Mark G. Kuczewski

Teaching biomedical ethics as professionalism in the United States

Diametros nr 25, 30-37

2010

MUZEUM HISTORII POLSKI

TEACHING BIOMEDICAL ETHICS AS PROFESSIONALISM IN THE UNITED STATES

- Mark G. Kuczewski -

The teaching of bioethics is widespread in the United States and is done on many educational levels. Elective bioethics courses are available at the undergraduate level through many different academic departments and schools of many universities. Graduate programs in bioethics have proliferated at the master's degree level and increasingly, at the doctoral level. Of special interest is the manner in which biomedical ethics is taught to physicians-in-training. Despite the important changes during the last fifty years in the way health-care is delivered, physicians still play the lead role in the delivery of health care and the doctor-patient relationship remains central in biomedical ethics.

I will provide a brief overview of the development of educational strategies in biomedical ethics as they have evolved in medical schools and residency programs in the United States. In particular, I will describe the incorporation of biomedical ethics education into the larger professionalism movement that has become the dominant paradigm and suggest that this approach hold promise for improving the ethical and interpersonal aspects of the physician-patient relationship. Furthermore, I will consider some of the potential pitfalls of the professionalism movement in medical schools in the U.S. Finally, I will outline what I believe is the international import of the professionalism movement. That is, the professionalism movement is in many ways, the completion of the ethical movement in the West that seeks to anchor ethics in the objective needs of human beings. This has been an important achievement in overcoming the relativism that had dominated Western philosophy for much of the twentieth century and had threatened to undermine practical ethical discourse.

The Emergence of the Professionalism Movement

Bioethical thinking in the United States still takes place mainly within the language of the famous "four principles of biomedical ethics" popularized by Tom Beauchamp and James Childress (Beauchamp, Childress [2001]). The concepts of respect for patient autonomy, beneficence, non-maleficence, and justice provide handy touchstones to anchor analyses of contemporary ethical dilemmas. Of

course, these concepts are mainly obligations that the physician owes the patient as part of the good faith relationship between the professional and the patient. Over time, the concepts have not become widely used as a method per se but are the language in which ethical deliberations are conducted according to case-based reasoning and narrative methods (Kuczewski [2007]).

As this approach to biomedical ethics became paramount in the United States in the 1980's, some medical schools began to offer a required course in biomedical ethics. These courses were typically located within the first or second year of medical school, which are the pre-clinical years of medical education. Providing didactic sessions and moderated case discussions was logistically more feasible in the pre-clinical years than in the clinical years. These courses often covered typical concepts that were emerging as part of the legal consensus on forgoing life-sustaining through important court cases (Meisel [1992]). These concepts included informed consent, patient decision-making capacity, standards of decision making, advance directives, and forgoing life-sustaining treatment.

Teaching ethics in the clinical years is far more faculty-intensive. Students rotate in small groups through various clinical services for several weeks at a time and most education must take place in these small groups. This structure thereby multiplies the number of faculty required to moderate ethical discussions if such a discussion is to happen in each service through which a student rotates. For this reason, only elite ethics programs that undertook significant faculty development efforts were able also to offer clinical ethics education during the clinical years (Frader, et al. [1989]).

Two developments in the late 1990's significantly altered biomedical ethics education in medical schools in the United States. First, medical educators increasingly wished to integrate the presentation of discursive content with exercises to develop the skills necessary to implement that knowledge. As a result, "doctoring" courses that combined theory with interpersonal and professional skills became common. These courses integrated biomedical ethics with interviewing and communication skills as well as the many other topics related to the social, legal, and interpersonal context of medicine. These courses often span more than one year of medical school. Second, medical educators became aware of the need to support the character development of medical students. Researchers showed that medical students suffered "moral erosion" during their medical education (Feudtner, Christakis, Christakis [1994]; Hafferty, Franks [1994]). The environment of medical school which is highly competitive and has been known to tolerate disturbing levels of student mistreatment was admitting idealistic young people but jading them and making them into worse people. As a result, many medical

schools developed curricula and programs to help students achieve a modicum of professionalism. These two factors have led to the rise of "professionalism" as a broad competency that is a major focus of medical education.

