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

Understanding, Being, and Doing: Medical Ethics in Medical Education

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Over the past 15 years, medical schools have paid some attention to the importance of developing students' communication skills as part of their medical education. Over the past decade, medical ethics has been added to the curriculum of most U.S. medical schools, at least on paper. More recently, there has been growing discussion of the importance of professionalism in medical education. Yet, the nature and content of these fields and their relationship to one another remains confused and vague, and that lack of clarity, in turn, impairs the effectiveness of medical education. This ambiguity invites serious contention over who should design and teach the curriculum as well as when, where, and how it should be taught.

Today, we also encounter vastly different views on the tools, discipline, and skills that are inherent in medical ethics itself. Some see medical ethics as an interdisciplinary field and invite humanists of every persuasion, assorted health professionals, and multiculturalists to join their ranks and contribute to their deliberations. Others see medical ethics as a demanding specialty that brings the insights of philosophers to bear on contemporary clinical dilemmas arising from dramatic advances in medical technology and knowledge. And others see philosophers as having nothing especially distinctive or valuable to contribute to the field. In what follows, we explain the centrality of philosophy in medical ethics by pointing out an important distinction between two concepts of medical ethics. We then elucidate the significant implications of that distinction and show how philosophy can be used to construct an ethical framework for the medical professions by drawing on the work of John Rawls. Finally, we offer an account of how education on the ethics of medicine should relate to the training and assessment of communication skills and be integrated into the medical school curriculum.

Two Concepts of Medical Ethics

When teachers and program directors set out to design a program or course, they begin by asking themselves questions about their audience and their goals: Who will be the students? When in their education will they be learning the material? Why are you teaching the material? How much time will you have for this education, and how will that time be organized? What should be included? How should it be taught?

The answers, with respect to teaching medical ethics, will differ significantly depending on whether you are attending to the educational needs of under-

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graduates taking an introductory course in philosophy, philosophy majors, philosophy graduate students, medical students, or seasoned clinicians. It would be a huge mistake to imagine that the same materials and the same presentation would meet the needs of all of these diverse groups. It is also a huge mistake to overlook the distinction between two distinct subjects that both are called "medical ethics."[1] Educators need to recognize that: (1) "medical ethics" is a subject in applied ethics; and (2) "medical ethics" is the sum of moral commitments of healthcare professionals. These are very different subjects, and educators need to be aware of which one is the subject of their concern.

Applied Ethics

Ethics is a field of philosophy. It has a long history, a rich literature, and a long narrative of debate over theoretical approaches and philosophic commitments. From its beginning, those engaged in moral philosophy have recognized the importance of applying their theories to practical problems. Examples explain and clarify their points, applicability demonstrates the usefulness of a theory, and the coincidence of theoretical implications with moral intuitions argues for a theory's acceptability.

Difficult ethical problems in the practical lives of philosophers also provide them with the opportunity for ethical insight. Moral quandaries challenge philosophers to refine their theories, to clarify previously obscured vagueness, to recognize distinctions that were not apparent at a higher level of abstraction, and to develop conceptual tools for sorting out answers to different cases. In sum, applied ethics has, and always has had, an important role in ethics.

Medical ethics is but one of several areas of applied ethics. It is most typically associated with innovative biomedical technology or challenging questions at the intersection of medicine with law, public policy, or personal morality. Among others listed in Table 1, standard topics now include: justice and access to healthcare, allocation of scarce resources, abortion, separation of conjoined twins, physician-assisted suicide, legalization of drugs, cloning, and stem-cell and embryo research.

Recent debates in medical ethics are inherently interesting subjects. Because the material is self-motivating, it provides an excellent entree for teaching

Table 1. Some Popular Topics in Medical Ethics (Applied Ethics)

Definitions of illness and disease	Euthanasia
Definitions of death	Legalization of drugs
When life begins	Cloning
Personhood	Sex selection
Personal identity and dementia	Abortion
Genetic determinism	Informed consent in research
Justice and access to healthcare	Using animals in research
Allocation of scarce resources	Xenotransplantation
Sterilization	Stem-cell and embryo research
Separation of conjoined twins	International research
Physician-assisted suicide	Payments to research subjects

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introductory students about philosophical argument and moral theory. Medical ethics, as an area in applied ethics, therefore presents an ideal introduction to moral philosophy for undergraduates. It provides an opportunity for learning about the difference between premises and conclusions, about argument and consistency. It also provides an opportunity for students to learn what a philosophical theory is, how theory is applied, how theories differ, and how differences in theoretical commitments lead to different conclusions. Medical ethics can also provide students with an understanding of the specific concepts that play important roles in contemporary ethical and political debates. Some examples include the concepts of justice, liberty, autonomy, and personhood.

