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ABSTRACT

This guide compiles information reported by medical schools on their efforts to help students develop a sound code of professional ethics. The introduction opens with background information on an Association of American Medical Colleges (AAMC) 1992 survey of medical schools and on why it is imperative that schools assist medical students' ethical development. The guide's organization follows the medical student's journey with the first chapter addressing admissions. The second chapter covers the orientation to medical school and learning its code of conduct. The third chapter, the longest, treats curricular innovations and focuses on case scenarios drawn directly from students' immediate ethical dilemmas. The fourth chapter addresses evaluation of students. The fifth chapter looks at influencing faculty. The sixth chapter is titled "Teaching Research Ethics" and is by Allan C. Shipp. The seventh chapter examines other initiatives. The final chapter offers a summary and conclusions and draws together the most important recommendations. Each of these chapters reports results from the AAMC study as well as findings from the literature. Of 35 appendices, 25 are cases illustrating ethical dilemmas encountered by medical students. Includes an index of schools named and roster of respondents. An annotated bibliography contains 63 references.) (JB)

AAMC ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Promoting Medical Student's Ethical Development: A Resource Guide

Prepared by Janet Bickel,
Division of Institutional Planning and Development
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PROMOTING MEDICAL STUDENTS' ETHICAL DEVELOPMENT: A RESOURCE GUIDE

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PREFACE

A primer on ethics for medical students? Why should it even be necessary? Medical students and their faculties are joined in the noblest and most explicitly moral of professions. In that context, a few simple guidelines - the Golden Rule and always telling the truth - ought to be enough. So why a primer on ethics?

Like a lot of things in life, the issue isn't so simple as it sounds or as it once was. Notwithstanding their altruism and idealism, medical students are the product of a tough competitive winnowing (getting into medical school) and picture themselves mired in another one (getting a preferred residency). Their evaluation for both prizes is heavily based on publicly visible behavior such as examinations, recitations, and declarations. But their ethical and moral behavior is played out largely in private, unobserved and unevaluated. In many of these smaller, less visible moments, they are working with faculty whose own lives include many stresses. Housestaff are sleep deprived, buffeted by clinical disappointments, and caught up in their own needs to please the attending staff. The faculty are struggling to earn grants, to take care of desperately ill patients, to adjust their own efforts to a changing world, and to have time for family and personal pursuits. Faculty dishonesty, or at least questions about it, have never been more prevalent. When is unacknowledged citation the ultimate flattery and when is it plagiarism? How much contact with a research project does the laboratory head have before putting his name on a paper? When is joint work by students on a computer-based exam collegial problem-solving and when is it deliberate deception.

Another reason to pay more attention to medical student ethics is the need to make the vague explicit. Although most faculty feel that the principles of moral behavior are obvious and familiar, both accused students and their uninvolved peers often say they didn't recognize the right and wrong of the issue at hand. They tell us that the faculty should have placed more emphasis on the ethical behavior expected.

New eras make new problems. This book is an effort to harvest the experience, insights, and ideas of people throughout American medical education to craft a preventive approach in the ethical guidance of medical students. We have chosen a case-based format to illustrate the innumerable permutations and gradations of morality that confront those learning medicine. We have emphasized not just the formal curriculum - lectures, handouts, clinics - but also the myriad moments of the informal curriculum that provide ethical emergencies and ethical epiphanies. And finally we consider it just one step in a well-intentioned struggle to help our students achieve a profound goal - living up to their original ideals in entering medicine.

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ON THE USE OF THIS GUIDE

This Resource Guide compiles efforts reported by medical schools to help students develop a sound code of professional ethics. The introduction opens with background on AAMC's 1992 survey of medical schools and on why it is imperative that schools assist medical students' ethical development.

The busy reader may wish at first to focus only on one or two particular areas. The Guide's organization basically follows the arduous journey of medical students--beginning with their admission, then their orientation to the school and learning about its code of conduct, then immersion in the curriculum and the often heavy emphasis on examinations and evaluations. Of these chapters, the longest is on curricular innovations,focusing primarily on the use of case scenarios drawn directly from students' immediate ethical dilemmas. The next focus of attention is faculty evaluation and development. Each of these chapters reports results from the AAMC study as well as findings from the literature. The most important recommendations from these chapters are drawn together in the summary and conclusion. The special areas of research ethics and of initiatives underway at other organizations also precede this concluding chapter.

Of the 35 appendices, 25 are cases illustrating ethical dilemmas encountered by medical students. The annotated bibliography is provided to assist further exploration of the issues raised in the Guide.

INTRODUCTION

Description of the Study

In 1991, AAMC formed an ad hoc Working Group on Student Professional Ethics, chaired by Daniel Federman, M.D., Dean of Medical Education, Harvard Medical School (see p. i). The Working Group examined numerous ethical dilemmas that students experience by virtue of their student-status and concluded that medical educators and ethicists have paid insufficient attention to students' need for guidance with these. As a stimulus to further discussion, a summary of the AAMC Working Group's deliberations was published in *Academic Medicine* (Bickel).

To identify resources and to better understand the perceptions of medical school administrators about influences on medical students' ethical development, in February 1992, AAMC President Dr. Robert Petersdorf sent a two-page survey (Appendix 1A) developed by the Working Group to U.S. and Canadian medical school deans. A second request to nonresponders was not sent.

Eighty-five of the 140 schools (61%) returned the survey (the last section of the Guide lists the schools and respondents). Of these, 51% sent in supporting materials as well. Follow-up communications with over 30 of these respondents and contact with educators at 3 nonresponding schools yielded additional information and insights.

One survey item asked "how would you rank the following in terms of their influence on your students' development of high professional standards?". (The percentages shown are the percent of the 85 respondents who ranked the influence as 1, 2 or 3 out of the 6):

- 16% medical school admission (e.g., use of essays on ethical questions)
- 59% medical school orientation (including discussion of standards of conduct)
- 82% role modeling of faculty and residents
- 45% use of honor code (or similar system)
- 27% improvements to student evaluation process
- 66% components of medical ethics or other courses

While one simple item cannot reveal much about these complex influences, these results do show some consensus around role modeling as the primary influence, with teaching medical ethics and orienting students to professional standards as the next two most promising influences on students' ethical development. Schools were also asked to describe any current activities in the areas they ranked highest.

Outlining the Challenges

How can medical educators be expected to attend more closely to students' moral development, when all the other demands on faculty and deans seem to be increasing as well? And how are faculty with little training in ethics to help students recognize and grapple with ethical dilemmas?

Consideration of these questions might well begin with the observation that physicians have always worked in the midst of moral conflicts. Jonsen describes the tension between altruism and self-interest in medicine as ancient and chronic (Jonsen). Competition for medical school admission and then for a residency, and subsequent struggles to advance as a faculty member or practitioner, involve intense self-interest. At the same time, "the absolute asceticism of the residency" encourages an ethic of immediate response to the needs of patients and unmitigated responsibility for correct decisions, sometimes without pause to eat or sleep (Jonsen).

While the pull between the two poles of altruism and self-interest may be structural, determinants of actual behaviors are rarely so clearcut. For instance, can physicians who have a financial stake in particular treatments or referrals prevent self-interest from interfering with their clinical decisions? Does some physicians' overtreatment of dying patients

arise more from incorrect information about the law and a tendency to protect themselves than from altruistic concerns? How will physicians' respond to the conflict between their perception of professional duty to individual patients and intensified pressures to limit time and resources spent?

Most would agree that the "ethical environmental hazards" that students now face dwarf those experienced by most of today's seasoned practitioners in their early years. Actions necessary to ensure economic survival are often now at odds with the humane purposes of academic medical centers and with maintenance of high quality care. The continual bombardment of financial restrictions that hospitals are experiencing lowers the morale of all healthcare providers who then respond with less alacrity to the legitimate demands of patients (Rabkin). Humane care is also endangered by layers of paperwork and bureaucracy. Moreover, shortened hospital stays and the use of advanced technology have reduced opportunities for meaningful interactions between patients and physicians and students. These contemporary features exacerbate existing tensions between altruism and self-protection that run through medicine's center.

The darkening public perception of physicians also argues for increased attention to students' professional development. Consider the steep slide downhill from Dr. Kildare and Dr. Welby to "The Doctor" portrayed by William Hurt and the starchy, narrow physicians in "Lorenzo's Oil" (Angier). Medicare fraud, acceptance of expensive "perks" from pharmaceutical companies, reports of exceedingly high incomes, and other "bad press" have damaged the profession's credibility. Another cautionary example comes from the state of Washington's Department of Medical Licensure; its Medical Disciplinary Committee recently asked for evidence that the medical school was teaching students about ethical conduct (personal communication from Dr. Thomas McCormick, University of Washington School of Medicine). In order to salvage the public's trust, medical schools must better prepare students to ethically weather an increasingly confusing storm of economic pressures and other demoralizing forces.

In order to be prepared to help patients and families explore moral dilemmas, physicians need practice in ethical "self-examination" so that they can be clearer about the influence of their own values on their deliberations and recommendations. Physicians also need to be better prepared to work with an expanding circle of participants in bioethical debates. Now that the Joint Commission on the Accreditation of Health Care Organizations requires that health care institutions establish mechanisms for responding to ethical issues, increasing numbers of ethics committees are being established on which physicians must learn to work with persons from diverse fields and backgrounds. In order to be effective in these regards and to guide public policy, physicians must not only be capable of identifying and analyzing bioethical issues but should also bring a moral leadership to this work (Thornton et al).

To educate physicians who are better prepared to deal with ethical challenges, more attention should be paid to the immediate ethical issues that students face. Findings from moral psychology indicate that solving real-life moral problems stimulates more growth than discussing fictional dilemmas, suggesting the wisdom of an "experiential" approach to ethics education (Lickona). Even though medical ethics education has "come of age" (Miles et al.), ethics curricula have focused almost exclusively on the moral dimensions of *medical practice* and *patient care*, with students' real-life quandaries usually going unmentioned. In defense of medical ethicists, many institutions still only have one or two full-time professionals, and their plates are always over-full, with the continually expanding range of clinical and legal ethical issues and with curriculum development and committee work. Nonetheless, many opportunities continue to be lost because ethicists at the podium are not helping students apply ethical principles to their immediate moral dilemmas. Influences on

students' professional development clearly range far beyond ethics courses, and no one expects medical ethicists to do this work alone. But their leadership is urgently needed.

A few words about the terms "professional" and "ethics" are appropriate here, since both have many connotations. Originally, the Greek word *ethos* referred to a person's interior dwelling place, what a person carries within herself. Throughout history there has been a tension between this "inner being" meaning and the academic discipline, *ethics*, that has emphasized habits or customary actions. While to a large extent medical ethics has become so preoccupied with particular actions that the older meaning is ignored (Drane), the ethics referred to in this Guide harken back to the original meaning as well.

The original meaning of *profession* referred to a public declaration or promise to practice certain ideals: "When a student consciously accepts his degree he makes a public avowal that he possesses competence to heal and that he will do so for the benefit of those who come to him. In that declaration, he binds himself publicly to competence as a moral obligation, not simply a legal one; he places the well-being of those he presumes to help above his personal gain" (Pellegrino). As illustrated by this statement, the reach of the term "professional" is broader than what is understood by "moral" or "ethical". In addition to the ideal of conducting oneself with integrity through a self-imposed code of conduct, in medicine to be "professional" also implies the qualities of competence, commitment to the needs of the patient, self-awareness, and compassion; others would add other qualities and responsibilities. Although the two are perhaps inextricable, the term "professional" rather than "personal" ethics is employed in this project in order to keep the emphasis on the responsibility of *medical schools* to foster students' development.

In order to give some immediacy to these amorphous subjects, following are three perspectives on the challenges inherent in addressing students' ethical development. This faculty member, dean and student may well not be "typical", but their voices serve to illustrate the experience of many.

From a Senior Clinical Faculty Member

In my day, the pace of medical care and education was much slower, and students and faculty got to know each other and the patients. Because faculty weren't under so much pressure to bring in clinical income, the reward system didn't so dramatically interfere with time spent with students and patients. Lost are all too many opportunities that were so crucial to my development, to observe and be guided by truly great physician role models. Without those sources of inspiration and wisdom about the humanity and care of patients, I believe I could not have discovered for myself what it means to be *privileged* to be a physician--especially in the face of the poverty, violence and homelessness that now besiege so many of our medical centers.

Not only has the medical education environment deteriorated and become more complex in terms of our ability to inspire students regarding their professional obligations, the students themselves present greater challenges. There are so many of them, and some of us white males are unprepared for their cultural diversity. I am also at a loss when students discuss career choices in terms of "lifestyle" considerations. What distresses me most of all is that many seem to feel "entitled" to knowledge and to expect easy exams. They seem to be lacking a sense of personal responsibility for their behaviors and don't want to work as hard as my generation did. Some don't even want to attend classes but send a tape-recorder instead. In order to deter this, one of my colleagues required students to sign in at crucial lectures; but so many students signed their friends in, that he gave this up and is now so cynical about students' "morals" that he should stop teaching altogether. However, he will continue because his academic appointment is important to him for other reasons. An unfortunate number of faculty are similarly "detached" from their teaching responsibilities;

some faculty even treat students as if they were in the way!

From a Seasoned Student Affairs Dean

We read that academic dishonesty is a growing problem among college students, and perhaps we shouldn't be surprised given examples of dishonesty that are pervasive in our society, even in our government. But educational institutions are ill-equipped to play the role of values-shaper that families and churches once served more effectively. Now we administrators must work extra hard to design fair procedures to prevent confusion about what behavior is expected and to discourage would-be cheaters. For instance, we make our financial aid forms and procedures as clear and fair as possible. But every year we discover a student who does not consider lying to a financial aid officer "cheating"; one even asked how to "get around the rules"!

I am confident that most of our students enter with sound moral character and become humane physicians, but there are always a number whom we graduate with reservations--for instance, the "manipulators", the "complainers", the ones so apparently lacking in good judgment as to border on pathology ("I had no idea that copying from another student was cheating!"). If our student evaluation system encouraged all members of the academic community who have contact with students to document such problems, we could do a better job of identifying and remediating (or dismissing) such borderline students. However, given everyone's time constraints and legal worries, such a process remains an ideal.

As a medical school administrator, I must recognize that the unprofessional behavior on the part of both students and faculty that I hear about is just the tip of an iceberg. Even though my door is open and students trust me, silence is the name of the game; no one wants to be a "tattler".

Moreover, ethical dilemmas faced by students are always filled with ambiguities related to their precarious roles on health care teams. Students' roles are so ill-defined that ethical compromises seem inevitable. The less mature students worry constantly about their inexperience and convince themselves that "the attending wouldn't do it if it weren't right". They fear that "making waves" will not only draw attention to their ignorance but result in denied learning opportunities and in the assignment of extra "scut". Yet if they do not question what they observe, they risk self-recrimination and finally, apathy. As medical educators, we should be helping students to pay attention to their "queasy" feelings, but their position at the bottom rung and their lack of power makes it most difficult for them to act on anyone's behalf but their own.

From a Fourth Year Student

The main fact of life in medical school is stress. The amount we're supposed to know seems to increase daily, and on most exams, there's only one right answer. Many of us tend to be perfectionists but there is no way we can meet our own standards, thus we are continually disappointed in ourselves. So the last thing we need is more humiliation, right? Not only is there small margin for error in medicine, often you can't admit you don't know something without being made to feel ignorant. There has got to be a way to legitimize discussion of mistakes and uncertainty. In the meantime, medical students are very practical--we do what we have to in order to survive, and often that means conforming.

Conflicts among competing responsibilities can be very confusing. With whom can these be discussed? Usually not with faculty. I recently observed an attending retaliate against a brave MSIII who had quietly suggested that a patient was being caused unnecessary pain. From the very beginning in anatomy lab, students with too much empathy pay a big price because emotion can get in the way of learning from the cadaver. It's even harder on the wards where as medical students we sometimes cost patients extra discomfort. At what point does this become wrong? Another conflict is that my school's honor code "requires" me to report a peer's unethical behavior. Since

I see so few examples of the "brother's keeper" ethic among physicians, I figure that lip-service to such codes is all that's expected. Students must sign a pledge to follow an honor code and are evaluated on every dimension possible, but what standards of behavior are faculty required to live up to? I understand that to some extent distortions of ethical standards are part of the woodwork of hospitals. "DRG cheating" helps the place survive financially. Refreshments and books paid for by pharmaceutical companies entice us to very educational conferences. And when does "inappropriate" cross the line to "unethical"? Being so uncertain about what "counts" as unethical breeds cynicism--if you can't tell what is immoral, if there doesn't seem to be a "victim", maybe means do justify ends. Besides how are we poor sots at the bottom of the learning curve to distinguish between the hard realities of medicine and unacceptable behaviors? There are also alot of acute double messages: we need more primary care doctors, but subspecialists and the use of high technology are what make money to keep hospitals open.

This feeling of "moral relativism" is also abetted by how selectively "rights" are defined. Academic medicine is terrifically hierarchical, with each level "lording over" the ones beneath, and with other gradations as well, for instance, tenured faculty get more respect than untenured. Nurses are still sometimes treated like handmaidens of doctors. Women in general are held in lower esteem than men. I also witness examples of bias against gays, racial minorities, poor people, and the non-English-speaking. I know this is true the world over, but medicine is supposed to be the most caring of professions.

Because our duty is to care, society sets standards higher for physicians than for others, and one of the agendas of residency is to teach us to put patients' needs above our own. But physicians have personal needs too. Denying these can start unhealthy patterns interfering with physical, mental and emotional well-being, that ultimately detract from our ability to recognize, care about and serve patients' needs.

Studies of the Moral Development of Medical Students

The literature on moral education supports the views that well-developed educational interventions can enhance moral reasoning (Leming, Rest) and that moral reasoning is linked to behavior (Blast). Specifically, individuals at higher stages of reasoning are less likely to cheat on a test than lower-stage individuals, more likely to resist the instructions of authority in order to help someone in distress, and more likely to honor a commitment (Lickona). An important pedagogical implication of moral development theory is that the major impetus for movement through the moral stages is the person's own activity as a problem solver, as called forth by challenging interactions with the environment (Lickona).

Very few well-designed studies of medical students' moral development have been published. The instrument most often used for gathering empirical data on moral reasoning is Rest's Defining Issue Test (DIT), based on the work of Kohlberg.[1] Self and colleagues administered the DIT to medical students before and after a 44 hour medical ethics course which extended for two quarters. Scores increased significantly; and regression analysis revealed that neither age, gender, MCATs or GPA were related to the changes in moral reasoning scores. However, students taught by the case-study method showed greater increases in scores than students taught by lecture only format (Self, 1989). Self and colleagues also administered Kohlberg's Moral Judgment Interview to 42% of one medical school class at the beginning and end of medical school (Self, 1993). The normally expected increases in moral reasoning scores did not occur, suggesting that their educational experience overall may have inhibited rather than facilitated students' development.[2]

Other Considerations related to Students' Academic Honesty

According to a study of students attending highly selective colleges, 67% admitted to cheating in college, leading educators to worry that academic dishonesty is becoming the survival technique of choice (Kibler and Kibler). Exploring students' decision to cheat, Kibler and Kibler found that, while many understand that cheating is wrong and unacceptable, students' motivation to cheat is greater than their moral principles. While acknowledging the role of "situational" factors (such as unfair exams), these authors focus on the internal factors of low self-esteem and the fear of being incapable of meeting the requisite challenges. Other college faculty report that the problem is not self-esteem but rather students' unwillingness to work any harder; such students sometimes actually fight for the "right" to continue to cheat (Goulet). It is to be hoped that few of these students apply to medical school.

Jack Su, a medical student at the *University of California-San Francisco School of Medicine*, surveyed the Classes of 1995 and 1996 about cheating, achieving a 37% response rate. Asked "why do students cheat?", students ranked influences as follows: overwhelming workload, insufficient study time, competition for grades, high self-expectations, and course materials perceived as unimportant or poorly taught. A majority of the students believed that cheating in medical school is a critical issue to address. Almost 70% agreed that "cheating during the first two years of school predicts future unethical behavior during the clinical years". Ninety percent agreed that more attention should be focused on the ethical dilemmas faced by medical students. Ninety-nine percent agreed with the statement "If I question my attending's ethical behaviors, I will receive an unfavorable evaluation" and 77% with "I feel inadequately informed to effectively deal with unethical behaviors by my colleagues or superiors". In the comments section, many students asked for help regarding how to deal with unethical behaviors of superiors.

Similarly, an anonymous mail survey of students at six Pennsylvania medical schools revealed that 60% of respondents had witnessed what they believed to be unethical behavior by other clinical team members (Feudtner et al.). Over 65% felt bad or guilty about something they had done as clinical clerks and 62% believed that at least some of their ethical principles had been eroded if not lost. After controlling for other factors, the investigators founds that students who witnessed an episode of unethical behavior were more likely to have acted improperly themselves, to feel guilty about their own actions, and to feel that their ethical principles had eroded. Moreover, students were twice as likely to report erosion of their principles if they had behaved unethically for fear of poor evaluation or to fit in with the team.

It would seem then that in order to better promote academic integrity, institutions must take a comprehensive approach that includes not only educational and disciplinary interventions but also supportive ones, such as the ready availability of tutors and of skill-building programs on strategies for academic success. The perspectives expressed by the senior clinician, student affairs dean, and medical student likewise reveal the need for as comprehensive approach as possible in raising the "ethical consciousness" of the medical academic community.

Getting Started

Certainly the moral disposition of students is formed prior to medical school. However, "the fabric of their ethical beliefs can be unraveled, tattered, and even rewoven[;] it would seem to make more sense then to speak of an emerging 'ethical self': a composite entity that encompasses not only individuals' evolving personal values but also the operational rules for handling ethical dilemmas that they adopt from their colleagues and institutions" (Feudtner and Christakis). In a nutshell, "like everyone else, doctors shape the ethical narrative of their lives by the way they do ordinary things over and over again" (Drane).

Following from all of the preceding observations, this Guide is predicated on the premis-

es that:

- A professional education that does not foster, support, and implement an examination of the moral life will defeat its own purposes, the needs of its students, and the welfare of society (Hastings Center Project).
- Institutional policies and programs can make a difference in the shaping of students' ethical development;
- Given the havoc that can result from the actions of one unethical physician, almost any "preventive medicine" that medical educators can facilitate is worth the effort; and
- Schools can learn from each other about ways of heightening students' and faculty members' awareness of moral responsibilities.

N.B.: *Schools' permission has been obtained to reprint materials shared for purposes of this project.*

Notes

[1] While not directly relevant here, moral *orientation* needs to be distinguished from moral *reasoning ability*. "Orientation" refers to the framework by which one perceives situations to be moral dilemmas. "Moral reasoning" refers to the logical application of moral principles to determine what is right or wrong in a situation. Until fairly recently, Kohlberg's rights- or justice-orientation reigned alone in the field of cognitive moral development. Kohlberg delineated three levels of development known as preconventional, conventional, and principled morality. The highest stage is a commitment to the universal ethical principles of justice, equality, autonomy and respect for the dignity of all human beings as individual persons. In 1982 Gilligan articulated a moral orientation based on care, needs, and relationships as distinct from an orientation based on rights and duties (Gilligan; see also Noddings). In the first empirical study of the moral orientation of medical trainees, a group of 139 medical students and practicing physicians from most specialties were interviewed (Self and Olivarez). In the resolution of moral dilemmas, 43% of this group exhibited a justice orientation, and 52% exhibited a care orientation, with the remainder showing a predominance of neither orientation. However, while men showed no significant preference between the justice and care orientations, women showed a decisive preference for the use of a care orientation (as would have been predicted from Gilligan's work). Two recent books offering feminist perspectives in medical ethics further extend this debate (Holmes and Purdy; Sherwin). However, assuming gender-based dichotomies of moral thought may perpetuate assumptions of deep difference between men and women and limit creative thinking about gender-neutral ethical and power structures (Sherwin).

[2] While no significant gender difference was observed in this study, Self and Olivarez also studied results of the DIT taken by 705 first-year medical and veterinary students. Here women scored significantly higher than the men, indicating that these women were more effective than the men in the use of justice for resolving moral dilemmas.

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CHAPTER 1

MEDICAL SCHOOL ADMISSIONS

Since about 96% of those who enter medical school are awarded the M.D. (Kassebaum et al.), the selection of students of sound moral character assumes paramount importance. While 16% of AAMC survey respondents ranked the influence of the medical school admission process as one of the top three influences on students' development of high professional standards, this does not imply that admissions committees are uninterested in ethical character. However, the challenges of assessing ethical character are particularly great at this juncture. Prediction of academic success is difficult enough, but assessment of those personal qualities likely to be related to ethical practice is many times harder. In fact, personal responsibility and virtue, which are fundamental to ethical medical practice and to professionalism, seem often to be simply assumed of candidates. While the enduring emphasis of admissions committees on predictors of academic success ensures that most medical students have the aptitude to successfully complete the course of study leading to the M.D. degree, no one is satisfied with the assessment of all the other important but harder-to-measure qualities such as integrity and empathy. As Glick (a professor of internal medicine in Israel) has observed, it is not that brilliance interferes with integrity; the two are unrelated. However, the modern Western approach to life emphasizes self-fulfillment, and it is not surprising that medicine attracts many who want to receive more from this profession than they give (Glick). If the goal is selection of students with integrity and a strong commitment to others' welfare as well as high scholastic abilities, then better efforts must be made to assess integrity and related personal qualities.

Almost 10 years ago, the Personal Qualities, Values and Attitudes Working Group of AAMC's General Professional Education of the Physician (GPEP) Project addressed schools' over-reliance on grades and MCAT scores and the dearth of ways to assess candidates' attitudes and values (Muller). This Working Group recommended that schools only use GPAs and MCATs to ensure that applicants have met an agreed-upon level of proficiency and then shift attention to personal qualities. Support for the feasibility of the "cut-off" approach comes from AAMC's *Trend plus*. With regard to students entering medical school in 1988 with a premedical science GPA between 3.51-4.00, 3.0% were dismissed or withdrew; the attrition only increases to 3.5% and 5.0% of those between 3.01-3.50 and 2.51-3.00, respectively. Likewise, with the MCAT: for Reading Composite scores of 12 or higher, 1.1% were dismissed or withdrew; attrition increases to 3.1% for scores of 9-11 and to 4.4% for 7-8. As expected, GPAs and MCATs correlate inversely with attrition; however, the great majority of students with "average" MCATs and "good" grades do graduate. In setting a floor, it may be necessary to calculate different floors for some minority groups.

The GPEP Working Group further recommended that faculties establish criteria to assess the personal qualities sought (testing these through longitudinal study of graduates) and devote whatever time is necessary to improve the value of the information obtained from the interview. A study of Dartmouth Medical School students found that strong performance in admission interviews is associated with dean's letter ratings in the top third of the class and poor performance with dean's letter

ratings in the bottom two-thirds (Hall et al). This finding was corroborated at the University of Missouri-Columbia; ratings of personal characteristics from interviews were more predictive of superior dean's letters than were undergraduate GPA or MCAT scores (Murden).

In 1989, AAMC President Robert G. Petersdorf recommended that medical school admissions committees pay more attention to the moral backgrounds of the students they admit, looking beyond MCAT scores and interesting research projects (Petersdorf).

Approaches to Assessing Personal Qualities

Unfortunately, studies of the medical school admission process reveal little progress in the assessment of qualitative variables (McGaghie). A variety of personality tests have been tried with conflicting results and usually with little predictive value relative to clinical competence (Green et al.). However, a recent study of students' psychosocial characteristics found that noncognitive measures increased the magnitude of the correlations between predictive and criterion measures beyond that achieved with conventional admission measures alone. Fewer stressful life events, less anxiety, less loneliness, less externality in locus of control, and more sociability contributed the most to predicting students' clinical competence (Hojat et al.). While these are promising results, the logistics of administering a battery of psychosocial measures to applicants are daunting.

A recent descriptive analysis of medical school application forms found that 22 or 17% of schools using supplemental (to AMCAS, AAMC's application service) forms asked in-depth essay questions (Emmett). Most of these schools were seeking information about either a primary care orientation or religious affiliation. However, nine schools were also seeking to assess such noncognitive attributes as compassion, personal integrity, and motivation through their essay questions.

A study of current practices with admission interviews found that virtually all schools use the interview to assess applicants' noncognitive skills (Johnson and Edwards). However, fewer than half the schools provide training to help interviewers improve specific skills, and the authors conclude that many practices that would enhance the interview's reliability and effectiveness (such as adding structure) remain underutilized. Moreover, interviewers and admission committee members often lack guidance on relating judgments about candidates to the values and mission of the school (McGaghie).

Ben-Gurion University in Beer Sheva, Israel, remains the best example of a medical school methodically focusing on personal qualities. This small school, established in 1974 with a community orientation, has from its beginning emphasized the evaluation of empathy, flexibility and responsibility in the admissions decision (Antonovsky). Candidates complete an autobiographical form including three standard questions (on a moral dilemma, a significant experience, and a major achievement). Interviews take off from these responses, focusing as much as possible on students' actual *deeds*. Interviewers receive intensive training, and new interviewers are paired with experienced ones. With particularly promising candidates, interviewers shift to more stressful questioning.

While Ben Gurion's admission process is more time-consuming than most schools, those most closely involved with it continue to be convinced that the results are worth the effort (Personal communication from S. Glick, 3/3/93). Moreover, a study comparing Defining Issues Test (DIT) (an instrument measuring moral reasoning ability) scores of applicants to Ben Gurion and to a Tel Aviv medical school confirms that Ben Gurion's admission process is measuring other abilities (Benor). No difference was found between the DIT scores of the accepted and the rejected applicants to the Tel Aviv school where the admission criteria are the traditional scholastic ones. However, although DIT scores correlated only moderately with interview scores, at Ben Gurion there was a great difference between the DIT scores of

accepted and rejected applicants. This example of a medical school planning its admissions process based on its primary mission and emphasizing the evaluation of non-academic qualities certainly bears watching.