The emergence of professionalism as a focus has not been limited only to the level of medical schools but has taken hold at the level of national professional societies and medical specialty organizations and accreditation bodies. Furthermore, it has been reinforced through a revival of scholarship on medical professionalism (Wear, Kuczewski [2004]). The wider professionalism movement seems to be a reaction to the increasing bureaucratization of medical practice. Professionalism has been attractive to practicing physicians as a rallying cry because it asks them to reflect upon what it means to be a doctor. It asks them to recall the elements of being a physician that first caused them to commit to this vocation (Parsi, Sheehan [2006]).

The Promise of Biomedical Ethics as Professionalism

The professionalism movement in the United States has been very salutary. While many differing lists of the elements of professionalism have been put forward in the literature, there are generally three kinds of attributes that make up medical professionalism, i.e., commitment to the good of the patient, sensitivity to the social context and narrative elements of patient care such as the patient's culture and spirituality, and advocacy for patients in need (social justice). Paramount among the elements is a commitment to the good of the patient. This is sometimes expressed in terms of putting the patient's interests above the self interest of the physician, i.e., altruism. (Swick [2000]; ACGME) But, in general, the leading analyses of professionalism recognize that there are a variety of threats to the interests of the patient that come from the many relationships in which the physician must engage in order to deliver medical care. The physician must order relationships with health-care institutions such as his or her group practice, hospital, health-care team, pharmaceutical representatives, and research sponsors such that these relationships contribute to the care of the patient rather than compromise that care. For this reason, medical professionalism is sometimes said to be the norms that the guide the relationships in which physicians engage in the care of patients. (Kuczewski, et al. [2003]).

This attention to the multiple relationships surrounding the physician–patient relationship is meant to promote the integrity of the latter. The physician–patient relationship has its own norms, those of biomedical ethics that guide the process of treatment decision making. Furthermore, most discussions of medical professionalism also include an understanding that this relationship must evidence cul-

tural and spiritual sensitivity in order to meet the needs of the patient. But perhaps the most interesting aspect of this way of viewing professionalism are the norms that lead the physician to think outwardly toward issues of social justice.

Much of the literature on medical professionalism calls for the physician to take up an advocacy role for individual patients and also for underserved groups or populations of patients (Rothman [2000]; Kuczewski [2006]; ABIM, et al. [2002]). The ability to offer effective treatments is intimately related to systemic arrangements for financing and delivering health care. The medical profession cannot remain silent in the face of inadequate and unjust systems for addressing the health and health-care needs of sizable populations. Physicians are obligated to advocate for the needs of specific patients as well as for the needs of groups of patients. The recognition of this obligation was successful in transforming the American Medical Association (AMA) from an organization that had clearly limited its advocacy to the interests of physicians into one that became an effective advocate for the expansion of health insurance coverage in the recent health care reform debate in the United States.

The concept of medical professionalism therefore, includes the rights of patients to make their own treatment decisions in concert with their physician. But, it also acknowledges that human beings are entitled to more than a mere right of informed refusal of treatments that they do not think benefit them. Being a physician also means being a compassionate partner in the decision-making process who can engage the patient in shared decision making. Such a partner has the skills to be sensitive to the needs of the patient in terms of his or her cultural and spiritual meaning-making activity. Furthermore, the right to make an informed refusal does not address the basic needs of patients to be able to consent to beneficial treatments. When such beneficial options are artificially truncated by unjust social arrangements, it is part of the concept of medical professionalism that physicians advocate for social change.

The Challenges of Medical Professionalism: Evaluating and Valuing Professionalism

Because all of the relational elements of medicine becoming part of the single, broad concept of professionalism, we must be vigilant against the trivialization of the concept. Many precepts that are related to etiquette tend to be included alongside the weightier considerations of biomedical ethics and social justice in list of the elements of medical professionalism. While this poses no theoretical problem, in practice several dangers may emerge.

