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BEYOND THE HIPPOCRATIC OATH: THE NEED FOR ETHICS COURSES IN MEDICAL SCHOOL CURRICULUM

A Thesis

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Master of Arts

Degree

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ABSTRACT

This thesis is an attempt to defend the movement toward implementing ethics courses into the medical school curriculum. In Chapter I, the need for ethics courses is demonstrated by the number and importance of moral and ethical concerns in the clinical setting. Factors such as technology, economics, and the changing structure of health care delivery are shown to intersect with the practice of medicine, and at these intersections, moral and ethical issues can be sharply defined.

Chapter II discusses the traditional methods of dealing with medical moral concerns - adherence to codes and oaths by the physicians. Such codes and oaths are shown to be inadequate in dealing with moral issues in the medical setting and the conclusion is reached that a new approach must be implemented.

In Chapter III, formal courses in ethics are proposed as an alternative or supplement to codes of ethics. The goals of such courses are discussed, and contrasted to those goals promoted by the Hastings' Institute.

In Chapter IV, empirical evidence for the correlation of moral reasoning and moral behavior is presented. It is then concluded in this chapter that if courses in ethics focus on cultivating students' abilities to rationalize and justify their moral behavior, subsequent improvement in behavior should follow.

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CHAPTER I

INTRODUCTION

The past three decades have witnessed a subtle but undeniable transformation in the intervention of medical technique on illness and injury. This transformation has developed slowly, amidst the explosion of medical miracles and the wonder of technical triumphs. Insidiously it has grown into the fiber of medical practice such that now, even as its cumulative effect is felt by all who participate in the medical system, its appearance goes unrecognized and its ill effects go unsolved. This transformation has come about with the successful harnessing and directing of scientific knowledge towards solving the puzzles of illness and injury that plague society.

This transformation was the gradual fusion of technological skill with the medical aim of curing and caring for the sick and injured. Originally partners in a common goal (to elucidate the mysteries of nature to thereby improve the quality of man's existence), aspects of technology and medicine have fused and hence become confused in aims and goals. This partnership has undoubtedly advanced the state of the science of medicine with remarkable speed. The past thirty years have brought medical advances unparalleled at any point in the history of medicine. Presently however, the inability of society to separate technical performance

from the fundamental purpose of medical care has resulted in the creation of a new form of human drama - that of determining the extent of medical intervention into the life and death processes of patients.

As the medical profession becomes increasingly dependent on technology as the response to illness, injury, and some would argue even death, the moral dilemmas inherent in the practice of medicine[1] become more frequent, more acute, and more complicated. In an age where the medical tools of the trade were limited, and knowledge of the human body was restricted to immediately observable phenomena, the course of action in the healing process was relatively straightforward. The Galenic maxim of the physician being Nature's helper implied the over-arching understanding that Nature should be allowed to run its course. To interfere with the natural course was not the physician's aim.

The advancement of scientific knowledge gradually dispelled the notion that the course of Nature was unalterable and the medical profession quickly adopted this new attitude. Science and technology have become synonymous with medicine in their aims to control and manipulate nature for the benefit of man. The physician's primary aim in modern medicine is to combat the natural course of action of bodily injury

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[1]Edmund D. Pellegrino, M.D., Bulletin of the New York Academy of Medicine, 54(7), July 1978, pp. 625-639

and disease to prevent the human body from succumbing to disease and death.

The benefits of this fusion of technology and medical practice have been well-documented. The most dramatic examples are provided with such highly technical tools as pacemakers, respirators, dialysis machines, CTscans, artificial limbs, artificial hearts, and the like. Surgical instruments have also been revolutionized by technology. Lithotripsy by laser is one recent example of the reduction of a major invasive surgical procedure to a relatively minor one due to the improvement of the surgical instruments used.

Pre-natal diagnostic procedures involving amniocentesis and ultrasound techniques have made early detection and subsequent treatment of fetal anomalies possible. Laboratory procedures have improved in efficiency and accuracy with sophisticated microscopes and computers. Pharmacological advances, due to progress in biochemistry, produce a host of new drugs yearly to combat illness, and progress in the field of immunology combined with pharmacology has brought organ transplantation within an acceptable risk-benefit ratio.. The production of so-called test-tube babies is convincing proof of the sophistication that the fields of biochemistry, microbiology, and cellular biology have attained.

The media have personalized many of these medical miracles. There was the poignant story of David the "Bubble

Boy" who, because of his birth with severe combined immunodeficiency disease (SCID) lived the twelve years of his life in a specially designed chamber known as the bubble. It protected him from the germs that his body could not fight. The bubble was a crowning technological achievement, yet David's death in 1984 touched off controversy about life in a laboratory. Then there was the joy of the Browns with the birth of Baby Louise, the first baby ever to have been conceived by in vitro fertilization. Public and professional opinion ranged from outrage of conception in a petrie dish, to hope for thousands of childless couples. The nation watched with a mixture of fascination and horror as Baby Fae struggled to live with a tiny baboon heart beating in her chest; and, upon her death, she was hailed as the tiny pioneer of cross-species organ transplantation. There was the massive search for a life-saving liver for young Jamie, when her father, frantic in his fight to save his daughter's life, broke down and sobbed "Please don't take my sunshine away" on a nation-wide televised appeal. And finally, the nation cheered as Barney Clark, the new recipient of an artificial heart, smiled and waved to news reporters from his hospital bed.

These names, and the controversies their particular circumstances evoked, are immortalized in the history of medical progress. For some, like Louise Brown, their very existence is controversial. For others like David, Baby Fae,

and Jaime, controversy surrounded their continued existences, and for still others like Barney Clark and Karen Ann Quinlan, the controversies surrounded the prolongation of their lives. These are perhaps the most dramatic examples of the influences of technology in the context of the practice of medicine. The highly dramatic invasiveness of technology in each of these circumstances illustrates how dependent on and directed by technology physicians have become.

This litany of examples by no means exhausts the influences of technology on medical practice. As dramatic examples they serve only to point out the extremes of technological intervention. These influences are apparent in even the most mundane encounters of the clinical setting. The purpose of listing the above examples is to underscore the dramatic shift in the abilitites of medicine and technology to radically alter human life - from its very conception to its end. The result is an increasing inability of the medical profession to keep pace with the ramifications of the use of technology in patient care.

In addition to the situations created by an increasingly sophisticated technology, the changing structure of health care delivery is also raising issues no less important than those posed by technology. Implementation of the Diagnostic Related Groups (DRG's) is placing constraints on hospitals and physicians alike with regards to length of patient hospitalization and third party payments. Medicare and medicaid

are heavily depended on by the elderly and indigent patient populations respectively, to pay for medical expenses but limitations of coverage often lead to economic burdens that must be absorbed by the hospitals and society. These social and economic factors play as large a role in medicine as does technology, and bring with them their own sets of problems and concerns.

In their uncertainty, the medical profession has exhausted the traditional guidelines of ancient declarations, finding little more than vague allusions to broad classes of actions and accompanying guidelines. Traditional medicine such as that practiced by Galen and Hippocrates, with limited tools and knowledge of the human body, is no longer being practiced. New guidelines must be set and a new approach must be implemented to deal with the problems in modern medicine, if technology is to continue playing a major role in medical care and social and economic factors are to be dealt with effectively. The modern physician must be trained to deal with the ramifications of medical care in an increasingly complex society.

This thesis examines the proposal to institute courses in ethics in the medical school curriculum as a means of preparing young physicians for their roles in a profession that is undergoing radical changes in both its ability to alter human life and its impact on society at large. The proposed aim of such courses is to provide an educated

profession with a means of coping with the pressing moral concerns of their practice, highlighted and dramatized by such cases as Baby Fae and Louise Brown. Although many physicians may never encounter such dramatic cases in their work, issues will arise in the every day clinical setting that are of equal importance.

> Medicine is at heart a moral enterprise. All its efforts converge ultimately on decisions and actions which are presumed to be good for some person in need of help and healing.
>
> What has not been so clear until very recently-and what puzzles many physicians today - is that medicine must also be an ethical enterprise. That is to say, the physicians' actions must have some rational justification beyond simple conformity to one or another ancient or modern professional code, however admirable. It is now essential, I submit, that ethics as a formal discipline be recognized to be as integral to the practice of responsible medicine as the basic clinical sciences.2

As Dr. Pellegrino has pointed out, ancient codes of conduct are no longer the whole solution to the concerns facing today's physicians.

The barrage of technical triumphs and medical miracles has matured the technical aspects of medicine at an extraordinary rate. The boundaries of the Hippocratic Oath and other professional codes have long since been outgrown, and the dilemmas that are raised by innovative techniques threaten to outpace the ability of the medical profession to

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[2]Ibid., pp. 625-626

ascertain the ethical solutions. Added to this is a growing cultural awareness of individual rights, most notable for the medical profession, patient rights. In addition to the rights' movement there is an increasing moral pluralism in the American society as well as economic and social factors that intersect with and effect the practice of medicine.