Only seven AAMC survey respondents reported addressing ethical issues in the interview, but it is probably fairly common for admission interviewers to ask candidates to discuss a particular ethical issue applicants are likely to have thought about, e.g., euthanasia. Too often interviewers receive no guidance here but simply pick the issue they're most comfortable with; the intent is to see if the applicant has thought the issue through and is capable of seeing multiple points of view. Some applicants, because of their religious or cultural orientation, do have difficulty rising above moralistic conclusions, especially on such issues as teenage pregnancy and AIDS, with no awareness that this moralizing may affect their candidacy. A related frustration is with the maturity levels of some students; admissions officers worry whether young people, who may be very intelligent but who are also insular and self-absorbed, can learn to care about someone very different from themselves.

Other challenges to obtaining useful information via topical questions include the facts that applicants may not feel free to express themselves and simply try to conform as closely as possible to "expectations" and that in some cases the interview is also used to "sell" the institution to applicants and thus is intentionally "easy".

Conclusion and Recommendations

During this period of increasing numbers of applicants, admissions officers are more likely looking to streamline than to add evaluation criteria. Another problematic fallout of a large applicant pool is that competition for slots heats up, and more premeds resort to unethical behaviors, such as lying about credentials, razoring out required articles from journals, and sabotaging others' experiments. This kind of individualistic, competitive approach to premedical education is likely inimical to moral development (Lickona) and carries over into medical education.

However, the need to graduate higher numbers of generalists is motivating schools to attend more carefully to personal characteristics likely to be predictive of primary care practice (Roberts et al.); and there is evidence of some concordance between primary care practice and the qualities of altruism and compassion (Antonovsky).

- Experiments and programs (e.g., combined B.A.-M.D. tracks) that can help reduce competitiveness among premeds should be encouraged.
- Adding structure to the interview seems to be advisable. For instance, generate a list of characteristics desired in graduates from which can be derived standard interview questions with behaviorally-anchored rating scales (Edwards, et al.).
- Schools should provide interviewer training on specific skills, such as questioning techniques, reducing rater bias with regard to gender and ethnicity (Johnson and Edwards). Specially trained interviewers may be effective in questioning candidates about accepting responsibility for their actions, demonstrating compassion, and articulating views about the physician in society and about societal values.
- Admissions officers need to work as closely as possible with health professions advisors, so that advisors become more forthcoming in communicating information when the integrity or morality of an applicant is in question.
- Consider specifying to applicants what principles and codes of behavior they will be expected to live up to (Altman). Not doing so leaves a student free to say "no one told me". Moreover, a student who disagrees with the duty to treat AIDS patients or other patients with infectious diseases needs to know prior to entry that "they are binding themselves to standards of conduct that transcend their private moral calculations" (Barnard).

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CHAPTER 2

CODES OF CONDUCT AND MEDICAL SCHOOL ORIENTATION

This chapter opens with consideration of oaths at graduation. The second section pertains to medical school honor systems and codes of conduct. The last part deals with components of orientation programs focusing on students' ethical development.

Graduation Oaths

The oath taken at graduation is a "public promise to colleagues, friends, family and future patients that the graduate can be trusted to seek something other than self-interest, that she or he has a requisite degree of competence, and that this competence will be used in the patient's interest" (Pellegrino 1990).

A recent examination of graduation oaths in use at U.S. medical schools found that most schools use a version of the Oath of Hippocrates (see Appendix 2A) or the Declaration of Geneva (Dickstein et al.). Most oaths contain the principles of beneficence and nonmaleficence. However, even though today's society highly values respect for patients' autonomy, few of the oaths reflected this. Even in those pledges affirming respect for patients' autonomy, the principle of veracity was absent, as is any awareness of the principle of justice in the distribution of scarce medical resources. The investigators also found that many schools retain the traditional title of the oath while including ideas that are inconsistent with statements in the standard version. The authors suggest both that graduates need to ask themselves *why* they are taking a particular oath and that the content of traditional pledges may not be perfectly relevant as guides for present-day medical care.

Halperin found that few physicians were able to answer even rudimentary questions concerning the contents of the oath they took at graduation (Halperin). Likewise, twenty-six residents representing 20 medical schools were asked five questions about the Hippocratic Oath (Moffic et al). The only principle named by more than half was "do no harm". These investigators suggest that this lack of retention probably reflects both a lack of formal study of such oaths and the excitement of the moment what an oath is recited. These studies suggest that the practice of administering oaths at graduation may be more of a ritual than a meaningful promise that physicians make to society.

The Class of 1985 at *Pennsylvania State University College of Medicine* wrote their own covenant read responsively with their friends and families at graduation (see Appendix 2B) (Clouser). Dr. Clouser reports that this covenant continues in use there and that a number of schools have requested permission to copy it.

During the orientation to medical school at *New York Medical College*, the dean presents the Hippocratic Oath that students will re-take on graduation day and asks them to take the oath then as a commitment to maintaining high ethical standards during medical school. A possibility for making this practice even more meaningful for students and *faculty* to take an oath *together* at the beginning of medical school that "they enter a covenant with society when they accept the privileges of learning" (Pellegrino, 1993). Preceding this with an interactive educational session on the "ethics of obligation" and how to approach conflicts between obligations would make the covenant even more meaningful. A similar but more clinically-focused session could be held at the beginning of the third year and include chief residents.

While a challenge to organize, another idea is for students to devote the last hours of

medical school to a study of medical oaths (Moffic et al.). In fact educational objectives related to medical oaths have been outlined for each year of medical school (Pearlman).

Honor Codes

A 1990 study of medical student honor codes found that over half the medical schools had a code and that requiring students to sign a pledge was common (Aschenbrener). Infractions covered by the majority of codes included: academic dishonesty in exams, plagiarism, falsification of patient records and clinical presentations, unethical conduct with a patient, harassment of others in the medical community, and willful property damage. Student responsibility for peer conduct is an important component of the majority of honor systems, with 81% requiring students to report infractions by other students and 55% indicating that a student failing to was subject to discipline.

A survey of medical students at the *University of California-San Francisco School of Medicine* (described in the Introduction) reveals how controversial honor codes can be. The survey included the statement "an honor code is necessary at *UCSF* to address the issue of cheating"; only 14% of respondents strongly agreed, 31% agreed somewhat. No more than 52% agreed that "it is my responsibility to report a suspect incident of cheating".

Seventeen schools sent copies of their codes and related materials in response to AAMC's survey. Perhaps the simplest of these is *University of California-Los Angeles School of Medicine*'s honor code which is signed by all students as a matriculation requirement: "1) Students will act at all times in a manner creditable to the school and their future professions; 2) No student shall seek unpermitted aid, and no student shall give aid for examinations, papers, or other assigned work; 3) It is the responsibility of each student to uphold these ideals and aid in their enforcement." *Louisiana State University School of Medicine in New Orleans*' code of ethics is similar but is preceded by the statement of four principles related to the ethical growth of students; students are encouraged, though not required to sign this, which then becomes part of the student's permanent record.

Mayo Medical School combines its honor code statement with its guidelines for nonacademic probation and dismissal. The statement opens as follows: "By matriculation at Mayo Medical School, the student agrees to abide by general professional standards of honesty, integrity and mutual respect. Such behavior is confidently expected of all students at Mayo. Behavior judged by the administration, students and/or faculty to be illegal, unethical or so objectionable as to be inconsistent with assumption of the role of a physician may be cause for the imposition of probationary status or dismissal. Examples of such behavior are harassment, lying, cheating, stealing, and breach of patient confidentiality".

At the *University of Nebraska Medical Center*, one component of the first-year humanities curriculum for the past three years was for students to write their own code of conduct. Student representatives were elected from discussion groups to serve on a Code of Conduct Committee (CCC) to write the Code. The penultimate draft was presented to the entire class for final approval. All three Codes were eventually accepted by class members but with markedly less support in one class than the other two.

The Code of Conduct project was designed to accomplish several objectives: 1) to provide students an opportunity to articulate those values and principles which they hold especially dear and which motivate them early on to pursue careers in medicine; 2) to engage students in a discussion about values in medical practice, their relative importance and compatibility, and their willingness to tolerate others whose values may at times conflict with their own; 3) as a class project it provided experience in policy development and representative government for the CCC members.

The course director has drawn the following conclusions from the three-year experience: 1) there is much value to students but direct rewards (i.e., grading credit) significant-

ly enhance its perceived value to students; 2) imposing time limits for project completion is useful; 3) multiple Codes operating at one institution have potential for conflict; 4) acceptance of a Code of Conduct by the COM administration raises difficult issues including (i) the proper role of the Code in guiding decision-making in cases of alleged unethical behavior by students, (ii) possible objections to specific provisions in individual Codes, and (iii) appropriate enforcement of the Code's content by the administration, class members, or others (Reitemeier).

Likewise, as part of *State University of New York at Stony Brook Health Sciences Center School of Medicine's* Medicine in Contemporary Society course, each year the entering class writes its own honor code. Each discussion group (8 groups of 13) propose a code that the group unanimously agrees would bind them during their four years. This task forces students to think about the attributes of a "good" medical student, decide what norms are intrinsic to the study of medicine,and produce something that may have real power over their lives. Once students agree on a code, they are asked to apply its provisions to a set of situations closely resembling actual situations that have arisen at *Stony Brook*. The final step is evaluation: 1) each participant evaluates the level of participation of the group members, prompting discussion of cooperativeness in collective tasks; 2) section leaders evaluate the performance of the group as a whole. At the end there are eight honor codes; students have the option of organizing as a whole and adopting a class honor code which the dean agrees to rely on. However, thus far no class has continued the exercise to this point.

Dartmouth Medical Center recently developed a comprehensive code of professional conduct (see Appendix 2C) to which all medical staff and students are expected to adhere in their interactions with patients, colleagues, other health professionals and the public. Again, the process of creating and approving this document helped to heighten the level of awareness of these issues among members of the academic community.

The *University of Washington School of Medicine's* Task Force on Code of Ethics promulgated nine ethical principles that apply equally to faculty, administrators, residents and students, e.g. commitment to veracity in all relationships, nondiscrimination. Each principle is illustrated with a problem scenario and an example of how the principle applies. This school reports that this ethical code has helped to "develop a sense of personal responsibility and responsibility for peer accountability".

Some schools have developed fairly elaborate honor systems. *Temple University School of Medicine's* has a constitution, bylaws, and student-faculty board of ethical conduct. The *University of North Carolina*'s Instrument of Student Judicial Governance is quite detailed and includes a companion guide written for faculty. *University of Maryland School of Medicine* has a longstanding Judicial Review System which applies to all members of the academic community and which has proven quite workable. One of the 13 items included in its statement of ethical principles, practices and behaviors is: "professional relations among all members of the community should be marked by civility"; while the definition of "civility" is open to interpretation, it has proved helpful in discussions of student maltreatment.

Since 1981 the *University of Kentucky Medical Center* has published a pocket-size booklet "Behavioral Standards in Patient Care". Among the seven principles delineated with standards are these: "each patient shall be treated as a whole, irreplaceable, unique and worthy person" and "the privacy of the patient and the confidentiality of every case and record shall be maintained". This medical center also distributes a Health Sciences Student Professional Behavior Code and a 90-page booklet on Student Rights and Responsibilities.

University of Cincinnati College of Medicine's Student Code of Conduct (see

Appendix 2D) is quite specific about behaviors considered cheating and specifies a number of other types of misconduct such as disturbing the peace and unauthorized use of alcohol.

Because students come from a wide range of cultures, it is probably preferable to err on the side of specificity in informing them about expectations, particularly with regard to such problems as plagiarism. For instance, *East Carolina University School of Medicine's* Department of Medical Humanities distributes guidelines for plagiarism to students, including a number of examples. Another approach to use with students in discussing the proper use of sources is showing how their own education suffers when they over rely on the words of others (White). While a lack of clarity about plagiarism is part of the problem, students' feeling that plagiarism is *justified* in some circumstances is much more difficult to address. Some students similarly try to justify entering fictitious lab values in patient charts. The more ambiguous the circumstances, the easier it is to justify dishonesty. While all circumstances can never be spelled out, specificity about evaluation mechanisms, course objectives and what constitutes an infraction at least creates a clear picture for students of expected behavior.

Accepting responsibility for peer conduct is probably the most elusive requirement of all. While reporting can be mandated, it can hardly be enforced. Students are naturally reluctant here, just as faculty are. In fact, two schools commented that students' inability to agree about reporting honor code infractions resulted in the decision to have *no* honor code. These schools apparently rely on strict proctoring of exams and stiff penalties to reduce the incidence of cheating. Such a "policing" approach, however, certainly does nothing to advance students' sense of personal responsibility or their appreciation of the peer review responsibilities of physicians.

Peer accountability can be emphasized, however, as *Michigan State University College of Human Medicine's* one-page honor code statement does (Appendix 2E). Likewise, schools with student honor boards, (e.g., *Ohio State University College of Medicine, University of Maryland School of Medicine*) report that such boards help encourage peer accountability. Whether students care enough about their educational environment to put individual qualms aside to "whistle blow" also depends on the security of the school's reporting mechanisms and whether the student has ever witnessed a positive case of physician or faculty peer review. Even so, the emphasis in medicine on collegial loyalty runs deep, and this loyalty tends to be more immediately experienced than a "higher duty" to protect the public or to safeguard an academic climate.

Finally here, a recent study of medical school application forms revealed that at least three schools have taken the proactive approach of requesting that the applicant sign an honor code, with one school saying that not signing would affect chance of admission (Emmett). This study also found that 42 schools request information concerning whether the applicant had any prior criminal or felony convictions or charges pending and 22 schools request information on academic disciplinary action, with two requiring disclosure forms from undergraduate colleges.

Orientations

Medical school orientations vary widely in length and approach, but common features are to inspire pride in the institution and a sense of the educational and professional responsibilities that will be required. Since students have little idea of how medicine can change them emotionally and shape their personal development; these would also seem worthwhile to address. Whether or not the school has an honor code, the student affairs dean is likely to give an overview of how the school handles academic dishonesty and other student conduct problems, along with information about support services and due process in these regards.

Twenty-five schools provided information about orientation activities related to professional ethics. Some schools include presentations on ethics and values or panel discussions

of student-related ethical issues, followed by small group discussions. Another practice is for the honor council leadership, rather than a dean, to try to establish a sense of peer responsibility for maintaining honesty in the academic environment. Because students tend to be overwhelmed by information during orientation, one school delays discussion of professional conduct until later in the first quarter. In fact, one respondent believes that students are "spongers, not thinkers" during orientation and that it is better to postpone discussion of issues of central importance. In another vein, one respondent noted with regret that during her school's orientation, students are subjected to a "paranoid, legalistic diatribe" from a hospital attorney about protecting the hospital's "financial exposure".

At *University of Texas-San Antonio School of Medicine*, professionalism is discussed with students even prior to registration. Two days before registration, the dean offers an open house, to which students' families (e.g., parents, children, partners) are invited as well. Family members comment that this orientation is helpful to them in understanding the rigors of the educational process and their own roles in the student's professional development. Then during the first two weeks of school, on at least two further occasions, the dean addresses the students regarding personal ethics and professionalism. Throughout the first semester, the student affairs dean addresses such issues in a series of "Class Hours".

To reinforce that students' ethical behavior as individuals matters, the *University of Iowa College of Medicine* recently developed an "Affirmation for Students of Medicine" (see Appendix 2F). It includes such statements as: "Because my personal feelings and beliefs affect my behavior, I will make myself aware of the influence these convictions have on the professional decisions I make". Students participate in a discussion of the traits emphasized in the Affirmation and have a chance to discuss it during their Human Dimension in Medicine groups.

During orientation the Honor Council of the *University of Cincinnati College of Medicine* distributes a two-page pamphlet called "Becoming a Professional" which includes an overview of the Hippocratic Oath and of activities which support the development of professionalism, including electives and participation in the Honor Council.

Ethical *cases* are part of orientation at the *University of Oklahoma College of Medicine*, and faculty facilitators receive a guide to their discussion. One case concerns a student who mentions that she lied about some previous academic failure on her medical school application (the faculty guide describes AAMC's national application service and how irregularities are handled). In another case, an upperclassman offers a freshman access to an old exam (the faculty guide outlines the university policy and reporting mechanisms in cases of infraction).

At *Rush Medical College's* orientation, fourth-year medical students present a Clinical Pathological Conference, devoting at least one-third of the time to ethical aspects of medical student involvement in clinical care. At the end of the second year as part of Rush's orientation to clerkships (and immediately preceding the clerkship lottery), students hear presentations on the pressures they will experience and what is expected professional behavior, especially with regard to patient confidentiality, introducing yourself to patients, and charting (i.e., students' writing on charts must be their own work or identified as someone else's).

Rush Medical College has also added a cultural competence component to medical school orientation, with the joint goals of helping students of various cultures acclimate to each other and preparing them to work with diverse patient populations (DeVita). Since stereotypes can hinder the ability of a physician to "see" and "hear" patients, becoming aware of and overcoming one's biases are important ethical abilities. The half-day program at Rush uses videotaped vignettes and non-competitive games that are designed to open up communication among people who are very different.

Louisiana State University School of Medicine in New Orleans' Introduction to Clinical Medicine includes a segment on "how to survive negative feelings in the clinical years" which touches on: reframing "threats" into challenges; constructing your own priorities, and learning to say "I don't know".

At *Albany Medical College*, the Honor Code Orientation Progam has grown into a four-year curricular module titled "Health, Care and Society". Students explore the honor code in small groups (around such questions as "what are your personal concerns and hopes of an honor code"?), followed by a panel discussion led by Honor Committee co-chairs. After this discussion, students sign the honor code and take the Hippocratic Oath. In the course that follows, students explore professional ethics and resonsibilities more thoroughly. In the original orientation program, faculty-led small groups discussed a scenario (e.g., "you encounter a classmate at a bar who is inebriated and the next day hear him give fictitious lab values to his resident"). Faculty facilitators received discussion objectives for these small group sessions, including: defining responsibilities in terms of *actions*, accountability, and teacher/learner relationships; examining how friendship may interfere with reporting honor code violations; and discussing the honor code as the basis of professional quality assurance (see Appendix 2G).

Conclusion and Recommendations

The above examples indicate that many schools are exploring a variety of innovative and constructive ways to inform students about their ethical responsibilities as entrants into the profession of medicine. Optimally, linkages between the student honor code and future ethical obligations would be reinforced not only during orientations but also in ethics discussions and not only by the student affairs dean but by other leaders and faculty as well. A barrier that students, faculty and administrators need to consider together is students' fear of reporting a peer or a superior who is guilty of unethical or unprofessional behavior. In academic medical centers, so much seems to hinge on pleasing the one above on the pecking order that students become quickly sensitized to a "code of silence" and conclude that coming forward with a charge is way too risky. A new study of faculty mistreatment of medical students found that 75% of seniors experienced an incident of abuse; over 80% of these reported "fear of retribution" as the main reason why they did not come forward with a complaint (Kane et al.). Clearly, each school needs to consider what can be done to make the climate safer for students report concerns about unprofessional behavior of peers and faculty members.

- The *process* of creating or revising an honor system or code of conduct, especially one applying to *all* members of an academic community, offers benefits beyond the value of the created document. Almost any opportunity for faculty and students to dialogue about the challenges inherent in meeting their ethical obligations is worthwhile because such discussions can focus areas of conflicts, help clarify thinking, and raise moral sensitivities.
- Orientation activities should include attention to strategies for academic success and guided opportunities for consideration of ethical responsibilities of medical students (especially responsibilities likely to be ambiguous, such as plagiarism, confidentiality and civility). Orientation to clinical medicine should include discussion of the ethics of charting, of introducing oneself to patients (Cohen), and of other ethically "grey" areas that all students must navigate.
- Student affairs deans and/or ethics faculty should work with each class of students, helping them consider which oath they will use at graduation. Consideration might be given to students writing their own in the form of a covenant and to taking it during orientation or at the beginning of the clinical clerkships with core faculty and possibly with residents as well.
- When housestaff are oriented to their

educational responsibilities to students, they should be shown how not to add to students' conflicts of obligations. Housestaff should also be evaluated in their capacity as role models for medical students.

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CHAPTER 3

CURRICULAR INNOVATIONS

In his 30-year overview of the metamorphosis of medical ethics, Pellegrino states that the "real question, as old as moral philosophy itself, is how to go from universal principles to individual moral decisions and back again?" (Pellegrino). For purposes of this chapter, perhaps an even better question is: "how can medical students best be encouraged to acquire a model for ethical problem-solving that will continue to evolve?" Certainly physicians require enough familiarity with ethical principles to be able to conduct an "ethical work-up" of a wide variety of patient care dilemmas. But as one student writes: "Ethics classes usually focus on the sensational problems . . . [but] everyday ethical problems faced by students on the wards are more relevant and, in addition, provide an ideal springboard from which to illustrate important ethical principles" (Miraie). For instance, after ten years of experience with a course in scientific ethics at the *University of Texas Health Science Center at Houston*, Bulger and Reiser report that group discussion of actual ethical dilemmas faced by students not only stimulated students' interest in engaging in moral discourse but also seemed to increase their capacity to reason (Bulger and Reiser).

Even more striking evidence has emerged from the *University of Pennsylvania School of Medicine*. As a component of the internal medicine clerkship, two senior medical students asked junior students to submit cases focusing on dilemmas they encountered on the wards (Christakis and Feudtner). They found that many dilemmas are intimately tied to the student's unique role on the health care team. The most frequently recurring themes are the student's pursuit of experience, differing degrees of knowledge and ignorance among team members, and disagreement within the hierarchy of the team. Christakis and Feudtner recommend that "personal problems culled from the daily events of students' lives and rooted in the complex social situation of the ward more thoroughly capture their consciences [than moral theory]".

Medical Schools' Use of Student Cases

Thirty-five schools wrote some response to the AAMC survey item: "If any of your medical school's ethics courses use cases designed to elicit discussion of ethical dilemmas medical students face as students, attach a copy and briefly describe the objectives". Twenty-five of these schools appeared to be using written cases of student dilemmas, and 16 schools sent a copy. Of the other ten schools: a few were planning to begin to use such cases; a number sent materials in which the role of the student was very minor compared to other content; and two schools stated that student ethical dilemmas are discussed in case conferences but that no *written* cases are used.

It is certainly possible to advance students' incorporation of ethical principles without relying on cases, but this method seems custom-made. Most ethical dilemmas require balancing one incommensurable value against another, e.g., a friend's right to privacy versus her welfare; and case studies lend themselves to individuals' listing the values they see as conflicting. Moral principles and "balancing equations" are usually much more complicated than the moral *actions* taken as a result of the balancing (Hundert), e.g., discussing the friend's drinking problem with the student dean. However, as Hundert describes, the struggle to bring articulated principles into harmony with one's conscience equips individuals with new moral experience and principles. Each new case exposes a novel division of

values conflicting around the facts of a case, sharpening one's weighting system as the problems associated with each alternative action are contemplated.

Kohlberg found that posing dilemmas which challenge (but do not over-challenge) one's current level of moral reasoning best facilitates growth in moral reasoning (Kohlberg). Regarding their course for graduate students on scientific ethics, Bulger and Reiser write: "Our experience with group discussion of actual ethical dilemmas faced by our students is consistent with Kohlberg's belief that only the presentation of genuine and difficult moral conflicts will result in the stimulation of moral development" (Bulger and Reiser).

Other built-in advantages to case-based teaching is that medical students and faculty are accustomed to thinking in terms of illustrative dilemmas and that when conducted in concert with others of differing views, case analysis can help participants learn to tolerate ambiguity and the built-in uncertainties of the practice of health care (Thornton et al.).

Topic Areas

The five problem areas most frequently identified by Christakis and Feudtner's analysis of student cases were:

1) *Performing procedures: education vs. patient care*

Cases here illustrate the often-conflicting aims of learning new procedures, working as part of a medical team, and caring for (as opposed to inflicting pain on) patients. The requirements of informed consent also come up, as well as powerful social forces e.g., students being more concerned about their resident's impatience than about the patient's discomfort when they have trouble hitting a vein.

2) *Being a team player: team vs. individual ethics*

Fitting into the team can easily become paramount in a student's mind, but this goal leads students to do things they might otherwise question, e.g., writing progress notes on unexamined patients in compliance with the resident's request.

3) *Challenging medical routine: the effects of relative ignorance*

Students' relative lack of knowledge makes it hard for them to challenge any decision. The tendency is to leave the job to the "experts", though there is danger in perpetuating an uncritical reverence of technical knowledge.

4) *Knowing the patient as a person: medical vs. social knowledge*

Because of the time they spend with patients, students often become better acquainted than residents with patients' feelings, leaving them with questions about residents' and other team members' medical assessments. Students are loathe to challenge authority, but to be silent with information is likewise uncomfortable. While the predicament of challenging authority is hardest for students, it is replicated at each step of the medical hierarchy.

5) *Witnessing: to rock the boat or stay the course*

Angry feelings and guilt arise when students participate in sub-optimal patient care or are encouraged to treat some kinds of patients (e.g., retarded citizens) differently from other patients. These emotional aspects of unethical behavior need to be addressed in addition to the cognitive aspects (Christakis and Feudtner).

Following are the main subject areas of topics submitted by AAMC survey respondents. Since cases can illustrate many ethical principles, this grouping is but one of several possibilities. While many are very similar to those presented in the above reference, the range of cases submitted is naturally much broader since all educational levels are spanned (not just an internal medicine clerkship). Examples of cases on most topics appear in the Appendix. Related literature is cited as possible background for case discussion.

1) *Learning on patients*

a) *Introducing oneself as a medical student*

The most frequent case in use appears to

be "The Student Doctor and a Wary Patient" (Basson) (see adaptation used at *Michigan State University College of Human Medicine*, Appendix 3A). This case balances the virtue of students' truth-telling about their inexperience against patients' need to be reassured. Another common case, "Your First Lumbar Puncture" (Appendix 3B) poses a similar dilemma: the resident introduces the student as "doctor" and then leaves the room with instructions for the student to proceed with the procedure. Of interest here is an informal poll of nonphysicians asked if they wanted to know if "this is the doctor's first spinal tap": all said no (Oski, et al.). Students experience great pressure to "do it right" the first time and thus to say whatever they think the patient wants to hear under the circumstances.

A 1987 study found that only 37% of teaching hospitals specifically informed patients that students would be involved in their care (Cohen et al., 1987). Moreover, only 51% of the medical schools that gave their students instruction on initial patient interaction insisted that students introduce themselves as students and clarify their role in patient care. Cohen and colleagues next studied a sample of medical students and found that only 5% both introduce themselves as medical students and explain that they are not physicians (Cohen et al., 1988). In general, all the students were less forthright about their status when given the opportunity to perform invasive procedures. With improvements to Introduction to Patient Care courses and with hospitals' eye on liability problems, it is possible that the percentages collected in 1987 have increased in intervening years. However, as clinical teaching opportunities in hospitals continue to decrease, medical centers and students may prefer to overlook the importance of truth-telling here. Moreover, evaluation systems naturally tend to reward individuals who aggressively pursue skill-building experiences; in this pursuit it is easy for students to "justify" not clarifying their student-status.

b) *Informed consent and other patients' rights issues*

Actually, medical students' clarification of their role to patients falls under the umbrella of informed consent, which spans numerous complex issues in patient care and research. The main question here that students have is "when is it ethical to learn on patients?" One answer is that there is a societal imperative for educating physicians, and everyone should do their part to assist in their training. In reality, however, the burden of participation in students' education falls disproportionately on the poor and on those who lack access to care or who have some other disadvantage.

Schools submitted a variety of cases on how students should proceed when instructed to obtain practice on patients who are anesthetized (Appendix 3C), inebriated (Appendix 3D), retarded (Appendix 3E), unconscious, or dead. Drawing blood for an HIV test without the patient's permission illustrates a similar dilemma (exacerbated when the student has sustained a needlestick and thinks the patient is likely to refuse permission) (Appendix 3F). These cases pit patients' rights and the viture of truth-telling against students' desire for clinical experience and their fear of challenging faculty.

c) *Causing patients pain*

Closely related to "first time" dilemmas, additional questions can arise about the legitimacy of causing patients unnecessary discomfort (Appendix 3G). In seeming conflict with the primary ethical tenet to "first do no harm", causing patients pain is emotionally difficult for many students. As is discussed below under "Distancing", too often the answer for students is to "block out" their own and their patients' discomfort. This denial can lead to over-detachment and under-concern.

2) *Dealing with evaluation pressures*

It is widely understood that evaluation mechanisms heavily influence what and how students learn, although the more mature and self-directed learners are probably less driven by these pressures than younger ones.

a) *Challenging authority*

Hierarchy in medical centers is only slightly less important than in the military. Students jeopardize a positive evaluation when they stand up to anyone above them (Appendix 3H). In forfeiting the good opinion of the resident, students may also lose learning opportunities. While there are obvious reasons why those with more experience have more authority, sometimes students know more than other team members about patients' wishes and feelings. The decision about when and how to challenge authority for the benefit of a patient can leave students feeling queasy and isolated; it is clear that residents view questioning the authority of the attending to be pointless. A searching treatment of these tensions from the point of view of the chief of medicine can be found in the recent book *The Healer's Power* (Brody).

Students face similarly hard decisions about faculty who harass students or who flaunt racial, gender, and other prejudices (Appendix 3I). Few "whistleblowing" dilemmas are clear-cut, especially when the power imbalance is great. Students need help ascertaining whether speaking out is in fact in the public interest and how likely it is that speaking out will precipitate changes for the better (Bok). Given the difficulty of these questions and the likelihood of retaliation, it is not surprising that offenders are rarely educated or reprimanded.

b) *Relationships with peers who cheat*

Cases submitted primarily illustrate the conflict between a "brother's keeper" ethic, including personal responsibility for maintenance of an honest academic climate, and allegiance to a friend (Appendix 3J). More difficult to address, however, are students who seem completely self-absorbed, with no sense whatever of any responsibility for or to a peer or colleague. Encouraging in such students a sense of institutional responsibility represents a difficult challenge.

c) *Making mistakes*

Interviews with physicians about their mistakes reveal: their ubiquity in clinical practice; the infrequency of self-disclosure to colleagues, family and friends; a lack of support among colleagues; and a high degree of emotional impact on the physician (Christensen, et al.). While no case on this subject was mailed in, it seems clear that discussion of mistakes should be legitimized from the beginning of medical training. However, in order to learn to admit *their* mistakes, students need more stimulus than an academic discussion; they also require a supportive educational climate and courageous role-models.