First, the term 'professionalism' may simply lose strength through association with relatively unimportant considerations. As medical educators repeatedly use the term to cover all matters of etiquette from appropriate dress to being on time for classes and case conferences, the term may lose its ability to inspire medical students and physicians. Professionalism could become a term that is dreaded and lose its ability to call them to renew their vocation. Similarly, the current obsession with "objective" evaluation will likely enhance this negative trend.

Medical education in the United States currently emphasizes objective evaluation of behaviors that show competence in various skills. Performance of such skills should be directly observed and documented. Of course, this paradigm of evaluation is ideal for the performance of procedures because competence can often be demonstrated through observation of a single performance. Because professionalism cannot be so easily demonstrated, professionalism is often assumed unless an incident calls it into question. Evaluation often focuses on the documentation of single instances of "unprofessional" behavior such as being tardy, not completing an assignment on schedule or other small transgressions. The student whose professionalism is thereby called into question is unlikely to find the term one that suggests more than nit-picking and bureaucratization. This is quite ironic when the success of the professionalism movement thus far has resided in its ability to suggest the core meaning of doctoring and the call to a vocation beyond the day-to-day bureaucratization of medical practice.

These problems have resulted from a confusion of evaluation and valuation (Kuczewski [2006]). It has become a common adage among U.S. educators that we improve what we evaluate. This would seem to imply that evaluation is a way that we convey the value of a particular task or domain. While there is some merit to this implication, it assumes that evaluations focus on the relevant aspects of the task or domain. As our description of the evaluation of professionalism indicates, evaluative techniques often focus on what is easiest to evaluate and document rather than on what is important. So, the challenge for the future of medical education is to demonstrate to the students in our charge that we genuinely value professionalism and therefore, promote it among them. This is not as difficult as it might seem.

Several techniques are commonly showing a good deal of promise. First, one can directly observe some skills related to biomedical ethics. For instance, medical students sometimes practice explaining "bad news" such as delivering a terminal diagnosis to a patient through exercises with standardized patients. "Standardized patients" refer to actors who deliver pre-scripted responses in playing out a particular scenario with medical students or residents. In these exercises,

the skills to express empathy and compassion are developed in addition to the interview techniques needed to help make decision in regard to referral to hospice or forgoing death-delaying treatments. Second, an institution can develop a culture of fostering and respecting professionalism. Faculty and students who demonstrate a strong commitment to service and scholarship that benefits the underserved can receive a variety of kinds of reinforcements and honors that mark them as role models to be emulated. Honors programs for students are one method by which students who evidence facility in the ethical and social justice dimensions of professionalism can be rewarded and raised up. Finally, it is important to create a culture that cares for medical students. This may be a step toward overcoming the moral erosion associated with medical education that we noted is associated with a corrupt culture that too often has tolerated student mistreatment.

The Future of Cross Cultural Professionalism

In conclusion, it is worth considering whether the model of teaching biomedical ethics through a focus on medical professionalism can engage other models of teaching bioethics. I believe that several features of the U.S. model are congruent with current international developments and worthy of further dialogue.

First, this concept of professionalism incorporates an ethics of the physician-patient relationship that is congruent with the human rights emphasis that has come to characterize Western thinking in regard to the medical profession. The concepts of respecting patient autonomy, beneficence, and non-maleficence undergird a respect for the fundamental self-determination of vulnerable patients that is often expressed through widespread practices such as informed consent.

Second, the concept of professionalism has effectively expanded a narrow focus on bedside clinical ethics among U.S. medical educators to include the responsibility of the medical profession to advocate for social justice. This role is increasingly important in the contemporary world in which basic needs are often politicized and less fortunate persons stigmatized and demonized by those opposed to their interests. Medical professionals occupy a respected place in most Western societies and can function as teachers of society by expressing the objective connections among socio-economic status, health, and the common good. The role of medical professionals as objective advocates for those lacking the means to address fundamental needs is translatable across most borders. Indeed, our common humanity requires that our vision of human need and our response to such needs extend across borders.