There is an apparent need, although there are those who question its validity[3], for serious reforms in the education of the modern physician, if the medical profession hopes to be able to cope and practice effectively in the highly technical and morally pluralistic society we now find ourselves confronting. Ancient Grecian precepts no longer satisfactorally address the pressing moral and ethical issues of medicine in our society. To adhere to them simply on the basis of tradition is to lose sight of the true aim of medicine - that of improving the quality of health, and therefore life of the people it professes to serve through its knowledge and skill.

This introduction has outlined some of the factors such as moral pluralism, increasing technological skill, economic factors, and the structure of the health care delivery system, that all intersect with the practice of modern medicine. A claim has been made that there is a serious need to educate

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[3]Frank W. McKee, M.D., "Teaching Medical Ethics," Letter to the Editor, JAMA, 241(1), 27, Jan. 5, 1979

the physicians in a formal manner to deal with such factors and the ramifications that these factors have on the practice of modern medicine.

In Chapter II of this thesis, codes of ethics, beginning with the Hippocratic Oath, are examined critically to determine the extent of their usefulness in resolving moral and ethical dilemmas in the practice of medicine. It will be shown that, although the utilization of codes has some value in approaching moral dilemmas, there are for the most part too many deficiencies in the codes to promote effective and ethical resolutions of the dilemmas.

It is the contention of this thesis, therefore, that the modern medical profession must go beyond codes such as the Hippocratic Oath and Declaration of Geneva in the search for ethical resolutions of the moral dilemmas inherent in the practice of medicine. In Chapter III, formal courses in ethics will be proposed as a necessary supplement to the utilization of codes in attempting resolutions of ethical and moral dilemmas.

Two alternatives to the utilzation of codes and oaths will be discussed - the alternative of formal courses in ethics, and the alternative of allowing students and physicians to approach moral concerns individually, without the guidance of either codes or oaths. Within this discussion, the goals of the courses of ethics will be discussed. The

recommendations made by the Hastings Center Institute of Society, Ethics, and the Life Sciences, will be analyzed as a valuable and informative comparison of those goals and recommendations proposed by this thesis for ethics courses. Questions and conception of relativism and indoctrination, as well as a working definition of morality will be dealt with in this chapter.

In Chapter IV, the actual implementation of ethics courses into the medical school curriculum will be discussed. Before this is done however, the appropriate question of whether or not the development of moral reasoning can be related to the development of moral behavior must be answered. In an attempt to illustrate this relationship, the structural-developmental approach developed by Harvard's Lawrence Kohlberg will be looked at. Given the impact and the implications of his theory, it provides a useful means of empirically determining (or at least indicating) that such a relationship between moral reasoning and moral behavior exists.

Since it is not the purpose of this thesis to outline or propose a specific and detailed educational program for the implementation of ethics courses into the medical school curriculum, but only to point out that the need for such education exists and that formal moral education will prove effective in addressing the moral concerns in medicine, the comments concerning the instruction of medical ethics

will therefore be brief. It will be left to those who specialize in curriculum development to design such courses as are proposed here.

In summary, it is hoped that this thesis will provide a convincing argument for the utilization of ethics courses in medical education.

CHAPTER II

MEDICAL CODES OF ETHICS

Throughout the history of medicine, codes, oaths, prayers, and creeds have been formulated to articulate the responsibilities and obligations of physicians towards their patients and their profession. This chapter will explore some of these formal expressions of directives for medical conduct. It will begin with the exploration of one of the most ancient and revered codes of the medical profession and follow the evolution of three medical codes taken to be representative of the progressive expansion of ethics codes, through to the Ethics Manual put forth by the American College of Physicians in 1984.

In this comparison of the various codes and oaths, it will be pointed out that from ancient Greek medicine to that which is practiced today, there is a shift in the complexity of the issues that are brought before codes of ethics for resolution. This shift is apparent in the progressive expansion of the codes in an attempt to make them more applicable to the variety of issues facing the modern physician. Expansion of the codes to incorporate guidelines on the growing number of issues however, does not necessarily entail that they have become more explicit in their recommendations for appropriate action. Indeed, in many instances the codes have been expanded at the expense of becoming

more general, more vague, and therefore open to wider interpretation.

The difficulty of interpretation underlies many of the difficulties in applying codes, which are by nature written in broad generalizations:

> simple reliance on professional moral codes is inadequate to cope with the complex obligations imposed on the modern physician. Professional codes are of necessity couched in general terms, terms often vaguely defined and open to serious differences of interpretation in their application to specific cases.[1]

This chapter will compare three codes of ethics - the Hippocratic Oath of ancient Greece, the Declaration of Geneva of the 1948 World Medical Association, and a new revision of the Principles of Medical Ethics adopted by the American Medical Association in 1980. The Ethics Manual put forth by the American College of Physicians in 1984 will also be discussed. This comparison is intended to show an evolution of the codes to incorporate an increasing number of issues that intersect with the practice of modern medicine. The effectiveness of such codes in dealing with increasingly complex factors will be discussed throughout the chapter.

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[1]Edmund D. Pellegrino, M.D., Bulletin of the New York Academy of Medicine, 54(7), 629, July 1978

We begin with the Hippocratic Oath. This Oath is perhaps the single most dominant influence on the development of Western medical codes of ethics. For centuries, this Oath has been the helmsman of the ethical course of action for various groups of physicians, at times used literally and at other times used as a basis for more elaborate codes of ethics or as an expression of an ethical "spirit" which cannot be expressed in a code.

Historically, the Oath reflects the central teachings and beliefs of the Pythagorean school of philosophy and medicine of ancient Greece. The Pythagoreans however, were but a small segment of the Greek population and the Oath was not widespread in its acceptance by medical practitioners. In fact, admonitions in the Oath forbidding the physician to assist his patients in suicide, abortion, euthanasia, or through surgery, ran contrary to accepted practices in ancient Greek society. It is well known for instance, that infanticide was practiced in Sparta upon the birth of sickly or deformed infants, or perhaps even if the infant was an unwanted female. Many references are made in the ancient literature to the recognition of suicide as an acceptable alternative to a life of illness and impairment:

> an excellent verdict in Plutarch's opinion - with regard to "those who patiently endure long illnesses: 'I hate the men who would prolong their lives/ By foods and drinks and charms of magic art/ Perverting nature's course to keep off death;/ They ought, when they no longer serve the land,/ To

> quit this life and clear the way for youth'" (Consolatio ad Apolloonium 15; Loeb). 2

And with regard to the physician's assisting the death of the patient, Plutarch also states that, "The best physician is he who does not allow his patients to linger but buries them as quickly as possible."[3] Plato himself states that

> therefore our politic Asclepius may be supposed to have exhibited the power of his art only to persons who, being generally of healthy constitution and habits of life, had a definite ailment;...he did not want to lengthen out good-for-nothing lives, or have weak fathers begetting weaker sons; - if a man was not able to live in the ordinary way he had no business to cure him; for such a cure would have been of no use either to himself, or to the state.[4]

He suggests in this statement, a form of passive euthanasia condoned by examples of Asclepius.

Written by the Pythagorean physicians for the Phythagorean physicians, the Oath outlined behavior appropriate for their particular medical philosophy. The Oath states:

> I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill

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[2]Owsei Temkin and C. Lillian Temkin, Ancient Medicine: Selected Papers of Ludwig Edelstein, Baltimore, The Johns Hopkins University Press, p. 382. 1967

[3]Ibid., p. 382

[4]Plato, The Republic and Other Works, Translated by B. Jowett, Anchor Press/Doubleday, Garden City, N.Y., p.97, 1973

according to my ability and judgement 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 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 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 fulfill 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.[5]

In 1948, the General Assembly of the World Medical Association undertook to rewrite the Hippocratic Oath in an

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[5]Warren T. Reich, Editor in Chief, Encyclopedia of Bioethics, New York: The Free Press, p. 1731, 1978

effort to make the Oath more applicable to the standards of medical care in the twentieth century. The resulting guideline was the Declaration of Geneva. The Declaration was drafted under conditions much different from those in which the Hippocratic Oath was written, and these conditions are reflected in the Declaration's mandates. Most notably, the world was in shock in the aftermath of the revelation of the medical atrocities committed on prisoners in Nazi Germany in the name of science and research, and hence the rationale for the statements concerning party politics and the practice of humane medicine even under the threat to do otherwise. The Declaration states that:

> At the time of being admitted as a member of the medical profession:
>
> I solemnly pledge myself to consecrate my life to the service of humanity;
> I will give to my teachers the respect and gratitude which is their due;
> I will practice my profession with conscience and dignity;
> The health of my patient will be my first consideration;
> I will respect the secrets which are confided in me, even after the patient has died;
> I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;
> My colleagues will be my brothers;
> I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;
> I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honor.[6]

The focus of the Declaration of Geneva is obviously much broader than that of the Hippocratic Oath. The concerns of the medical profession are more worldly and are expressed in such statements as "service to humanity," avoidance of considerations of "nationality," and "party politics." The code was designed to provide guidance to a post-war group of physicians facing a larger number of issues than those faced by the relatively homogeneous and less worldly group of physicians in ancient Greece.