Professional Ethics

The reasons for teaching medical ethics, the subject matter, the goals, and the methods are (and should be) vastly different in medical school undergraduate and graduate education than they are in nonprofessional school education. As part of the students' professional training, the broad educational goal is to provide students with the knowledge and skills that they will need to be good physicians. Medical education should also promote the development of essential habits of disposition and attitude to perform as a good physician should—that is, the character (i.e., virtues) of a good physician.[2] In other words, as a part of medical education, medical ethics education is (and should be) primarily concerned with inculcating medical professionalism. This involves helping students to understand the *content* and the *justification* of their special responsibilities as physicians as well as to accept their professional responsibilities as important and overriding.

The content of medical-school ethics education, therefore, has to be significantly different from other applied ethics education. Medical students do not need to become fluent in moral theory. They do need to become fluent in the concepts that are most relevant to clinical practice, and they have to learn to navigate the situations they are most likely to encounter. In their professional careers, few will need to make professional decisions about cloning, stem-cell research, or healthcare allocation policy. Instead, they need to understand the ethical necessity of professional competence. They have to develop a clear understanding of the moral nature and requirements of the doctor-patient relationship including the importance of caring, presence, responsiveness[3] and respect, the centrality of trust, confidentiality, nonjudgmental regard, nonsexual regard, truth-telling, and informed consent, and they have to see the relevance of these principles to clinical practice. They also need to learn to apply the principles and use them in case discussions so that they can reach a consensus with peers on difficult cases, even in the face of unavoidable uncertainty, or recognize when to tolerate reasonable differences in views. Students also have to understand the moral importance of their relationships with peers and other health professionals. They have to develop a clear understanding of patient capacity and surrogate appropriateness so that they can decide when patients lack capacity and when surrogate decisions are unacceptable. They have to learn the local legal constraints on physician action so that they can make judgments about conforming with or violating the law. They have to learn standards for allocating the resources that fall to their discretion (e.g., time, energy, priority, beds). They have to be given templates for approaching

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difficult issues like giving bad news, dealing with medical errors, nonadherence, and helping patients with important decisions at the beginning and end of life. They have to learn about their responsibilities to society at large and how to triage their principles and commitments when they conflict. They have to understand the importance of clinical research and their role in clinical investigations. In sum, rather than focusing on highly unusual issues or subjects that will be decided by the legislature, courts, or voters, medical-student ethics education should address issues that are common and relevant to situations that they are likely to encounter with some frequency. Some of these issues are listed in Table 2.

Teaching methods and materials have to be chosen with a clear recognition of who these students are and their special needs. Small-group, interdisciplinary, case-based teaching that provides an active learning experience is the rule. Readings have to be short, clear, engaging, and selected for didactic value rather than for illustrating a theoretical approach. Students' preparation time, as well as instructional time, is very limited by the competing demands of a crammed and rigorous curriculum. Hence, each piece of assigned reading and every written assignment should have clear and compelling justification. And the topics and timing of medical ethics education should be linked and integrated into the overall curriculum so that students can appreciate their relevance.

A good part of professional education involves habit formation. In that respect, medical ethics is very much like the other subjects taught in medical schools. Basic concepts have to be revisited in different settings, and students have to develop fluency in their use and application. That is why most statements on medical ethics education call for programs to span all years of medical education.[4] Like any other medical skill, the ability to recognize the ethical issues involved in a case, to work through the moral tangles, and to find a resolution through discussion with peers requires practice at different levels of medical education. These skills are developed through repetition, planned

Table 2. Some Essential Topics in Medical Ethics (Professionalism)

Essential characteristics of a physician	Assessing patient capacity
Codes and traditions of medical ethics	Assessing surrogates and surrogate decisions
Centrality of trust	Protecting others and the limits of confidentiality
Foundations and uniqueness of professional responsibility	Adherence and compliance
Fiduciary responsibility	Errors
Caring	End-of-life decisionmaking
Presence	Advance directives
Respect and the primacy of patient values	DNR orders
Truth-telling	The scope of medicine
Informed consent for treatment	Physicians' roles in clinical research
Confidentiality and privacy	Research ethics
Nonjudgmental regard	Giving bad news
Nonsexual regard	Definition of death
Professional relationships and responsiveness	Responsibilities to the bereaved
Using patients as learning tools	Peace-time and war-time triage
Using animals in medical education and research	

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redundancy, and modeling in carefully constructed exercises in the context of an integrated comprehensive curriculum designed to meet the unique requirements of training for professionalism.

Many relevant articles and case discussions can be found in journals or scavenged from textbooks. Two relatively recent collections are especially useful resources: *Ward Ethics*, edited by Thomasine Kushner and David Thomasma[5]; and *The Cambridge Medical Ethics Workbook*, edited by Michael Parker and Donna Dickenson.[6] Both focus specifically on issues faced by medical students and house staff. Unfortunately, the unifying justification that is needed to explain medicine's special obligations and to serve as a touchstone in adjudicating conflicts has hardly been explicated, and hence is hardly taught.[7] Yet a clear understanding of the foundation of medical ethics would make its distinctiveness and importance transparent.