Finally, this robust sense of biomedical ethics as professionalism requires that we focus on the character formation of the physician. We cannot expect to

develop compassionate and virtuous physicians in educational systems that are insensitive and at times abusive toward their students. Biomedical ethics and social justice require that physicians are caring human beings and persons of practical wisdom and judgment. Such character formation requires that we provide appropriate experiences in which the students can exercise their developing capacities and then offer opportunities for reflection and discernment.

Biomedical ethics is amenable to many approaches and models. The medical schools in the United States have chosen a model that integrates biomedical ethics into the concept of doctoring, of medical professionalism. I have tried to outline the key reasons for this approach and the opportunity that it affords. It holds the promise of the renewal of medicine as a vocation. Of course, I have also noted the potential danger of equating professionalism with medical etiquette and the trivialization this entails. Nevertheless, if we can avoid the danger of trivialization, we can steer a path beyond relativism to a vision of medicine anchored in human need, compassion, and virtue.

Bibliography

ABIM, et. al [2003] – ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine 2003, *Medical professionalism in the new millennium: A physician charter*, "Annals of Internal Medicine" 136 (3) 2003: 243-246.

ACGME – ACGME Outcome Project, *Advancing education in medical professionalism: An educational resource*, available from: http://www.acgme.org/outcome/ implement/profm_resource.pdf [07.06.2010].

Beauchamp, Childress [2001] – T.L. Beauchamp, J.F. Childress, *Principles of Biomedical Ethics*, fifth edition, Oxford University Press, Oxford 2001.

Feudtner, Christakis, Christakis [1994] – C. Feudtner, D.A. Christakis, N.A. Christakis, *Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development*, "Academic Medicine" 69 (8) 1994: 670-679.

Frader, et. al. [1989] – J. Frader, R. Arnold, J. Coulehan, R.L. Pinkus, A. Meisel, K. Schaffner K, *Evolution of clinical ethics teaching at the University of Pittsburgh*, "Academic Medicine" 64 (12) 1989: 747-750.

Hafferty, Franks [1994] – F.W. Hafferty, R. Franks, *The hidden curriculum, ethics teaching, and the structure of medical education*, "Academic Medicine" 69 (11) 1994: 861-871.

Kuczewski [2006] – M.G. Kuczewski, *The problem with evaluating professionalism: Against the current dogma*, [in:] *Professionalism in medicine: Critical perspectives*, Delese Wear, Julie M. Aultman (eds.), Springer, New York 2006: 185-198.

Kuczewski [2007] – M.G. Kuczewski, *The soul of medicine*, "Perspectives in Biology and Medicine" 50 (3) 2007: 410-420.

Kuczewski, et. al [2003] – M.G. Kuczewski, E. Bading, M. Langbein, B. Henry, *Fostering professionalism: The Loyola model*, "Cambridge Quarterly of Healthcare Ethics" 12 (2) 2003: 161-166.

Meisel [1992] – A. Meisel, *The consensus about forgoing life-sustaining treatment: Its status and prospects*, "Kennedy Institute of Ethics Journal" 2 (4) 1992: 309-345.

Parsi, Sheehan, [2006] – K. Parsi, M. Sheehan (eds.), *Healing as Vocation: A Medical Professionalism Primer*, Rowman & Littlefield, New York 2006.

Rothman [2000] – J. Rothman, *Medical professionalism – Focusing on the real issues*, "New England Journal of Medicine" 342 (17) 2006: 1284-1286.

Swick [2000] – H.M. Swick, *Toward a normative definition of medical professionalism*, "Academic Medicine" 75 (6) 2000: 612-616.

Wear, Kuczewski [2004] – D. Wear, M.G. Kuczewski, *The professionalism movement: Can we pause?*, "American Journal of Bioethics": 4 (2) 2004: 1-10.