The final code in this comparison is the new AMA's Principles of Medical Ethics adopted by the AMA House of Delegates in 1980. It reads as follows:

> The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.
>
> I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
> II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

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[6]Ibid., p. 1749

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best intersts of the patient.
IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use talents of other health professionals when indicated.
VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.[7]

Again, this code is much broader in scope than the Hippocratic Oath. Like the Declaration of Geneva, it is concerned to a large extent with responsibilities to patients in the context of society. Most notable in the AMA's statement are the number of references to legal observances.

The comparison of these three codes of ethics, as well as the Ethics Manual, will illustrate the increase in the number and complexity of issues that intersect with the practice of medicine in the modern society. The codes have therefore expanded in their guidelines out of necessity, but how effective they are in providing appropriate and in-

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[7] Connecticut Medicine, 44(9),p. 599, Sept. 1980

informative direction in dealing with ethical and moral problems is questionable. The evolution of the expansion of the codes and their effectiveness in directing ethical action will be the focus of the following discussion.

The Hippocratic Oath is divided into two areas of concern regarding the practice of medicine. The first part is concerned with the physician's professional ethics - those duties and obligations involving medical education, the physician's teachers, and his colleagues. The second part of the Oath is concerned with what may be termed the physician's clinical ethics - those duties and obligations entailed in the involvement with and treatment of patients.

With regard to the physician's professional ethics, the Oath relies heavily on the imagery of the family unit to convey the relationships that the physician should employ when dealing with his teachers or colleagues. The ideal of the family evokes expectations of respect, loyalty, and interdependence between its members. These expectations however can be broadly construed. Take the example of family loyalty as an attribute that physicians should emulate in dealing with their colleagues and teachers. How is the degree of loyalty to be employed established? Is it not conceivable for instance, for loyalty to be interpreted as standing by and protecting the members of a family regardless of what they do - the "family right or wrong" attitude? Those who define family loyalty as absolute may be unwilling

to acknowledge a professional obligation to report an incompetent practicing physician.

While the underlying ideal of the family image is important in its intention to foster loyalty and respect among the physicians and to promote a strong unity between students, teachers, and colleagues, the attributes need further articulation and justification in order to be truly effective in guiding ethical action. As such, although familiar, the image is vague in its guidance of ethical dilemmas that arise between physicians and their colleagues.

The Declaration of Geneva reduces the image of the family to that of a brotherhood. Teachers, instead of being accorded the status of parents are given due respect and gratitude. Colleagues are still regarded as brothers, but the model of the family unit has been abandoned in favor of a fraternal affiliation. There is however, still the difficulty of interpreting what the attributes of a brotherhood should entail, and how such attributes, once defined, should apply to the medical profession. In the AMA's Principles, no mention is made of either the family unit image or the fraternal one, although most medical communities still consider themselves part of a brotherhood. In the AMA's Principles, the physician's duties towards his or her colleagues are expressed as honesty in dealing with them and respect for their rights. In addition, it is explicitly stated that the physician has the duty to expose an incompetent physician.

The gradual abandonment of the use of the image of the family as a guideline for professional relationships can be better understood in the context of the historical development of medical practice. Much has changed since the Hippocratic Oath was drawn up by the Pythagoreans ofancient Greece. The highly influential Flexner Report[8] of 1910 catalyzed an entire restructuring of the American and Canadian medical educational systems. This reform eliminated virtually all forms of medical education outside of that provided in selected and approved institutions. Guidelines and requirements have become progressively regulated such that today, access to comprehensive medical knowledge along with the legal conferral of the privilege to practice are only provided through medical schools. Gone are the days of Hippocratic apprenticeship, when a young man learned the techniques and art of medicine through service with an experienced physician. Medical education is now standardized in its course of instruction and requirements to practice.

With the institutionalization of medical education however, came the loss of the highly personalized father-son relationship between teacher and student in the Hippocratic tradition. It has been replaced by the pressured and largely

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[8]Abraham Flexner, Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching, The Carnegie Foundation for Advancement of Teaching, Bulletin no. 4, New York, 1910

impersonal environment of the medical school. Large lecture halls are now the forum in which thousands of facts are fired from instructor to students. Training once imparted by one physician to one or two apprentices has been replaced by large institutions that educate thousands of students each year. There is little opportunity for students to develop close enough personal relationships with all of their instructors and fellow students for the family unit image to be useful in guiding their personal relationships. Necessarily then, the code has evolved to eliminate this image and incorporate the broader obligations of respecting individual's rights.

The second part of the Hippocratic Oath articulates the physician's clinical ethics. It is quite explicit regarding certain treatments for patients. The physician may never administer a deadly drug deliberately to anyone, even if asked for it, thereby eliminating any discussion or consideration of acts of beneficent euthanasia. The physician may not give a woman an abortive remedy thereby disallowing for situations in which the unborn child will be delivered at the expense of the mother's life. Finally, the Hippocratic physician may not employ surgical means to help heal the patient.

Perhaps the most important concept in the Hippocratic Oath in the treatment of the patient is the concept of nonmaleficence mentioned twice in the code's guidelines. In

one place the Oath obliges the physician to "keep them from harm and injustice" and in another place states that the physician must go to the patient's house "for the benefit of the sick, remaining free from all intentional injustice." This concept has been generally verbalized in the words "do no harm" and this maxim is still predominant as a guiding principle of ethical action. The difficulty of interpreting this principle will be explored in more detail at the end of this chapter.

The Declaration of Geneva has no explicit guidelines on the treatment of patients. At most it compels the physician to respect life "from the time of conception." Given this statement, what must be done in the case where only the mother or child, but not both, can survive the childbirth? Since the continuum of life must be respected from the time of conception to the end according to the Declaration, what criteria should the physician use in determining which life will be saved, if the ability to save either life is possible? Although the Declaration does not specifically prohibit abortion, neither does it provide guidance in this particular decision. The predominant principle in the treatment of patients according to the Declaration is a version of the "do no harm" maxim that instructs the physician to have the health of his patient as the primary consideration, but it lacks any specific guidance in situations such as the maternal-fetal one discussed above.

The Principles of the AMA have even fewer specific guidelines on the actual treatment of patients than did the Declaration of Geneva. At most, it states that the physician has the duty to provide competent medical service to patients. There are no specific huidelines on the administration of drugs, deadly or otherwise, nor are there specific guidelines on abortion. In place of specific guidelines, the physician is encouraged to provide relevant information to the patient population and to seek changes in the social setting of factors which are contrary to the health of those people.

With regards to assisting the physician in making treatment decisions, codes have evolved to allow for the maximum amount of interpretation in each case. For example, whereas the Hippocratic Oath forbade its physicians to give a woman an abortive remedy, the AMA Principles state only that the physician should be providing competent care for his or her patients. In Current Opinions of the Judicial Council of the American Medical Association it states that:

> The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.9

However, the vagueness inherent in such a broad guideline of allowing the physician to perform an abortion as long as it

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[9]Current Opinions of the Judicial Council of the American Medical Association, Chicago, Il., p. 2, 1982

is done competently and within the limits of the law, does not begin to address the relevant moral issues involved in what in most cases would be termed competent medical care.

For example, competent care is not the issue in providing a therapeutic abortion. There are significant ethical considerations such as respect for life and maternal versus fetal (?) rights that come into play and should be addressed. There are no provisions within this code to provide for clear-cut guidance in analyzing the values of such an action.

Involved in the actual treatment of patients is the development of relationships and interactions with them. Guidance concerning this aspect of the physician's clinical ethics also varies in specificity in the development of the codes. The Hippocratic Oath approaches the physician-patient relationship from a paternalistic viewpoint. Twice the Oath refers to the physician's ability and judgement in determining what should be done for the patient. No mention is made of the patient's participation in such decisions.

Also stated in the Oath in relation to the physician's interaction with patients is the duty to refrain from sexual exploitation of patients and the obligation to keep confidential any information regarding the patient and/or the patient's life. These are essentially the guidelines for the physician's conduct towards his patients, according to the Hippocratic Oath.

Finally, in the AMA's Principles of Medical Ethics, confidentiality is once again stated as an important principle in the interactions with patients. There is however, an added condition to the confidentiality. Patient confidences may be hald safeguard only within the constraints of the law.

The paternalism so apparent in the Hippocratic Oath is almost non-existent in the 1980 AMA Principles. In lieu of this, physicians are encouraged to respect the law and in particular, to respect the rights of patients. The difficulty in allowing for the respect of each patient's rights as opposed to a paternalistic approach leads to conflicts within the clinical setting. Different people have different priorities concerning the values that go into making a decision about appropriate medical treatment. Inevitably, differences in values sometimes lead to conflicts over the course of action concerning the care of the patient. How is this to be resolved by a code that merely says to respect the rights of patients?