Although the theoretical work to produce such an account requires the tools of philosophy, philosophers have been devoting their attention to the first kind of medical ethics. They have thoroughly discussed the controversial, politically and legally contested topics, but not professionalism. Nevertheless, the theories and concepts of moral philosophers do provide the resources for constructing and explaining the content of physicians' unique professional responsibilities.[8] To illustrate what such an account would entail, and also as a reply to the radical pluralists who argue for the priority of each agent's unique perspective over the common standard of professionalism, we offer a sketch of the ethics of the medical profession by drawing on the theory of Rawls's *Political Liberalism*.[9] We invoke the later Rawls for his theory's usefulness and intuitive appeal. Also, we choose Rawls to echo the spirit of John Gregory drawing on David Hume and Thomas Percival drawing on John Locke over the course of the history of medical ethics. Above all, we choose Rawls's theory because, surprisingly, the practice of medicine in the contemporary hospital setting often instantiates the concept of political liberalism and provides clear examples of the practice and success of Rawlsian public reason.[10]

Constructing Medical Ethics Rawls's Way

It is important to recognize that medicine is a social institution; it develops as a distinctive part within a society, and its role, tools, principles, and commitments vary somewhat because of the individuality of societies. Yet, because of its distinctive position in society, medicine has its own ethical principles[11] that are different, in some notable respects, from the rules of ordinary morality, and they have a distinctive rationale. Reflection on a few examples should make the singularity of medical ethics apparent and justify an independent account of the principles of medical ethics.

- The core content of ordinary morality is primarily negative responsibilities, duties to avoid harming others in various ways. The core content of physician responsibilities is to positively promote the patient's good by using the tools of medicine.
- In ordinary morality we are supposed to be discriminating in our choices of friends and associates. Physicians are committed to nonjudgmental regard and to providing treatment for anyone who needs it.
- In ordinary morality we are to presume as far as possible that others are acting autonomously and leave them alone to live according to their own

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lights. Physicians suspend the presumption of autonomy and constantly assess patients' capacity with an eye toward protecting them from the dangerous consequences of impaired decisionmaking. Doctors educate, suggest, emphasize, employ a variety of influencing strategies, occasionally decide that a patient lacks decisional capacity and bring the matter before the court or, in an emergency situation, override an apparent refusal of treatment.

- In ordinary morality it is useful and entertaining for us to share information that we learn through the commerce of daily life and the special obligation to safeguard some information requires a specific promise. Physicians are committed to confidentiality.
- Absence of consent makes sex between adults unacceptable. Consent does not make sexual interaction with patients acceptable for physicians because the rule is nonsexual regard.

These examples make the case for the distinctiveness of the ethics of medicine. As Rawls notes,

> it is the distinct purposes and roles of the parts of the social structure, and how they fit together, that explains there being different principles for distinct kinds of subjects. Indeed, it seems natural to suppose that the distinctive character and autonomy of the various elements of society requires that, within some sphere, they act from their own principles designed to fit their peculiar nature.[12]

Although Rawls may not have been explicitly thinking of professional ethics, or even the ethics of medicine in particular, medicine is clearly a part of society that is ethically autonomous. This crucial factor is overlooked by most bioethicists, who mistakenly presume that the ethics of medicine is merely an extrapolation from ordinary morality.[13]

Faced with the pluralism of modern society, Rawls recognizes the need to establish a common framework, or overlapping consensus, for establishing and sustaining society's political and social institutions. He provides an account of its content through a hypothetical construction of political justice. In essence, according to Rawls, everyone (or their representatives reasoning from behind a veil of ignorance) must first affirm some basic foundational principles, each for reasons from his own comprehensive religious, moral, or philosophical framework. Once those foundational principles are endorsed by all citizens, further agreements must be supported by reasoning "only from general beliefs shared by citizens generally"[14] and governed by the precepts constructed with reference to those beliefs by what Rawls calls "public reason."

Whereas Rawls provides a thorough account of the principles that are to govern political institutions, our task will be to apply Rawls's methods to the construction of the principles that should govern the social institution of medicine. And although the principles that we shall offer are not radically different from those listed by others, the justification and rationale for their importance is, in this case, drawn from "the distinctive character and autonomy" of the profession rather than from theories or principles of ordinary morality.

Rawls sets the standard for participation in the process of assenting to principles at a minimal set of two moral powers, "the capacity for a conception

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of the good and the capacity for a sense of justice"[15] and a capacity for reason and reasonableness. Rawls explains that "all ways of reasoning . . . must acknowledge certain common elements: the concept of judgment, principles of inference, and rules of evidence . . . and include standards of correctness and criteria of justification."[16] Reasonableness, which he distinguishes from reason, is the willingness to propose and to abide by rules on the condition of reciprocity. Anyone who can meet these criteria is able to participate in the hypothetical procedure to construct foundational principles and then endorse them.