3) *Personal development*

a) *Abuse of alcohol and drugs*

Questions here arise over personal use (Appendix 3K), peers in trouble (Appendix 3L), and superiors witnessed to have problems (Appendix 3M). With regard to peers, a study of hypothetical vignettes found that fourth year students were *least* likely to report classmates who: abused alcohol only (rather than drugs), were acquaintances, and excelled academically (Brown et al.). The authors conclude that students need help in recognizing their responsibility to report impaired classmates.

b) *Time conflicts*

Clerkships mark students' introduction to the reality of hospitals' 24-hour days. Some residents and attendings treat students' attention to their family as detracting from their dedication to be a physician. Dilemmas most frequently concern truth-telling, putting the patient first, setting limits, and requesting help; and arise around marital responsibilities (Appendix 3N) and pregnancy/child care. Certainly, many trainees and employees would benefit from more flexible personnel policies and better child care facilities at medical centers (Bickel, 1991). An even deeper problem is the lack of orle models successful at establishing appropriate boundaries between work and personal life. Interviews with interns reveal their intense concern for their patients but with

resulting difficulties in maintaining realistic boundaries (Yedidia et al.). This in turn slows the development of more balanced approaches to sharing responsibility and delegating authority. This study of interns concludes that the imposition of limits on work hours acknowledges the finite capacities of physicians as workers but that most residencies promote an autonomous, individualistic outlook which conflicts with delegating reponsibility to colleagues.

c) *Distancing*

When students are torn between the conflicting demands of compassion and science, many react by putting psychological distance between themselves and patients. Most students' first confrontation with invasive procedures is their cadaver in human anatomy, and studies show that students are frequently quite moved by the dissection experience[1], especially dissection of body parts with a strong psychosocial significance such as the face and genitals (Gustavson, Horne et al., Hafferty). Hafferty also shows that anatomy lab can influence students' definitions of "human" and of "error". Students become accomplished at isolating their feelings because "feelings get in the way of learning". To help prevent the premature take-over of detached indifference, educators can make better use of the learning opportunities presented at this early stage. For instance, in conjunction with *Duke University School of Medicine's* anatomy course, students discuss an article on learning from a cadaver, differences between learning on animals and on human bodies, and stages of "distancing".

Emotional sensitivity is a much bigger liability on the wards than in anatomy lab. Students who express concerns about a "bad" death, i.e., one that was emotionally wrenching and prolonged by painful interventions, may be told to "suck it up". In some programs this kind of boot camp mentality is passed down the ranks from senior residents to third-year clerks. In addition to indifference, such a macho ethic unfortunately also encourages trainees to trivialize patients' concerns. The "algorithms of hospital care that armor [students] against feeling too much" formed the theme of at least one school's 1993 commencement address: "Equanimity has been our model, and sadly will be yours: In medical school you have learned to appear cool, not to express your feelings, not to say what you think. Long practiced, this repression will turn into denial and it will someday make you fail to recognize emotion in yourselves as well as in your patients" (Spiro). Clearly, equanimity exacts a high price.

4) *Sexuality*

Most patient-centered dilemmas under this heading stem from conflicts between personal beliefs and professional role. These are well-illustrated by the "Ethical Issues in Human Sexuality" segment that *University of Washington School of Medicine* added to its Introduction to Clinical Medicine course. Appendix 3-O presents the introduction to this course plus cases on the following major sub-areas:

a) *Abortion and birth control*
b) *Sexual attraction to patients*
c) *Consensual student/teacher relations*
d) *Confidentiality*

While confidentiality dilemmas arise in many other settings, the case of whether to tell a wife about the husband's gonorrhea is widely used. Since students do not have this level of responsibility, the case could focus on a student being told information in confidence and asked to keep it from a superior (Appendix 3P).

Other dilemmas to be discussed related to human sexuality include:

* The student holds that premarital sex is morally wrong but has a promiscuous patient who wants help with birth control.
* The student's religious beliefts teach that homosexuality is wrong, but on one elective he finds that a number of his patients are gay and present with a variety of concerns regarding "safe" sex (adapted from *University of Washington School of Medicine* materials).

5) *Economic issues*

Today's students will be practicing in a very different health care financing world than the one in which today's faculty trained. To the extent possible, faculty need to help students acquire a better sense of the ethical implications of the changes, particularly the likelihood that all practitioners will be connected in competition for fewer sources of income. In addition, a number of extant problems deserve focus:

a) *Insurance abuse and physicians' vested interests in facilities*

While students do not bill for procedures, they are in the position to witness physicians' decisions about charging for services, treating patients with no insurance, lying to insurance companies on patients' behalf (Appendix 3Q) and other financial decisions. A preceptor who regularly performs more lab test and requests more follow-up visits from Medicaid patients (Appendix 3R) is one example of a student dilemma.

While the new health financing system may better prevent the over-use of tests, equipment and facilities, the intersection of medical economics and ethics will remain important. The *Oregon Health Sciences University School of Medicine* developed a special curriculum covering this intersection (Garland).

b) *Accepting gifts from pharmaceutical companies*

Physicians' interactions with pharmaceutical representatives must balance the risks of ethical compromise against the value of information and services provided (Waud). In a study of internal medicine residents and faculty, residents were more likely than faculty to perceive contacts with sales reps as potentially influencing physician decisions (McKinney, et al.). A majority of both groups favored eliminating presentations by pharmaceutical representatives at their hospitals, and only 10% thought they had sufficient training during medical school and residency regarding professional interaction with sales representatives. Another study of faculty found that, of 14 characteristics of interactions with sales reps, only a physician's personal relationship with an industry rep was perceived by a majority to influence prescribing (Banks and Mainous). However, a higher proportion of Ph.D. than M.D. faculty agreed that the following influence prescribing patterns: free samples, trivial gifts, meals, and subsidies for meetings; the authors suggest that M.D. faculty are less negative because they receive such gifts and might miss this occupational perquisite.

In 1990, the AMA published guidelines for physicians' acceptance of gifts from the pharmaceutical industry. In 1993 AMA's Resident Physician Section supported a resolution that the AMA recommend Accreditation Council for Graduate Medical Education require residency programs to develop policies and educate housestaff regarding such gifts (AMA, 1993).

While only one school submitted a case on the possible influence of pharmaceutical companies (Appendix 3S), in response to the last AAMC survey item, a few others did describe related activities here. At some schools, the student affairs dean has ongoing discussions with students about the use of drug company gifts. At the *University of Massachusetts Medical School*, the use of "free" stethoscopes, dictionaries, trips, etc. are discussed in small groups during the ethics course. The *University of Ottawa Faculty of Medicine* reported that relationships with drug companies are part of a published policy.

c) *Treating resourceless patients*

The *University of Nebraska College of Medicine*'s Section on Humanities and Law integrates into its courses discussion of cases illustrating a variety of social ethics issues. Both cases submitted (Appendix 3T and 3U) pertain to elderly women with virtually no resources, but they raise a broad range of important social responsibility and patient care dilemmas.

d) *Financial aid applications*

While there is no literature on and no school submitted a case related to students' lying on financial aid applications, problems here may be increasingly likely to arise, given the competition for funds and also the increasing cultural differences among students. Parental values related to what constitutes lying, tax avoidance, measures to save money, debt, etc. can heavily influence students' money management behavior. Some students have trouble seeing how there could be a problem with "small inaccuracies" on their aid applications.

In sum, whether medical ethicists offer help with them or not, students *must* come to terms with a large range of ethical dilemmas. In fact, students probably experience *more* angst in the throws of ethical quandaries than do their elders, whose ethical sensitivities may have been blunted by the tertiary hospital setting. The evidence is convincing that these diverse and real quandaries represent the best foundation for stimulating students' ethical development.

Moreover, students ethical dilemmas relate closely to those most often encountered in practice, that is, showing compassion, truth telling, maintaining competence, participation of patients in decision making, obtaining informed consent, relating to other professionals, and respecting confidentiality (Pellegrino et al). Some ethicists at schools not using written student cases start with physician cases and work backwards. Students are urged to commit to an ethical stance (e.g., whether to reveal the husband's gonorrhea to the wife) and then asked to apply that stance to a dilemma currently within their ken. While this approach may cut down on students' "wiggle room", the direct use of student cases assures that students' most immediate dilemmas are explored.

Pedagogical Considerations

The cases included in this report as examples are best considered as components of a goal-directed educational approach.

First of all, what makes a good case? A good case can be said to:

- present a situation in which two or more issues come into conflict over substantive moral issues;
- stimulate discussion of reasoning and provoke disagreement about action;
- include no unnecessary details;
- end with a question about what action one should take; and
- be followed by insightful probe questions, preferably revealing subtle or additional possibilities about the case.

While not all of the cases included here meet all of these criteria, particularly with regard to probe questions, most of them come close.

One route to working through a case is to: 1) state the facts that are given; 2) identify all the values at stake; 3) articulate the values conflicts; 4) choose an alternative; and finally 5) defend your choice and respond to objections.

When sorting out the moral questions faced in a given case, the leader might ask the following questions:

- What is going on in the case, i.e., what is the link between the factual and the moral?
- By what criteria should decisions be made? Philosophical inquiry may be necessary to uncover all pertinent alternatives.
- Who should decide, i.e. who has the most authority? These dilemmas are especially ticklish in the health professions, even when the competence of the patient is not in question.
- For whose benefit does the professional act? Here the problem of double agency arises, e.g., whom should the physician serve when experimenting--the patient or medical progress?
- How should the professional decide and act? This asks about both procedures and style, i.e., a feeling for what is congruent with reality (May).

Turning to the issue of teaching objectives, key goals of ethic teaching are: stimulating the moral imagination, recognizing ethical issues,

eliciting a sense of moral obligation, developing analytical skills, and tolerating and reducing disagreement and ambiguity (Callahan). Each teaching setting dictates omewhat different pedagogical techniques, different assumptions about student capacities, and different teacher preparation.

It is increasingly clear that accurate information about the law helps to clarify some ethical issues. A study of physicians' knowledge of their state's law regarding treatment of terminally ill patients revealed that only 23% could answer 70% of the questions correctly and that incorrect information usually leads to overtreatment of unnecessary suffering by patients (McCrary et al). Thus, teaching objectives in ethics related to legal knowledge deserve to be included.

Only a few of the schools that provided cases also sent a description of their course objectives or requirements:

- *Texas A&M University Health Science Center's* first-year Medical Humanities course, designed by Dr. Don Self to make extensive use of student cases, includes the following as course objectives: critical thinking, effective oral and written communication skills, self-knowledge, knowledge of ethical issues, and tolerance. Innovative course requirements include keeping a "values conflicts" journal and writing a "letter to the editor" with carefully reasoned views on an ethical or social aspect of medicine.
- Dr. Thomas McCormick (*University of Washington School of Medicine*) reports that the discussion of ethical cases with first-year students in Introduction to Clinical Medicine "helps to clarify key concepts at the cognitive level regarding ethical-professional duties. . .and engages students in a dialogue which contributes to their moral development as young professionals".
- *Mount Sinai School of Medicine's* second-year mini-course in ethics includes consideration of patients as learning tools. Since the acceptability and parameters of this practice comprise the immediate dilemma all the students are facing at this point, Dr. Barry Stimmel reports that no written case is necessary. The objectives of this discussion are: 1) to examine the argument for using patients in medical education and thereby come to understand that, when it is done in the right way, the practice is moral and not shameful; and 2) to examine the issue of deceiving patients about the medical student's status.
- *Mount Sinai School of Medicine's* major third-year clerkships include scheduled ethics clinical case conferences in which students are encouraged to raise issues stemming from their place in the hierarchy, e.g., being given inadequate direction, being told to withhold the truth, being berated by a nurse. The objectives are to: 1) recognize when problems are moral issues, 2) analyze through argument what is unethical or inappropriate about a situation, and 3) try to find a solution for the student in the situation or, at least, identify what the ethical behavior would be for the others involved.
- For many years, *Michigan State University College of Human Medicine's* Medicine clerkship in the Lansing community has included an ethics orientation by Dr. Howard Brody and a substantial requirement to write-up an ethics care, for which students may select a student dilemma.

In the ethics module of the Internal Medicine clerkship at the *University of Pennsylvania School of Medicine*, Christakis and Feudtner developed a pedagogical approach that they describe as:

- Stage-specific and developmentally-sensitive: case materials are drawn from students' immediate experience, and discussions are facilitated using analogies most familiar to the student.
- Student-driven and "safe": with no faculty or housestaff present, most students feel free to be critical both of their own actions and motivations as well as those of other

team members.

- "Blameless": without recriminations, students analyze good and bad ethical decisions in order to understand why they were made.

This curriculum targets the following cognitive and inter-personal tasks:

- How to tactfully voice disagreement with authority.
- How to ethically participate in team-directed care.
- How to weigh educational needs against patients' rights.
- How to maintain an ethical self-identity in the ambiguous world of clinical medicine (Christakis and Feudtner).

With regard to place in the curriculum, in addition to medical ethics courses, student cases are also used in Introduction to Clinical Medicine and in courses with titles such as "Medicine in Contemporary Society" and "Professional Responsibilities". Turning to clerkships, *New York University School of Medicine*'s Psychiatry Clerkship devotes five 1 1/2 hour periods to medical ethics discusions, taught jointly by a clinician and a philosopher; one of these focuses cases generated out of students' clinical experiences. *New York University* has also developed a faculty advisory system organized under "colleges", with optional meetings throughout the year in the evenings. At these meetings, students feel safe in bringing up improprieties they witness.

Extending beyond the formal curriculum, *Duke University School of Medicine*'s program for integrating ethics and human values into medical education involves four advisory deans, each of whom is responsible for a quarter of each class (Puckett et al.). In regular groups of about 10, students meet weekly during the first year (less frequently thereafter), with discussions focusing mainly on values-related concerns raised by students. In addition to being deliberately nurturant, this system allows closer evaluation of students and earlier identification of problems.

Helping facilitators prepare for their roles as case discussion leaders is crucial. AAMC's recent overview of medical education highlights the need for training for faculty who assume the responsibility of being small-group facilitators (Swanson and Anderson). While handbooks are available on this subject (e.g., Whitman et al.), specific faculty development programs are more effective.

Mt. Sinai School of Medicine's medical ethics education programs are based on interdisciplinary cooperation and include special education for faculty. Faculty receive reading packets and participate in pre-meeting briefing to familiarize them with the issues and arguments that will be addressed. Teaching sessions are also typically followed by debriefing sessions so that the entire course faculty can benefit from the experiences of the other group leaders. Dr. Stimmel also reports that at *Mt. Sinai* a philosopher regularly participates in unit rounds and interdepartmental meetings and that all faculty are encouraged to participate in monthly Faculty Seminars in Philosophy and Medicine, monthly Center-wide Ethics Luncheons, as well as annually sponsored conferences on medical ethics. At *Texas A&M University Health Science Center*, Dr. Self offers a workshop on group leader skills and meets with course facilitators before each lecture. Faculty participate eagerly in these opportunities to discuss ethical dilemmas, and Dr. Self reports he now has more faculty facilitators than he can use. The *University of Oklahoma College of Medicine* and *Albany Medical College* were noted in the previous chapter as providing a "faculty guide" for discussion of ethical dilemmas with students during Orientation.

A final but important consideration here is the benefits accruing when students educate each other. Security is a crucial element for students; they are likely to be more honest with each other than when being led by a faculty member (Christakis and Feudtner). Moreover, the group's acknowledgement of individuals' personal quandaries is both cathartic and supportive. Student-led focus groups should therefore be encouraged.

Educational Challenges

Students bring to medical school an enormous diversity of values, and some "types" of students pose greater educational challenges than others. Particularly troubling are students who are slow to recognize that they make moral judgments and that they are enmeshed in a moral environment (Rosen). Another group requiring special attention are those who have concluded that individual responsibility is anachronistic in today's corrupt world (Parr). It is to be hoped that such students are capable of change, or serious questions ought to arise about their candidacy for the M.D. degree. An evaluation program that assists faculty in quantifying their impressions of problem students (see the *University of New Mexico School of Medicine's* Chapter 4) could be quite helpful here.

Other stances present a different kind of challenge. Some students' emotional energy surrounding their religious beliefs conflicts with the analysis of some ethical problems, particularly those related to sexuality. For instance, at the *University of Utah School of Medicine*, some students fear that ethicists will tell them how to act and will teach against their beliefs. Similar tensions are mentioned by schools with sizeable numbers of fundamentalist Christians. Abortion can be another polarizing issue. At *Johns Hopkins University School of Medicine*, students were surveyed at the beginning and end of medical school about their attitudes toward abortion; their views changed very little (Dans). The director of Hopkins' first-year Ethics and Medical Care course writes knowingly about the difficulties of teaching normative ethics in a secular environment where a diverse group meets for a short time without a unifying moral theory (Dans).

A number of stereotypes are also problematic:

- Bias against poor people: Unconscious of their own advantages and the extent to which they have been supported, some students equate poverty with lack of intelligence and lack of individual worth. As part of ethics education at the *University of Nebraska College of Medicine*, students meet with mothers on welfare, eat the lunch that can be bought with food stamps, and hear thought-provoking presentations from professionals who work with the impoverished. Course director Dr. Andrew Jameton has found that it is important to channel students' anger at the poor to serve an educational purpose and to help them develop a bigger picture, including a *social* ethics agenda.
- Gender bias: Not only have researchers paid inadequate attention to women's health, stereotypes of women continue to interfere with physicians' ability to see their needs as patients (AMA). Moreover, women medical students and physicians report inequitable treatment and harassment (Bickel, 1993). Gender bias is thus a legitimate subject for consideration in ethics courses. Warren Reich, STD, has incorporated into *Georgetown University School of Medicine's* second-year Bioethics course a lecture and case discussion of sexism in medical education (See Appendix 3I).
- Ethnic and cultural biases: The statements regarding gender bias apply to ethnic biases as well. One resource here is a series of videotaped vignettes illustrating common prejudices against ethnic minorities and how they affect these medical trainees and patients (American Academy of Family Practice).
- Bias against HIV-infected persons: Accepting some personal risk comes with the territory of providing health care, but this challenge is exacerbated by views regarding behaviors associated with HIV-infection (AAMC).
- Bias against homosexuals: This prejudice often reflects religious views and misunderstandings about homosexuality.

While these are daunting challenges, if medical educators do not address them, they

will continue to perpetuate themselves and impair physicians' ability to meet health care needs. Achieving unanimity of view about such emotional topics cannot be the aim. The primary purposes of educational efforts here are to encourage self-knowledge, critical thinking, and respect for others.

Conclusion and Recommendations

Faculty at a number of schools report positive experiences with cases illustrating students' ethical dilemmas. These discussions are usually led by ethicists, often jointly with clinicians, and have been integrated into medical ethics and a wide variety of humanities courses, as well as into clinical clerkships and introduction to clinical medicine courses. Cases work best when they are part of a goal-directed educational approach and when they illustrate genuine moral conflicts which students are presently facing.

- Some dilemmas (e.g., how students identify themselves to patients, what "freebies" to accept from pharmaceutical companies) may be important enough to warrant the promulgation of institutional guidelines. Some concerns deserve special attention from the curriculum committee, e.g., arranging for students' first spinal tap to be under less than critical conditions using teaching assistants instead of patients to teach the pelvic exams?
- With the increasing multiplication of ethical concerns in medicine, especially those related to economics, technologies, and patient advocacy, medical schools should consider expanding the numbers of faculty trained in ethics. As with faculty in most other units, most of today's ethics faculty are so busy with other responsibilities that medical students have not been the beneficiaries of their best efforts or of optimal teaching methods.
- Videotaped ethical vignettes are an educational resource worth developing. In displaying dilemmas, one "picture" can be worth a thousand words.
- Faculty facilitators deserve carefully prepared guidelines and educational opportunities to help them prepare to lead discussions of ethical topics. Ideally, faculty would also be assisted to examine their own stereotypes and prejudices that may be interfering with their "seeing" and "hearing" various categories of patients and students.

Notes

[1] The following poem by student Nancy Roston illustrates the challenge:

Now, student,
of anatomy:
cleave and mark this slab of
thirty-one-year-old caucasian female flesh,
limbs, thorax, cranium, muscle by rigid muscle
disassemble this motorcycle victim's
every part (as if
so gray a matter
never wore a flashing ruby dress).

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CHAPTER 4

EVALUATION OF STUDENTS

While this chapter will not explore them, it is appropriate to begin by noting that problems associated with evaluating students' clinical skills have been well-documented (Tonesk and Buchanan). Insights into these problems laid the foundation for AAMC's Management Education Program on the Evaluation and Promotion of Medical Students, which coached school teams in a systems approach to designing institutional change strategies. Over the course of five years, 39 schools participated in one or more of these workshops, indicating substantial efforts nationwide to improve the evaluation of students.

The inadequacy of methods to evaluate noncognitive and personal attributes surfaced frequently during discussions at these workshops. The most recent survey of medical schools' use of noncognitive criteria in evaluating students found that 55% of U.S. and Canadian schools possessed written noncognitive criteria (Miller). The expectations mentioned most frequently were honesty, professional behavior, and dedication to learning. While it is obvious that noncognitive characteristics make a big difference in an individual's success as a physician, criteria for evaluating these abilities usually seem too vague and open to interpretation to be reliable. Thus, while "students may be expelled for failing to accumulate enough factual information or technical skills, rare is the student who is terminated for a demonstrated lack of compassion" (Glick). Many faculty members do not seem to realize that courts have upheld a school's right to establish both cognitive and professional character requirements for graduation and have upheld dismissals of students for failure to meet these requirements (Irby et al.).

While in some regards faculty and deans are to be applauded for an attrition rate from medical school of less than 4%, virtually all residency program directors have experience with "problem" residents. Because residents' problems so frequently stem from deficiencies in their humanistic qualities, the American Board of Internal Medicine has published two editions of its *Guide to Awareness and Evaluation of Humanistic Qualities in the Internist*. For purposes of certification and recertification, the ABIM defines these qualities as respect (i.e. the personal commitment to honor others' choices and rights), integrity, and compassion (see also Chapter 7).

Looking specifically at ethics courses, evaluating students' performance here is difficult for many of the same reasons that evaluation of "humane" qualities is difficult. In addition to conceptual knowledge and analytic skills, hard to pin-point values and attitudes also fall under scrutiny. Looking at methods to evaluate humanistic behaviors, Arnold and colleagues found that programatic efforts are often marred by ambiguous goals (Arnold et al.). Overly diverse objectives are likewise evident in ethics courses. The Hastings Center Project recommended that methods for evaluating ethics instruction focus primarily on assessment of students' ability to understand central concepts; construct coherent moral arguments, orally and in writing; and recognize moral problems and examine them in a rational way (Caplan). However, in addition to analytical ethical problem-solving skills, many also consider compassion and empathy to be components of ethical competence (Miles et al.). Other complex teaching objectives are not uncommon as well, for example, "to promote sensitive communication with patients, families, and others on the care-team and to assist decision-makers who must live with the outcomes".

Certainly the burden of evaluating non-cognitive characteristics should not fall disproportionately on ethics courses. Indeed some ethics faculty would question the appropriateness of including behavioral objectives as well as cognitive ones, e.g., "demonstrates respect for conflicting viewpoints", "treats patient with respect and dignity", and "displays concern for whole patient". Most ethics faculty would, however, agree that: "Diverse educational objectives . . .demand evaluative techniques that are flexible, and sensitive to teacher and program intentions. Papers, quizzes, case-study analyses, and active classroom discussions seem to meet these requirements better than behavioral measures or psychometric tests of attitudes or judgments" (Caplan).

Improvements Described by Schools

Given the challenges entailed, it is not surprising that only 27% of AAMC survey respondents identified "improvements in student evaluation" as one of the top three influences on their students' development of high ethical standards. Only 13 schools submitted comments about their activities in this area. Most of these comments were general statements such as "routinely request information about students' attitudes toward patients, demeanor, moral character, etc." and "our promotion standards include ethical principles". Another school stated: "We have concerns that a student with weak standards can slip by the usual evaluation system, but our final year comprehensive clinical exam does evaluate interpersonal skills".

Other elaborations are of greater interest. *New York Medical College* reports: "The student evaluation form that is completed by faculty at the end of each rotation asks that all students be evaluated not only in regard to their clinical skills and attained knowledge, but also regarding their humane attributes. Feedback is given to all students at the mid-point and completion of their rotation, and problems are discussed and recommendations made for improvement. This process fosters the development of high professional standards by setting goals for students and providing a mechanism for documentation and constructive criticism." Likewise, *Loyola University of Chicago Stritch School of Medicine* reports that the behavioral and attitudinal components of student clinical performance "are consistently documented by faculty, reaffirming the importance of professionalism to students".

The *University of South Carolina School of Medicine* recently implemented a new policy on personal and professional conduct which requires a separate non-academic assessment at the end of each clerkship. The policy's introduction states: "Medical students have the responsibility to maintain the highest levels of personal and professional integrity and to show compassion and respect for themselves, colleagues, faculty, staff and, most importantly, the patients who participate in their education". The criteria for evaluation are detailed under six headings including trustworthiness and responsibility to duty. Faculty are instructed to rate students as "highly effective" (exemplary professional conduct), "effective" (appropriate conduct), or "unsatisfactory". An "unsatisfactory" evaluation in any of the six areas requires that the rotation director provide written documentation of the events leading to this evaluation, notify the student, and forward the documentation to student affairs personnel. Students receiving one or more "unsatisfactory" evaluations may be subject to dismissal.

The *University of Ottawa Faculty of Medicine's* Subcommittee on Attitudes and Behaviors in Students observed that: "The medical school experience requires students to assume new and potentially unsettling responsibilities which may result in negative feelings. If these become repetitive and unresolved, habitual behaviors may develop which interfere with students' ultimate performance." The Subcommittee's report outlines the attributes expected under the headings: self-education, personal behaviors, interrelationships with the health care team, and attributes displayed to patients, families and the community. Principles of assessment include the following: 1) Attitudes are difficult to measure but can be

assessed as either "meets expectation" or "does not meet expectation"; 2) Observations should take place in all teaching settings throughout all the years; 3) Multiple observers should be involved in the evaluation process, including patients, their families, peers, nurses, and allied health personnel; 4) If problems are identified, an appropriate faculty mentor should be identified to provide assistance and remediation.

As part of its outline of student promotion requirements, the *University of Iowa College of Medicine* includes: 1) a description of grading policies; 2) six ethical principles modified from the American Medical Association's Principles of Medical Ethics; and 3) eleven additional expectations, including "students are expected to attend scheduled instruction" and "students are expected to respond to criticism by appropriate modification of behavior".

Michigan State University College of Human Medicine was the only school to send an evaluation form specific to an ethics exercise (Appendix 4A). As part of the medicine clerkship, students are required to prepare an ethical case-analysis of a case of their choice (see Chapter 3). Faculty rate student cases on nine dimensions, including fair representation of alternatives and use of medical ethics literature. *Michigan State* is also one of the very few schools to have published a study of student performance in a preclinical medical ethics course (Howe and Jones). Results demonstrated that objective tests can be sensitive measures of specific ethics content knowledge and that short essays can detect gains in problem-solving skills.

A promising example of innovation from the recent literature comes from the *University of New Mexico School of Medicine*. A new evaluation program enables faculty to quantify their impressions of problem students in a uniform manner, using an evaluation form describing seven basic professional traits (Phelan et al.). Basic scientists more often identified problem students than clinicians did. Of the reports received from faculty in the program's first 4 years, 19 were on first-year students, 30 on second-year, 11 on third, and only 4 on fourth-year students. Examples of comments are "negative attitude, seems to feel put upon when asked to do something" and "manipulative, aggressive, and badgering of faculty". These investigators conclude that assessments delineating the professional characteristics that students must meet assist faculty in providing evaluations noncognitive of qualities.

The *University of New Mexico School of Medicine* has also developed and pilot tested the Professional Decisions and Values Test, designed to assess how medical and law students deal with ethical conflicts and which moral values motivate them (Rezler, et al.). In providing descriptive feedback to faculty and students, it can assist with: 1) clarifying and identifying students' values; 2) assessing the effect of on-going instruction; 3) comparing students at different levels of training; and 4) comparing students in different professions.

Another recent example from the literature is the *University of Toronto Faculty of Medicine's* objective structured clinical examination (OSCE) to assess students in clinical ethics situations (Cohen et al.). The results of a pilot study suggest that an ethics station is feasible.

Reducing Cheating

One medical student writes: "Medical school is a high-pressure environment filled with driven people who must periodically participate in a ritualized crisis called an examination. It should come as no surprise that some students feel that their best honest effort is not always good enough or that others simply look for an easier way out" (Jennings).

Only a few schools commented about improvements in student evaluation aimed at reducing cheating. One school noted that efforts to increase faculty members' rewards for and involvement in teaching should lead to better designed courses and evaluation methods. These should reduce students' anxiety and thereby the incidence of cheating. With the goal of diminishing students' anxiety, the

University of Massachusetts Medical School's pharmacology course now offers students the option of "pass/fail" versus the traditional grading system.

Andrew Jameton, Ph.D., associate professor, Department of Preventive and Societal Medicine, *University of Nebraska College of Medicine* conducted a focus group with eight medical students to explore questions and solutions relative to cheating. The findings of greatest interest here are suggestions on defining a strategy, including the following elements:

- In consultation with the class, the instructor defines clear ground rules on what constitutes academic dishonesty. Discussion with the class would include considerations of fair and unfair assistance.
- Evaluation instruments would come as close as possible to testing the actual knowledge and abilities taught in the course.
- Course materials would have relevance to the practice of medicine in ways that are apparent to the students.
- It would be difficult for students to perform dishonest acts because of careful handling of exams, structured paper assignments, etc.
- The instructors treat all students fairly and honestly; this may require faculty to take a course in teaching techniques.