Guidelines in the codes concerning actual physician-patient relationships have changed to accomodate society's perception of the role of the physician and the subsequent role of the patient. The paternalistic view which dominated the Hippocratic tradition of medical practice has been replaced in modern codes by talk of patient rights, respect for patient autonomy, and respect for the law. Continuous

throughout the practice of medicine is the principle of patient confidentiality, but it too is being limited by legal constraints.

The authority of medical care appears to have shifted in a major way from the physician to society. The practice of medicine has become more closely associated with values and laws of society, and codes have developed along this trend. The scope of codes, as has been shown here, has widened to incorporate these elements which intersect with the practice of medicine. They have not, however, become any more definitive in their directives for action.

The American College of Physicians has attempted to fill in some of the major gaps in codes by publishing an ethics manual. This thirty-four page manual provides a bit more detail regarding the basic tenets of the AMA's code of ethics, but it still lacks effective guidance for the physician. For example, with respect to confidentiality, the Manual merely reiterates what has already been stated by the AMA with the additional statement that the physician must be prepared to accept legal consequences if he or she determines that the court's order to release confidential information does not override the obligation to the patient. This statement does little to help the physician to weigh the values involved in making a decision involving this dilemma.

From a forty line code written in ancient Greece to a thirty-four page manual written in 1984, the content has evolved to include an increasing number of factors from outside the medical profession that influence medical practice. As has just been illustrated, these factors include moral pluralism, patient rights, technology, legal constraints, and societal obligations.

The main point in this chapter is to indicate the inherent difficulty in the interpretation of those tenets and principles put forth in codes and oaths. For the most part, codes and oaths state the principles as absolutes giving little opprtunity for evaluation of the values that underlie such statements.

To illustrate the need for a more detailed approach to the interpretation of the principles that are put forth in codes and guide the practice of modern medicine, the following discussion will focus on one such principle and two very different approaches to medical care based on subsequent interpretations of the principle. An analysis of each approach exemplifies ethical reasoning. It is this ethical reasoning in which, it is argued in this thesis, medical students and practicing physicians alike should be versed in order to be able to apply their own codes to concrete situations, and also to resolve disagreements between interpretations such as that which is to be illustrated in two approaches to the interpretation of the principle of non-maleficence.

The principles of "do no harm" is perhaps one of the most, if not the most, significant guideline in the practice of Western medicine. It appears in the Hippocratic Oath and is present in some form in nearly every subsequent ethical code since then. Robert Veatch considers this principle to be the "core of traditional physician ethics in Western medicine."[10] For the purpose of this discussion, interpretation of the word "harm" will be the focus in the application of the principle of non-maleficence to the practice of medicine by Richard Brandt and Ivan Illich.

Richard Brandt, in his article "A Moral Principle about Killing"[11] formulates the consideration of a non-injurious, almost beneficial killing. He gives the example of a severely mangled, but not quite dead, cat. He happens upon the animal and swiftly kills it, putting it out of its suffering. He claims that although he has killed the animal, he has not injured it. Brandt appears to equate the extent of injury inflicted with the amount of pain caused by the infliction and concludes therefore that he surely cannot have injured the cat by relieving it of its pain. In other words, it can be interpreted that since the mangled cat is

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[10]Robert M. Veatch, A Theory of Medical Ethics, Basic Books, Inc., Publishers, N.Y., N.Y., p. 10, 1981

[11]Ronald Munson, Intervention and Reflection, Wadsworth Publishing Co., Belmont, Ca., pp. 174-178, 1983

beyond any other pain than it is already suffering (meaning that the cat is in a state of maximal physicial suffering), Brandt cannot possibly cause it any more pain by killing it, and therefore by not causing the cat any pain, he has not injured it. In this way, by equating harm with pain, Brandt suggests a non-injurious killing, contrary to the belief that all killing is the greatest harm that can be inflicted on a living being.

He then quickly moves this concept into the hospital ward where a person is being kept alive only by means of an extensive life-support system and has no prospect of ever regaining consciousness. Brandt claims that this situation is analogous to the cat example. This person is in a state that is beyond any greater injury (by his definition of injury as inflicting a greater pain than is already being suffered) that can be inflicted on him. Thus by killing him, one would be relieving him of his suffering and by not causing any greater pain in the process, no injury will have occurred. In other words, the principle of non-maleficence has not been violated according to Brandt. Since no greater pain has been inflicted on the person than he is already suffering, no injury and therefore no harm has been done to the patient. The maxim of "do no harm" has not been violated.

Brandt suggests that we view killing with these considerations in mind: First, we should question whether or not the killing is injurious in the sense that Brandt has

defined injurious to mean (that of causing greater harm or pain than is already being suffered), and second, we should consider the wishes and directives of the person involved if possible. If the person has stated at one time or another what he or she would want done in that particular or similar situation, those wishes should be followed. He concludes with the statement that

> killing a person is not something that is prima facie wrong in itself; it is wrong only if and because it is an injury of someone, or if and because it is contrary to the known preferences of someone.[12]

Brandt concludes that there is no obligation to continue (or not to terminate) the life if the patient is beyond injury.

> there is not a prima facie obligation not to terminate (life) when there would be no injury, or when there would be a positive benefit (release from pain) in doing so provided the patient has not declared himself otherwise or there is evidence that his wishes are to that effect.[13]

An interesting contrast to Brandt's views on pain and injury and his subsequent conclusions, is provided by Ivan Illich's chapter on "The Killing of Pain" in his book Medical Nemesis: The Expropriation of Health. In this essay, Illich seems to regard the alleviation of pain by drugs as a

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[12]Ibid., p. 175

[13]Ibid., pp. 177-178

dulling of the person him or herself. "Increasingly, pain-killing turns people into unfeeling spectators of their own decaying selves."[14]

Illich's conception that pain-killing is a violation of the principle of non-maleficence is subtle but powerfully provoking in its implications. He deals with several cultural conceptions of pain and contends that in the modern Western context, medicine is defined as the art or science of dealing with illnesses of the human body. He claims though that in dealing with bodily dysfunctions, Western medicine seeks to remove the "human" entity from this definition, and with it the social context in which it defines itself. To be human implies social interactions or collective relations to other human beings and the environment. Illich claims that modern Western medicine seems to be attempting to divorce illness in man from the social context in which it is manifested, and to define it within the limits of the individual's own body. Modern Western medicine is a systematic deconstruction of the relationship between the biological and social body of man. Pain, illness, and death are taken out of context of social and cultural experience and alienated as foreign or detrimental threats to the stability of the social structure. Illness and disease are not

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[14]Ivan Illich, Medical Nemesis: The Expropriation of Health, Pantheon Books, N.Y., N.Y., p. 154, 1976

seen as results of, or necessary interactions with society and human relationships, but as biological flaws in the individual entity.

Medical intervention for the alleviation of pain then, violates the maxim of "do no harm" not on man the physicial being, but on man the social being. Illich claims that prior to the onset of technological intervention and therapeutic pharmaceuticals, the Western man had a culturally acceptable way of dealing with illness, pain, and death. With the advancement of Western medical practice, illness, pain, and death were transformed into technical matters. He claims that because of this transformation,

> People unlearn the acceptance of suffering as an inevitable part of their conscious coping with the reality and learn to interpret every ache as an indicator of their need for padding and pampering.[15]

Illich contends that traditional cultures

> confront pain, impairment and death as challenges soliciting a response from the individual under stress; medical civilization turns them into demands made by individuals on the economy, into problems that can be managed or produced out of existence.[16]

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[15]Ibid., p. 133

[16]Ibid., p. 133

Illich refers to pain as intense aliveness and states that with the elimination of pain comes the loss of independence. Dulling the pain reduces patients into docile household pets and with the rising levels of induced insensitivity to pain, the capacity to experience simple joys and pleasures of life has equally declined.

> Increasingly stringer stimuli are needed to provide people in an anesthetic society with any sense of being alive...by equating all personal participation in facing unavoidable pain with 'masochism', they justify their passive life-style. Yet while rejecting the acceptance of suffering as a form of masochism, anesthesia consumers tend to seek a sense of reality in ever stronger sensations.17

This loss of independence, the dulling of the senses to alleviate pain is what Illich sees as a violation of the "do no harm" maxim. It is this 'killing of pain' as he calls it that does the greatest harm to a person, replacing dignified suffering with "artificially prolonged, opaque, depersonalized maintenance."[18]

Brandt and Illich illustrate, with their analyses and subsequent interpretations of the principle of non-maleficence, how very broadly the principle can be construed. Brandt is able to justify euthanasia without violating the principle, while Illich sees the alleviation of pain as a

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[17]Ibid., p. 152

[18]Ibid., p. 154

harm against man the social animal, and therefore a direct contradiction to the "do no harm" maxim. Illich states that pain is a part of life and to flee from it through either drugs or death is to give up intense aliveness. Brandt on the other hand seems to indicate that when the pain or injury is so great that no greater pain can be inflicted, as in the mangled cat example, fleeing the pain, and in the case of those responsible for the care, the obligation not to extend the suffering, is perfectly acceptable even to the point of killing the person.