Because the profession and institutions of medicine are social goods and social artifacts, "the first principles that are to regulate the basic structure"[17] of medicine are constructed through a process that produces an overlapping consensus on foundational principles. Every reasonable citizen appreciates her susceptibility to injury and disease. So, in the case of medical need, every reasonable citizen would want attention for herself and her loved ones from skilled and knowledgeable practitioners who could cure disease, alleviate symptoms, restore function, and ease suffering. These realizations create an overlapping consensus for constructing a profession of medicine and granting the profession special license to acquire special knowledge and skills, as well as special powers and privileges on the condition that they be used for the good of citizens (however each may define his own good).[18] Hence, the first principle of medical ethics involves the *fiduciary responsibility* of physicians—that is, the commitment of physicians to act for the good of their patients individually and collectively. Furthermore, because any reasonable member of society can appreciate the potential danger that physicians can present through wielding their special knowledge, powers, and privileges, as well as the special vulnerability of the patient, everyone would want physicians and medicine to be trustworthy. Hence, the second foundational principle must be that physicians and the institutions and profession of medicine must *seek trust and make themselves deserving of that trust*.

Several corollaries follow from these foundational principles. For example, *professional competency* is a basic principle because reasonable people would want those whom they trust to have the requisite skills and knowledge. *Caring* is a basic principle (or professional virtue) because all patients prefer their physicians to genuinely care about their well-being and because the caring doctor is more likely to fulfill her obligations in the face of conflicting desires.[19] *Confidentiality* is a basic principle because physicians need to understand their patients' habits and problems. Patients would be reluctant to disclose private information unless they were assured that the information would be carefully guarded and used for their good rather than the advantage of others. *Nonjudgmental regard* is a basic principle of medicine because no reasonable person would want to be denied medical attention from a physician who found her patient unappealing. Hence, each would only endorse a system on the grounds that judgments of worthiness and congeniality would not be admissible. *Nonsexual regard* is a basic principle because, to perform examinations, make diagnoses, and administer treatments, physicians need access to personal sexual information, and they have to see and touch sexual organs. Patients would be reluctant to allow these intrusions unless they could trust that the access was for their own good, rather than the benefit of a voyeur, and that the physician would treat the exposure as nonsexual. *Respect* for patients' values

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and allowing the patient's conception of the good to rule is a basic principle because for patients to be able to accept treatment, they need to be able to trust that physicians will not impose their own, different conception of the good and override a patient's values. *Truth-telling* is a basic principle because patients need information about their condition so they can take it into account in prioritizing their own goals. Also, unless they could feel confident that their physicians' reports were honest, they could have no trust in good news, bad news, or directions. Thus, the physician's counsel would be useless.

Because the two foundational principles and their several corollaries, all presented in Table 3, would be endorsed by all reasonable participants regardless of their own background comprehensive views "on the basis of mutually recognizable reasons and evidence,"[20] and because they are independent of any particular comprehensive religious, moral, and philosophical views, they can be seen as "freestanding"[21] or "autonomous" views, expressions of public reason that are "acceptable to citizens as reasonable and rational, as well as free and equal."[22] Everyone knows and accepts these principles, knows that everyone else also accepts them,[23] and everyone counts on physicians to observe them. Rawls explains that

> [t]he underlying unity is provided by the idea that free and equal moral persons are to construct reasonable and helpful guidelines for moral reflection in view of their need for such organizing principles and the role in social life that these principles and their corresponding subjects are presumed to have.[24]

These foundational and corollary principles together with commitments to "the virtues of reasonableness and fair-mindedness as shown by abiding by the

Table 3. Constructing Medical Ethics Rawls's Way

Foundational principles of the ethics of medicine
First principle
Physicians have a *fiduciary responsibility* to their patients; they are committed to act for the good of their patients.
Second principle
Physicians, institutions, and the profession of medicine must *seek trust and make themselves deserving of that trust*.
Some corollary principles
Physicians must be *knowledgeable* and *skilled* and convey *professional competence*.
Physicians must be *concerned with their patients' good* and convey *caring*.
Physicians must be *respectful of patient values* and convey *respect*.
Physicians must be *truthful* and convey *honesty*.
Physicians must observe *confidentiality* and make that commitment obvious.
Physicians must be nonjudgmental and convey their *nonjudgmental regard*.
Physicians must have no sexual interest in patients and must convey their *nonsexual regard*.
Prima facie rule
A physician's personal perspective should not take precedence over professionalism.