Conclusion and Recommendations

While only one school provided an example of an exercise to evaluate students' ethical problem-solving skills, several described broader efforts targeted at improving evaluation of students' personal and professional conduct. Fortunately, as was evident in a 1987 study of integrating human values programs into clinical education, educators have not let evaluation difficulties impede curricular innovation (Bickel).

- Course directors need to develop clear learning objectives but should not eschew non-cognitive goals, such as respect for others, simply because those dimensions are harder to evaluate.
- Improving the evaluation of students' personal and professional development depends on faculty expending extra effort; this is unlikely to occur unless the dean and department chairs are committed to this improvement and adapt faculty reward mechanisms accordingly.
- While features such as competition for grades and insufficient study time are major influences on whether students cheat, course directors should also do what is possible to establish an academic climate characterized by fair examinations, respect for students, discussions with the class about what constitutes unfair assistance, and ready availability of tutors.

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CHAPTER 5

INFLUENCING FACULTY

Faculty members are probably as tired as students are of having their responsibilities pointed out to them. Certainly faculties' responsibilities cover a broad range, for instance, setting the tone of the learning climate, conveying the value of education, not discriminating against any category of student (Bulger and Dunn).

In 1984 the General Professional Education of the Physician Working Group on Personal Qualities recommended that faculty members should: be sensitive to the ways in which subtle signals affect students' perceptions of what is prized and show respect for every student and resident under their supervision so that students perceive a genuine interest in how they are faring (Muller).

These goals were hard enough to meet ten years ago, but many features of academic medicine affecting faculty/student relationships have only grown more troublesome. The list is depressingly familiar. The human qualities of physicians' interactions with patients are blunted by the nature of the tertiary corporate hospital setting. The pace of academic life has increased, as has competition for all resources. Medical faculties have become larger and more specialized, resulting in less personalized contact with students and residents (Strong et al.). Faculty have more distracting objectives related to generating clinical and research income and to career advancement, and time spent with students usually contributes to none of these objectives. Fear of lawsuits puts a chill on honest evaluations.

Certainly students perceive a competitiveness and wariness emanating from many faculty members (Kane et al.), cutting drastically into the supply of good role models. Since "lived codes of ethics. . .are passed on as part of the apprenticeship process" (Bulger), how are the many unapprenticed students to develop sound and durable "lived codes"?

Role modeling of faculty and residents was the top choice of AAMC's survey respondents as to influences on students' development of high ethical standards. Another item read: "If you have strong or innovative policies or programs relative to ensuring that faculty and residents live up to high professional standards in their interactions with students, please describe them. If not, feel free to comment on this subject". Only 24 schools (28%) replied to this item, and three of these were limited to expressions of enthusiasm that AAMC was producing this Resource Guide. The majority of the comments pertained to recently developed codes of ethics and policies on student harassment or abuse, some of which are described below. Only a few efforts fell directly into the category of faculty evaluation or faculty development. One comment was a criticism: "a major shortcoming of medical education is responsibility to the consumer for quality assurance; students don't get what they pay for".

Codes of Conduct

Last year, AAMC's Executive Council approved a statement on "Reaffirming Institutional Standards of Behavior in the Learning Environment". While it pertains to students as well as to residents and faculty, AAMC's Group on Student Affairs urged its adoption mainly out of concerns about faculty and residents' mistreatment of students (see also Chapter 7). It opens: "The development and nurturing of [professional and collegial] attitudes is enhanced and, indeed, based on the presence of mutual respect between teacher and learner." However, it acknowledges that "the social and behavioral diversity of stu-

dents, faculty, residents, and staff, combined with the intensity of the interactions between them, will, from time to time, lead to ...incidents of inappropriate behavior or mistreatment." Therefore, each medical school should: "reaffirm, on a periodic and regular basis, its expectations; [this] should be undertaken in a manner that encourages the exchange of ideas among all who participate in the learning process...and clear examples of appropriate and inappropriate behavior...should be delineated and disseminated."

The *University of Medicine and Dentistry of New Jersey* publishes in its faculty handbook a code of ethics based on New Jersey law requiring faculty to avoid using their rank to gain unwarranted personal privileges and advantages and to avoid conflicts of interest. Extensive policies relative to impaired faculty and sexual harassment have also been promulgated. The latter includes the statement: "The university views as inappropriate any amorous relationship involving a teacher and student where the teacher has authority, influence, or responsibility with regard to the student". The *University of Iowa* has taken an even stronger position on consensual relationships: "A faculty member who fails to withdraw from participation in activities that may reward or penalize a student with whom the faculty member has or has had an amorous relationships will be deemed to have violated his or her ethical obligation to the student, to other students, to colleagues, and to the University".

In its statement on Professional Ethics and Academic Responsibility, the *University of Iowa College of Medicine* approaches professional conduct from a "responsibilities" point of view. Nine responsibilities to students are enumerated. For instance: (i) "The faculty member should conduct himself or herself at all times so as to demonstrate respect for the student . . . and should always respect the confidence deriving from the faculty-student relationship"; (ii) "The faculty member owes to the student and the University a fair and impartial evaluation of the student's work"; (iii) The faculty member has obligations as an intellectual guide and counselor".

As was noted in Chapter 2, some schools have recently developed codes of professional conduct that apply to all members of the academic community. At *Jefferson Medical College*, the Code of Professional Conduct emphasizes honesty, integrity and civility and includes the following statements: "The achievement [of acceptable professional conduct] is an ongoing process which begins with entry into medical school and is cultivated both in the classroom and in the hospital, where the faculty should serve as role models... This Code is not intended to allow one to dictate another's life style or to assume self-righteous pretensions. It is to emphasize to those individuals who may not abide by these professional standards, and to remind and protect those who do, that a procedural framework has been implemented." While there is a common code, the students and faculty have separate Professional Code Committees (PCC) , each of which is a confidential body aiming to assist with resolution of problems. Thus all matters pertaining to faculty conduct are first routed through the Faculty Code Committee, which functions as is a subcommittee of the Faculty Affairs Committee. Under *Jefferson's* Code, anyone who becomes aware of any unprofessional behavior by a faculty member must first confront the person. If the matter remains unresolved, one must either: discuss it with a member of the Faculty PCC, refer it to the PCC chair, or contact the department chair or senior associate dean for scientific and faculty affairs. The details of implementation of the Code are periodically evaluated to see if improvements are advisable.

A few schools noted that a copy of the Professional Code is enclosed with each appointment and re-appointment letter.

Evaluation of Faculty

With regard to students' evaluating faculty, the *University of South Alabama College of Medicine's* form that is completed monthly by housestaff and students includes an assessment of the faculty member as a role model, with

items on the individual's integrity and professional standards. Another school noted that faculty promotion is considerably influenced by students' and residents' evaluation of instruction and that teaching awards have a great deal of significance to faculty and students.

In terms of faculty evaluation, *Northwestern University Medical School's* promotion standards includes the following statement under "personal qualities": "The candidate should possess those qualities that will merit emulation by associates and students: fairness, open-mindedness, objectivity, tolerance, and patience".

A recent study of peer ratings of physician performance found that obtaining reliable peer assessments of clinical skills, humanistic qualities, and communication skills is feasible (Ramsey et al.). In an accompanying editorial, Petersdorf questions "whether 11 raters [the number obtained in the study] know the subject well enough to provide reliable answers" (Petersdorf). But he further comments: "Physicians are generally a tad paranoid when it comes to evaluation of their professional competence, and although this entire process is anonymous, no one likes to hear that his or her colleagues think poorly of him or her. On the other hand, the aggregated results can provide constructive feedback on how they are viewed by their peers and can contribute to continuous quality improvement and to changing behavior."

Most faculty affairs administrators will admit to a frustrating inability to either terminate or rehabilitate certain disengaged faculty members. Responses to a published fictional case of an impaired surgeon illustrate the difficulties of evaluating senior staff whose skills and knowledge have deteriorated (Management Grand Rounds). The case drew quite a large range of responses, including suggestions to: ask the physician for his suggestions on upgrading his skills, pressure the hospitals' patient care assessment committees to do their job, seek an emeritus position so that he can maintain his dignity, have the medical director express the concerns to the physician and his wife at an informal meeting over lunch, and work with the department chair to generate surgical case review reports and other evaluations to demonstrate that this surgeon is in fact an outlier. In short, no consensus on how best to proceed emerged.

While schools tend to be adding rather than subtracting specificity to faculty promotion standards, medical schools have not moved aggressively to institute periodic reviews of tenured faculty (Bickel, 1991). It is these senior faculty whose leadership and role modeling are so necessary to the maintenance of high professional standards and a supportive educational climate.

Faculty Development and Orientation

The *University of Ottawa Faculty of Medicine*'s Subcommittee on Attitudes and Behaviors in Students concludes its report with the statement: "There must be a commitment on behalf of the medical school to provide opportunities for faculty development in the humanistic and ethical behaviors of medical professionals such that the faculty may assume roles of mentors, teachers, and evaluators of student attitudes and behaviors." However, no school submitted an example of faculty development opportunities along these lines.

Dr. Henry Pohl, associate dean for medical education at *Albany Medical College*, now offers faculty a lecture on Ethics in Teaching that is very well received. This presentation walks faculty through their obligations as generated by the models of beneficence, autonomy, and justice with regard to students. Since responsibilities to students and responsibilities to third parties (e.g., university community, state) can conflict, an analysis of these conflicts is also presented.

Because residents are the faculty most visible to clinical clerks, attention to their preparation as teachers is crucial (Edwards). *Vanderbilt University School of Medicine* conducts workshops for chief residents addressing the importance of student teaching and teacher-student relationships. The associate dean comments: "An improved student-teacher

relationship opens up difficult patient care issues for discussion and inquiry and thereby encourages enhanced student development". Two other schools noted that resident orientation now includes discussion of professional standards and communicating professionally with students. It is also encouraging that 60% of all residency programs now offer a structured ethics curriculum and make ethicists available for consultation with residents (Martini et al.).

The only other type of activity reported are workshops for faculty and residents to educate them about the problems of gender discrimination, sexual harassment, and other forms of student mistreatment. Some journal clubs and committees also examine and discuss recent literature on these topics.

Conclusions and Recommendations

Many features of the present academic environment in medical centers work against faculty spending more time teaching, caring about, and apprenticing students. While it is easy to be discouraged, several schools did report activities to help faculty members reflect on and improve the conduct of their responsibilities to students. Moreover, recent studies of medical schools reveal that a sizeable number are heightening the attention paid to educational accomplishments in the faculty promotion process (Swanson and Anderson; Bickel 1991).

- Deans should examine all possibilities for influencing faculty to spend more time teaching and nurturing medical students. Changing the reward structures is probably the most difficult to bring about. But a number of other efforts should be considered as well, including more attention to: personal qualities (particularly openly displayed prejudices) recruitment, promotion, and post-tenure review; new faculty orientation; and educational opportunities for faculty to improve their teaching and evaluation skills.
- Especially at schools without a professional code that applies to faculty, policies covering sexual harassment and other forms of student mistreatment are important. Workshops and other programs to educate faculty about their responsibilities in these regards should be regularly offered. For instance, all department chairs at *Stanford Medical Center* were required to participate in a workshop on gender-related insensitivities (Bickel, 1993).
- Faculty who continue to be poor role models for students should be relieved of their educational responsibilities.

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CHAPTER 6

TEACHING RESEARCH ETHICS

by Allan C. Shipp
Senior Staff Asociate
AAMC Division of Biomedical Research

The practice of medicine derives from knowledge that is obtained through scientific research. Thus, whether or not medical students pursue research careers later in life, they require a thorough grounding in the biomedical sciences and a full appreciation of the scientific method. Such training is especially key, of course, for that subset of students who will go on to devote at least some portion of the career to research endeavors. In 1992, 30% of graduating seniors indicated that it was their primary goal to become a full-time academic, and only 7% indicated that they anticipated no involvement whatsoever in research during their career (AAMC). These medical students in particular must understand the dimensions of good research practice and the responsibility to uphold the highest standards of integrity in the pursuit of knowledge.

The manner in which researchers acquire a sense of appropriate research practice and scientific integrity is of increasing interest. Widely publicized disputes and accusations related to the integrity of specific research endeavors have led the public to question the ethical underpinning of the scientific enterprise. Perhaps more common than the rare, yet often highly visible instance of outright fraud, are the more routine "questionable" research practices stemming from laziness, expediency, or a simple lack of consensus within the scientific community as to what is appropriate. Indeed, many of these controversial situations simply point to a lack of standards governing a specific area of research practice. One area, for example, in which standards are particularly hard to discern is the management of data. In other areas, such as authorship, standards are only now emerging. Discussions of all of these problems -- fraud, poor practice, and a lack of standards -- benefit both individual participants and the collective research enterprise, which strives for a better understanding of these phenomena.

Recognizing the benefit of exposing researchers to these issues, the National Institutes of Health (NIH) implemented in July 1990 a new requirement of all institutions receiving National Research Service Award (NRSA) training grants. These institutions must provide instruction in "the responsible conduct of research" for trainees participating in this program. A training grant (which is an institutional award) is distinct from a fellowship (an award made directly to individuals) in the parlance of the NRSA program. The NRSA trainee programs support Ph.D. and M.D./Ph.D. candidates, as well as M.D. and Ph.D. recipients engaged in postdoctoral research. The emphasis is on those who will pursue research, not clinical, careers. Most medical students are not targeted by this requirement nor by the resulting programs in the responsible conduct of research. Nonetheless, medical schools as research institutions are clearly affected by this activity, since they represent the sites in which much graduate level training takes place.

In fact, a flurry of activity is underway at medical schools and other research institutions as a consequence of this training grant requirement. Although the NIH allows great leeway in how institutions may meet this requirement, it does set forth certain guidelines. For exam-

ple, institutions are "strongly encouraged to consider" including in their programs the following topics: conflicts of interest, responsible authorship, policies for handling misconduct, policies regarding the use of human and animal subjects, and data management. In addition, institutions are "encouraged" to include all graduate students and post doctorates in the program, regardless of their source of support. Institutions must also outline for the NIH the subject matter, format, frequency of instruction and the degree of faculty and trainee participation.

Thanks to the flexibility allowed by these guidelines, institutions have developed interesting and diverse responses guided by local and situational needs.

Course Characteristics

Frequency and formality

With respect to the frequency and formality of the courses, two common approaches emerge: the semester long course for credit and the informal "pizza" session. These two formats represent extremes in many respects, and many programs may be hybrids, entailing features of both of these models.

- Semester long course for credit: At some institutions, courses in the responsible conduct of research are treated as formal course offerings for which enrolled students will receive credit toward their degree. Knowing that their absorption of the material will be tested, students will presumably work harder and be more attentive in class. A graded course also encourages regular attendance and participation by trainees. A disadvantage to this approach is that unless the course is required, it will only reach that subset of trainees who choose to take it as an elective. In addition, even as a required course, there may be no incentive or mechanism to involve post-doctoral fellows, technicians, and faculty. As a result, the class will be more homogeneous, limiting the perspectives from which discussion can be generated.
- Informal and sometimes sporadic evening "pizza sessions": In this approach, instruction usually takes place "after hours" and attendance is generally voluntary, though pizza or some other modest perquisite is often provided as an inducement to attend. An advantage to this format is that the informality of setting can encourage freer discussion among participants who may be inclined to view, or even be encouraged to view, such after-hours sessions as "off the record." In addition, these less formal sessions are not constrained by the time limitations of semesters or quarters, and thus can be offered on a continuing basis throughout the year. Mentors, technicians, and other "non-student" laboratory personnel can be brought in, enriching the discussions with diverse perspectives and enabling the course to reach a broader audience. Disadvantages may include sporadic participation and a lack of continuity of instruction.

Content of instruction[1]

While there is significant variability in course content, the subject matter can generally be grouped into three topical headings.

1) Basic elements of appropriate research practice: Topics under this heading include formulating a hypothesis, selecting and recording data, maintaining a lab notebook, sharing research materials, attributing the contributions of others, and determining authorship. While these topics may seem self-evident to some individuals, there is in fact no consensus as to what constitutes appropriate practice in many of these areas. Moreover, even for the most routine aspects of research practice, most investigators would have difficulty identifying when they first came to understand how to carry out these activities responsibly. They may never have been formerly instructed, developing instead their own personal sense of responsible and ethical behavior on an ad hoc basis. Thus, there is great value in testing one's own sense of appropriate conduct against that of other individuals; if not serving to

achieve a common set of standards, at least some sensitization to the values and standards of others will occur.

2) Ethical dilemmas presented by certain types of research: This rubric includes research activities that often become the focus of broad public policy discussions. Unlike the preceding set of issues, these topics often carry weighty moral and religious implications. Some representative topics include:

- the use of human subjects in research
- the use of animals in research
- the use of fetal tissue in research
- genomic research (and the use of genomic information as a derivative issue)

3) Fraudulent behavior and how to handle allegations of research misconduct: Trainees are at a particular disadvantage in dealing with suspicions of fraud or other inappropriate activities. First, they are less likely than faculty and administrators to know about the institutional system for handling allegations of misconduct and may not fully comprehend the implications of making an allegation. More importantly, trainees' inferior position in the hierarchy and fear of retaliation or blacklisting may deter some trainees from reporting suspicious activities. Since trainees must first be taught to recognize fraudulent research activity and to distinguish it from other inappropriate activities, topics to be covered should identify *federally sanctionable* research misconduct, which is defined by the NIH and the NSF as including:

- fabricating research data (recording results on experiments never conducted)
- falsifying research data (altering data obtained most often to create more convincing support for one's hypothesis)
- plagiarism (which can relate to the theft of ideas, as well as text)

Another instructional task is to review *institutional* policies and procedures for handling allegations. This should include counseling on a) the responsibility to report research misconduct, b) the repercussions of making an allegation, and c) any protections afforded those who make allegations.

Mechanisms and tools of instruction

One of the most successful tools of instruction about research ethics is the case scenario. In the case approach, a situation that is fictional or blinded (i.e., based on a real incident, but masked by changing names and certain circumstances) is recounted to students, who then must evaluate the dilemmas and decisions inherent to the event. The students are guided by thoughtfully prepared questions, which often add new wrinkles to the situation. The role of the faculty member is critical in the effective use of cases. In other modes of learning, students can glean a great deal of information on their own. When using cases, it is the class discussion that stimulates learning, and the quality of the discussion usually depends on how well the instructor facilitates it. Even the best prepared cases need a good facilitator to bring out the full range of their possibilities.

Many institutions have assembled handbooks or other instructional materials to further class discussion. Some more notable examples include those at the *University of Pennsylvania*, the *Massachusetts Institute of Technology*, *Virginia Commonwealth University*, and *Harvard Medical School* (see References). Common to all of these handbooks are case scenarios for use in class. In many instances, these handbooks also include institutional guidelines on research conduct, the institution's rules for pursuing possible misconduct in research, and relevant readings. The publication *On Being a Scientist* (National Academy of Sciences), and the play *A Stampede of Zebras* (Martin) are two examples of relevant material that have been included.

The AAMC Research Ethics Handbook Project

Because many institutions do not have formally prepared resources for teaching research ethics, the AAMC is developing such a resource with support from the NIH (Korenman and Shipp). To guide this effort, a subcommittee of the AAMC's Ad Hoc Committee on Misconduct and Conflict of Interest

in Research was established, augmented with individuals having experience and repute in research ethics.

The handbook, to be published this winter, will contain close to 30 case scenarios, developed with the special assistance of Dr. Stanley Korenman, Associate Dean for Ethics and Medical Scientist Training at University of California, Los Angeles, School of Medicine. The topics include: conducting research (e.g., data selection and management and the falsification of data); reporting research (e.g., authorship practices, plagiarism); peer review of grants and publications; handling research materials and information; mentoring and laboratory supervision; addressing possible misconduct in research; conflicts of interest; human subjects and clinical research; animals in research; and genetic testing and uses of genetic information. An introductory chapter outlines the theory of case-based instruction and how to make use of the book. Each topical section concludes with an annotated "selected readings" list. The readings provide technical and background information helpful in assessing what is going on in the cases.

The handbook is *not* intended to serve as a model curriculum but should be amenable to any number of instructional approaches and may be accompanied by lectures, films, readings, and other resources. The instructor remains central to this educational effort and must use his or her own ingenuity and creativity to fill out the educational experience.

Some examples of the cases found in the handbook are included as Appendices 6A-D. As the AAMC handbook project is not yet finalized, some of these cases may appear somewhat differently in the final product.

Conclusion

Of all the areas of ethics pertinent to the medical student, the responsible conduct of research may seem tangential to many. However, since medicine derives from science, this type of instruction is pertinent for all students, even those who intend to pursue careers of a purely clinical nature. Consideration of ethical issues, whether they relate to research, clinical practice, or academic standards, creates sensitivities that can carry over into and enhance numerous areas of activity.

Institutional programs in responsible research practice are still largely in their nascent phase, at least when compared to programs in the ethics of clinical practice. Institutions can learn much from each other through the generous sharing of resource materials and information on curricular approaches. The AAMC project, through the provision of case scenarios, instructional notes, and annotated references, will afford institutions the opportunity to work with a core set of materials that they can augment and tailor to suit individual needs. All are welcome to provide feedback on its utility and to suggest additional resources that the AAMC may provide to be of service to the community.

Note

[1] This section on course content was based on a preliminary draft of material prepared for an AAMC publication on teaching the responsible conduct of research (see Korenman). This will be available by late December from AAMC Publications (202/828-0416).

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CHAPTER 7

OTHER INITIATIVES

Association of American Medical Colleges

1) The Group on Student Affairs (GSA) includes admissions, student affairs, and financial aid officers who work to advance medical education with particular attention to students' welfare and development. Three of GSA's recent projects are:

**Recommendations regarding Health Services for Medical Students*:

Approved by AAMC's Executive Council in June 1992, these 18 recommendations include a number of points pertinent to this project:

- That schools provide access to confidential counseling by mental health professionals for all students and establish policies to safeguard students' confidentiality.
- That evaluation and/or treatment of students be undertaken by non-teaching faculty or at a minimum, by different individuals than those rendering promotion decisions.
- That schools regularly update and publish a list of available mental health assessment and counseling services and associated costs.
- That schools establish policies regarding institutional response to known or suspected chemical dependency, including definition of what constitutes impairment, and also to develop programs that will identify and assist impaired students.

** Guidelines for the Development of Chemical Impairment Policies for Medical Schools*

Approved by AAMC's Executive Council in September 1992, these six guidelines are meant to assist schools in developing programs and policies to insure appropriate care for any students impaired because of chemical abuse, for example, promoting student wellness through prevention programs and insuring appropriate levels of confidentiality for individuals seeking information and treatment.

**Reaffirming Institutional Standards of Behavior in the Learning Environment*

Approved by the Executive Council in 1992 as well, this statement concerns faculty mistreatment of students and urges the maintenance of a learning environment that facilitates students' acquisition of the professional attitudes necessary for compassionate health care. Schools should publish expected standards, including clear examples of appropriate and inappropriate behavior, and should establish fair mechanisms for dealing with individuals who do not meet institutional expectations. (For more information on the above, contact Frances Hall, Director, Section for Student Programs, 202/828-0684).

2) AAMC's Organization of Student Representatives (OSR) has recently completed two initiatives related to students' professional development:

**OSR Guidelines for Student Evaluation of Teaching Effectiveness*

Published in August 1992, this document discusses overall guidelines for developing an evaluation program and offers sample evaluations for lecture formats, small group tutorials, and clinical teaching sessions.

** Preservation of Rights and Confirmation of Student Responsibilities*

To be published in October 1993, this document addresses institutional approaches to protecting students' rights and a number of ethical responsibilities described under the following headings: nondiscrimination, confidentiality, professional demeanor, self-representation, honesty, conflict of interests, sexual misconduct, impairment, criticism of colleagues, research, evaluation, teaching, disclo-

sure and informed consent.

Also included are four discussion cases and a series of recommendations regarding student conduct.

(For more information on the above, contact Donna Quinn Yudkin, OSR Staff Director, 202/828-0682).

American Medical Student Association

**Between a Rock and a Hard Place: Values, Ethics and the Physician-in-Training* is an award-winning video that addresses critical areas in the moral development of medical students, particularly respect for others and informed consent. Four vignettes are enacted:

- Spinal tap: truth-telling; informing the patient
- Kicking the dog: barking down the hierarchy; empowering patients; persuasion and coercion
- Salvage chemotherapy: communications; assessing competency
- Phone home: maintaining significant relationships.

The video comes with an excellent new Discussion Guide and may be ordered for $40 from AMSA, 1890 Preston White Dr., Reston, VA 22091; 703/620-6600.

American Board of Internal Medicine

**Guide to Awareness and Evaluation of Humanistic Qualities in the Internist*, 1991-95:

This second edition of the Guide emphasizes the following principles:

- Physicians certified by ABIM are expected to demonstrate integrity, respect for others, and compassion in their relationships with patients and their families.
- Moral behavior is an overriding professional consideration in caring for patients.
- The opportunity to affect attitudes, behavior patterns, and moral conduct in the provision of medical care must be used during residency and fellowship training.

As discussed here, criteria for assessing humanistic behavior overlap with, but are not identical to, criteria for assessing moral standards. Some behaviors, such as sexual abuse of a patient, are simultaneously unethical and inhumane. Other types of behavior, however, such as sarcasm and tasteless jokes show disrespect and lack of compassion but do not necessarily constitute immoral conduct. This Guide focuses on relationships in the clinical setting and includes an annotated bibliography organized under such headings as: altering residency programs to foster humanistic behavior, difficult patients, caring for HIV infected persons, integrating work and parenting, and cross cultural issues.

The Guide also incorporates improved evaluation strategies applicable for use in both internal medicine and subspecialty training programs. Four cases are offered, each presenting complex challenges such as unrecognized differences in values, uncertainty about responsibilities, and distortions due to stress. Also included are examples of a professional associate rating form, a nurses evaluation form, and a patient satisfaction questionnaire. (For more information, contact ABIM, 3624 Market St., Philadelphia, PA 19104; 215/243-1567).

Society for Health and Human Values

Founded in 1969, the SHHV works to promote the inclusion of humanistic disciplines in the medical curricula. Members may join a special interest group, e.g., for medical humanities faculty, residency education, ministers, clinicians, directors of human values programs, etc. SHHV's annual and spring meetings include many interdisciplinary opportunities for discussion of ethical and values-related issues in medical education and care. (For further information, contact SHHV, 6728 Old McLean Village Dr., McLean, VA 22101; 703/556-9222.)

American Medical Association

**Statement on Teacher-Learner Relationships in Medical Education*

This code of behavior was promulgated by AMA's Section on Medical Schools in cooperation with the AMA Student and Resident Sections. It emphasizes why educators must

work to preserve the priority of education, however great the pressures to generate revenue. The Statement outlines the legitimate expectations that faculty and students should have of each other and lists behaviors that are destructive to the relationship. It also recommends that all medical centers disseminate policies setting forth expected standards of teacher and learner behavior, including delineation of procedures for dealing with breaches of that standard. (For more information, call the AMA: 312/464-5000).

**AMA Video Clinic*

In 1993, four videocassettes and study guides were produced on the following subjects: informed consent, death and dying, physician-assisted suicide, and economics and health care. The kit may be obtained for $29.95 by calling 800/398-2622.

CHAPTER 8

SUMMARY AND CONCLUSIONS

Ten years ago, it was confidently stated that: "Medicine. . .remains what it has always been, a profession rather than a trade, with its own ends, means, and intrinsic norms of conduct" (Kass). Today medicine's lack of a unifying vision is more evident. Marketplace values have become common--patients are "consumers" of medical "commodities". Competition for resources and patients turns biomedical researchers and health care professionals into hungry special interest groups. A concomitant impediment to a unifying vision is a chronic lack of time for reflection on and discussion of professional responsibilities — to each other, to individual patients, and to the community and general public.

If the profession of medicine is to retain its best qualities and the respect of the public, tomorrow's physicians will need to be more committed to a service ethic and better at ethical peer-review than most physicians in practice today appear to be. Without such a unifying commitment, medicine will become even more fragmented than it already is, with physicians losing even more autonomy. Prerequisite to high standards is a code of ethics that is "in here" rather than "out there". Educators should recognize that ethical principles and codes of conduct are likely to stay "out there" unless they are linked to students' immediate experiences and choices. As is clear from the case scenarios in the Appendix, students must come to terms with a wide range of ethical dilemmas. It is whether students receive assistance with these formative struggles that is at issue.

In exploring beyond the "parental values" response to the question "how do students acquire the will to behave ethically," it is important to recognize that ethical development is hard work. Every step forward requires individuals to face up to limits, uncertainty and the dissolution of established beliefs, while simultaneously demanding new decisions and the undertaking of new responsibilities. Countervailing forces are strong and include such tendencies as the wish to retain earlier securities, the wish to maintain family values, reluctance to admit one has been in error, and doubt of one's competence to take on new uncertainties (Perry). While some medical school faculty may argue that they are not responsible for helping students to mature in this way, surely they would be hard pressed to deny their formative role in students' acquisition of the "culture" of medicine and science. Faculty need to think of students as "dynamic....ethical-selves that develop in sympathy with the social and cultural context of modern hospital practice" (Feudtner and Christakis).

Aristotle said that the will to act in morally responsible ways is a matter of *practice*. Not only do students need to understand the forces that will be influencing their behaviors, they also require guided opportunities to deal with some of the complexities and pressures of actual problems. This preparation should not idealize the contexts and institutional settings where ethical decisions are made but rather be as realistic as possible (Lickona). Because real ethical questions are rarely clearcut and come wrapped in emotions and personalities, designing cases and other learning tools can be quite a challenge. In this regard, Feudtner and Christakis comment that "philosophical abstractions or principles too often sidestep the less savory aspects of human motivation and behavior". If ethics education truly focuses on students' experiences, it will include "unflinching social and cultural scrutiny as a means to better understand motives and actions, with particular regard to how the medical context

affects personal ethical development". Additionally, "ethics education must provide a safe and supportive haven, free of recriminations or grade anxiety, outside the hierarchical medical team." Feudtner and Christakis approximated such an environment in their ward ethics discussions (see Chapter 3); they conclude that providing such safety not only prevents some of the disillusionment that clinical medicine produces but also encourages medical students to teach and support each other (Feudtner and Christakis).