From the identical maxim, two very different interpretations based on two different priorities of values - Brandt with the priority of death over a life of pain, and Illich with a priority of life with pain, over death as a solution or life dependent on drugs to escape the pain (loss of independence) - have resulted in widely diverging opinions about health care and the obligations of health professionals. In the case of an accident victim whose body has been severely burned over ninety percent for example, the approaches to health care advocated by Brandt and Illich would differ widely. Brandt would argue that if this victim is beyond any greater pain that could be inflicted on him, then there is no obligation to sustain his life. Illich on the other hand views this solution, as well as treatment by drugs, as giving up what he terms intense aliveness. Granted both of these articles are somewhat extreme in their contentions,

but the comparison is helpful in acquiring a realization for the difficulty in the interpretation of three deceptively simple words.

As was pointed out a few pages ago, most codes of ethics insist that the physician "do no harm" to his or her patients. What does this principle mean for the physician who must implement some sort of treatment plan for the severely burned patient in the example above? Is the physician in violation of the principle if he or she medicates the patient to reduce the level of pain, as Illich would contend? Or is the principle unviolated if the physician injects the patient with a lethal dose of phenobarbitol to induce the patient's death and put him out of his suffering? According to Brandt, the principle of non-maleficence has not been violated by this approach.

Such is the major problem with the utilization of codes of ethics or oaths in dealing with ethical problems in medicine. Written with words that are of necessity general and vague, codes and oaths leave open a wide range of interpretations and can result in conflicting and inappropriate actions in the care of patients.

The solution proposed here in this thesis is that of implementing ethics courses into the medical school curriculum in order to equip the physician to evaluate interpretations of ethical principles, and to apply such principles effectively in the clinical setting. Take for example the two

interpretations of "do no harm" presented by Ivan Illich and Richard Brandt. Which interpretation would a physician implement, if either, in clinical practice and why or why not?

A brief analysis would begin like this: in Brandt's interpretation of the "do no harm" maxim, "harm" is equated with the infliction of pain greater than that already being suffered. What is the basis for this definition? Is there a justification of equating harm with pain? Is it a valid justification if there is a justification? If so, why, and if not, why not? This question of the validity of Brandt's equation of harm with pain is a crucial one to answer, because it is the basis for Brandt's entire interpretation and conclusion of the principle of non-maleficence. To briefly summarize his argument, if harm equals infliction of pain greater than that which is already being suffered, and someone or something is in a state of pain such that no greater pain can be inflicted, than the killing of the person or thing to put it out of misery is not a harm, since no greater pain has been inflicted. Therefore, the principle of non-maleficence has not been violated. If it can be shown however that there is no basis for equating harm with pain, the Brandt's interpretation and subsequent conclusions are invalid. The same methodology of analysis can be employed with Illich's interpretation to determine its validity.

Once such an analysis is made of the interpretation of the principle, resolutions must be made between disagreements in interpretation or implementation of the meaning in a clinical situation. For example, what must be done if it can be shown that both Brandt and Illich have sound arguments and interpretations of "do no harm?" Only one or the other interpretation can be applied, so which will it be?

There are those who might argue that the freedom of interpretation is what constitutes the art of medicine. Just as formal principles of science are interpreted and manipulated at the physician's discretion according to each individual case, some might argue that the formal principles of morality and ethics should likewise be left to the physician's interpretation in each individual case.

This point is well taken. However, in the practicing of the art of medicine, a good decision is distinguished from a bad decision according to how well scientific principles are manipulated. The basis of this process is the quality of reasoning employed in manipulating the principles and interpreting them in the individual case. Moral problem solving can likewise be done well, or it can be done poorly depending on the rationale used in manipulating formal principles and defending value priorities.

It can also be argued that before a physician is free to interpret the principles of science in treating patients, he or she must first be instructed as to what those principles

are and how they are employed. The art of medicine, in order to be successful, must have its basis in sound scientific knowledge, clinical skills, and interpretive judgment. The same argument can likewise be stated for the interpretation of ethical principles in the clinical setting. Interpretation of ethical principles must likewise be grounded in knowledge and skill, as well as in judgment.

The following chapter will argue that courses in ethics in the medical education can provide the basis from which good moral decision-making can be developed. Chapter III will raise some important arguments concerning the goals of ethics courses.

CHAPTER III

ETHICS COURSES

In Chapter I, several examples of moral concerns in the medical profession were illustrated. They represent, although by no means do they exhaust, areas of moral and ethical components in the medical field. For the purpose of this thesis, it is not necessary to claim as some do that "every decision -- even those which are unproblematic -- has significant value and ethical components."[1] It is only necessary to show, as Chapter I has done, that there are some important medical decisions which have significant value and ethical components. These decisions cannot be adequately addressed by the sole manipulation of scientific facts and therefore require another approach.

In Chapter II, one approach of dealing with moral concerns in the clinical setting was discussed and rejected on the grounds that it was inadequate in approaching resolutions to moral problems. It is important to note here that the rejection of the use of codes and oaths as the sole method in addressing moral problems is not an objection to the content of the codes and oaths per se, but is rather an objection to the promotion of and adherence to the codes and oaths by

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[1]Glenn C. Graber, "Teaching Medical Ethics in the Clinical setting: Objectives, Strategies, Qualifications," University Of Tennessee, forthcoming

students and physicians without adequate consideration, reflection, and understanding of them and their application to medical practice.

In this chapter, two other alternatives in approaching and attempting resolutions of moral concerns in the medical setting will be discussed. One alternative to codes and oaths is the implementation of formal courses in ethics into the medical school curriculum. It will be argued that this alternative, as opposed to the one of not having formal courses and allowing students and physicians to approach moral concerns individually, will be the more effective of the two.

Before the mechanics of the actual implementation of the courses can be discussed, we must begin by establishing what the aims of ethics courses in the medical school setting should be. This discussion will serve a two-fold purpose; by establishing the aims of ethics courses, (1) the content of such courses can be better defined and (2) certain objections to formal ethics courses, based on misconceptions about the purposes of such courses, will be overcome.

In order to define the aims of ethics courses, we should first ask what it is that we hope students to gain through the study of such courses. Two main goals have been alluded to in previous chapters. In Chapter I, a number of clinical situations were outlined to illustrate moral concerns in the medical profession. At some point in each of these

situations, as is the case with a majority of clinical encounters, the physician is faced with the question of which course of action he or she should follow in treating the patient. A choice for action therefore usually must be made. It would be ideal of course, if all possible courses of action could be probed, considered, and argued to determine which action is the best of all possibilitites. Realistically however, it is a fact of medical practice that a decision usually has to be made in a relatively short period of time. Sustained and detailed philosophical argumentation and discussion about each alternative in treatment is not a realistic nor a necessary expectation in the clinical setting. Time with patients is limited and circumstances of illness and injury establish their own time limits, resulting in decisions which require quick assessment, judgment, and action.

To be relevant for the physician in the clinical setting therefore, ethics courses must be concerned with and sympathetic to the circumstances in which many medical moral decisions are made. Decisions requiring immediate action must often be made without the luxury of sustained reflective thought enjoyed in the practice of armchair philosophy. Ethics courses therefore must be concerned with cultivating students' dispositions toward moral behavior in situations which allow for little opportunity for sustained reflection and consideration, as well as in the many sutuations where there is ample time to engage in philosophical reflection.

In Chapter II however, medical oaths and codes of ethics were shown to be inadequate in dealing with moral concerns in the clinical and professional settings, in part because they promote action according to pattern or rule without explanation or justification. If courses in ethics are to avoid these same objections in dealing with medical moral concerns, they must also be concerned with cultivating the students' abilities to support their actions through systematic reflection and consideration of alternative actions, objective rationality, and justification. Ethics courses therefore must work within this dynamic tension created by the need for ample time for sustained philosophical reflection and inquiry, and the actual availability of only limited time in many instances for actual decisions in the clinical setting.

The proposed aim of ethics courses therefore is two-fold: (1) to cultivate students' dispositions towards moral behavior, by which is meant to promote that the students act in accordance with those moral principles deemed relevant in any given situation through philosophical consideration, and (2) to cultivate students' abilities to support those actions by reflective consideration and rational justification. To focus solely on promoting that students act in accordance with moral principles is to fall into the same trap of conditioning behavior (or indoctrination) promoted by the sole use of codes and oaths, or more markedly by "role model"

teaching of attending physicians, which ultimately stunts the development of students towards becoming morally autonomous individuals. In the same respect, to focus only on the intellectual aspects of morality without relating the teachings to actions, transforms the study of ethics solely into an exclusively intellectual enterprise, interesting in itself but irrelevant to immediate clinical cases. Courses in ethics therefore, should focus on cultivating students' dispositions towards moral behavior as well as focusing on the intellectual aspect of that behavior in relation to the medical setting.