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criteria and procedures of common sense knowledge and accept[ed] methods and conclusions of science"[25] provide the core professional ethic of medicine. They serve as the "common ground"[26] for addressing ethical problems that arise in the practice of medicine. These principles provide a singular perspective for moral deliberation about medical decisions, and history can show us how far back and how broadly this consensus has been shared. No agent's personal perspective should take precedence over them.

Although this construction of the principles of medical ethics may be novel, we can actually witness its acceptance in the common practice of clinical medicine. Doctors publicly justify their actions by reference to these principles, doctors criticize institutional policies and one another by invoking these principles, and doctors teach their students by citing these principles.[27] Problematic clinical cases and policies, however, provide the most vivid examples of the ethics of medicine as an autonomous view. In unit discussions, on rounds, or when a particularly challenging or controversial case or policy is brought for an opinion from an ethics committee, the discussions are limited to sharing facts and employing the principles of medical ethics that are supported by public reason. Because the discussants (physicians and other members of the interdisciplinary healthcare team) all start with a common view of what counts as fact and what counts as relevant reason, a consensus on one or more appropriate options emerges. In our experience and from the anecdotes we have heard from others, principles derived from personal comprehensive views do not enter these deliberations. The consensus achieved is, therefore, not an accident of compromise or a fortuitous coincidence but a genuine endorsement from all involved.

On the one hand, we notice persistent disagreement on political and moral issues in medical ethics, such as the legalization of abortion, cloning, stem-cell research, brain death, and physician-assisted suicide, Rawls would tell us that people are not behaving reasonably but instead trying to impose their personal comprehensive views on others. It is easy to discern the religious, moral, and philosophical views that lie beyond the scope of public reason and tend to dominate those discussions. On the other hand, at least within the corridors and conference rooms of clinical medicine that are not explicitly governed by religious doctrines, consensus flowing from public reason is the rule and professionalism points the way.[28]

Our medical students and residents have to be taught the ethics of their profession so that they can share in its public reason with their peers and colleagues.[29] They have to understand the procedure that produces the fundamental and corollary principles, so that they are well prepared for addressing the moral conflicts that will inevitably arise in their careers. Headline-grabbing issues are, typically, far less important than the basic issues in medical education and should be triaged in favor of subjects that are more likely to be used often in clinical decisionmaking.

Character and Communication Skills

The conceptual framework for understanding the ethics of medicine defines the character and communication skills of the medical professional. The ethical commitments and principles of the profession explain what is right or wrong for a physician to do. But, being a certain kind of person—that is, having a

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certain kind of character or particular virtues—makes it easier, hence more likely that a physician will do the right thing and abstain from wrongdoing. Furthermore, some people are more or less inclined than others to succeed in accomplishing what they think they ought to do. These factors make it crucial for medical education to attend to the cultivation of students' character and the attitudes that are associated with particular virtues, and also to help students develop the skills in expressing what they want to convey through their speech, actions, and body language.

Character

It is more likely that physicians who are medically knowledgeable and technically skilled will arrive at a correct diagnosis and implement a correct treatment plan than someone who is unprepared. It is more likely that physicians (and students) who genuinely care about their patients' good will try to do the right thing than someone who is indifferent. It is more likely that physicians (and students) who have an attitude of respect toward their patients will try to behave respectfully than someone who is disdainful or contemptuous. That is why character development is important and why it should be recognized and nurtured in medical education. In broad terms, the specific virtues that professionalism requires physicians to cultivate are, therefore, *professional competence*, *caring*, and *respect*.

Communication Skills in Medical Education

Communication skills are now accepted as an important component of medical education. Licensing and accreditation boards, such as the Medical Council of Canada, the Educational Commission for Foreign Medical Graduates, the United States Licensing Medical Exam (by 2005), and, recently, the Association Commission of Graduate Medical Education, now include communication components on their examinations as part of the evaluation process.[30] Communication in the medical setting encompasses the way in which information is obtained from the patient (history taking) as well as how it is disseminated to the patient (explanation of diagnosis and patient education). Communication skills also involve establishment and maintenance of the relationship (interpersonal behavior) between the patient and clinician. The ability to obtain relevant information from patients as well as the ability to educate patients are, obviously, crucial for effective medical care. Studies have also demonstrated that the patients' trust in their physicians and their feeling of "being heard and genuinely cared for" is directly related to improved compliance and lower malpractice rates.[31]

In the nineteenth century, Sir William Osler wrote, "Listen to the patient, he is telling you the diagnosis." Listening is an active process that involves teachable skills. Other communication skills, such as attentiveness, thoroughness, organization, respectfulness, validation of pain, validation of emotional state, facilitation of decisionmaking, negotiation of a follow-up plan, and confirmation of understanding, can also be taught and assessed. Each component performed with caring confidence enables patients to feel as if they have been heard, respected, and treated competently with genuine care and concern. These are marks of successful doctor-patient communication.[32]