In order for students to become ethically "vested" in their medical school and in the profession, students also require a steady stream of faculty role models who bolster rather than detract from their development. Concomitantly, students need to see the consequences of unprofessional behaviors, with violators dealt with fairly and with due process; when problems are ignored or receive either overly harsh or lenient treatment, all other efforts to encourage professional standards are undermined.

Improvements to evaluation methods and to the learning climate are also crucial to students' learning to work together. Too often clinical academic success is measured by the ability to serve up correct answers to housestaff's or attending physicians' questions on rounds and to recite lists of symptoms (Pounds et al.). This emphasis on memorization runs counter to the development of lifelong learning skills; it also creates a competitive climate valuing "roundsmanship" over more patient-centered skills. In addition to improving evaluation methods, medical school administrators should continually strive to demonstrate to students that the institution cares about them. The availability of excellent tutoring and counseling, health awareness workshops, and parents' clubs that give money to needy students are a few examples.

Any measures suggested are likely to sound like "pie in the sky" to some. It is very easy to be cynical about educating consciences, especially given the variety of situational pressures on medical students and faculty. But medical educators are obligated to "take the high road" when it comes to ethical standards and to make good use of all opportunities to inspire and encourage students along these lines. All faculty need to supplement their teaching of competence with efforts to strengthen students' professional development. For this to happen, institutional leaders must send the clear message that human development and fairness should take precedence over other values: "It seems self-evident. . .that, at every level, we Americans are seeking greater integrity from each other and from our institutions; we want our institutions of higher education--and our human service institutions especially--to remain committed to the highest ideals; and we want institutional leaders who can help bring these things to pass" (Bulger). This leadership is a worthy task indeed.

Recommendations

The following recommendations in particular deserve repeating:

Medical School Admissions

- Schools should provide interviewer training on specific skills, such as questioning techniques and reducing rater bias with regard to gender and ethnicity. Specially trained interviewers may be effective in questioning candidates about accepting responsibility for their actions, demonstrating compassion, and articulating views about the physician in society and about societal values.
- Admissions officers need to work as closely as possible with health professions advisors, so that advisors become more forthcoming in communicating information when the integrity or morality of an applicant is in question.
- Consider specifying to applicants what principles and codes of behavior they will be expected to live up to. Not doing so leaves a student free to say "no one told me". Moreover, a student who disagrees with the duty to treat AIDS patients or other patients with infectious diseases needs to know prior to entry that "they are

binding themselves to standards of conduct that transcend their private moral calculations"

Codes of Conduct and Medical School Orientation

- The *process* of creating or revising an honor system or code of conduct, especially one applying to *all* members of an academic community, offers benefits beyond the value of the created document. Almost any opportunity for faculty and students to dialogue about the challenges inherent in meeting their ethical obligations is worthwhile because such discussions can focus areas of conflicts, help clarify thinking, and raise moral sensitivities.
- Orientation activities should include attention to strategies for academic success and guided opportunities for consideration of ethical responsibilities of medical students (especially responsibilities likely to be ambiguous, such as plagiarism, confidentiality and civility). Orientation to clinical medicine should include discussion of the ethics of charting, of introducing oneself to patients, and of other ethically "grey" areas that all students must navigate.
- When housestaff are oriented to their educational responsibilities to students, they should be shown how not to add to students' conflicts of obligations. Housestaff should also be evaluated in their capacity as role models for medical students.

Curricular Innovations

- Some dilemmas (e.g., how students identify themselves to patients, what "freebies" to accept from pharmaceutical companies) may be important enough to warrant the promulgation of institutional guidelines. Some concerns deserve special attention from the curriiculum committee, e.g., arranging for students' first spinal tap to be under less than critical conditions, using teaching assistants instead of patients to teach the pelvic exam.
- With the multiplication of ethical concerns in medicine, especially those related to economics, technologies, and patient advocacy, medical schools should consider expanding the numbers of faculty trained in ethics. As with faculty in most other units, most of today's ethics faculty are so busy with other responsibilities that medical students have not been the beneficiaries of their best efforts or of optimal teaching methods.
- Faculty facilitators deserve carefully prepared guidelines and educational opportunities to help them prepare to lead discussions of ethical topics and students' ethical quandaries. Ideally, faculty would also be assisted to examine their own stereotypes and prejudices that may be interfering with their "seeing" and "hearing" various categories of patients and students.

Evaluation of Students

- Course directors need to develop clear learning objectives but should not eschew non-cognitive goals, such as respect for others, simply because those dimensions are harder to evaluate.
- Course directors should do what is possible to establish an academic climate characterized by fair examinations, respect for students, discussions with the class about what constitutes unfair assistance, and the ready availability of tutors.

Influencing Faculty

- Deans should examine all possibilities for influencing faculty to spend more time teaching and nurturing medical students. Changing the reward structures is probably the most difficult to bring about. But a number of other efforts should be considered as well, including more attention to: personal qualities (particularly openly displayed prejudices of faculty) in recruitment, promotion, and post-tenure review; new faculty orientation; and educational opportunities for faculty to improve their teaching and evaluation skills.

- Especially at schools without a professional code that applies to faculty, policies covering sexual harassment and other forms of student mistreatment are important. Workshops and other programs to educate faculty about their responsibilities in these regards should be regularly offered.
- Faculty who continue to be poor role models for students should be relieved of their educational responsibilities.

Into the Future

As previously outlined (Bickel), if there is sufficient interest in one or two years, AAMC will re-survey those individuals designated as the contact for purposes of this project (see the Roster of Respondents for the present list). The purpose would be to request an assessment of the school's use of or experience with any materials or recommendations contained here, particularly with the student cases. If the response warrants it, a second improved version of this Guide could be produced.

Another resource that could grow out of such feedback would be videotaped vignettes illustrating a variety of ethical dilemmas faced by students. This method, as opposed to reading cases out loud or silently, has the advantages of immediacy and drama, and can be a more economical use of time. Developing such a resource would depend on financial support being obtained and should be guided by medical schools' experience with written cases illustrating students' dilemmas.

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INDEX OF SCHOOLS NAMED IN TEXT

LIST OF APPENDICES

APPENDIX 1A

February 27, 1992

MEMORANDUM #92-14

TO: Council of Deans

FROM: Robert G. Petersdorf

RE: Survey on Student Professional Ethics

From many directions and for many reasons, the integrity of physicians is increasingly scrutinized. The importance of graduating physicians who will practice with high professional standards focuses renewed attention on the determinants of medical students' ethical development. Attending largely to thorny clinical problems, medical ethicists have not dwelt on the more immediate ethical dilemmas that medical students face as students, e.g., temptations to lie or cheat. But the challenges of addressing questions relative to students' ethical development extend well beyond ethics courses into the admissions process, student orientation and governance, student evaluation and faculty evaluation.

The attached article summarizes efforts of an ad hoc AAMC Working Group to examine these challenges. In the spirit of the AAMC initiative suggested (see p. 729), we request your cooperation in completing a brief survey. The results will allow creation of an unprecedented resource for deans and faculty. As spelled out in the conclusion of the article, the Working Group recommends that you consider appointing a contact person(s), who would be responsible for this survey and who will be contacted in the future regarding the utility of the resource.

Because of the multifaceted nature of the survey, and in order to facilitate your response, a copy of this memo and enclosures has also been sent to your Dean of Student Affairs.

cc: Dean of Student Affairs

Note: AAMC contact person for this project is Janet Bickel, Assistant Vice President for Women's Programs, Division of Institutional Planning and Development.

AAMC SURVEY ON STUDENT PROFESSIONAL ETHICS

As outlined in the attached reprint of "Medical Students' Professional Ethics: Defining the Problems and Developing Resources", AAMC proposes to publish a Resource Manual for faculty and deans containing approaches and aids to bolstering students' development of high professional standards. The immediate focus of this project pertains to helping students face the ethical dilemmas that arise related to their student-status (for instance, deciding whether to report a peer who has cheated on an exam). While the distinction is not hard and fast, the project is thus more about "personal ethics" than about "clinical ethics".

We recognize that the information requested below will not be simple to collect, but if your school has experience in any of these areas, we encourage your describing it in order that the resulting national Resource Manual be of maximum utility to faculty and deans (please attach as many extra sheets as necessary).

1. If any of your medical school's ethics courses use cases designed to elicit discussion of ethical dilemmas medical students face as *students*:

___ a. attach a copy

___ b. briefly describe the objectives related to the use of the case(s) and comment on the extent to which these objectives appear to be achieved.

2. How would you rank the following in terms of their influence on your students' development of high professional standards. *For the two or three areas you rank highest, please briefly describe your approach or activities*:

___ a. Medical school admission (e.g. use of essays on ethical or conduct-related questions)

___ b. Medical school orientation (including explicit statement and discussion of standards for students' personal and professional conduct)

___ c. Role modeling of faculty and residents

___ d. Use of honor code (or similar system)

___ e. Improvements to student evaluation process

___ f. Components of a medical ethics or other course

3. Check the areas that your school has recently addressed relative to <u>faculty members' moral and professional standards</u>.

___ a. Language in faculty appointment/promotion policies related to standards for moral or professional behavior.

___ b. Policies related to faculty impairment/substance abuse

___ c. Scientific integrity

___ d. Conflict of interest

___ e. Sexual harassment

4. If you have strong or innovative policies or programs relative to ensuring that faculty and residents live up to high professional standards with regard to their interactions with students, please describe them or enclose a copy. If not, feel free to comment on this subject.

5. Are there *other* student ethics-related activities or approaches deserving mention (e.g. greater limits on drug company gifts to students)?

Name of school:

Name & title of contact person(s):

Address & phone number:

Return to:

Janet Bickel, Division of Institutional Planning & Development
Association of American Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037

APPENDIX 2A

Oath of Hippocrates*

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witness, that I will fulfil according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art--if they desire to learn it--without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

*Ludwig Edelstein: "The Hippocratic Oath: Text, Translation and Interpretation." *Bulletin of the History of Medicine*, Supplement 1. (Baltimore: Johns Hopkins University Press, 1943), 3.

APPENDIX 2B

The Covenant (in use at Pennsylvania State University College of Medicine)*

Physicians:	In the light of all we hold sacred, we make this covenant with the persons whom we will serve.
Public:	As representatives of humankind, we acknowledge and accept your covenant with us.
Physicians:	We are enriched and humbled by centuries of research and experience in the healing arts.
Public:	May that inheritance enable you to enable nature's healing power.
Physicians:	We are indebted to you for our education: the resources, the institutions, the support, the freedom, and your willingness for us to practice our fledgling skills upon you.
Public:	And we are indebted to you for your long hard years of study, your anxious years of stress, your risks and sacrifices, your dedication.
Physicians:	We feel called to our healing profession by divine direction or the cry of human need.
Public:	We are grateful for your high calling. Recognize that we too are individuals who have callings, goals, and ideals; that we too serve humankind with our talents.
Physicians:	We respect and cherish life and the lives of individuals.
Unison:	We are all individuals who live and love, who dream and sorrow, who laugh and cry, who think and feel, who cherish life and other humans.
Physicians:	We will strive always to be sensitive to your feelings, needs, and thoughts.
Public:	And we, to yours.
Physicians:	We earnestly seek to alleviate pain and suffering and to sustain human life.
Public:	But do so only so long as both are compatible and appropriate.
Physicians:	We know there are time when maintaining life seems not worth the suffering.
Public:	We each differ when that time occurs. Argue with us, but honor our decisions.
Physicians:	We will. But we will never desert you.
Public:	Cure if you can, alleviate if you can't, but listen and comfort always.
Physicians:	We will, and we will never desert you. We will act in your best interests.
Public:	But discuss with us our "best interest." Consult us in weighing risks and planning outcomes.
Physicians:	Yours are the governing goals, and ours the medical means.
Public:	We are partners in our care.
Physicians:	There can be no deceit between us.
Public:	Make known to us all matters concerning our health, whether good or bad, certain or suspected.
Physicians:	And you make known to us all matters concerning your health, whether good or bad; certain our suspected.
Public:	Protect our confidences as best you can, and tell us wherein you cannot.
Physicians:	Pressures come from all quarters: government, families, agencies and organizations.
Public:	But we are your patients. It is our will you need to know, not government's nor family's.
Physicians:	We will be your advocate.
Public:	Guided by our will.
Physicians:	And by the laws and regulations of the land.
Public:	So long as they are just and democratically determined.
Physicians:	When forming public policy, we will do justice.
Public:	Be rational and impartial.

Physicians:	As human life is infinitely precious, so is it infinitely complex. It far surpasses human knowledge.
Public:	Moreover we are each unique in our complexity.
Physicians:	Certainty eludes us, mistakes will happen; we are not gods; we work, explore, and serve. Our craft is art and science.
Public:	We understand the stress of uncertainty and applaud your willingness to work within it.
Physicians:	We will be the best we can and do the best we know.

*From: Clouser, K. Danner. A covenant between physician and patient: An innovation by a Graduating Class. Annals of Internal Medicine, 1985;103:941-943.

Dartmouth-Hitchcock Medical Center

CODE OF PROFESSIONAL CONDUCT

The Ad Hoc Committee on Code of Professional Conduct:

James L. Bernat, M.D. (Chair)
Professor of Clinical Medicine

Robert J. Cimis, M.D.
Associate Professor of Clinical Medicine

J. Miguel Marin-Padilla, M.D.
Professor of Pathology

William T. Mosenthal, M.D.
Professor of Anatomy and Clinical Surgery

Anne C. Bracken, M.D.
Resident in Maternal and Child Health

Donna A. B. DiSciplo, M.D.
Resident in Medicine

Anthony J. DeRosa
DMS IV

Archie R. McGowan
DMS III

Peggy Shedd, R.N.
Department of Psychiatry

June, 1992

Preamble

The Dartmouth-Hitchcock Medical Center (DHMC) and its component institutions are committed to excellence in: patient care; education and training of medical and graduate students, house officers, attending staff members, and other trainees; and research. To further the goal of excellence, all medical staff members and medical and graduate students are expected to adhere to a Code of Professional Conduct in their interactions with patients, colleagues, other health professionals, and the public.

The Code of Professional Conduct is a series of principles and their subsidiary rules that govern professional interactions. The Code consists of two complementary sections: professional obligations and professional ideals. "Obligations" refer to *necessary* professional behaviors that are required by the ethical foundation of medical practice, teaching, and learning. "Ideals" refer to *desirable* professional behaviors that physicians and faculty at all levels should attempt to acquire because they enhance professional excellence.

Failure to meet the professional obligations described below is a violation of the DHMC Code of Professional Conduct. Alleged infractions of the professional obligations of the Code will be dealt with by the appropriate DHMC disciplinary committees. Alleged failure to meet the professional ideals although less serious may also be grounds for committee review.

Professional Obligations

1. Respect for persons
    - Practice the doctrine of informed consent for any patient diagnostic test or therapy.
    - Treat patients, colleagues, students, and teachers with the same degree of respect you would wish them to show you.
    - Treat patients with kindness, gentleness, dignity, empathy, and compassion.
    - Do not use offensive language verbally or in writing when referring to patients or their illnesses.
    - Respect the privacy and modesty of patients.
    - Do not harass others, physically, verbally, psychologically, or sexually.
    - Do not discriminate on the basis of gender, religion, race, age, or sexual preference.

2. Respect for patient confidentiality
    - Do not share the medical or personal details of a patient with anyone except those health care professionals integral to the well being of the patient or within the context of an educational endeavor.
    - Do not discuss patients or their illnesses in public places where the conversation may be overheard.
    - Do not publicly identify patients in spoken words or in writing without adequate justification.
    - Do not invite or permit unauthorized persons into patient care areas of the institution.
    - Do not share your confidential Clinic Information System or VA computer system passwords with nonprofessionals.

3. Honesty
   - Be truthful in verbal and in written communications.
   - Acknowledge your errors of omission and comission.
   - Do not knowingly mislead others.
   - Do not cheat, plagiarize, or otherwise act dishonestly.
   - Do not falsify or fabricate scientific data.

4. Responsibility for patient care
   - Assume 24-hour responsibility for the patients under your care; when you go off duty, assure that your patients' care is adequately covered by another practitioner.
   - Follow up on ordered laboratory tests and complete patient record documentation conscientiously.
   - Coordinate with your team the timing of information sharing with patients and their families to present a coherent and consistent treatment plan.
   - Do not use alcohol or drugs that could diminish the quality of patient care or academic performance.

5. Awareness of limitations, professional growth
   - Be aware of your personal limitations and deficiencies in knowledge and abilities and know when and of whom to ask for supervision, assistance, or consultation.
   - Do not engage in unsupervised involvement in areas or situations where you are not adequately trained.
   - Avoid patient involvement when you are seriously ill, distraught, or overcome with personal problems.
   - Medical students should have all patient workups and orders countersigned by the appropriate supervisor.

6. Deportment as a professional
   - Clearly identify yourself and your professional level to patients and staff; wear your nametag when in patient areas.
   - Do not introduce medical students as "doctor" or allow yourself as a medical student to be introduced as "doctor."
   - Dress in a neat, clean, professionally appropriate manner.
   - Maintain a professional composure despite the stresses of fatigue, professional pressures, or personal problems.
   - Do not write offensive or judgmental comments in patients' charts.
   - Do not have romantic or sexual relationships with patients; recognize if such relationships develop, seek help, and terminate the professional relationship.

7. Responsibility for peer behavior
   - Take the initiative to identify and help rehabilitate impaired students, nurses, physicians, and other employees with the assistance of the DMS Impaired Students Committee, the DHMC Impaired Physicians Committee, or the employee's supervisor.
   - Report important breaches of the Code of Professional Conduct to the appropriate administrator.

8. Respect for personal ethics
   - You are not required to perform procedures (eg. abortions, termination of medical treatment) that *you* feel are unethical, illegal, or may be detrimental to patients.

- You have an obligation, however, to inform patients and their families of available treatment options that are consistent with acceptable standards of medical care.

9. Respect for property and laws
   - Do not misappropriate, destroy, damage, or misuse property of DHMC or its component institutions.
   - Adhere to the regulations and policies of Dartmouth College, DHMC, and its component institutions, such as policies governing fire safety, hazardous waste disposal, and universal precautions.
   - Adhere to local, state, and federal laws, and regulations.

Professional Ideals

1. Conscientiousness
   - Complete all assignments accurately, thoroughly, legibly, and in a timely manner.
   - Notify the responsible supervisor if something interferes with your ability to perform clinical tasks effectively.
   - Learn from experience and grow from the knowledge gained from errors so as not to make the same mistake repeatedly.
   - Dedicate yourself to lifelong learning and self-improvement by implementing a personal program of continuing education and continuous quality improvement.
   - Attend scheduled classes, laboratories, seminars, and conferences except for justified absences.

2. Collegiality
   - Cooperate with other members of the health care team.
   - Teach others at all levels of education and training.
   - Be generous with your time to answer questions from trainees, patients, and patients' family members .
   - Shoulder a fair share of the institutional administrative burden.
   - Adopt a spirit of volunteerism and altruism in teaching and patient care tasks.
   - Use communal resources (equipment, supplies, and funds) responsibly and equitably.

3. Personal health
   - Develop a life style of dietary habits, recreation, disease prevention, exercise, and outside interests to optimize physical and emotional health.

4. Objectivity
   - Avoid providing professional care to members of your family or to persons with whom you have a romantic relationship.

5. Responsibility to society
   - Avoid unnecessary patient or societal health care monetary expenditures.

APPENDIX 2D

THE CODE

The Student Code of Conduct identifies those behaviors considered unacceptable and not permitted for all students of the University of Cincinnati while on University owned or controlled property, while on professional practice assignment, or while representing the University in the community.

The following section defines behaviors that are misconduct.

DEFINITIONS OF MISCONDUCT

ACADEMIC DISHONESTY: includes but is not limited to the following conduct:

AIDING or ABETTING ACADEMIC DISHONESTY: Knowingly helping, procuring, or encouraging another person to engage in academic dishonesty.

CHEATING: Any dishonesty or deception in fulfilling an academic requirement such as:

(1) Using unauthorized material during an examination (any written or oral work submitted for evaluation and/or grade), such as tape cassettes, notes, tests, calculators, or computer programs.

(2) Obtaining assistance with or answers to examination questions from another person with or without that person's knowledge.

(3) Furnishing answers to examination questions to another person.

(4) Possessing, using, distributing, or selling unauthorized copies of an examination, or computer program.

(5) Representing as one's own an examination taken by another person.

(6) Taking an examination in place of another person.

(7) Obtaining unauthorized access to the computer files of another person or agency, and/or altering or destroying those files.

PLAGIARISM:

(1) Submitting another's published or unpublished work, in whole, in part, or in paraphrase, as one's own without fully and properly crediting the author with footnotes, citations or bibliographical reference.

(2) Submitting as one's own, original work, material obtained from an individual or agency without reference to the person or agency as the source of the material.

(3) Submitting as one's own, original work, material that has been produced through unacknowledged to collaboration with others without release in writing from collaborators.

From: University of Cincinnati College of Medicine

AIDING AND ABETTING MISCONDUCT: Knowingly helping, procuring, or encouraging another person to engage in misconduct (refers to all behaviors listed below and extends beyond Aiding and Abetting Academic Dishonesty).

ALCOHOLIC BEVERAGES, UNAUTHORIZED USE: Possessing or consuming alcoholic beverages except during events or in circumstances authorized by University officials; failing to comply with state or University regulations regarding use or sale of alcoholic beverages under the University Alcohol Policy.

ASSAULT: Intentionally or recklessly inflicting bodily harm upon any person, including, but not limited to sexual battery or assault, physical assault, date rape or fighting; taking any action for the purpose of inflicting bodily harm upon any person; taking any reckless action that presents a substantial risk of bodily harm to any person or causing a person to reasonably believe that the offender may cause bodily harm.

DESTRUCTION OF PROPERTY: Intentionally or recklessly damaging, destroying, defacing, or tampering with the property of the University or the property of a member of the University community.

DISHONESTY AND MISREPRESENTATION: Furnishing false written or oral information, including false identification to University officials, faculty and/or staff; forgery, alteration, or misuse of University documents or records.

DISRUPTION/OBSTRUCTION: Disrupting, obstructing, or interfering with University functions or activities or the pursuit of the University mission.

DISTURBING THE PEACE: Disturbing the peace of the University, including but not limited to, disorderly conduct, failure to comply with an order of dispersal, fighting, quarreling, being intoxicated, or any such conduct in conjunction with a civil disturbance.

DRUGS or NARCOTICS: Manufacturing, distributing, selling, offering for sale, or possessing anabolic steroids (except in compliance with professional training requirements) or any illegal drug or narcotic including but not limited to: barbiturates, hallucinogens, amphetamines, cocaine, opium, heroin, or marijuana.

FAILURE to COMPLY or IDENTIFY: Failing to comply with directions, including posted or written rules of the University, its officials and/or their designees, police, or any other law enforcement officers acting in the performance of their duties and/or failing to identify one's self to any of these persons when requested to do so.

FALSE REPORT of EMERGENCY: Knowingly causing, making, or circulating a false report or warning of a fire, explosion, crime or other catastrophe or emergency, e.g., activating fire alarm.

IDENTIFICATION, MISUSE OF: Transferring, lending, borrowing or altering University identification.

PROPERTY or SERVICES, UNAUTHORIZED USE: Unauthorized use or possession of property or resources of the University or of a member of the University community, for example, computer services.

SAFETY EQUIPMENT, MISUSE OF: Unauthorized use or alteration of firefighting equipment, safety devices, fire alarms, fore extinguishers or other emergency safety equipment.

STOLEN PROPERTY: Possession of property known to be stolen and/or that may be identified as property of the University or of a member of the University community.

THEFT: Theft of the property or services of the University or of a member of the University community.

TRESPASS OR FORCIBLE ENTRY: Unauthorized trespass, or use of forcible entry into any University building, structure or facility, or onto University property.

UNIVERSITY KEYS, MISUSE OF: Unauthorized use, distribution, duplication or possession of any key(s) issued for any University building, laboratory, facility, or room.

VIOLATION OF CRIMINAL LAW: Violating any criminal law where the student's conduct interferes with the University's exercise of its organizational objectives or responsibilities.

VIOLATION OF PROBATION: Violating the Student Code of Conduct while on University Disciplinary Probation or violating the specific terms of that probation.

VIOLATION of the RESIDENT STUDENT CODE OF CONDUCT: Violating the Housing Contract or published rules and regulations of the Office of Residence Life/Housing and/or its Dining Facilities.

VIOLATION of SMOKING POLICY: Violating the University of Cincinnati Smoking Policy.

VIOLATION of the UNIVERSITY POLICIES ON DISCRIMINATION AND HARASSMENT.

WEAPONS: Unauthorized possession of a firearm, weapon, dangerous chemical, or an explosive device of any description, including compressed airgun, pellet gun or BB gun.

Draft #4

HONOR CODE STATEMENT

Honor and integrity is predicated on a concept of human dignity which is basic to the philosophy of the College of Human Medicine. When students enter medical school, they are entering the medical profession and must exhibit patterns of behavior that reflect the highest personal and professional integrity. Application to the College of Human Medicine commits the students to the essential nature of abiding by the Honor Code. They should possess this sense of integrity before choosing the College of Human Medicine for their education. Honor is a fundamental part of the value system of the College's curriculum and is integral to the maturity that students should demonstrate as members of the profession.

The College of Human Medicine seeks to emphasize excellence, competance and self-responsibility while deemphasizing competition. Students must assume responsibility for their own education and ethical behavior, realize that the health of the people they will care for depends on the knowledge and skills they acquire in their lifelong education. It is expected that a student will not compromise academic standards through dishonesty in any situation. Students are expected to show concern and support for their peers in the sharing of information and learning material, and in establishing a supportive atmosphere for their classmates. Just as all physicians must share responsibility for promoting a standard of integrity among members of the profession, students must similarly accept responsibility for monitoring the actions of their colleagues. The purpose of such peer review is both to provide help for those having difficulties and, to recommend disciplinary action when appropriate. An Honor Code rests on the integrity of each student acting with the greatest responsibility and respect for the rights, feelings, privacy, and dignity of others.

From: Michigan State University College of Human Medicine

AFFIRMATION FOR STUDENTS OF MEDICINE

Because I am committed to being competent and current throughout my career, I will develop habits effective in life-long learning.

Because the primary aim of my medical education is the personal mastery of medical knowledge and skill, I will attain these through honest effort.

Because my personal feelings and beliefs affect my behavior, I will make myself aware of the influence these convictions have on the professional decisions I make.

Because the best medical treatment incorporates the patient's viewpoint and concerns, I will relate to all patients and their families with compassion, truthfulness, and respect for their experience and human dignity.

Because the patient benefits most when all members of the health care team can function effectively, I will relate to my peers, my teachers, and other care givers in a spirit of collaboration and mutual respect.

Because my training provides access to privileged information from both patients and colleagues, I will recognize and honor this trust by preserving confidentiality.

The University of Iowa College of Medicine

HONOR CODE ORIENTATION WORKSHOP

SMALL GROUP SESSION DISCUSSION OBJECTIVES

I. Responsibility should be defined in terms of:

   A. Actions - understanding, reasoning, control of conduct, ability to deliberate and to reach decisions

   B. Accountability - self, institution, society and profession

   C. Patient/Doctor Relationship, Peer/Peer; Teacher/Learner vulnerability of patients, perception of role

II. An Honor Code should be the basis of professional quality assurance. The Honor Code is NOT a vigilante tool or a punitive policy.

III. The Honor Code should be discussed as it relates to "college testing" vs. the beginning point of professional practice, i.e., the clinical clerkships. Stress differences and similarities.

IV. The Honor Code should be discussed as a means of discouraging acts against one's fellow man. This should be a comprehensive discussion that defines abusive behavior, harassment and intimidation. "Looking the other way" should be discouraged.

V. Confidentiality should be defined in relation to the Honor Code and also the medical profession (i.e., patient care).

VI. Discuss how friendship might interfere with reporting Honor Code violations. Personal relationships vs. professional responsibility.

VII. The concept of cooperation should be discussed. Discuss the benefits of peer support to assure quality of the profession.

REMEMBER: ALL THESE POINTS DO NOT HAVE TO BE COVERED IN EVERY GROUP.

From: Henry S. Pohl, M.D., Associate Dean for Medical Education, Albany Medical College

APPENDIX 3A

Truth-Telling*

James Mitchell is a third-year medical student doing a month-long rotation in anesthesiology. He has been reviewing the records of Mr. Jackson, a 65-year-old man who is scheduled for surgery the next morning, and reasons that because of his age and his history of heavy smoking, a spinal anesthetic would be the safest option. The attending anesthesiologist agrees with James' choice, and asks him if he's done lumbar punctures before. "Yes, twice" James replies, "and I've seen probably three or four. I guess I'd still feel a little shaky doing one."

"Well, you won't get any better just by watching. I want you to do Mr. Jackson's tomorrow morning. I'll be around if you need any help." James nods his agreement.

The next morning, James introduces himself as "Medical Student Mitchell, a member of the anesthesiology team," and proceeds to explain to Mr. Jackson what the procedure will be like and the risks that are normally associated with it. After Mr. Jackson has signed the consent form, he says "Medical *student*, huh? You said this might be painful. I hope you've had some practice!"

James doesn't really want to lie to Mr. Jackson, but neither does he want the patient to believe that he can't competently perform this procedure. What should he say to Mr. Jackson?

Adapted from Marc D. Basson, The student doctor and a wary patient, *Hastings Center Report*. February 1982, 27-28.)

*Submitted by Howard Brody, M.D., Director, Center for Ethics and Humanities, Michigan State University College of Human Medicine.