As a valuable and informative comparison, as well as a justification of these aims, I have chosen to discuss and critique the recommendations made by the Hastings' Center Institute of Society, Ethics, and the Life Sciences, for appropriate goals of ethics courses. The publication "The Teaching of Ethics in Higher Education" is a compilation of current problems and suggestions of teaching ethics by an impressive group of scholars and educators. Their insights and suggestions are valuable, but there are underlying sentiments in their suggestions of teaching ethics that defeat the ultimate purpose of ethics courses. This point will be drawn out in some detail.

In the section "Ethics in the Professional Education" Daniel Callahan and Sissela Bok, and the supporting contributors to the publication recommend that:

> courses in professional ethics at the graduate level include the following emphases: (1) personal ethical dilemmas that will be faced by professionals; (2) the ethical choices and judgments involved in selecting, defining, and analyzing concrete problems, and in weighing, judging, or recommending particular broad policies and patterns of conduct; (3) an analysis of value dimensions, and implicit biases of methodologies and practices of particular disciplines.[2]

They go on to state that

> Students being introduced to ethics at the professional school level should, that is, understand the kinds of personal decisions they are likely to encounter and the broader context of those decisions (where ethical issues may be as much a matter of policy or institutional practice as of individual dilemmas);[3]

This approach is qualified by the statement that students

> should recognize that almost all methods or approaches used by particular disciplines in analyzing problems in their field may themselves contain a significant value component.[4]

Most obvious in the comparison of the goals of ethics courses set forth in this thesis and those promoted by the Hastings Center, is the specific omission by the Institute

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[2]Daniel Callahan, Sissela Bok, et. al, "The Teachings of Ethics in Higher Education," Hastings-on-Hudson,N.Y.,1980,p.34

[3]Ibid., p. 34

[4]Ibid., p. 34

of recommending that influencing student behavior should be the goal of ethics courses. In fact, after listing five specific goals of ethics courses - (1) to stimulate moral imagination, (2) to promote recognition of ethical issues, (3) to develop analytical skills, (4) to elicit a sense of moral obligation and personal responsibility, and (5) to promote tolerance and resistance of disagreement and ambiguity, the Hastings' Committee makes the following statement:

> One goal frequently propsed for courses in ethics is missing from our list: that of changing student behavior. It was the most troublesome issue we had to face. Many educators and others, we discovered, believe that there is no point in teaching an ethics course unless it will assure improvement in student conduct. We have concluded that this is not an appropriate explicit goal for a course in ethics. At the least, it would be naive to pin one's hope for improvement in behavior on any one course. Moreover, to bring about such changes, professors might engage in highly questionable techniques of manipulation. These would not only be inappropriate, they would also beg some important moral questions - about what constitutes improvement, for instance - that are precisely those that the students should be free to debate.[5]

They admit to one possibility of ethics courses contributing to a behavioral change. The course does not directly change the students' behavior but merely "sets the stage" for change by providing them

> with the skills necessary to change their verbal behavior, i.e., by providing them with the tools for a

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[5]Ibid., p. 54

> more articulate and consistent means of justifying their moral judgments and of describing the process of their ethical thinking.[6]

They recognize the implications of sophistry in this approach but state that

> that danger must be run in order that students learn the necessity of providing public and articulate reasons for their ethical conclusions.[7]

The Hastings' Committee concludes the section on the goals of teaching ethics by stating that

> the courses will have served an important purpose so long as they help students perceive, articulate, and analyze moral problems, even in the absence of direct effects on conduct.[8]

Let us review the five goals promoted by the Hastings' Committee and then look at the subsequent statements concerning ethics courses in some detail so as to draw out the underlying assumptions of these recommendations.

The goals stated by the Hastings' Committee are unexceptional and unobjectionable as definitions of the basic structure of ethics courses. The first goal that the Hastings' Committee aims for in ethics courses is to stimulate the

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[6]Ibid., p. 54

[7]Ibid., p. 54

[8]Ibid., p. 55

moral imagination of students. By this they mean that

> Students should be encouraged to understand that there is a "moral point of view" (to use Kurt Baier's phrase), that human beings live their lives in a web of moral relationships, that a consequence of moral positions and rules can be actual suffering or happiness, and that moral conflicts are frequently inevitable and difficult.9

In other words, this is an exercise in sensitivity, designed to promote empathy for those experiencing the consequences of moral positions and rules.

The second goal stated by the Hastings' Committee is to promote the recognition of ethical issues, which is an attempt to

> shift from the emotions and feelings that have been evoked to a conscious, rational attempt to sort out those elements in emotional responses that represent appraisal and judgment...Beyond an appraisal of emotional responses, courses should emphasize that many technical, social, psychological, and political problems raise fundamental questions of right and wrong, good and bad...A capacity to sift out ethical issues and to see the moral implications of individual and collective decisions are all-important teaching goals.[10]

In recognizing ethical issues, skills must be developed to enable the student to explore such issues critically. This leads to the third goal of the Hastings' Committee, that of developing analytical skills. "Concepts, rules, and principles

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[9]Ibid., p. 48

[10]Ibid., p. 49

are the tools of rationality in ethics,"[11] and as such must be developed.

> The definition of concepts, the import and consequence of moral rules, and the meaning and scope of general ethical principles will all have to be explored...Coherence and consistency are minimal goals for the development of analytical skills, both in the analysis of ethical propositions and of moral actions and in the justification of rules, principles, and specific moral decisions.[12]

The Hastings' Committee therefore has promoted that first, students be brought in contact with ethical concerns on the emotional level. Since emotions however are not necessarily the most reliable guidelines to action, the cognitive must also be utilized. Emphasis is shifted from the emotional response to the rational analysis of the situation. Analytical skills are needed to explore the ethical issues critically and therefore the Committee recommends that such skills be developed as stated above.

The question of "why ought I to be moral?"[13] is the fundamental question of ethics and the Committee states that this question should be explored in ethics courses. The fourth goal therefore is to elicit a sense of moral obligation and personal responsibility from the students. Students should

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[11]Ibid., p. 50

[12]Ibid., p. 50

[13]Ibid., p. 50

wrestle with the questions as did previous generations - questions such as

> What does it mean to take ethics seriously? Does it simply mean recognizing the logical implications of certain moral rules or behavior, or is there a stronger entailment; that one ought necessarily to do that which one perceives to be good or right?... Any course on ethics must explore the role, in practice, of freedom and personal responsibility. It makes no sense to talk of ethics unless one presupposes that individuals have some freedom to make moral choices and that they are responsible for the choices they make.[14]

As a final goal in ethics courses, the Hastings' Committee recommends that students learn to tolerate "the disagreements and to be prepared to accept the inevitable ambiguities in attempting to examine ethical problems."[15] They caution that tolerance does not necessarily mean automatic acceptance of disagreements and that there must be "an attempt to locate and clarify the sources of disagreement, to resolve ambiguity so far as possible."[16]

These goals stated by the Hastings' Committee are unexceptional and unobjectionable as definitions of the basic structure of ethics courses. However, these goals define the content of ethics courses. But to what ends are these goals

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[14] Ibid., p. 51

[15] Ibid., p. 51

[16] Ibid., p. 51

aiming? Why should moral imagination be stimulated and why should students learn to recognize ethical issues and to analyze the decisions made regarding these issues? Why do any of this?

One answer to this question seems to be that these goals are in themselves valuable and "will have served an important purpose so long as they help students perceive, articulate, and analyze moral problems."[17] This is unobjectional in itself since the first steps in resolving moral problems, conflicts, and dilemmas are the abilitites to recognize, articulate, and analyze these moral concerns. However, if left on this level, ethics courses remain solely intellectual enterprises. There must be some move to relate these goals to action and behavior if such courses are to be more than intellectual exercises.

The Hastings' Committee moves in the direction of relating the intellectual skills to action with goal #4 - to elicit a sense of moral obligation and personal responsibility from the students. They stop short however of promoting that a goal of ethics courses should be to change student behavior (presumably towards moral behavior) or develop such behavior. The goal of eliciting a sense of responsibility and moral obligation from students remains on the meta-ethical level. The goal is only to encourage students to wrestle

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[17]Ibid., p. 55

with questions like 'what does it mean to take ethics seriously?' and 'why should I be moral?'. No mention is made of moving from this theoretical level to specific promotion of moral behavior in students. In this respect, the Hastings' Committee allows courses in ethics under their design to remain on the intellectual level.

As was stated before, the goals of the ethics courses recommended by the Hastings' Committee are unobjectionable as a basis for the study of ethics. Philosophical skills must be honed, empathy evoked, and ethical issues recognized. All are commendable goals in themselves - to promote empathy, to improve rationality and articulation in argument, to creare awareness of ethical issues - but to what <u>end</u> have they been singled out as necessary components of an ethics course? As was asked earlier in this chapter, to what ends are these goals aiming? What is their united purpose? The Committee states that

> Our own general conclusion can be stated quite directly. We believe that the primary purpose of courses in ethics ought to be to provide students with those concepts and analytical skills that will enable them to grapple with broad ethical theory in attempting to resolve both personal and professional dilemmas, as well as to reflect on the moral issues facing the larger society.18

Note however the focus of their statement concerning the

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[18]Ibid., p. 48

purpose of ethics courses. The Hastings' Committee has focused on "concepts," "theory," "dilemmas," and "issues," not on people and their actions. In a broad sense, ethics is concerned with actions and the relationships between people through action. This particular definition requires more detail so before proceeding with this argument, I will briefly outline the basic definition of morality from which I am working.