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An affective teaching program requires a well-trained faculty. To facilitate learning and assessment, those who teach communication must first learn how to break it down into distinct, teachable skills. The teachers must be able to explain the goals of each component and the essential elements in successful communication. Because communication is an interactive process, it is best taught and practiced in settings where people can interact—that is, through face to face encounters and in small groups. Teaching will often involve role-play between students, observation of student interaction with real patients, or sessions with standardized patients (SPs). Faculty development is essential for effective learning. This training should provide guidance to help faculty members facilitate creative teaching formats and provide constructive feedback.[33]

Particularly in the last decade, SPs have increasingly been used to help with the training and assessment of communication skills in medical institutions and they have proven to be excellent patient simulators and highly reliable evaluators of communication skills.[34] SPs perform as "real patients" and interact with medical trainees. SPs can be trained to provide students with a skills evaluation immediately after the encounter in the form of written and verbal feedback on their performance. Checklists and rating scales are utilized to facilitate the evaluation and help the SP recall the interaction and record what was done or not done and how well it was performed. Videotaping has also become an integral feature of SP communication skills training. The videotape of an SP encounter allows students the opportunity to review and critique their communication skills alone, with faculty or in small groups.

Being and Doing

Physicians have to become professionally competent, respectful, and caring, and they have to learn to express and communicate these associated attitudes in their interaction with patients. That same set of virtues has to be modeled in teaching communication skills, evaluated in clinical and team encounters, and assessed in exercises with SPs. In other words, the understanding of professionalism dictates what kinds of people physicians should be, the attitudes they should have, and the kinds of behavior they need to master.

In clinical interactions, physicians (and students) should *be* professionally competent because that makes them trustworthy, and they should also *act* so as to display competent confidence to engender patient trust. Physicians (and students) should *be* caring because that makes them likely to fulfill their duty to patients, and they should also *act* so as to display caring to assure patients of their fiduciary interest. Physicians (and students) should *be* respectful because that will give the appropriate priority to patient values, and they should also *act* respectfully to encourage patient responsiveness.

The list of attitudes and behaviors that need to be cultivated is not arbitrary and does not vary from case to case. The list is dictated by a clear understanding of professionalism. First, students have to be helped to understand the content and the justification of the ethics of medicine. Then their character has to be nurtured as they are guided in just how to convey their professional competence, caring, and respect in each of their professional actions. The questions that mentors ask throughout medical education should be focused on these specific issues: How can you show competence in your examination? How can you show caring? How can you show respect? Direction and correc-

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tion should reflect the same concerns: Did your presentation of bad news reflect caring? How might you have conveyed more compassion? Will concealing that error from the patient convey respect? How can the information be communicated so as to show both respect and caring? How can you ask your question so as to relate your competence and also show respect? How can you interview the patient in teaching rounds with compassion and so as to avoid disrespect? What messages might a patient gather from a doctor's soiled coat?

Aristotle recognized that both clear understanding and the proper disposition or virtues are required for the consistent performance of right action.[35] Whereas some people may congenitally have the appropriate character, and others may have been well trained in their early life, others can cultivate their own moral development through understanding and practice.[36] From the beginning of medical education and on through the entire curriculum, medical educators have to specifically raise issues about the kind of person that a physician should be. Without careful and explicit attention to character, students are likely to absorb unacceptable habits and attitudes through the silent curriculum of observing medical misconduct and mistakenly adopting that as their norm.[37] Yet, by focusing critical attention on the character of a physician, by making it a legitimate subject for discussion, and by repeatedly endorsing the view that character is a crucial aspect of professional responsibility, over time students can be transformed and encouraged to transform themselves. More skeptically, such a program may curb moral erosion. It could allow those students with the right inclinations to feel comfortable when they notice that they are out of harmony with objectionable behavior, help ambivalent students choose the right path, and give those with inappropriate inclinations the message that callous or disrespectful behavior will be criticized.

Aristotle also appreciated that it was not enough for someone to try to do the right thing; rather, the right thing must be done in the right way. Physicians have to be trustworthy, and they also have to promote trust through their words, deeds, interaction, and comportment. The physician's character, attitudes, decisions, and their execution are all very significant for patients, and they can have a serious impact on patient choices and behavior. Students, therefore, have to learn to attend to the nuances and implications of what they say and do, and they have to be helped to learn how to speak, stand, sit, look, and touch so as to communicate the messages that they want to give rather than subvert their best intentions with inadvertent gestures or tactless expression.

Consequently, medical education has to pay serious attention to these three aspects of physician training. As medical educators, we have to help our students to *understand* their professional responsibilities and *be* people who have the requisite character, and we have to enable them to *do* the right thing as the well-formed professional would do it. That is the essence of professionalism.