APPENDIX 3B

Your First Lumbar Puncture*

In your first clerkship as a third year student you are on the internal medicine service at the VA Hospital. Your supervising intern comments that VA patients are good teaching cases as they are receiving care at governmental expense and as a result they are more accepting of care from medical students and residents. He also informs you that when you do your second six weeks of medicine at Swedish Hospital, it will be hard for you to do any "hands on" procedures since private patients expect that their private attending will be providing care. As a result, you will be looking over the attending's shoulder much of the time.

Today, your team has a patient with suspected bacterial meningitis who will require a lumbar puncture and spinal tap for a definitive diagnosis. You have observed three of these procedures which were done by the residents. They went smoothly and you understand the details of the procedure. Your intern makes it clear that he expects you to do your first lumbar puncture on this patient.

As you enter the room, the intern greets the patient by name, introduces you as doctor _____, indicates that you will do the procedure, asks that you explain the procedure, have Mr. Smith sign the consent form, and get things started. Just then he is paged. As he leaves the room he tells you to go ahead and do the procedure, he will return as quickly as possible. You feel fairly confident that you can do the procedure.

What ethical considerations occur to you in these circumstance? What do you think you should do?

*Submitted by Dr. Thomas R. McCormick, Department of Medical History and Ethics, University of Washington School of Medicine.

APPENDIX 3C

Patient vs. Attending*

Rubio is a third-year medical student in a major teaching hospital doing a clerkship in OB/GYN. Learning to perform pelvic examination that produces minimal discomfort to female patients is an essential educational objective of the clerkship. One morning after taking Mrs. Brown to surgery, Rubio scrubs and prepares to assist in a D&C. After Mrs. Brown is anesthetized, the attending physician tells the three medical students to do a pelvic examination on the patient to sharpen their clinical exam skills. He says that this practice will serve a basic educational need while resulting in no discomfort to Mrs. Brown and causing no harm. However, while standing in line, Rubio worries about the principles of respect for persons and patient autonomy and considers refusing to do the practice pelvic examination.

Discussion Questions

- Should Rubio refuse to do the pelvic examination on Mrs. Brown?
- Would it matter if Mrs. Brown had an ovarian cyst that the students needed to learn how to diagnose?

*Adapted from case created by Don Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3D

Facial Lacerations in the ER*

Your rotation in the Emergency Room at Harborview has been one of the best learning experiences of medical school. You have seen more trauma than you even dreamed existed and you have had lots of hands on experience. You have observed that cases are triaged according to severity with the most extreme cases receiving first priority and less severe cases waiting their turn. You have also observed another more implicit form of triage. When patients come in with facial lacerations, if they are young and healthy and have insurance, their facial lacerations are sewn up by the surgery residents. However, if the patient is a chronic alcoholic or medically indigent with facial lacerations, such patients are frequently sutured by the medical students.

You are interested in improving your suturing technique. After all, the only real experience you've had was suturing lacerations in a pig's foot during a suturing lab in ICM-II the previous year.

At 3:20 a.m. a police car delivers an inebriated patient to the ER with two facial lacerations. Your intern recognizes the patient and greets him by name. She then turns to you and says, "George is going to be a great opportunity for you to practice your suturing skills. He's a chronic alcoholic and is constantly getting into fights or falling down. We've sewn him up at least a dozen times." When you protest that you are really not good enough to sew faces the intern replies, "it's not George's first time, and it won't be his last to be sewn up in our ER--besides he really isn't concerned about appearances--and drunk as he is tonight, he'll scarcely feel a thing!"

What are the ethical considerations in this case? What should you do?

*Submitted by Dr. Thomas R. McCormick, Department of Medical History and Ethics, University of Washington School of Medicine.

APPENDIX 3E

Clinical Experience for Medical Students*

In one of Canada's smaller medical schools, where there is continuous difficulty finding sufficient appropriate patients for teaching, a physician was assigned a small group of second year medical students in the clinical skills program. Since she was clinically responsible for patients in an institution for severely retarded children, she sent her student group there to examine patients and advised them that they could perform rectal examinations as part of the physical. This clinician had a reputation as one of the most humane and compassionate clinical teach models on the faculty.

Some of the group of students objected, however, and did not go.

Later that year, in an open class presentation on ethics, at which several invited guests were present, one student of that group raised the question as to the suitability of the assignment earlier in the year. One of the guests was a member of the local Association of the Retarded, and reported the discussion at their next meeting, which included some parents of some of the patients in the institution.

What is your reaction to this sequence of events?

*Written by Robert Veatch, Ph.D. and submitted by A. Corvin, M.D., Coordinator, Medical Ethics, Dalhousie University Faculty of Medicine.

APPENDIX 3F

HIV and the Needlestick*

A fourth year medical student starting an IV on a patient sustains a needlestick. The patient is a 32 year old carpenter admitted for asthma who denies any risk factors for HIV infection. He refuses to be tested for HIV, saying that he will be unable to renew his health insurance if his carrier finds out that he even had the test done. A resident suggests that you simply have another tube of blood drawn and send it for HIV testing without telling the patient.

Should you have the blood drawn without the patient's consent?

Why or why not?

Probe Questions:

- Would it matter if the patient acknowledged risk factors but still refused testing?
- Several laboratories are working on a urine test for HIV antibodies. Would the availability of such a test change your decision to test the patient?
- Are there serious risks to a patient being tested whether the test turns our positive or negative.
- Does the health care provider have important rights to the information gained from testing the patient?
- Would the results of HIV testing influence the decision concerning the health care provider taking AZT? (No, the results would not be known for several days to weeks and the AZT has to be taken immediately to be of any use).

Options:

- The patient consents, is tested and the information is given to the patient and entered in to the medical record.
- The patient consents, is tested and the information is not given to the patient who does not want to know and is not entered into the medical record. (additional ethical problems if positive?).
- The patient refuses and is tested without his knowledge of it.
- The patient refuses and is not tested.

(Adapted from: Bernard Lo, M.D., University of California, San Francisco)

*Submitted by Don Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3G

Health Care Delivery vs. Education: The Femoral Stick*

While on a clerkship in internal medicine a third year medical student accompanied Dr. Kaylor into the room of Mrs. J. Dr. Kaylor explained to Mrs. J. that they were going to draw some blood from her femoral artery for laboratory tests. She pointed out that it would hurt a little bit but that they would try not to hurt her too much. Dr. Kaylor then instructed the third year medical student to draw the blood. A little nervous, the student attempted the femoral stick but removed the needle failing to get the blood. Dr. Kaylor took over and demonstrated several points as she easily obtained the needed blood. She then told the student to try once more. The student resisted, but reluctantly proceeded under Dr. Kaylor's insistence and was fairly readily able to obtain the unneeded blood. However, the student was uncomfortable and worried about the principles of "do no harm," informed consent, patient autonomy, etc.

Should the student have performed the procedure?

Why or why not?

Probe Questions:

- Did the student and physician violate any major patient's rights? (Legal or moral or both).
- What if it had been a more serious procedure such as getting a lumbar puncture sample?
- What if it had been a less serious procedure such as getting blood from a finger stick?
- Does it matter whether this was a teaching hospital or a private nonteaching hospital?
- What is the nature of the relationship between a medical student and an attending physician?
- Under what circumstances should a medical student question the authority of a physician and/or refuse to carry out a physician's orders?

*Submitted by Don Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3H

Challenging a Resident*

LaJuan was just beginning her long-awaited 3rd year of medical school. The dream of finally making it to the wards had kept her going through many long nights of study during the first two years. Her first clinical rotation was OB-GYN. Upon her arrival at 6:00 a.m., Kevin, the chief resident, assigned LaJuan a patient that had been admitted the night before and instructed her to be prepared to present the case during rounds at 6:30 a.m.

As she reviewed the chart, she notice that a CBC (complete blood count) had not been ordered and mentioned this to Kevin. Kevin remarked that there was no reason to believe the values would be abnormal and told LaJuan to report the CBC as being within normal limits. As Kevin was writing the order for the necessary CBC, he explained that their attending this month was a real stickler for a complete lab evaluation. Kevin notice that LaJuan looked uncomfortable and told her not to worry. If she didn't want to say that the CBC was normal, Kevin would; but he also made it clear that LaJuan should not challenge him about the CBC in front of the attending.

"The first rule you should learn about survival on the wards," Kevin informed his new student, "Is that you should never make your resident look bad in front of the attending."

Probe Questions:

- What should LaJuan do, risk condemnation by her conscience or her resident?
- Can such situations be avoided or prevented?

*Adapted from: Case Presentations at the AAMC 1990 Annual Meeting Council of Deans/Organization of Student Representatives/Women's Liaison Officers and Group on Student Affairs Plenary Session.

APPENDIX 31

Sexual Harassment*

Jane was a member of the first class at Prestige Medical School in which the proportion of women is over 50%. In the past, Prestige had been below the national average in admitting women (some faculty suspected that the departing dean of admissions accepted up to a certain "quota" of women). While the faculty generally agreed that Jane's class was one of the most energetic and committed in recent memory, some were unprepared for and uncomfortable with this large a group of women. In turn many of the women felt frustrated by how frequently the "white male" was used to illustrate test results and clinical findings. By the end of their second year, Jane had become notorious for raising her hand to ask about significance and differences in female patients. While many students of both sexes appreciated her efforts, a number of both men and women classmates had tired of the points she was continually making.

Since Jane had known for years that she wanted to become an Obstetrician/gynecologist, she eagerly awaited this rotation and elected it as her first clerkship. Newly recruited from a premier Southern medical school where he had built a highly regarded department, the new chair of Prestige's Ob/Gyn department gave the opening lecture. Included in Dr. Blunt's slides were numerous shots of female genitalia and breasts displayed in sexually suggestive ways. Jane interrupted the lecture without raising her hand, charging Dr. Blunt with treating women as if they were sexual objects. A number of the men students hissed their disapproval at her interpretation and interruption. Jane then walked out of the room and into the student dean's office, accompanied by a few other women.

The student dean arranged a meeting between Dr. Blunt and the concerned students. Dr. Blunt explained that he had been showing those slides to students for years, with no complaints. When the students explained why they found the images offensive, he stated that part of his goal was to "desensitize" students to the potentially sexually arousing patients they would encounter. After a long discussion regarding how such "desensitization" might be better achieved, Dr. Blunt agreed not to use those slides again. However, he also made it clear that he believed he was in the right and that this handful of students were simply over-reacting. Jane left the meeting worrying about whether she would receive a fair evaluation in this clerkship.

By the end of the fourth week, Jane was very uncomfortable. A number of the residents and faculty regularly spoke condescendingly to their patients, many of whom were black and on Medicaid; one resident liked to make jokes about such patients and was not careful who overheard him. Jane could barely resist speaking out but restrained herself out of fear for her evaluation. Finally, after hearing an attending say in a loud voice to a crying woman "honey, I just don't have time to explain the procedure right now", Jane ran after him and confronted him about his lack of respect for this patient. The attending dismissed her, saying Jane didn't know what she was talking about and that he was late for a meeting. Jane's friends advised her to let the matter drop and to concentrate on passing the rotation.

During her last week, Jane overheard a conversation in a corridor between two of the women residents. One had just overheard Dr. Blunt say to a woman interviewing for a residency slot: "None of my residents had better get pregnant. We run a tight ship here. I expect 100% from everyone." Since Jane had worked in a woman's law center, she knew that the law prohibits discriminating in

hiring on the basis of sex (including pregnancy). Jane decides to wait until her grade is in before speaking up about this "outrage". But her friends advise her that if she wants to apply to Ob/gyn residencies, she needs the best possible OB/gyn references. Jane has heard that the national grapevine among program directors is very efficient; if she makes any more enemies in this department, she might not stand a chance.

What should Jane do?

Probe Questions:

- What are students' responsibilities relative to faculty when they have a grievance or when they disagree with or disapprove of teaching methods or materials? What kind of process would be optimal in resolving such conflicts?
- Does a student have a responsibility for action after witnessing a patient being treated in less than respectful ways? Does it matter whether the problem is with a nurse vs. a resident vs. an attending vs. a department head? Because of their long hours and often difficult working conditions, should residents ever be excused for using humor at patients' expense?
- The multiple missions of medical centers, i.e., education and research as well as patient care, create a complex and challenging environment that is difficult to change unless change is a priority of the leaders. What problems with this clerkship environment most need to be addressed? What resources might have helped Jane out of her bind between her conscience and the need for a good evaluation?

*Developed by Janet Bickel, Assistant Vice President for Women's Programs, Association of American Medical Colleges.

APPENDIX 3J

Cheating on Exams*

Jan is a first year medical student who works hard and is in about the middle of her class academically. One evening her lab partner offers to show her a copy of the biochemistry exam they would be taking in a couple of days. He does not say how he obtained a copy of the exam and Jan does not ask. When Jan hesitates, he says, "Look, everybody else in the class is seeing it, so it wouldn't be fair for *us* to be at a competitive disadvantage by *not* looking at it."

Discussion Questions:

- Should Jan look at the exam? Are the students who use the exam participating in a lie? Who are the biggest losers?
- If Jan is not going to participate in the scheme, should she inform the professor about it?
- Would it matter if the professor has a reputation for giving very difficult exams that demand inappropriate amounts of memorialization of minutiae?

*Adapted from Case developed by Don J. Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3K

Stress and Substance Abuse*

Your life as a medical student is exhausting and stressful, and you use alcohol to help you relax and go to sleep. Initially, you used alcohol just occasionally, but lately you've been using it daily and have begun drinking earlier in the evening or as soon as you get home from school. You're beginning to think that you drink more than you should. However, the stress of medical school makes you think that cutting back or giving up alcohol right now would be difficult or impossible. Further, you believe that these stresses are mostly to blame for your increased drinking, and that next quarter when things get better at school, you won't need to drink so much anymore. At home, others are beginning to complain of your unavailability during the evening hours even while you're home.

Because of your daily drinking, you are beginning to worry that someone at school might find out and accuse you of being an alcoholic. In fact, there were some early mornings after late nights when you thought you might have the scent of alcohol on your breath. No one at school has said anything to you about this, but you think that some of your classmates may suspect something. You are thinking about getting a prescription for tranquilizers to help you better deal with the stress of medical school so you won't have the drinking problem.

Should you get a prescription for tranquilizers?

Why or why not?

What are other options:

- Nothing.
- Wait. If anyone at school expresses concern, take further action.
- Look into changing to another medical school that will be less stressful.
- Take a leave of absence.
- Use a stimulant in the morning to get over your grogginess until medical school is over, then seek help.
- Discuss you concern about your drinking with a close and trusted friend.
- Discuss your concern about your drinking with your close supervisor.
- Start therapy.
- Go for couple's counseling.
- Try to cut back on your drinking.
- Try to stop drinking completely.
- Join AA.
- Enter into a formal assessment and treatment program.
- Make an appointment with your personal physician to discuss your drinking and any possible affects.
- Seek advice from the impaired medical student committee.

(Adapted from: *Health Professional Impairment*, editors: Alan Wartenberg, Michael Goldstein, and Catherine Duke)

*Submitted by Don Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3L

Classmate's Drug Abuse*

A fellow classmate and close personal friend has confided in you. She has been struggling with a problem with drug abuse. She is sure that no one has taken much notice of her problem, but over the past several months she has been using stimulants in order to keep up with work and stay awake on late nights. She has been taking increasing amounts over the past few weeks, but has decided to stop, cold turkey. She seems sincere, and in fact has not taken any stimulants for the past two days. She is telling you about this now because she considers you a close friend and is seeking your approval and support in her efforts. She has asked you to keep this between the two of you, and especially not to let it get around the school. Her drug abuse problem is somewhat surprising to you, but in retrospect, you recall her acting "wired" on some occasions. You wonder if you should inform the impaired student committee so that she can get professional help.

Should you inform the impaired student committee?

Why or why not?

What are other options:

- Try to convince your friend to get into a professional treatment program right away.
- Inform her supervisor so that her work may be appropriately monitored.
- Inform her immediate family.
- Make efforts to follow up with her on a daily basis to monitor her abstinence and to take appropriate action if necessary.
- Continue to be supportive on a daily basis and encourage her to continue abstinence.
- Since the problem seems under control, do nothing unless she resumes her drug use.

(Adapted from: *Health Professional Impairment*, editors: Alan Wartenberg, Michael Goldstein, Catherine Duke)

*Submitted by Don Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3M

Resident's Alcohol Abuse*

During Midori's internal medical clerkship, she smells alcohol on her supervising resident's breath. The resident looks a little drawn but is functioning at a competent level and seems to be on top of his clinical responsibilities. His speech is not slurred and his gait is normal. When Midori asks a friend about it, she suggests that it's probably mouthwash she smells. About an hour later, Midori smells alcohol on the resident's breath again. The resident later says he is not feeling well and goes home. Midori has been working with this resident for one month, and this has never happened before. She wonders if she should take some action now or wait until he is *clearly* intoxicated at work before taking any further action.

Discussion Questions

- Should she delay in talking to her supervisor about this? What are her responsibilities here?
- What if the problem were with a prescription drug?

(Adapted from: *Health Professional Impairment*, editors: Alan Wartenberg, Michael Goldstein, Catherine Duke)

*Submitted by Don J. Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3N

Balancing Clerkship and Marriage*

Ben is a third year medical student in the midst of his Internal Medicine clerkship. The clerkship is very demanding, both in terms of the time and the emotional and intellectual commitment required. Yet, Ben has excelled. He has noticed that over the past weeks his wife, Becky, has seemed distant and hostile. Their communication which was once excellent, is now minimal at best.

When Ben arrived home last night a 8:00 p.m. (his usual time), Becky told him that she could no longer live with his coldness and insensitivity and that she was leaving unless some changes were made. She told Ben that she hated what medicine was "doing to him" and wondered if the price they were paying as a family was too high. She also told him that she had a marriage counselor who was expecting them both at 2:00 p.m. on Tuesday, and that this was, in Becky's view, the last chance to salvage their relationship.

Today when Ben asked his attending resident for time off at 2:00 p.m., he was flatly refused. Ben was told that his marital problems were to be dealt with on his own time, and that Becky would have to adapt. "You are a very talented student, and will be a gifted physician," his resident had said, "Sacrifices have to be made by our families for us to achieve greatness. If you explain that to your wife I'm sure she will understand."

While he is driving home Ben is considering all of these things and is unsure what to do.

Should he tell Becky the counselling is off?

Why or why not?

Probe Questions:

- As a classmate, what might you say or do to be supportive of Ben if he asked for your help?
- Should Ben go over the head of his resident and talk to his supervising physician?
- Should Ben just leave for the appointment without asking for time off?

*Submitted by Don Self, Ph.D., Department of Humanities in Medicine, Texas A&M College of Medicine.

APPENDIX 3O

Ethical Issues in Human Sexuality*

Ethical issues present in every arena of health care. Patients, and at times, professionals not infrequently experience some level of discomfort or embarrassment in addressing sexual issues, particularly when associated with value-ladenl content. Ethical issues in human sexuality thus require particular sensitivity and skill on the part of the health care professional.

In a pluralist culture such as the United States, a diverse variety of values, both secular and religious, can be assumed not only for our patients, but for the professionals as well.

Physicians-in-training often ponder the question of how they may equip themselves to provide the broadest possible array of services to patients and at the same time, to conduct themselves within the boundaries of their personal value system.

It is clear that we have a set of rather consistent duties to our patients, including the duty to:

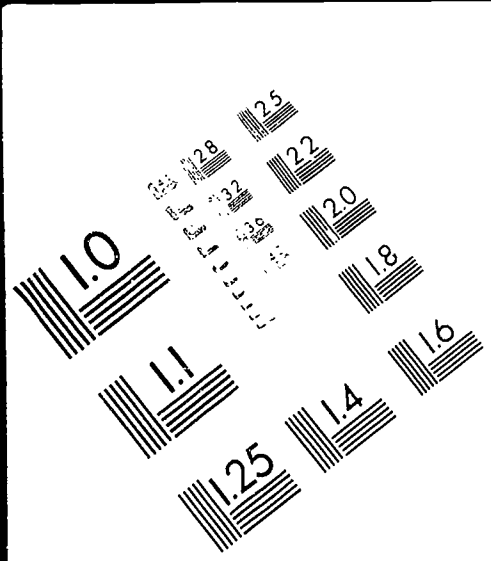
- Serve the health-seeking goals of the patient
- Develop a clear diagnosis and treatment plan
- Elicit the informed consent of the patient prior to any procedure
- Ensure the principle of proportionality in any treatment regimen
- Provide patient education appropriate to the situation
- Serve as an advocate to the pat. nt in taking responsibility for the preservation and maintenance of health
- Protect the privacy and confidentiality of the patient.

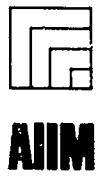
It is sometimes unclear what action to take when the goals of the patient are contrary to our personal or professional values. On the one hand, every physician has the right to hold his or her own set of personal values and/or religious values. On the other hand, the physician has a duty to respect the values of the patient. When these values conflict, how may the situation best be resolved? The physician is usually perceived by the patient as holding a more powerful position. The patient, feels at least "one step down" on the power ladder. How may the physician best meet the presenting needs of the patient, provide education or care for needs that may be perceived by the physician but not yet by the patient, without overly imposing his or her values on the patient?

In considering the following cases, first consider what the patient is asking for. Then look ahead and consider other issues, problems or factors which will likely need attention. Next, consider your personal frame of reference: do you have any reservations about providing the services which the patient is explicitly requesting? What additional services or information should you appropriately render, if any?

Birth Control

A fourteen year old female presents to your out-patient service in an OB-GYN clerkship. Her presenting problem is identified as a need for contraception. She announces that she has recently become sexually active with her boyfriend, a senior in high school; she has heard about the "pill" and





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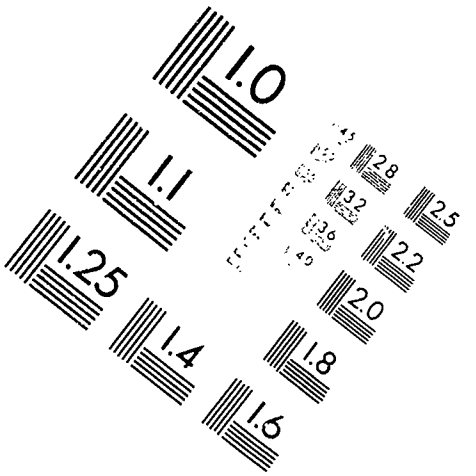

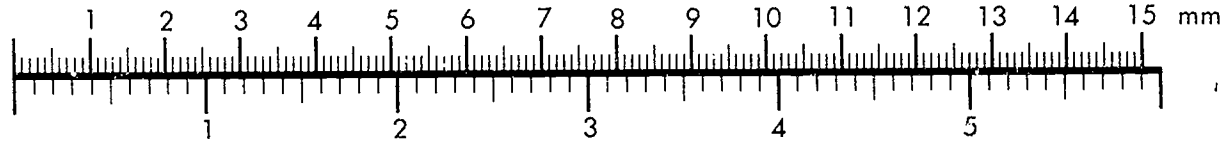

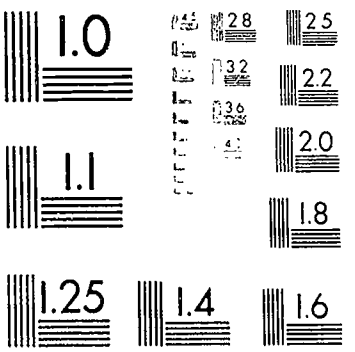

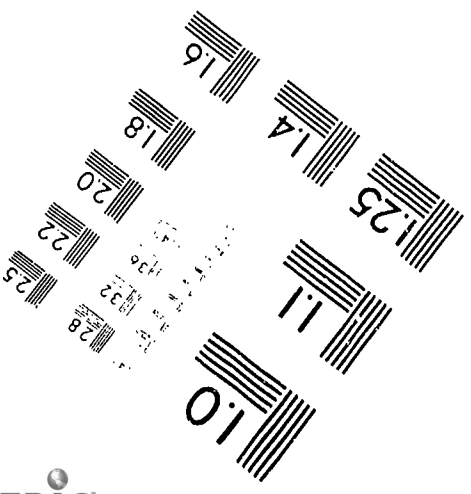

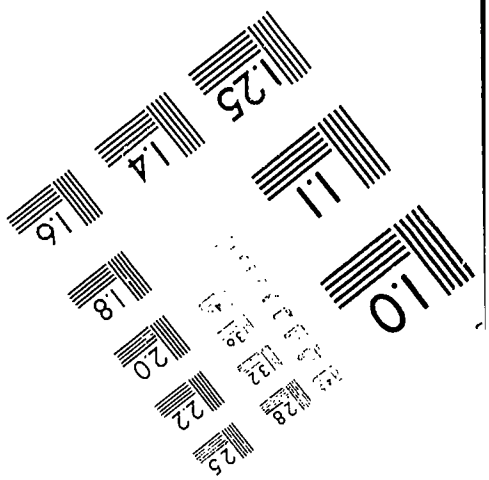

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would like you to get her started on oral contraceptives.

Abortion

A seventeen year old female is the next patient on your service. She is back for the results of her pregnancy test. You find from her lab results that she is pregnant and from her sexual history is now at eleven weeks gestation. She is very upset by the confirmation of the pregnancy and requests an abortion. Your resident suggests that the procedure could be scheduled for later that afternoon, and suggests that you assist in performing this vacuum aspiration of the uterus as an important part of meeting your learning goals in this clerkship.

Student/Teacher Relations

You are a third year clerk on this service; the first two weeks have gone well and you have enjoyed getting acquainted with the other students and the residents. By the end of the third week you can no longer deny to yourself that you feel a strong sexual attraction toward your intern, and the intern seems to be interested in you. You both have Friday night and Saturday night off and the intern invites you to come over after work for dinner, to watch a couple of movies, and maybe stay for breakfast.

Attraction to Patient

In your psychiatry clerkship, you have seen both inpatients and outpatients. You have hit it off particularly well with a patient of the opposite sex who has seen you for an intake interview plus six therapy sessions to help cope with stress and anxiety. At the end of the last session, in which you concluded your work together, coinciding with the end of the clerkship, your patient admits to feeling very attracted to you and invites you over for dinner.

Confidentiality

In your family medicine clerkship a pilot with Northwest Airlines presents with an apparent urinary tract infection. His culture comes back positive for gonorrhea. He is extremely remorseful in explaining that on a weekend layover in Hong Kong, he had been seduced by a woman at the bar and had had unprotected sex. He admits to having had sex with his wife upon returning home, and before he was symptomatic. He requests the standard antibiotic treatment for gonorrhea. His wife is in the waiting room, she has come to the doctor's office complaining of a sore throat and will be your next patient. The pilot requests that you treat her symptoms with antibiotics, giving her a sufficient dosage to insure that if she is infected with gonorrhea, that she will be effectively treated. He also asks that keep his sexual information confidential.

*Adapted from his Introduction to Clinical Medicine II, by Dr. Thomas R. McCormick, Department of Medical History and Ethics, University of Washington School of Medicine.

APPENDIX 3P

To Keep a Secret?*

A young unmarried woman is admitted to the hospital with excessive uterine bleeding which she states is related to regular menstruation. She explains that this has occurred several times during the past year and it greatly concerns her.

As a student on your OB/GYN rotation, you establish a good rapport with her. The day following admission, she asks you, "Will you keep anything I tell you a secret?" You assure her that her confidentiality will be preserved and she goes on to confide the following to you: she had been pregnant and took some medication that she was told would bring on an abortion. She insists that she wants no one even her doctor (your preceptor), to know about this and reminds you of her promise.

- How would this situation best be handled?
- Can you think of more than one option for dealing with this patient?
- What does the word "confidentiality" mean to you?

*Submitted by Andrew Puckett, Ph.D., Associate Dean, Duke University School of Medicine.

APPENDIX 3Q

Insurance Fraud*

You are the primary care provider for Mr. Ritter, a likeable 33 year old factory worker who is covered by his company's health insurance policy. Recently he has had some acute anxiety attacks brought on by several crises in his personal life. You have treated him with some antianxiety medication and with frequent, lengthy sessions of office counseling.

Today, Mr. Ritter states happily that he has had no symptoms in some time and feels the need for medication and counseling has passed. He is, however, concerned about the bills for his many office visits, pointing out that his insurance does not reimburse for psychotherapy or counseling. He requests that you fill out his insurance papers, substituting some organic diagnosis for his real problem. Otherwise, he will be stuck with the bill, causing hardship to himself and his family.

- What will you write on his insurance form?
- If you tell the truth, how will you address your patient's concerns?
- What circumstances would justify falsifying a report?

*Submitted by Andrew Puckett,Ph.D., Associate Dean, Duke University School of Medicine.

APPENDIX 3R

Medicaid Abuse*

Ruth Leavitt, as part of her primary care clerkship in her third year at Stony Brook, has been working for two months for Benjamin Herzen, M.D., a physician in a solo practice on the East End. The majority of the patients are poor and their care is paid for through Medicaid. Dr. Herzen has asked Ms. Leavitt to evaluate patients and propose management plans, e.g. laboratory testing, return visits, modes of therapy, etc. that she feels warranted. Dr. Herzen then reviews her suggestions and alters them as he deems appropriate.

Over the past month Ms. Leavitt has begun to notice a pattern to Dr. Herzen's management of his Medicaid patients. Dr. Herzen regularly performs more laboratory tests and procedures on and requests more follow-up visits for these patients than Ms. Leavitt believes are needed. Moreover his management of Medicaid patients is quite different than that of non-Medicaid patients with identical illnesses. In the latter group he systematically orders fewer tests, procedures and follow-up visits.

One day she is approached by Dr. Herzen, who wishes to discuss her suggested treatment plans. He tells her to be "more aggressive" in performing tests and scheduling return visits for Medicaid patients. When she asks what specific criteria he wishes her to follow, he dismisses her with the comment, "Doing more laboratory tests and procedures and scheduling more visits will increase our reimbursement income. Medicaid not only pays less per procedure than other insurance programs, but pays *so* little that doing more is the only way we can make ends meet. Everyone does it; if we didn't, these patients wouldn't have a doctor at all."