As human beings, we live in what G.J. Warnock terms the "human predicament." He defines this predicament as "the conditions in which these rational beings, humans, actually find themselves."[19] This predicament is defined by such limiting factors as limited resources, limited capabilitites, limited intelligence, limited information, limited rationality, and limited sympathies. Within these constraints, each person has certain needs, wants, and interests, some of which are naturally frustrated by the environment and circumstance, and others which are naturally satisfied by environment and circumstance. Warnock states however that:

> In an enormous range of cases, something both needs to be done, and also at least in principle could be done. And of course this is where the practical problems arise...not everything that is needed, or wanted, or would be advantageous can be done at the same time, or even could ever be done at all. This

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[19]G.J. Warnock, The Object of Morality, Methuen & Co., London, England, p. 16, 1971

> means, of course, that some 'satisfactions' must be postponed to others, with consequent problems about priorities; and some, no doubt, cannot possibly be secured at all.20

Given therefore the constraints of the "human predicament," particularly the limitations of sympathies by which Warnock means the natural tendency of human beings "to be more concerned about the satisfaction of their own wants, etc., than those of others,"[21] Warnock claims that

> There are two obvious ways in which, consequentially, things in the human predicament are liable to go badly. For people are not simply confronted, whether as individuals or groups, with the problems of getting along satisfactorally in material conditions that may, in varying degrees be ungenial or hostile. They are also highly vulnerable to other people; and they often need the help of other people. But given 'limited sympathies', it cannot be assumed that needed help will naturally be forthcoming; and it cannot even be assumed that active malevolence will not be forthcoming.22

Warnock concludes that given the human predicament of limited resources and capabilitites etc., to satisfy each person's needs, wants, and interests, the proper business of morality

> is to expand our sympathies, or, better, to reduce the liability to damage inherent in their natural

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[20]Ibid., pp. 18-19

[21]Ibid., p. 21

[22]Ibid., p. 22

tendency to be narrowly restricted.23

This particular interpretation is assumed in this discussion and is useful in pointing out the difficulties with the Hastings' Committee's recommendations on the objectives and goals of ethics courses. Given the situation of the "human predicament" as the state of things, the Hastings' Committee is promoting that courses in ethics focus on the results of the human predicament - the problems, dilemmas, and issues that stem from the conflicts of needs, wants, and interests within a framework of numerous constraints. The Committe promotes that students should be trained to recognize, articulate, and analyze the symptoms - to borrow from the medical jargon - of the condition in which rational beings find themselves. No move is made however, to promote the next step - that of dealing with the problems themselves, to treat them so to speak, by promoting evaluation of ethical actions as well as cultivating students' behavior toward certain moral dispositions.

There are two main reasons that the Hastings' Committee does not promote this second step (i.e. the "treating" of the human predicament through improved ethical action) in addition to emphasizing the recognition and analysis of the symptoms.

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[23]Ibid., p. 26

One reason is the belief in the principle of relativism - which they refer to as pluralism - which permeates the publication, and the other reason - resulting directly from the principle of relativism - is stated in various places throughout the report as the fear of "indoctrination."

Let us first outline the principle of relativism and draw out the implications of its use in the teaching of ethics courses. In general, three forms of relativism can be distinguished.[24] There is descriptive relativism which does not merely say "that the ethical judgments of different people and societies are different"[25] but rather that "the basic ethical beliefs of different people and societies are different and even conflicting."[26] The second form of relativism is meta-ethical relativism which states that "in the case of basic ethical judgments, there is no objectively valid, rational way of justifying one against another; consequently, two conflicting basic judgments may be equally valid."[27] The third distinguishable form of relativism is normative relativism, which states that

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[24]William K. Frankena, Ethics, Prentice-Hall, Inc., Englewood Cliffs, N.J., pp. 109-110, 1973

[25]Ibid., p. 109

[26]Ibid., p. 109

[27]Ibid., p. 109

> what is right for one individual or society is not right or good for another, even if the situations involved are similar, meaning not merely that what is thought right or good by one is not thought right or good by another (this is just descriptive relativism over again), but that which is really right or good in the one case is not so in another.28

The Hastings' Committee takes a relativist stand on all three definitions. They begin with the observation that we live in a society that is pluralistic with regards to our values and moral convictions, and make the descriptive claim that

> Our personal values will reflect the values of different ethical strands in society and the moral ideals of various ethical theories and perspectives; and the same is true of the values and moralities of societies.29

Given this situation, the Hastings' Committee is unwilling to promote that courses in ethics provide a means of evaluating the various ethical theories and take the meta-ethical stance that "the goals we have proposed above for the teaching of ethics do not entail any conclusion that the details of some moral systems, ethical theories, or moral rules are more correct than others."[30] They conclude with the

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[28]Ibid., p. 109

[29]Callahan, op. cit., p. 32

[30]Ibid., p. 56

normative claim that although there may be cultural agreements on moral rules of acceptable behavior (for instance, it is generally considered wrong to lie, murder, steal, etc.,)

> ethical problems that arise concerning that shared agreement normally come at a variety of critical junctures: when it is necessary to spell out exactly what is meant by accepted principles; when principles come into conflict with each other...and when it is necessary to determine how even widely accepted general principles ought to be brought to bear on complicated, particular issues.[31]

The general argument of the Hastings' Committee therefore is as follows. Given that we live in a pluralistic society, the goals of ethics courses should not include conclusions that some moral systems, ethical theories, and the like, are more correct than others. To do so would "endanger the plralistic fabric of our society."[32] The Committee states that "courses on ethics need not, and ordinarily will not, serve to erode some well-established traditional values and also that students should be willing and able to question their permanent validity, to treat them temporarily with some skepticism, and to bring them to the test of searching inquiry."[33]

It does not seem to be a strong enough argument however to state that we must preserve pluralism of values or morals

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[31]Ibid., p. 57

[32]Ibid., p. 58

[33]Ibid., p. 58

for pluralism's sake. The Hastings' Committee states that "students have a right to hold onto and to develop the particular traditions and value systems out of which they come,"[34] but the fact that there are different traditions and value systems does not justify that there should be different traditions and value systems. The descriptive statement that we have different values and ethical theories does not necessarily imply the meta-ethical statement that these differences are valid and therefore deserve to be left unquestioned and unchallenged. Frankena states that

> to prove meta-ethical relativism one must prove more than descriptive relativism. One must also prove that people's basic ethical judgments would differ and conflict even if they were fully enlightened and shared all the same factual beliefs. It is not enough to show that people's basic ethical judgments are different, for such differences might all be due to differences and incompletenesses in their factual beliefs.35

The Hastings' Committee admits that

> The history of Western philosophical thought - not to mention the more pedestrian experience of classrooms - indicates that those who hone such skills can and do come out with different moral judgments.36

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[34]Ibid., p. 56

[35]Frankena, loc. cit.

[36]Callahan, op. cit., p. 56

Although they are unwilling to state whether or not these different moral judgments, brought about by honing the skills of recognition, articulation, and analysis of moral concerns promoted in their courses in ethics, are an improvement (or are more correct) over those moral judgments held by the students previously, the fact that there is a difference in moral judgment brought about by the course indicates that perhaps Frankena's statement is correct. The Hastings' Committee indicates that students have the right to hold on to their particular value systems (since we live in a pluralistic society) but that many who hone the skills of recognition, articulation, and analysis of moral concerns, can and do change their moral judgments. The Committee does not elaborate on the change in moral judgments, but the fact that there is a a change points to Frankena's claim that differences in basic ethical judgments might not be differences in judgment at all, but only differences in the factual beliefs underlying such judgments. By stating only that we live in a pluralistic society, the Hastings' Committee has failed to show that pluralism in beliefs justifies upholding such beliefs throughout an ethics course. If anything, the Committee makes the contradictory statement that students who hone their intellectual skills of analysis and articulation, have been known to change their moral judgments, thus pointing to Frankena's argument that differences in moral judgment may be differences in factual belief, not in basic ethical judgments.