Conclusion

Medical education should provide students with the tools for navigating the ethically charged terrain of clinical practice. Students must be given a clear view of the foundations of medical ethics to serve as a framework for understanding their basic responsibilities and as a touchstone for resolving conflicts between these responsibilities. In designing courses and programs in medical ethics education, medical educators need to attend to the distinction between

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the two concepts of medical ethics and they have to keep their attention focused on professionalism. Students need a clear grasp of the basic concepts of medical ethics, together with conceptual models to guide them through common dilemmas.

Students also need a clear understanding of what is expected of them, and they have to be helped to develop the virtues of a good physician and the communication skills to help them convey their professional competence, caring, and respect. These crucial components of medical education go hand in hand. Medical education must attend to inculcating the ethics of the profession, the character of the physician, and the development of the knowledge and skills that will enable students to practice medicine the right way.

To do a good job of structuring a curriculum in any of these areas, however, requires a clear understanding of all of these elements and their interconnection. Mistakes, confusion, and faculty conflict can be avoided when medical educators share this understanding. Faculty members have to communicate and collaborate in implementing a curriculum that reinforces this learning by spanning all years of medical education. Our students will be well served by their faculties' awareness of these concepts and their appreciation of just how these three components of medical education fit together in the molding of medical professionals.

Notes

1. For a fuller discussion of these two concepts of medical ethics, see: Rhodes R. Two concepts of medical ethics and their implications for medical ethics education. *Journal of Medicine and Philosophy* 2002;27(4):495–510.
2. Pellegrino ED. The internal morality of clinical medicine: a paradigm for the ethics of helping and healing professions. *Journal of Medicine and Philosophy* 2001;26(6):559–79. See also: Pellegrino ED, Thomasma DC. *Virtues in Medical Practice*. London: Oxford University Press, 1993.
3. Little M. Invited commentary: is there a distinctively surgical ethics? *Surgery* 2001;129(6):668–71. Little specifically discusses responsiveness and presence as part of a surgeon's moral responsibility.
4. Fox E, Arnold RM, Brody B. Medical ethics education: past, present, and future. *Academic Medicine* 1995;70(9):761–9.
5. Kushner TK, Thomasma DC. *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*. New York: Cambridge University Press; 2001.
6. Parker M, Dickenson D. *The Cambridge Medical Ethics Workbook*. New York: Cambridge University Press; 2001.
7. An exception that proves this point is the recent issue of *The Journal of Medicine and Philosophy* devoted to "the internal morality of medicine." The two papers that argue for an internal morality of medicine take a (more or less) essentialist approach by deriving principles from an ideal (see note 2, Pellegrino 2001) or set of goals (Miller FG, Brody H. The internal morality of medicine: an evolutionary perspective. *Journal of Medicine and Philosophy* 2001;26(6):581–99) of medicine. Their critics rightly attack such metaphysically questionable starting points (Veatch M. The internal morality of medicine. *Journal of Medicine and Philosophy* 2001;26(6):621–42). The contractarian constructivist account of Rhodes, which is more in keeping with contemporary moral and political philosophy than ancient Greek essentialism, may avoid the shortcomings of other attempts.
8. For a fuller construction of such a theory, see: Rhodes R. Understanding the trusted doctor and constructing a theory of bioethics. *Theoretical Medicine and Bioethics* 2001;22(6):493–504.
9. Rawls J. *Political Liberalism*. New York: Columbia University Press; 1993. We follow the account on p. 262.
10. Clinical medicine may be a greater success for political liberalism than is encountered in politics, Rawls's primary example of public reason. In the political environment of the United

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States today, it is hard to separate business and economic interests from politics and even Supreme Court decisions. The Enron disaster and the 2000 presidential election are prime examples.