Questions:

Ms. Leavitt is distressed by these remarks and asks you, her classmate, what you think? In particular she wants to know your views on two things:

- What you think of Dr. Herzen's justifications for "padding" some bills?
- Are the arguments he gives to defend his practices sound?
- What, if anything, do you think Ms. Leavitt should do? Give reasons for your conclusions.

*Created by Peter Williams, Ph.D., Medicine in Contemporary Society I, State University of New York at Stony Brook.

APPENDIX 3S

Interaction with Pharmaceutic Companies*

During your second year in medical school, a representative from a major pharmaceutical company provides you and your classmates with stethoscopes.

During your third and fourth years, you attend occasional teaching conferences for which lunch has been provided by a pharmaceutical representative.

In your internship and residency years, you attend conferences with free lunches courtesy of the pharmaceutical firms as often as four times a month. In addition, you receive free textbooks at least once a year.

After a few years in practice, a major pharmaceutical company invites you, as an opinion leader in your local professional community, to a three-day "symposium" in Coral Gables on a new calcium channel blocker. You and your spouse will have all expenses paid for your stay at a very nice hotel which, as the letter points out, has a private beach, three swimming pools, tennis courts, and two golf courses.

Questions:

- How should you respond in each of these circumstances?
- Why are the pharmaceutical manufacturers so generous?
- How much does their generosity cost?

*From Professional Responsibility Course, Yale University School of Medicine.

APPENDIX 3T

A Patient Without Resources*

Mrs. G. is a 75-year-old widow who lives in a senior citizen high-rise in northwest Omaha. The medical student and resident note that the patient is on Medicare, so assume most medical bills will be covered when she is admitted to the Geropsychiatric Unit. Mrs.G. has been severely depressed since her husband died two years ago and she broke her hip three months ago. She has no children and no close friends in the area. She has never learned to drive and either has her groceries delivered or (before the hip fracture) walks to a nearby convenience store. After an unsuccessful trial of antidepressants, she is given a series of ECT treatments. Later she is put on Zoloft for prophylaxis. Toward the end of her hospital stay, she developed a UTI and is put on Macrodantin. On the day of discharge, she is given a handful of prescriptions, is advised to call a cab to get home, and is given a discharge instruction sheet with follow-up appointments to see the psychiatrist, orthopedic surgeon, and geriatric internal medicine specialist--all on different days. No one asks her how she will fill the scripts, pay for the drugs, or get back and forth to medical appointments. Mrs.G. fails to fill the scripts, misses her follow-up appointments, and six months later is referred by neighbors to Adult Protective Services because she isn't eating and is psychotically depressed.

Questions:

- What are the "red flags" in this case?
- What could the medical student have done differently?

*Submitted by Andrew L. Jameton, Ph.D., Associate Professor and Section Head, University of Nebraska Medical Center.

APPENDIX 3U

Collaborating With Social Services*

Mrs. N is a 79-year-old,single, Jewish, retired schoolteacher admitted via Adult Protective Services because her grandiose and persecutory delusions led her to believe that the FBI wanted her to live rent-free in her government-subsidized apartment for elderly Jewish residents; she was 3 months behind in her rent and about to be evicted. In the 1950's she had been evicted from the Paxton Manor for nonpayment of rent. The medical student was fascinated by her claims of being famous for her XYZ invention and really got to know her. He knew she was a bit of a hermit and probably wouldn't comply with outpatient Prolixin shots, even though she was under commitment. He collaborated with the social worker, and together they decided to get a home health nurse to give her her shots and talked Adult Protective Services into providing a transportation aide to bring her in to see the psychiatrist. The medical student next called her landlord and negotiate to have her eviction dropped in exchange for finding a guardian/conservator who would make sure the rent got paid. the student again collaborated with the social worker and asked if there might be a volunteer in a Jewish agency willing to be a guardian. They called the Jewish Bureau for the Aged and learned that the social worker there had known the patient for years and would serve.

Questions:

- What is your view of the medical student's efforts on Mrs. N's behalf?
- Do you see yourself going to similar lengths for a patient? Why or why not?

*Submitted by Andrew L. Jameton, Ph.D., Associate Professor and Section Head, University of Nebraska Medical Center.

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Community_____ S Su F W 19_____

	Inadequate		Adequate		Superior
Identification of moral problem	1	2	3	4	5
Listing of alternative positions	1	2	3	4	5
Fair representation of alternatives	1	2	3	4	5
Taking a position	1	2	3	4	5
Support for position taken	1	2	3	4	5
Acknowledgement of major weaknesses	1	2	3	4	5
Adequate accommodation of the facts	1	2	3	4	5
Use of medical ethics literature	1	2	3	4	5
Quality of writing	1	2	3	4	5
OVERALL	1	2	3	4	5

Final grade for exercise: ____Pass ____Fail

COMMENTS:

APPENDIX 6A

Reporting Preliminary Research Results*

Lauren Janss is a bright, hard-working post-doctoral fellow. She is carrying out important research on dopamine receptors in the brain that may yield a better understanding of Parkinson's disease. When the abstract deadline for the national neurosciences meeting approached, each trainee in the lab, including Lauren, was asked what he or she planned to submit. Lauren hesitated to respond. Dr. Jim Cummings, her chief, urged her to utilize data presented at a recent lab conference because it made a good story and she would have plenty of time to confirm and extend the results before the meeting. Lauren preferred to hold off because, as she explained to Dr. Cummings, she recently has been unable to confirm the main result fully. Dr. Cummings insisted, saying that Lauren was being too timid and that others would get the credit if she delayed. He added that Lauren should not be concerned, as the experimental results were consistent with theory. Dr. Cummings said, "Lauren, you must be more aggressive with your data if you are to succeed in the cutthroat world of contemporary science. After all, it's publish or perish! Why don't you take first authorship on this abstract?"

Reluctantly, Lauren submitted the abstract and to her surprise and Dr. Cummings' delight it was selected for a plenary slide presentation.

Despite an enormous effort, Lauren could not replicate or extend the results and announced to Dr. Cummings that she wished to withdraw the abstract. Visibly irritated by Lauren's request, Dr. Cummings told her harshly that this was not an option and pressed her to do more experiments.

Questions

- What should the research requirements be for submitting an abstract to a meeting?
- If you were Lauren, how would you have responded to the initial request for an abstract?
- If you were Dr. Cummings, how would you have approached Lauren?
- To what extent does a presentation at a meeting resemble a publication? To what extent does it differ from a publication?
- As first author on the abstract, are Lauren's responsibilities any different than if Dr. Cummings had assumed primary authorship?
- In light of her inability to replicate or extend the results, what should Lauren do to correct the record concerning the apparently erroneous results presented in her abstract? How should she respond to Dr. Cummings refusal to consider withdrawal of the abstract?
- Most submitted abstracts never become full papers. If you were Lauren, would you have felt differently if the abstract were accepted for a poster session?

*From: S.G. Korenman and A.C. Shipp. *Teaching the Responsible Conduct of Research Through a Case Study Approach: A Handbook for Instructors.*, Washington, D.C.: AAMC (in press).

APPENDIX 6B

Diversity*

Lisa Berns is a 26-year-old post-doctoral fellow working in the laboratory of Dr. Steven Hodson. There are three other post-docs in the lab, all men. In fact, Lisa's field of science is dominated by men, and she often feels rather isolated. Lisa also finds that, because of attitudes towards women, she has to work twice as hard as her male colleagues to establish her professional credibility.

Her mentor Dr. Hodson, who is forty years Lisa's senior, has an excellent reputation professionally and is extremely well-liked by his colleagues. Dr. Hodson has a charming manner and a clever, often self-effacing, sense of humor. Lisa is quite fond of Dr. Hodson and feels lucky to have acquired a position in his lab. Dr. Hodson does have one trait, however, that detracts from his otherwise admirable character. His repertory of humor often includes remarks about women that border on the distasteful. Often these remarks are couched in terms of Dr. Hodson's prowess with women that are humorous only for their irony, given Dr. Hodson's age and physical appearance. Nonetheless, these remarks, Lisa believes, foster a climate that makes it more difficult for her to succeed in the laboratory. In addition, Dr. Hodson's humor seems to spur the other male post-docs into exchanging jokes and remarks that are less well-intended than Dr. Hodson's brand of humor. Given the other positive aspects of the lab, Lisa decides for the time being to do her best to ignore this problem.

After Lisa has been in the lab for over a year, the time comes for the national science meeting for Lisa's discipline, which will take place across the country in Las Vegas. Last year, Dr. Hodson attended the meeting alone, but this year he has funds to take one post-doc with him. The decision is difficult, but several sessions relate very closely to Lisa's research and Dr. Hodson decides that Lisa has the most to gain by attending. Lisa is delighted, of course, but her fellow post-docs are clearly and understandably disappointed. One day Lisa overhears two of her male colleagues joking amongst themselves that Dr. Hodson's has other than scientific intentions for this meeting. Their quips also suggest that Lisa has done something inappropriate to curry favor with her mentor. Upon overhearing similar remarks on several more occasions, Lisa confronts her colleagues, who retort, "Well, there <u>are</u> certain advantages to being a woman, aren't there?" Lisa feels offended and angry and wishes to pursue the matter further. However, she finds the situation too embarrassing and awkward to discuss with Dr. Hodson and is uncertain what repercussions such a discussion would have on her career.

Questions

- Do Dr. Hodson's actions qualify as sexual harassment? Why or why not?
- Do the actions of Lisa's fellow post-docs qualify as sexual harassment? Why or why not?
- Although it appears that Dr. Hodson may have inadvertently encouraged the behavior of Lisa's male colleagues, should he be held accountable for their behavior? Why or why not?
- Given the awkwardness of discussing the matter with Dr. Hodson, and her affection for him otherwise, how might Lisa follow up on her concerns? What support should she have available to her?
- How might this sort of atmosphere in the laboratory be avoided? Now that the current situation exists, how might it be improved under these circumstances?

Further Discussion

- Consider a somewhat different scenario where the postdoctoral fellow is Gene, a 26 year old African-American male working in an all white laboratory. Rather than facing remarks and innuendo relating to his gender, Gene must deal with subtle, yet pervasive attitudes concerning people of color. When invited to attend the scientific meeting by Dr. Hodson, he overhears remarks, and is eventually told to his face, that Dr. Hodson is "bending over backwards" to provide opportunities for Gene simply because Gene is black and considered disadvantaged. Should Gene deal with this situation any differently than Lisa? Would the solutions proposed in answer to Question 5 above also help prevent this sort of climate in the lab?

*From: S.G. Korenman and A.C. Shipp. *Teaching the Responsible Conduct of Research Through a Case Study Approach: A Handbook for Instructors.*, Washington, D.C.: AAMC (in press).

APPENDIX 6C

Use of Confidential or Proprietary Information*

Tom Owens has an undergraduate degree in microbiology and has been working for almost a year in a lab at Simpson University. He had been planning on entering a Ph.D. program until several months ago when a change of heart led him to begin applying to medical school. His first choice for medical school is Weston University School of Medicine across town, which would afford him and his wife minimum disruption of their lives. Anticipating this future development he applied for a job in a lab at Weston working for a former professor of his, Dr. Larry Hamilton. His former professor is engaged in work very similar to that of his current lab, and is someone to whom he feels greatly indebted for years of mentorship and counsel. Dr. Hamilton has also indicated a willingness to write Tom a recommendation for his application package, a recommendation that Tom is sure will be weighty and influential when considered by Weston's admissions committee.

During a recent meeting when Tom discussed job prospects with Dr. Hamilton, Tom described many aspects of his on-going work because he believed it would make him appear qualified for the new position. As the conversation progressed, Tom began to realize that Dr. Hamilton's area of research was so similar to that of Tom's current boss, that in fact Dr. Hamilton could be considered a competitor. Dr. Hamilton's questions became increasingly oriented to getting Tom to describe the research methods used, and the results obtained by his current lab, questions to which Tom grew uncomfortable.

Questions

- Should Tom be uncomfortable with this situation? Why?
- Should the information that Tom is being asked to reveal be considered proprietary? Why or why not?
- Once employed in Dr. Hamilton's lab, should Tom feel any different about revealing the specific research methods used by his former employer? What about his former employer's preliminary research results?
- Is it necessary to think of Dr.Hamilton as a competitor of Tom's boss? How might Tom facilitate a positive outcome, given the similarity in the research of these two individuals?

*From: S.G. Korenman and A.C. Shipp. *Teaching the Responsible Conduct of Research Through a Case Study Approach: A Handbook for Instructors.*, Washington, D.C.: AAMC (in press).

APPENDIX 6D

Misconduct in Research*

Dr. Martha Shelby, a faculty member at Harrington University School of Medicine, was asked by the editor of a journal specializing in pediatrics research to review a paper on a new drug treatment for childhood leukemia. The paper was submitted by Dr. Stewart Crain, a pediatric oncologist at Cruxton Medical Center and a former colleague of hers when both were on faculty at Chandler Medical School.

In reviewing the manuscript, Dr. Shelby was struck by certain language in the introductory section that had a very familiar, yet not immediately recognizable, ring to it. After finishing the paper, which she found reasonably well prepared, she continued to experience a nagging feeling over the language that seemed to echo something she had read before.

Upon further contemplation, Dr. Shelby recollected a thesis prepared several years ago by an M.D./Ph.D. student at Chandler who worked under Dr. Crain's tutelage. She had reviewed the paper as a member of the thesis committee. By calling the medical library, Dr. Shelby was able to obtain a copy of the thesis and realized that Dr. Crain's introduction incorporated nearly word-for-word the history of therapeutic advances in leukemia described by the student. She was about to call William Sachs, the head of the oncology department at Cruxton, to complain, when she realized that Dr. Sachs was a co-author on the paper. She feared that Dr. Sachs might not take her compiaint to heart.

Questions

- Does Dr. Shelby have an obligation to report her finding? Why or why not?
- Given the various individuals and institutions that might have an interest in this incident, to whom might Dr. Shelby report the apparent plagiarism? Is there any institution to which, or person to whom, she has an obligation to report this finding?
- Assume Dr. Shelby relays her concerns to Dr. Sachs. As a co-author on the paper and Dr. Crains' boss, what are Dr. Sachs' responsibilities once aware of Dr. Shelby's concerns?
- Assume Dr. Sachs is unresponsive. What should Dr. Shelby do next?
- If made aware of the allegation, what are the responsibilities of

  a) the pediatrics research journal editor,
  b) Cruxton Medical Center,
  c) Harrington University School of Medicine, and
  d) Chandler Medical School,

  in responding to the possibility of plagiarism?

*From: S.G. Korenman and A.C. Shipp. *Teaching the Responsible Conduct of Research Through a Case Study Approach: A Handbook for Instructors.*, Washington, D.C.: AAMC (in press).

SELECTED ANNOTATED BIBLIOGRAPHY

Though this bibliography is offered to assist further exploration of the issues raised in this Guide. It is far from comprehensive; while no bright lines separate the following subjects, the bibliography is organized under the following headings:

A) Studies related to College Students and Moral Development
B) Admission to Medical School
C) Student Characteristics and Behavior
D) Medical School Environment
E) Adding Ethics and Human Values to the Curriculum
F) Codes of Conduct and Other Medical School Initiatives
G) Other Studies and Resources

A) Studies related to College Students and Moral Development

Callahan, S. Does gender make a difference in moral decision making? Second Opinion. 1991 Oct.; 17:67-77.

This professor of psychology addresses the claim that women by virtue of their gender engage in unique processes of moral reflection. She examines feminine life experiences arising form biology and social systems and finds that while some convey moral advantages, others are negative conditions to be overcome, and many are morally neutral. For instance, powerlessness can generate self-loathing and a desire to obtain dominance at any cost. However, rearing children provides an experience of actualizing power, as opposed to the less creative power that comes from force and domination. Callahan concludes that while women may weigh certain factors in certain moral decisions differently from men: "thinking, feeling, deciding, acting on behalf of the good and the right is a complex holistic activity that does not depend upon one dimension of the self such as gender".

Gilligan, C., Ward, J.V., and Taylor, J.M., editors. Mapping the moral domain: A contribution of women's thinking to psychological theory and education. Cambridge, MA: Harvard U. Press, 1988.

Well-known for differentiating a "care perspective" from the "justice perspective" on which most previous moral development work had been based, Gilligan expands here upon the theoretical base articulated in In A Different Voice. A central theme of these 14 articles is that morality, conceptualized in terms of how individuals and society construct what is good or bad, should acknowledge a difference in moral orientation related to gender. Individuals whose conception of self is rooted in connections to others seem to be oriented toward responsibility, compared to those whose parameters for self-definition are separation and autonomy. While these differences do not necessarily divide along gender lines alone, men tend toward autonomy and women, toward connections. One of the chapters reports on the responses of Harvard first-year medical students to the Thematic Apperception Test. In their stories in response to pictures, one-third of men but no women found intimacy anxiety-provoking. However, while no men linked isolation with danger, 44% of women found isolation anxiety-provoking. One of Gilligan and Pollack's conclusions here is that, while the men students tend to see more danger in relationships than the women do, women's worries about detachment may be exacerbated by the de-personalization common in many medical settings.

Kibler, W.L. Cheating: Institutions need a comprehensive plan for promoting academic integrity. Chronicle of Higher Educ. 1992 11 Nov.:B1-2.

This university director of student affairs argues that part of the reason why cheating remains such a problem in undergraduate education is that institutions are treating it more as a behavioral aberration rather than as a moral issue. Kibler summarizes results of a national study of 200 colleges and universities on what is being done to prevent or deal effectively with cheating. Nearly one-half could not report the number of cases of cheating handled on their campus over the previous three years because they had not kept track. Only 27% had honor codes, and fewer than half of those had implemented elements to make them "working honor codes". Many stated that they had abandoned their codes because of concerns about their effectiveness. Among other problems uncovered were inadequate involvement of faculty and students in developing and enforcing standards and lack of a

coordinating office or person. The author concludes with recommendations on promoting academic integrity on several fronts.

Noddings, N. Caring: A feminine approach to ethics and moral education. Berkeley: U. of California Press, 1984.

Noddings starts from the premise that we want to be moral in order to remain in the caring relation and to enhance the ideal of ourselves along this line: "It is this ethical ideal, this realistic picture of ourselves as one-caring, that guides us as we strive to meet the other morally." She rejects ethics of principle as ambiguous and unstable: "Wherever there is a principle, there is implied its exception and, too often, principles separate us from each other". Noddings finds a fundamental universality in an ethic of care, rooted in "early memories of being cared for and in our growing store of both caring and being cared for". This book examines that it means to care and be cared for, how caring for another person relates to the larger moral picture, and how caring ultimately functions in an educational context. The focus is one maintenance of conditions that permit caring to flourish.

Rest, J.R. Can ethics be taught in professional schools? Ethics: Easier Said than Done (publication of the Josephson Institute), 1988 winter:22-6.

A leading investigator of moral development, Rest surveyed recent psychological research and concluded that in young adulthood extensive changes occur in the basic problem-solving strategies that people use with ethical dilemmas. These changes are linked to fundamental reconceptualizations in how the person understands society and his/her stakes in society. Rest also found that formal education (as measured by number of years) is a consistent correlate to moral reasoning/judgment scores, with development plateauing when the person leaves school. While it is difficult to assess the relationship of internal psychological processes to actual behavior, some studies here have been reported, a few of which are summarized, e.g., moral judgment scores correlated with how teachers handled disciplinary problems in the classroom and student ratings of teacher performance. One of Rest's conclusions is that new and more effective forms of ethical education can be developed in professional schools.

Stern, E.B and Havlick, L. Academic misconduct: Results of faculty and undergraduate student surveys. J. of Allied Health. 1986 May: 129-42.

Faculty and students at a large midwestern university were surveyed regarding their experience with academic misconduct. Faculty and students differed substantially in their definitions of 24 of 36 described behaviors. The largest discrepancies were for working in a group on an assignment meant to be individual work and for previewing a test from an illicit test file. Over 82% of the students admitted to engaging in some form of academic misconduct during their college careers; there were few differences related to year or gender. The authors recommend that departmental faculty should attempt to reach consensus on the behavior that is expected of students, and then clearly outline the parameters of acceptable and unacceptable behavior.

B) Admission to Medical School

Antonovsky, A. Medical student selection at the Ben-Gurion University of the Negev. Isr. J. Med. Sci. 1987; 23:969-75.

Among the innovations introduced by this medical school in Beer Sheva, Israel, are the increased role of noncognitive factors in admitting students and increases in the responsibility and authority of the admission committee. Candidates to Israeli medical schools take a battery of intelligence tests. BGU applies the threshold concept: a cutoff point is established at close to the 60th percentile, then the individual test scores plays no further role in the selection process. BGU places a great deal of emphasis of the interview conducted by a team of two members of the admission committee. Interviewers receive intensive training, and new interviewers are paired with veterans. Candidates complete an autobiographical form including three standard questions (on moral dilemma, significant experience, and major achievement); interviews take off from these responses, focusing on the student's *deeds and experiences* rather than on "right" words. With particularly promising candidates, interviewers shift from

a relaxed to a more stressful questioning. This article also discusses the reliability and validity of the interview.

Benor, D.E., et al. Moral reasoning as a criterion for admission to medical school. Medical Education. 1984; 18:423-8.

Applicants from two Israeli medical schools were tested on the Defining Issues Test (DIT) which measures the level of principled moral reasoning. No difference was found between the DIT scores of the accepted and the rejected applicants to the Sackler School of Medicine in Tel Aviv, where the admission criteria are the traditional scholastic ones. However, there was a sizeable difference at Ben Gurion University, where great emphasis is placed on students' personal characteristics as assessed by interviews, although DIT scores correlated only moderately with interview scores. If moral reasoning is a key part of professional behavior, these findings deserve attention.

Edwards, J.C., et al. The interview in the admission process. Acad.Med. 1990; 65:167-77.

This overview and discussion of research on the interview includes results from psychology research likely to be of interest to medical school admissions officers. For instance, interviewers tend to develop a stereotype of a good applicant and then try to match the candidates to the stereotype. Another finding is that women applicants tend to be rated lower than men by both women and men interviewers. Among the conclusions are that: the various purposes of the interview may be weighted differently for different groups of applicants; bias in the interviewing process can be reduced by training; and adding structure to the interview increases its validity and reliability. The authors describe methods of adding structure, e.g., performing Success Analysis of Medical Students to generate characteristics on which standard questions can be derived with behaviorally anchored rating scales.

Johnson, E.K. and Edwards, J.C. Current practices in admission interviews at U.S. medical schools. Acad.Med. 1991; 66:408-12.

The authors report on results of a survey of U.S. medical school admissions directors; 72% responded. Virtually all schools reported using the interview to assess applicants' noncognitive skills, and 80% also employ the interview as a public relations tool. Other purposes are to predict applicants' success as medical students (53%), to provide a realistic preview of what medical school is like (47%), and to assess cognitive ability (26%). Less often noted were: clarifying written information, assessing the applicant's fit with the mission, and probing for potential psychological problems and immaturity. Medical schools interview schools interview about 42% of applicants. In admission decisions, schools rely most heavily on interview ratings, followed by science GPA, letters of reference, MCAT scores, and nonscience GPA. While 91% of schools subjectively incorporate interview information into decision-making, 22% statistically weigh the interview with the other variables. Almost two-thirds of the responding schools require applicants to have two interviews. About two-thirds said that their schools provide some type of training for interviewers, with "general interview skills" the most common area of training. Less than half of the schools provide training in more specific areas, e.g., questioning techniques (47%), rapport techniques (36%), listening skills (27%). Even though unconscious and conscious biases exist in most interview situations, only 17% offer training regarding rater bias. The authors collected data on many other aspects of interview structure as well. The authors conclude that practices that can enhance the interview's reliability and effectiveness remain underutilized.

McGaghie, W.C. Qualitative variables in medical school admission. Acad.Med. 1990; 65:145-9.

This essay discusses such qualitative traits as integrity, discipline, honesty and tact in the professional competence of physicians; which, the author states, are most conspicuous when absent. The author examines the available literature and concludes that in the U.S. no tangible progress has been made in using qualitative variables in medical school admission since the 1960s. He puts forward a number of recommendations pertaining to admission data organization and decision-making. For instance, because decision-makers tend to ignore qualitative variables and rely primarily on academic criteria, they need guidance about local values and preferences; evidence indicates that such guidance will help them adjust their judgments about prospective medical students. He also recommends actuarial (in contrast to clinical) methods to identify, weight and judge data about candidates, as a way of better capturing the policy intentions of decision makers.

Self, D.J. Moral dilemmas in medical school admission. Acad. Med. 1990; 65:179-83.

Three moral dilemmas facing admission committees are presented. The first one involves a substantive procedural error on the part of the admission committee which requires the committee to decide whether to violate its policies. The second case regards a clerical error resulting in the dilemma of whether to retract a letter of acceptance to an unqualified applicant. The last case raises confidentiality issues relative to an attempted suicide. Self's discussion of these cases differentiates between mores (which are determined by majority acceptance) and morals (which have to do with the principles of autonomy, justice and respect for persons).

C) Student Characteristics and Behavior

Brooks, C.M., et al. Student attitudes toward a medical school honor code. J. Med. Educ. 1981 Aug; 56:669:71.

This article presents results of a survey of U. of Alabama medical students which assessed their attitudes toward the honor code and personal adherence to its provisions. Support for the concept was high but so was students' reluctance to report suspected violations. Students also indicated confusion as to what constituted a violation. The authors suggest that the integrity of an honor code is jeopardized without an intervention strategy designed to clarify what behaviors constitute a violation.

Brown, R.L., et al. Medical students' decisions to report classmates impaired by alcohol or other drug abuse. Acad. Med. 1992 Dec; 67:866.

Fourth-year students at U. of Wisconsin were asked to assess the likelihood of their referring classmates (hypothetically described in vignettes) to a student-faculty committee for early detection and intervention if they strongly suspected these students of abusing alcohol or other drugs; 72% responded. Of the 99 respondents, 56 said they would report all 16 hypothetical classmates; eight said none. The 35 who would report at least one but not all 16 were less likely to report those who abused alcohol only, who were acquaintances, and who excelled academically. Other results of this study reinforce the conclusion that students at higher risk of substance-related disorders themselves are less likely than others to report impaired classmates. The authors conclude that students need to recognize their responsibility to report impaired classmates.

Cohen, D.L., et al. A national survey concerning the ethical aspects of informed consent and role of medical students. J. Med. Educ. 1988 Nov; 63:821-9.

As part of a larger project (see Cohen, section F), the authors surveyed a national sample of medical students to identify how students identify themselves to patients. Those who introduced themselves as "medical students" differed in their views on selected informed consent issues from students who introduced themselves as "physicians". In general, all the students were less forthright about their status when given the opportunity to perform invasive procedures. Students who introduce themselves as medical students and who also explain to the patients that they are not physicians (5% of respondents) were more likely to be female, serve their initial clerkship in a nonpublic hospital, and have experience primarily with private patients. After multivariate regression analysis, however, only the actions of the students' role models remained significantly associated with the students' behavior. The authors conclude that some students' behaviors are at odds with the requirements of informed consent and that educators should scrutinize the ethical dimensions of the policies they establish.

Crandall, S., et al., Medical students' attitudes toward providing care for the underserved, J.A.M.A. 1993; 269:2519-23.

First and final year medical students at the U. of Oklahoma completed an attitudinal scale about factors associated with the willingness to provide indigent medical care. Senior men students had signficantly less favorable attitudes than first-years, while women students showed no signficant decline. Except for the subscale of physician/student responsibility, women students' attitudes were more favorable than those of males, regardless of class. Given that academic medicine is challenged to supply society with physicians who are willing to provide services to all citizens, the authors suggest that medical educators should try to investigate why women students

seem to be more resistant than men to the process of becoming cynical about caring for the underserved.

Dans, P.E. Medical students and abortion: Reconciling personal beliefs and professional roles at one medical school. Acad. Med. 1992 Mar; 67:207-11.

In the required first-year course Ethics and Medical Care at Johns Hopkins U. School of Medicine, a survey was used from 1983 through 1990 to explore where students drew the line on moral issues. Starting in 1988, a similar survey was administered to fourth-year students. Attitudes toward abortion changed little between the two points and correlated the most strongly with personal beliefs about when a fetus was considered a human life. On this item there was no significant difference between men and women students, though women were more willing to perform and refer for an abortion when birth control failed. The author discusses the difficulty of teaching normative ethics in a secular environment where a diverse group meets for a short time without a unifying moral theory. The teaching approach utilized by the author was analytic and descriptive rather than normative, and he gives examples of how the survey facilitated discussion by displaying the class's pluralism.

Horne, D. J., et al., Reactions of first-year medical students to their initial encounter with a cadaver in the dissecting room. Acad. Med. 1990 Oct.; 65:645-6.

Students at the U. of Melbourne completed pre- and post-dissection questionnaires. About one-third of the students reported experiencing physical effects such as dizziness and nausea, and about one-third reported adverse psychological effects. The authors conclude that preparation for dissection could be improved, and that follow-up opportunities for dealing with professional and emotional issues raised during human dissection should be included.

Kalichman, M. and Friedman, P. A pilot study of biomedical trainees' perceptions concerning research ethics. Acad. Med. 1992 Nov; 67:769-75.

The authors surveyed over 2000 medical students, residents, fellows and graduate students at the U. of California, San Diego; 27% responded. Of these, 23% stated that they had received no training in research ethics; 36% responded that they had observed some kind of scientific misconduct; and 15% that they would be willing to select, omit or fabricate data to win a grant or publish a paper. The trainees planning an academic career were more likely to report having been aware of others' scientific misconduct. Exposure to ethics training was not associated with a difference in past or potential unethical behavior, underscoring the need to assess the efficacy of training activities.

Keenan, C. E., et al., Medical students' attitudes on physician fraud and abuse in the Medicare and Medicaid programs. J. Med. Educ. 1985 Mar; 60:167-73.

