn about, and participate in, the policymaking process. One approach would be to develop an elective practicum on the lawmaking process, including both legislative and administrative law components. Such a course would require didactic study, followed by participative activities, like fact gathering, community education, and lobbying. In addition to the practicum, teachers should make it a habit to remind students that they can contribute in meaningful ways to public policy by joining or starting an advocacy group with other healthcare providers, testifying at legislative or administrative agency hearings, or simply writing letters to their state and federal legislators. Even if few students actually take such actions, such reinforcement from faculty that healthcare providers can influence the process of making public policy may, over time, help empower students and wean them away from the learned helplessness that is currently so popular among medical professionals.

Conclusion

"The best lack all conviction, while the worst/Are full of passionate intensity." These lines from Yeats's famous poem "The Second Coming" in many ways capture the situation in healthcare today. Those who represent the "best" professional values in medicine find themselves wandering in a fog of disillusionment and indecision. They cling to the comparative solidity of their jobs and try to meet the needs of individual patients, but they seem to have lost their compass when it comes to social action, either within the profession or in the society at large. These professionals may also cling to their altruistic self-images, but they experience little community support for altruistic action. The demystification of medicine has progressed to the point where it seems to

many doctors that the claim to (or expectation of) medical virtue is embarrassing—a throwback to our thoroughly discredited paternalistic past.

On the other hand, there is a great deal of "passionate intensity" around, but in the healthcare field this passion is largely the province of entrepreneurs, empire builders, shysters, lobbyists, and generalized naysayers. Those who contend that the specialized knowledge that constitutes "real" medicine has become progressively more technical and more distant from everyday experience generate a lot of passion. They believe that, ideally, doctors ought to free themselves from the residue of human intercourse that mucks up today's practice and assume their rightful role as pure technicians, while others perform the peripheral, less important tasks, like talking to patients, following them over time, and advocating for them.

To the contrary, we want to generate some passion for virtue. We believe that medical educators have a responsibility to prepare their students and residents for lives of moral leadership and excellence. To take this responsibility seriously, we need, first, to recognize that the biomedical ethics movement, and the package of curricular changes it inspired, have very little to do with teaching students how to become good doctors. At best, biomedical ethics provides a set of concepts and rules that help the physician avoid or resolve conflicts and respect patient self-determination. At worst, principle-based ethics serves as an ineffectual checklist, ensuring that patient rights are "covered" but giving little guidance to the moral practice of medicine.

To develop a culture of socially responsible professionalism, we suggest that medical schools adopt curricula that feature regular opportunities for personal reflection, group process, and discussion of feelings; numerous social role models (real and fictional, contemporary and historical); the development of narrative competence through reading and writing; and socially relevant practice during all four years of medical school. The life and work of Robert Coles exemplifies all four of these strands—reflective practice, narrative competence, role modeling, and social action—brought together into a seamless whole. An opportunity for moral growth may occur every time a person is "seized by spasms of genuine moral awareness," to use Coles' phrase, but to encourage moral growth, we need to provide the right environment, an environment sadly lacking in medical education today. Every day students throw up their hands and remark, "What can I do?" as an expression of frustration and futility. As medical educators, we are obligated to provide our students with constructive answers to that rhetorical question.

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