11. Although I will specifically discuss the ethics of medicine, as I see it, all medical professions share a core of professional ethics. For the most part, physicians, nurses, physician assistants, nurse practitioners, psychologists, social workers, patient representatives, physical therapists, occupational therapists, genetics counselors, and so forth have the same ethical commitments and duties, the responsibility to develop the same moral virtues and communication skills. Beyond the core ethical duties of all healthcare professionals, there are some differences in role-based responsibilities to society, institutions, and the chain of command.
12. See note 9, Rawls 1993:262.
13. Clouser KD. Bioethics. In: Reich W, ed. *Encyclopedia of Bioethics*. 1st ed. New York: The Free Press; 1978:532–42. In this article, Clouser explains that "bioethics is not a new set of principles or maneuvers, but the same old ethics being applied to a particular realm of concerns." Similarly, most presentations of medical ethics start with a favorite approach to ordinary morality (e.g., virtue theory, utilitarianism, Kantianism, casuistry, common sense) or an amalgam of approaches (e.g., Beauchamp and Childress) and extrapolate from that to issues in bioethics. In contrast, we argue that the ethics of medicine is different from the ethics of ordinary morality.
14. See note 9, Rawls 1993:70.
15. See note 9, Rawls 1993:81.
16. See note 9, Rawls 1993:220.
17. See note 9, Rawls 1993:259.
18. In a constructionist account of a profession, the set of special licenses, tools, powers, and privileges and whatever is required to allow society to trust the profession to wield them defines the scope of the profession. A profession is not defined by any particular perfectionist conception of the good (e.g., "health" in medicine) or by any idealist or teleological realism. For example, firemen are called to rescue cats and children from tall trees and policemen are called to subdue the occasional escaped tiger even though there may be no fire or law-enforcement issues involved. Rather, these professionals have the wherewithal to accomplish the task, and these professionals are committed to use their resources for our benefit.
19. Rhodes R. Love thy patient: justice and care in the doctor-patient relationship. *Cambridge Quarterly of Healthcare Ethics* 1995;4(4):434–47.
20. See note 9, Rawls 1993:115.
21. See note 9, Rawls 1993:12.
22. See note 9, Rawls 1993:143.
23. See note 9, Rawls 1993:35, 66, 68, 316.
24. See note 9, Rawls 1993:262.
25. See note 9, Rawls 1993:139.
26. See note 9, Rawls 1993:115.
27. Medical Professionalism Project. Medical professionalism in the new millennium: a physicians' charter. *The Lancet* 2002;359(9305):520–2. The Medical Professionalism Project cites a similar list of principles.
28. Engelhardt HT. Consensus formation: the creation of an ideology. *Cambridge Quarterly of Healthcare Ethics* 2002;11(1):7–16. Perhaps this is what Engelhardt has in mind when he speaks of "concurrence of the collaborators" (p. 13).
29. The importance of physicians understanding their professional responsibilities has also been argued by: Creuss RL, Creuss SR, Johnston SE. Professionalism: an ideal to be sustained. *The Lancet* 2000;356(9224):156–9. The need for medical school education in professional responsibilities and virtues has also been argued by: Pellegrino (see note 2, Pellegrino 2001); Kopelman LM. Values and virtues: how should they be taught? *Academic Medicine* 1999;74(12):1307–10; Stephenson A, Higgs R, Sugarman J. Teaching professional development in medical schools. *The Lancet* 2001;357(9259):867–70; Kipnis K. Professional ethics and instructional success. In: *Professing Medicine: Strengthening the ethics and professionalism of tomorrow's physicians*. Chicago: American Medical Association; 2001:21–7; Siegler M. Lessons from 30 years of teaching clinical medical ethics. In: *Professing Medicine: Strengthening the Ethics and Professionalism of Tomorrow's Physicians*. Chicago: American Medical Association; 2001:8–13; and Cohen JJ. Our compact with tomorrow's doctors. *Academic Medicine* 2002;77(6):475–80. See also: Arnold L. Assessing professional behavior: yesterday, today, and tomorrow. *Academic Medicine* 2002;77(6):502–15.

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30. Cohen D, Colliver J, Robbs R, Swartz M. A large-scale study of the reliabilities of checklist scores and ratings of interpersonal and communication skills evaluated on a standardized-patient examination. *Advances in Health Sciences Education* 1997;1:209–13. See also: Cohen D, Colliver J, Marcy M, Fried E, Swartz M. Psychometric properties of a standardized-patient checklist and rating-scale form used to assess interpersonal and communication skills. *Academic Medicine* 1996;71(1):S87–8.
31. Deckman H, Markakis K, Suchman A, Frankel R. The doctor-patient relationship and malpractice. *Archives of Internal Medicine* 1994;154:1365–70.
32. Novac D. Clinical review: therapeutic aspects of the clinical encounter. *Journal of General Internal Medicine* 1987;2:346–55. See also: Langone J. Medical schools discover value in dispensing compassion. *New York Times* 22 Aug 2000; and Association of American Medical Colleges. Learning objectives for medical student education: guidelines for medical schools: Report I of the Medical School Objectives Project. *Academic Medicine* 1999;74:13–8.
33. Brukner H, Altkorn D, Cook S, Quinn M, McNabb W. Giving effective feedback to medical students: a workshop for faculty and house staff. *Medical Teacher* 1999;21(2):161–5.
34. Westberg J, Jason H. *Teaching Creatively with Video: Fostering Reflection, Communication, and Other Clinical Skills*. New York: Springer; 1994. See also: Ende J. Special communication: feedback in clinical medical education. *JAMA* 1983;250(6):777–81; and American Medical Association. *Communicating with Your Patients: Skills for Building Rapport*. Chicago: American Medical Association; 2000:2–6.
35. Aristotle. *The Nicomachean Ethics* (vi,13).
36. Aristotle. *The Nicomachean Ethics* (ii, 1).
37. Wilkes M, Raven BH. Understanding social influence in medical education. *Academic Medicine* 2002;7(6):481–8.

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