The authors surveyed students at the University of California, Irvine, about physician fraud and abuse in Medicare and Medicaid. The students gave these reimbursement programs low ratings, especially on administrative dimensions, and viewed physician fraud and abuse as relatively serious problems, but not as common practices. More than 50% pointed to situational or structural factors as contributing to fraud and abuse, while 20% cited physicians' greed or lack of ethics.

Kopelman, L., Cynicism among medical students. J.A.M.A. 1983 Oct.; 250:2006-10.

This author examines the concept of cynicism (i.e., the disposition to find fault with or to doubt the sincerity of those expressing highminded ideals) as it is used to describe what happens to medical students. The first section reviews common student grievances and their relation to frustrations such as having more material to learn than can be mastered, and being average in a superior peer group. These and other gaps in expectations become important because students must radically readjust their view of the real world, what it means to succeed, and whether it is reasonable to fight for change. The next section summarizes psychological studies of medical students. While the medical profession espouses the goals of gaining proper consent from all subjects and giving appropriate attention to excellence of research design, weaknesses on both accounts are apparent here. The article

recognizes the gap between standards professed and those applied, and concludes that, in some cases a cynical reaction, which shows that one's ideals are still alive, may be preferable to other reactions such as despair.

Kurtzman, C., Nursing and medical students' attitudes toward the rights of hospitalized patients. J. Nursing Educ. 1985 June; 24:237-41.

First- and fourth-year Israeli nursing and medical students completed a survey about the rights of hospitalized patients. All groups shared strong agreement with theoretical rights, but senior medical students scored lowest and senior nursing students highest. Senior nursing students attributed responsibility for protecting patients' rights to nurses, patients and doctors. However, 33% of senior medical students did not assign this responsibility to doctors.

Notman, M., et al. Stress and adaptation in medical students: Who is the most vulnerable? Compr. Psychiatry, 1984 May, 25(3):355-66.

This paper reports results from the first wave of data in a longitudinal study of psychological and physical health concomitants of medical school stresses. The 1980 entering classes at Harvard and Tufts were surveyed, and a subsample was interviewed twice. These students rated schoolwork as being the most stressful of the 11 domains; intimate relationships followed. There were no significant school, sex or minority group differences in the total number of stressful life events reported or the amount of perceived stress regarding life conditions. There were however, differences in perceived sources of stress. The authors discuss the possibility that those who acknowledge difficulties more readily develop an adaptive style permitting greater flexibility of response.

Rezler, A. G. and Haken, J. Affect and research in medical education. Med. Educ., 1984 Sept; 18:331-8.

The authors examined all studies addressing affective issues from a review of the Association of American Medical Colleges Proceedings of Research in Medical Education between 1970 and 1982. Twenty-seven papers were sorted into the following seven categories: personality and values; changes in attitudes; interviewing skills; personality and admissions; personality and career choice; stress and coping style; and miscellaneous. The authors drew a number of conclusions, including: the "typical" student has a high need for achievement, dominance, autonomy, order, and endurance and a low need for impulsivity and play; although studies show that career choice and patient care are influenced by personal characteristics, these bear little weight in the admission process; throughout the course of medical school, personality traits are stable; and informal learning is more powerful than formal coursework.

Self, D., et al. The moral development of medical students: A pilot study of the possible influence of medical education. Med. Educ. 1993; 27:26-34.

Kohlberg's Moral Judgement Interview was given to a sample of 20 Texas A & M medical students at the beginning and end of medical school. Normally expected increases in moral reasoning scores did not occur, suggesting that their educational experience somehow inhibited their moral reasoning ability. No significant correlation was found between moral reasoning score and age, gender, MCAT scores, or GPA. This article includes a theoretical overview of studies of moral development as well as discussing the results of this longitudinal study.

Self, D. and Olivarez, M. The Influence of gender on conflicts of interest in the allocation of limited critical care resources: justice vs. care. *J. Critical Care*, 8:64-74, 1993.

A literature review of moral development studies precedes presentation of the results of two studies. A total of 705 first-year medical and veterinary students took the Defining Issues Test. This test is derived from Kohlberg's work. The women students achieved a substantially higher score than the men, indicating that these women are more effective in the use of justice for resolving moral dilemmas. In another study, a group of 139 medical students and practicing physicians from most specialties were interviewed for moral orientation using the Self-Skeel Moral Reasoning and Orientation Interview instrument (which was partially derived from the Gilligan

Real-Life Conflict and Choice Interview). In the resolution of moral dilemmas, 43% of this group exhibited a justice orientation, and 52% exhibited a care orientation, with the remainder showing a predominance of neither orientation. However, while men showed no significant preference between the justice and care orientations, women showed a decisive preference for the use of a care orientation. The authors conclude that men are more likely than women to use justice in the resolution of moral dilemmas, but that if women do or are required to use justice, they may do a better job of it than men.

Sheehan, T. J., et al. Moral judgment as a predictor of clinical performance. Evaluation & The Health Professions, 1980; 3:393-404.

The authors studied 244 pediatric house officers over four years. Using Kohlberg's standardized interviews and Rest's Defining Issues Test as measures of moral reasoning, and faculty ratings as measures of clinical performance, the data show a consistent relationship between measures of moral reasoning and ratings of clinical performance.

Sierles, F., et al. Cheating in medical school. J. Med. Educ., 1980 Feb; 55:124-5.

A survey completed by over 400 medical students at two American medical schools revealed that 88% admit they cheated at least once in college and 58% in medical school. Positive correlations were found between cheating and three factors--being a transfer student, having cheated in college, and having a cynical attitude toward cheating. The authors also found highly significant correlations between cheating in school and cheating in patient care (e.g., falsifying information about a patient from a laboratory examination, history or physical examination and reporting a finding on a patient as normal without obtaining the information).

Simpson, D. E., et al. Medical students' perceptions of cheating. Acad. Med. 1989 Apr.; 64:221-2.

As part of an institutional review of the honor system, 683 students at a large private medical school completed a survey concerning the appropriateness of cheating behaviors and rated the acceptability of various rationalizations. Students agreed that three of the five traditional forms of cheating were inappropriate; however, only 69% and 38%, respectively, agreed that "copying a lab report from a friend" and "signing an attendance sheet for a friend" were cheating. Students rated three of the four items on dishonest clinical behavior as inappropriate; only 64% said that it is inappropriate to change a DRG diagnosis in order to increase hospitalization time. Freshmen were less tolerant of dishonest clinical behavior than were seniors; conversely, seniors were more likely to confront or report a colleague's misconduct. The finding that freshmen make judgments based on conventional acceptance of societal rules but that seniors more often judge the appropriateness of an act in terms of their internalized standards and by the consequences of an act is consistent with previous research findings and with Kohlberg's theory of moral development.

Stimmel, B. and Yens, D. Cheating by medical students on examinations. Amer. J. Med. 1982 Aug.;73:160-4.

One hundred twenty North American medical schools responded to a survey about cheating. Only 30% had not recorded a formal allegation of cheating in the previous four years. Those schools with an honor system reported an average of 2.4 episodes of cheating compared to 1.6 in schools without a code. The initial allegation of cheating was brought to the administration's attention by the faculty in 44% of instances, by students in 41%, and by proctors in 13%. A formal process to manage allegations was present in 86% of schools. Among the authors' conclusions are that there is substantial diversity of opinion as to how cheating should be prevented and that, although faculty are concerned about their legal liability, in the presence of a formal due process, litigation is extremely rare and likely to be resolved in favor of the school.

D) Medical School Environment

Banks, J.W. and Mainous, A.G. Attitudes of medical school faculty toward gifts from the pharmaceutical industry. Acad. Med. 1992;67:610-2.

The authors discuss results of their survey of U. of Kentucky faculty regarding whether 14 characteristics of interactions with pharmaceutical representatives influence physicians' prescribing behavior. Only a physician's personal relationships with an industry representative was perceived by a majority to influence prescribing. A higher proportion of M.D. than Ph.D. faculty agreed that the following characteristics do not influence prescribing patterns: free samples, trivial gifts, meals, and subsidies for meetings and conferences. The authors suggest that the M.D. faculty may be less negative in this regard because they were the recipients and, thus, limiting gifts would eliminate an occupational perquisite. The authors conclude that policies defining interactions between faculty and pharmaceutical representatives are needed, but more systematic study should be undertaken prior to policy implementation in order to take into account the attitudes of the entire faculty.

Farber, N.J., et al. How internal medicine residents resolve conflicts with attending physicians. Acad. Med. 1990 Nov.; 65:713-5.

Internal medicine residents in one program were surveyed regarding how they resolved conflicts with attending physicians. The results show that when residents find themselves in such conflicts, they tend to either go along with the attending or negotiate. Open defiance, withdrawal from the case, or appeal to a higher authority were used infrequently. In dealing with important procedures and issues, however, residents were more likely to sacrifice a "peaceful" situation for what they perceived as the benefit of the patient.

Hafferty, F. Into the valley: Death and the socialization of medical students. New Haven: Yale U. Press, 1991.

This sociologist followed a class of first-year medical students as they experienced the dissection of human cadavers and other exposures to death and dying. The resulting book is rich with insights about how physicians come to define who is or is not fully human, how they become accomplished at segmenting and isolating their experiences, and how they define error. For instance, Hafferty states: "It is. . .particularly through exposure to anatomy lab, that students are introduced to the expectation that norms about feelings and the control of affect are necessary precursors to the attainment of technical expertise. Feelings, students hear, 'get in the way' of learning." Among his many other insights is that women students were better able than the men to deal with situations involving ambiguity, were more reflective about their own reactions to situations, and were better able to anticipate how emotionally taxing certain situations might be, thus emerging as more supportive and empathetic when peers expressed concerns. In this regard Hafferty observes that a primary reason for their greater comfort with emotion is that a posture of detached indifference is not demanded of women to the same degree that it is of men. Nonetheless, in medical education the predominant trend is the reinforcement of the norms of detached indifference and emotional control.

Klass, P. Classroom ethics on the job. Harvard Medical, Summer 1986, pp. 35-8.

This essay contrasts the "book" learning of the preclinical years with the pragmatic learning that occurs on the wards, especially with regard to medical ethics where theories "take a back seat to considerations of time and pressure, the prejudices of your teachers, and the rhythms of hospital life." Another difficult revelation for students is that, while most start out believing their job is to minimize pain, "this ideal diametrically opposes the most basic elements of clinical training". The author also discusses situational ethics that students witness involving medical mistakes, unnecessary pain inflicted on patients, and patients who are treated aggressively without consulting the patient or family. She concludes: "As medical students see these dilemmas, they learn how they will behave. Either you swear a solemn oath never to do what you saw done, or else you carry with you what you saw as a template."

McCue, J. D. The distress of internship. New England J. Med. 1985 February; 312:449-52.

This overview of the stress of internship focuses on the experiences likely to affect young physicians' future behaviors and self-image. The personal difficulties of residency training are discussed under the following headings: time pressures and intense professional commitment; the shock of responsibility; the demands of delayed personal maturation (given residents' tendency to concentrate most of their energies on the development of their professional identity); and ways in which the resident's job is more difficult now than it was twenty years ago. Suggested interventions in residency training are: early recognition of problems, improved working conditions, and formal and informal supports. Opportunities for involvement in relationships, activities outside the medical center, and a working atmosphere that permits residents to discuss their frustrations are strongly encouraged.

Mizrahi, T. Coping with patients: subcultural adjustments to the conditions of work among internists-in-training. Social Problems, 1984 December, 32:156-63.

This participant-observer in an internal medicine residency program in an urban medical center shows how, as residents adjust to the stresses of their work environment distortions of the doctor-patient relationship and negative reactions to patients develop. She observed that residents use a variety of strategies to distance themselves physically and emotionally from their patients, including narrowing the possibilities for equality in doctor-patient interactions. For instance, attendings and senior residents teach interns and medical students to focus on "medically-relevant" aspects and to "get to the point" whenever the novices present "nonessential" information. The author describes the emotional environment in which the residents worked and their need to restrict the range and depth of their involvement with patients in order to manage their case loads. Much of the language used by the residents in reference to patients was pejorative and sarcastic. 2In her conclusion, the author states that while avoidance of contact with patients seems to contradict the very reason for becoming a doctor, given the structure of this work setting, avoidance may be the most efficient solution to the practical and emotional demands placed on residents.

Novack, D.H., et al., Physicians' attitudes toward using deception to resolve difficult ethical problems. J.A.M.A. 1989; 261:2980-5.

A questionnaire completed by over 200 practicing physicians presented four ethical problems that could potentially be resolved by the use of deception. The majority indicated a willingness to misrepresent a screening test as a diagnostic test to secure insurance payment and to allow the wife of a patient with gonorrhea to be misled about her husband's diagnosis if that were believed necessary to ensure her treatment and preserve a marriage. One third said they would offer incomplete or misleading information to a patient's family if a mistake led to a patient's death. However very few would deceive a mother to avoid revealing an adolescent daughter's pregnancy. The authors conclude that when confronted by conflicting values, many physicians tend to place a higher value on their patients' welfare and keeping patients' confidences that on truth telling for its own sake. They also raise a number of questions, e.g., how could codes of medical ethics more explicitly address the physician's obligation to be truthful and more clearly define which moral imperatives take precedence in situations of conflict. They recommend that a better understanding of deception should lead physicians to a clearer articulation of the principles that guide their actions.

Petersdorf, R.G. A matter of integrity. Acad. Med. 1989 Mar.; 64:119-23.

This essay discusses the likelihood that there may be more aberrations in the ethical behavior of scientists and physicians now than in the past. The author points to examples of students cheating in college and medical school, dishonesty during residency training, and fraud and misconduct in research and medical practice. He suggests that researchers and faculty may turn to fraud when faced with pressures to excel, publish, and win tenure. Also discussed are physicians' ties to research and commercial endeavors, which raise the possibility of conflict of interest. He thus encourages academic medical institutions to establish codes of conduct to govern professional life.

Pfifferling, J. H.. The role of the educational setting in preventing burnout. Family and Community Health, 1984 Feb; pp. 68-75.

This discussion starts from the premise that educational settings can contribute to students' unrealistic expectations. Students arrive with romantic ideas about their goals, expectations about what is deserved based on all the hard work, and an uncritical acceptance of the views of their professors. Unrealistic importance is placed on passing one large examination, which runs counter to encouraging the goals of flexibility, networking, using mentors, and self-education. A number of suggestions for changing educational values are offered, including orientation to problem-solving skills, use of memory-relieving tools, rewards for collaboration, and greater incorporation of community practitioners in establishing curricular objectives.

Sheehan, K.H., et al. A pilot study of medical student 'abuse': student perceptions of mistreatment and misconduct in medical school. J.A.M.A. 1990 Jan.; 263:533-8.

One third-year medical school class was surveyed regarding perceptions of mistreatment and professional misconduct during medical school. Three-fourths of students reported having become more cynical about academic life as the result of episodes of verbal abuse and unfair tactics, such as being assigned tasks for punishment rather than educational purposes. Sexual and racial harassment and ethical misconduct, such as classmates' falsifying information, were also reported by sizeable numbers of students.

Spiegel, D.A., et al. Interpersonal conflicts involving students in clinical medical education. J. Med. Educ. 1985 Nov.; 60:819-29.

Senior medical students at the U. of Illinois responded to questions about the frequency and difficulty of conflict situations. Students reported that, on the average, interpersonal conflicts arose every other work day. The majority of these situations involve conflict with residents, attendings and other individuals in authority roles over something to which the student has no a priori right, e.g., release from an obligation. Students reported the least difficulty with assertive-type conflict situations involving peers and with aggressive-type situations involving nurses. The authors comment that clarification of the rights and responsibilities of students, although possibly helpful in conflicts arising from misunderstandings, is unlikely to resolve or alleviate most of the interpersonal conflicts students experience.

Wu, A., et al. Do house officers learn from their mistakes? J.A.M.A. 1991;265:2089-94.

Asked about their most significant mistake, house officers most frequently reported errors in diagnosis (33%), prescribing (29%), evaluation (21%), procedural complications (11%) and communication (5%). Patients had serious adverse outcomes in 90% of the cases. Only 54% of house officers discussed the mistake with their attending, and only 24% told the patients or families. Those who accepted responsibility for the mistake and discussed it were more likely to report constructive changes in practice. However, residents who blamed job overload and perceived that the institution responded judgmentally to mistakes made *defensive* rather than constructive changes in practice. These results suggest that, since mistakes are inevitable in medicine, supervising physicians need to encourage residents to accept responsibility for their mistakes and provide opportunities for discussing them.

E) Adding Ethics to the Medical School Curriculum

Ales, K.L. et al., Using faculty consensus to develop and implement a medical ethics course. Acad. Med. 1992; 67:406-8.

A new required ethics course for second year students at Cornell U. Medical College was designed to teach students who had not yet started their clinical clerkships to think critically and systematically about ethical issues. A planning model involving faculty consensus was used with great success. Faculty members found the planning sessions intellectually challenging and enjoyable. The students' evaluations over the first two years documented their

satisfaction with the course's content and the structure.

Arnold, R.M., et al., The humanities, humanistic behavior, and the humane physician. Annals of Int. Med. 1987 Feb.; 106:313-8.

These authors observe that efforts to teach and evaluate humanistic qualities in physicians and trainees are marred by ambiguous goals. They posit that the humane physician can be characterized by four distinct qualities: technical competence, humanistic attitude, knowledge of ethical concepts, and humanistic behavior. Testing one characteristic does not ensure competence in other areas. For example, knowledge of informed consent requirements does not guarantee the ability to discuss this concept effectively with patients. The authors suggest ways to combine the humanities and communication skills training in the clinical setting.

Barclay, M.L. and Elkins, T.E. A computer conference format for teaching medical ethics. Acad. Med. 1991; 66:592-4.

At the U. of Michigan, as part of the Introduction to Clinical Sciences course, students participate in a computer conference on three cases raising ethical problems seen in obstetrics/gynecology. The format allows a studnet to respond to the ethics questions at any time during a 12-day period and offers a broad peer review of comments by making responses of the entire class available to everyone. Attendance at the mid-period lecture was not required; however, the high attendance was attributable to the interest generated by the ongoing computer conference .

Bickel, J. Human values teaching programs in the clinical education of medical students. J. Med. Educ. 1987 May; 62:369-78.

Medical school deans responded to a survey about courses designed to improve students' ability to: examine their values in relation to those of patients; communicate effectively with patients; or think critically about ethical issues in medical care. Of the 113 schools responding, 95 reported that at least one such course was required during the first or second year and 38 included a human values course as part of the required clinical curriculum. Faculty were interviewed from programs where integration into clinical education had been achieved. Factors considered most important in this regard were improvement of preclinical human values courses, support of the dean, and positive interactions between clinicians and medical ethicists. Also discussed were course and student evaluation, barriers to integration of courses, benefits of early patient contact, and faculty development efforts.

Christakis, D. and Feudtner, C. Ethics in a short white coat: A report on the ethical dilemmas that medical students confront. Acad. Med. 1993; 68:249-54.

As part of the first clinical medicine clerkship, all third-year medical students at the U. of Pennsylvania Hospital took an ethics mini-course (with 8 to 28 students per month). The fourth-year medical student organizers (the authors) of this course added a distinct session focusing on "ward ethics", i.e., the ethical dilemmas that students confront on the wards. Students were encouraged to present and discuss an ethical dilemmas that they had personally encountered as a clerk. During these discussions, the facilitators' goals included helping the students to: "unpack" their dilemmas, become more attuned to their rationales and motives, develop a framework with in which to address ethical issues with patients and colleagues of varying seniority, and establish a personal ethic appropriate to their role on the medical team. From the cases submitted by the students, the authors developed a taxonomy of students' dilemmas: performing procedures, being a "team player", challenging medical routine, knowing the patient as a person, and witnessing unethical behavior. The authors' recommend that the teaching of medical ethics should be more participant-driven and should assist students with such ethical developmental tasks as voicing disagreement with authorities and weighing educational against patient needs.

Drane, J.F. Becoming a Good Doctor: The place of virtue and character in medical ethics. Kansas City: Sheed & Ward, Inc., 1989.

This author proposes that medical ethics can be strengthened by a return to considerations of virtue and

character. He maintains that before the inner ethical self is forged, a person must be committed to an ideal or a vision of life. However, even if a medical student lacks a natural disposition toward virtue, after realizing that certain forms of moral conduct are indispensable to good medicine, the student can learn to be to be kind, respectful, promise-keeping and the rest. The book goes on to explore a number of specific "virtues" (eg, justice, friendliness) in connection with the demands and opportunities which the doctor/patient relationship presents.

Howe, K. R. Medical students' evaluations of different levels of medical ethics teaching. Med. Educ., 1987 July; 21(4):340-9.

This paper provides the evaluations by 137 preclinical and 216 clinical medical students of different levels of medical ethics teaching at the College of Human Medicine and the College of Osteopathic Medicine of Michigan State University. The results indicate that: students' satisfaction with medical ethics teaching is directly linked to how much they receive; students overwhelmingly prefer the input of both ethicists and doctors rather than either alone; and a preclinical medical ethics course followed by explicit medical ethics teaching in clinical training is a promising approach.

Loewy, E. H. Teaching medical ethics to medical students. J. Med. Educ., 1986 Aug; 61:(8):661-5.

This author examines the evolution and goals of teaching medical ethics and concludes that teachers of ethics must impart knowledge that can be applied to the problems medical students face. Because moral considerations are as much a part of medical decisions as technical considerations, this teaching is best done in the context of real cases with which the student is involved and in which ethical considerations make a critical difference. A brief description of such a teaching program is included.

Miles, S.H., et al. Medical ethics education: coming of age. Acad.Med. 1989 Dec.; 4:705-14.

Medical ethics education is one front of a broad curricular effort to develop physicians' values, social perspectives, and interpersonal skills. The authors review the emergence of medical ethics education over the last 20 years, examine the areas of consensus concerning objectives and premises, and describe teaching methods and program evaluation. Also discussed are premedical preparation and the four "institutional pillars" necessary for successful medical ethics education: dean's support; an administrative home; faculty development; and collaboration among faculty.

Self, D.J., et al., The effect of teaching medical ethics on medical students' moral reasoning. Acad.Med. 1989 Dec.; 64:755-9.

This study compares two methods of incorporating medical ethics into the curriculum. Students took the Defining Issues Test before and after the course. Results indicate a significant increase in the level of moral reasoning of students exposed to the course. The case-study method was more effective than lectures in increasing students' level of moral reasoning.

Southgate, L. J., et al. Teaching medical ethics symposium: A student-led approach to teaching. J. Med. Ethics, 1987 Sept; 13(3):139-43.

During a six-year period of teaching medical ethics in a general practice module, there was a shift from a teacher-centered to a student-centered approach in which students choose ethical issues to explore within the framework provided. The issues raised are discussed with examples, and future directions are outlined.

Wertheimer, M.D., et al., Ethics and communication in the surgeon-patient relationship. J. Med. Educ. 1985 Oct.;60:804-6.

Incorporated into the surgery clerkship at the U. of Massachusetts Medical School is a two-hour session on ethics and communication. Using videotape vignettes, the moderators assist the students to consider principles governing the doctor-patient relationship, the establishment of rapport, acquisition of bedside manners, and issues

of paternalism and control. Students are also encouraged to consider how their own personalities can assist or hamper understanding and treatment of patients.

F) Codes of Conduct and Other Medical School Initiatives

Aschenbrener, C.A. Student honor codes in medical school. GSA Report, 1990 Spring; 20:1,4.

AAMC's Group on Student Affairs surveyed U.S. and Canadian medical schools concerning student honor codes; 93 schools responded (66%). Forty-five schools indicated they currently have a student honor code. Of the 48 schools without one, 39 have never had one. Reasons given for discontinuance were student disinterest, need for revision to meet legal requirements, and belief that such a system was an insult to the honest but no deterrent to the dishonest. All 42 schools that described their honor system indicated that the honor code covered academic dishonesty in examinations; other infractions covered by the majority included: plagiarism, falsification of patient records, unethical conduct broadly-defined, falsification of clinical presentations, unethical conduct with a patient, harassment of others in the medical community, and willful property damage. Only 43% indicated that their honor codes applied to financial aid and substance abuse. Student responsibility for peer conduct is an important component of the majority of honor systems, with 81% requiring students to report infractions by other students and 55% indicating that a student who did not report an infraction was subject to discipline. Requiring students to sign a written pledge is common. This survey also collected information on appeal mechanisms and sanctions.

Borenstein, D. B. and Cook, K. Impairment prevention in the training years: a new mental health program at UCLA. J.A.M.A. 1982 May; 247:2700-3.

The program described here offers free psychiatric evaluation and short-term psychotherapy to UCLA medical students and house officers, utilizing a large group of physician volunteers. Autonomy, confidentiality and low-cost are distinctive features. Follow-up was conducted to explore whether patients' experiences with the program changed attitudes toward psychotherapy and toward passive, wait-it-out coping mechanisms on which medical trainees traditionally rely. The authors note that the program is designed to prevent not only disorders such as substance abuse, but also "hardening of the spirit".

Cohen, D.L., et al. Informed consent policies governing medical students' interactions with patients. J. Med. Educ. 1987 Oct; 62:789-98.

In order to determine compliance with the guidelines of the U.S. government and the Joint Committee on Accreditation of Hospitals pertaining to informed consent, the authors conducted a study of hospital administrators, medical school department chairpersons, and medical school deans concerning policies on student involvement in patient care. The results show that only 37% of all responding teaching hospitals specifically informed patients that students would be involved in care. Only 51% of the responding medical schools that gave their students guidance on initial patient interaction insisted that their students introduce themselves as students and clarify their role in patient care. The authors conclude that medical educators' compliance with the ethical requirements of informed consent is incomplete.

Clouser, K. D. A covenant between physician and patient. Ann. Int. Med. 1985; 103:941-3.

With the assistance of the author, a class of medical students wrote a covenant to be read responsively with the audience at their graduation. The covenant emphasizes mutual understanding and agreement between physician and patient and avoids pitfalls and anachronisms common in associated with traditional oaths.

Dickstein, E., et al. Ethical principles contained in currently professed medical oaths. Acad. Med. 1991;66:622-4.

In 1989 all U.S. medical schools reported administering an oath to graduating medical students. The most frequently used was a version of the Oath of Hippocrates. A pledge resembling the ancient Hippocratic Oath was used by 60; 47 used the Declaration of Geneva; 14 used pledges demonstrating contemporary ideas and wording;

14, the Prayer of Maimonides; 4, the Oath of Lasagna; and 2, the Doctors' Meditation by Axelrad. Some schools offered students a choice of pledges. Among those reporting oaths in the first three of these categories, the authors found that at many schools the oaths used did not necessarily reflect the schools' titles for the pledges. Even though traditional titles were retained, in many instances the oaths contained ideas that were inconsistent with the standard versions. No one pledge contained all of the ethical principles of respect for patients' autonomy, veracity, nonmaleficience, beneficence, confidentiality, and justice. The investigators also note that even though today's society highly values patient autonomy, most of the oaths failed to reflect this. The authors recommend that schools should examine their oaths for relevance in guiding present day and future medical care.

Puckett, A.C., et al. The Duke University program for integrating ethics and human values into medical education. Acad.Med. 1989 May; 64:231-5.

Beginning from the assumption that students who are treated humanely will be humane, ethical and caring in their relations--with each other, their instructors and their patients--this new program blends cognitive and affective approaches to integrating human values into medical education. At the core of the program is the establishment of direct relationships between four advisory deans, each of which is responsible for a quarter of each class. Other elements include clinical correlation seminars during basic science courses, improved career and mental health counseling, improved student feedback and evaluation during clerkships, and cultural enrichment opportunities.

G) Other Studies and Resources

American Board of Internal Medicine. A guide to awareness and evaluation of humanistic qualities in the internist. Portland, OR:ABIM, 1991.

The ABIM prepared the second edition of this Guide to further assist residency directors in fulfilling their responsibility to assess residents' humanistic qualities deemed essential for certification by the Board--integrity, respect and compassion. The Guide defines humanistic qualities and describes how attitudes and behavior can be influenced. Four cases are offered as bases for discussion as well as evaluations forms and a practical annotated bibliography.

American College of Physicians. Ethics Manual. Phila, PA: ACP, 1989.

This handbook for physicians opens with an overview of the historical evolution of medical ethics. Under "The Physician and the Patient", there are sections on medical risk to the physician, confidentiality, conflicts of interest, financial arrangements, and discontinuing the treatment relationship. Other major sections include "The Physician's Relationship to Other Physicians", "The Physician and Society", "Research", and "Initiating and Foregoing Life-Sustaining Treatment". The goal of the manual is to help practicing physicians address some of the challenging ethical dilemmas that confront them each day; the ultimate intent is to improve the quality of care provided to patients. (Reprinted from Annals of Internal Medicine. 1989; 111:245-52; 327-35.)

Association of American Medical Colleges. Policy guidelines for addressing HIV infection in the academic medical community. Washington DC: AAMC, 1988.

This report of the AAMC Committee on AIDS and the Academic Medical Center offers recommendations on the need for and objectives of policies regarding cases of HIV infection among medical students, residents, and faculty. It also includes recommendations on protecting individuals from discrimination, proper handling of information, medical school admissions, career counseling, and managing occupational risks. AAMC's statement on physicians' and students' professional responsibility in treating AIDS patients is included as an appendix (also published in Academic Medicine, Vol. 63, July 1988).

Association of American Medical Colleges. Report of the Working Group on Personal Qualities, Values, and Attitudes to the General Professional Education of Physician (GPEP) Project Panel. J. Med. Educ. 1984 November, 59:177-91.

This Working Group promulgated a number of recommendations for related to students' developing moral sensitivity and integrity and a commitment to help and work with others. Medical school faculty members are asked to accept greater responsibilities in four major areas: selection of students who have the potential to develop the values and attitudes desired in a physician; demonstration of behaviors they desire their students to develop; design of educational offerings that foster students' values; and design of evaluation systems to reinforce positive qualities and attitudes in students. Specific examples are offered in each area.

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