Coupling the statement that we live in a pluralistic society and have a duty therefore to "refrain from doing that which might undermine the existing plurality of values,"[37] with the objective that "the primary purpose of courses in ethics ought to be to provide students with those concepts and analytical skills that will enable them to grapple with broad ethical theory,"[38] the Hastings' Committee limits ethics courses in promoting resolutions to ethical issues. If one is to promote the development of articulate and consistent justifications of moral judgments, without at the same time providing some basis for the evaluation of the judgments and the principles they are based on as good/bad, right/wrong, etc. because it might "undermine the existing plurality of values," improvement in the human predicament is unlikely except in accidental cases, because there is no one who can determine what improvement is. Given what the relativist states about right and wrong, there can be no evaluation of which is the better moral judgment, and therefore no resolution of the conflict or dilemma is likely to happen. For if you believe X to be right, and are able to defend your position articulately, consistently, and rationally after taking the Hastings' course, and I believe Y to be right in the same instance,

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[37] Ibid., p. 56

[38] Ibid., p. 48

which is a belief polar to your view, and I have taken the same course and have honed my skills to the same extent as you, then although our moral judgments oppose each other, both must be acceptable in the relativist's viewpoint. Although the conclusions are inconsistent, if the argument is left at the intellectual level, then no harm will be done by keeping the debate suspended by the relativist's claim that neither standard can be judged as right or wrong. The moment that these opposing moral judgments come to bear on specific action s however, there must be criteria for resolution or evaluation if a course of action is to be chosen.

Let us look at a specific case contrived around a point made by Dr. Leon Kass about "Perfect Babies,"[39] to show the difference in applying moral reasoning to cases intellectually and actually implementing one's decision in action. The setting for this case is somewhere in the not-too-distant future where we will suppose that technology has refined and perfected medicine's predictive powers in genetic diagnoses, as well as in the diagnoses of other physicial and mental birth defects. For the purpose of this discussion, this future society holds the general opinion that "defectives should not be born." (We will not argue the moral implications of this principle here in this instance, but will accept it as

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[39]Leon Kass, M.D., Toward a More Natural Science, The Free Press, N.Y., N.Y., pp. 80-98, 1985

as the basic grounds for this discussion.) In some ways, our present society has already begun to move towards this sentiment, as pointed out by Dr. Kass:

> In the past two decades, with medical knowledge and power over the prenatal child increasing and with parental authority over the postnatal child decreasing, we have seen the appearance of a new type of legal action, suits for wrongful life. Children have brought suit against their parents (and others) seeking to recover damages for physical and social handicaps inextricably tied to their birth (e.g. congenital deformities, congenital syphilis, illegitimacy). Recently, genetic counselors and laboratories have been sued for not correctly diagnosing prenatally the disease now suffered by the child plaintiff, who, in the absence of such negligence, would have been prevented by abortion from being born to suffer.[40]

Given these indications, we see therefore that acceptance of this principle is not so far-fetched. Suppose still further that it is given to the parents

> to determine, according to their own wishes, and based upon their own notions of what is good for them, the qualitative as well as the quantitative character of their families.[41]

Couple A is confronted with the fact that their unborn child is suffering from spina bifida. This couple clearly and consistently articulates their processes of ethical thinking, and their reasons for wanting the pregnancy terminated -

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[40] Ibid., pp. 87-88

[41] Ibid., p. 94

excessive financial burden in caring for the child, the suffering of the child if it lives, the emotional strain on the family, the possible harm to their other normal children, the possible burden to society if something should happen to them as the primary care-givers, and so on. Now take the case of Couple B, who have been informed with the news that they will be giving birth to a "normal" child, but

> who for their own very peculiar reasons, wish to have an abnormal child, say a child who will suffer from the same disease as grandpa or a child whose arrested development would preclude the threat of adolescent rebellion and separation, or a dwarf who could work with them in the circus.[42]

What if couple B can likewise provide clear, consistent, and articulate justifications for wanting the pregnancy terminated? As physicians, are we to allow for both of these pregnancies to be terminated? Or must we not, in some sense, provide a judgment in each case? If so, on what do we base our judgments? Clearly a differential judgment cannot be made on articulation and consistency in rationality since both couples exhibit this. What is the question here? Are we to be primarily concerned with parental autonomy or infant normalcy? Which question is more important? How are we to judge? The Hastings' Committee is not willing to provide this step in ethics courses. If the principle "defectives

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[42]Ibid., p. 95

should not be born" is accepted (although "in the case of what other diseases does preventative medicine consist in the elimination of the patient at-risk?"[43]) who is to determine the primary consideration - parental autonomy versus infant normalcy? Who is to judge what constitutes a defect? Is Couple A right? Is Couple B right? Is either right? Is neither right?

If left on the intellectual level, no harm comes from suspending these questions to allow students to grapple and wrestle with them. No one answer need be forthcoming since this activity is intellectual. However, take this case in the clinical setting where judgment has to be translated into action. What then? We see illustrated here the direct consequences of the relativistic point of view of refusing to assess and assert some things as right/wrong, good/bad, and so on. Coupled with the tools of logic, consistency, and rationality, anything can be justified and therefore accepted by the relativist's viewpoint. It is not clear how such an approach could ever contribute to improvement in the human predicament. If anything, this approach gives license to all behavior in a pluralistic society as long as it can be justified.

This principle of relativism spawns the fear of indoctrination mentioned often throughout the Hastings' publication.

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[43]Ibid., p. 95

Given that the American society is pluralistic in its values and morals, the Hastings' Committee shies away from any suggestion of influencing student behavior. They go so far as to say explicitly that in order to promote or bring about such behavior, professors might engage in 'highly questionable techniques of manipulation.' Although this might happen, the Hastings' Committee is overlooking the fact that forms of indoctrination are definitely taking place within the medical setting already. "Role-modeling" is one such example. Attending physicians utilize, both knowingly and unknowingly, techniques of manipulation to bring about certain behavior in medical students and residents. Conformity to codes and oaths is likewise a form of indoctrination. And the Committee alludes to an unquestioned form of indoctrination in their statement that

> Americans have always had a strong faith in the importance of education, and a no less strong belief that what happens in schools, colleges, and universities can make a decisive social difference in the lives of those who pass through them.[44]

So if the Hastings' Committee believes that they do not have to worry about indoctrination of values and ethical theories by not allowing for cultivation of students' behavior as a proper goal for ethics courses, they are seriously mistaken.

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[44]Callahan, op. cit., p. 32

Although it might happen that some professors will engage in techniques of indictrination in ethics courses, it is already a fact of clinical instruction through "role-modeling" teaching techniques and promotion of medical codes of ethics, not to mention the indoctrinating influences of every-day life.

The Hastings' Committee likewise cannot assure that indoctrination will not occur in ethics courses by promoting that such courses only focus on recognition, articulation, and analysis of moral concerns, since a form of methodological indoctrination can occur under these circumstances. Although professors might not engage in explicit forms of indoctrination, students can be led to certain conclusions given the methods by which they are taught to view the problem. It is apparent therefore, that indoctrination can occur even in the absence of promoting that influencing students' behavior is a proper goal for courses in ethics to have.

Indoctrination is unlikely to occur in courses where teachers are truly promoting students' abilitites to perceive, articulate, and analyze moral concerns through a variety of methods. If indoctrination does occur, can we not assume that the nature of indoctrination lies in the failure of teachers to promote these analytical skills and not, as it were by specific promotion of any one set of ideals or beliefs per se? The method of teaching ethics advocated here is one of promoting critical reflection and justification of

any belief or opinion held as the basis for a decision. The fact that there is a certain belief or opinion about what a decision should be does not, as was discussed earlier, imply that this is what the the decision ought to be. Skills of analysis and articulation therefore should protect against indoctrination because they promote critical inquiry - not mere acceptance - of any belief or opinion as the basis of a decision.

The goals of recognition, articulation, and analysis of moral concerns have been discussed at length, but the goal of cultivating students' behavior towards moral behavior by which is meant promoting that students act in accordance with those moral principles deemed relevant (through philosophical consideration) in any given situation, must be drawn out in more detail. How is such a goal to be attained in courses in ethics?

Lawrence Kohlberg's theory of moral development, discussed in more detail in the following chapter, offers a major possibility in influencing students' behavior through courses in ethics. Briefly, Kohlberg has formulated the theory, supported by years of research and numerous empirical studies, that everyone goes through stages of moral development, each stage higher than the one preceeding it. Everyone begins at the lowest stage and reaches a different level at different times during the course of their lives. Kohlberg insists that this development takes place in all people.

What is particularly relevant to the goal of promoting that students act in accordance with moral principles in ethics courses, is that there appears to be a strong correlation in Kohlberg's studies, that the higher the person is in stage development, the more consistent the relationship between the stage of moral reasoning and the person's moral behavior. Given this, it can be stated that it is likely that courses which promote the development of moral reasoning therefore, will also promote the correlating moral behavior. As was stated in the beginning of this chapter, the goals of ethics courses advocated here are (1) to cultivate students' dispositions towards moral behavior and (2) to cultivate students' abilitites to support those actions by reflective consideration. The development of moral reasoning in goal #2, through the development of analytical skills, definition of concepts and ethical principles, justification of moral decisions, and so on, is also the key to promoting the development of students' behavior, towards moral behavior consistent with their moral reasoning. This claim will be discussed in more detail in the following chapter.

Throughout this chapter, it has been assumed that formal courses in ethics provide the best means, in the medical setting, of approaching moral concerns. Another alternative must be considered - that of disregarding both oaths and codes of ethics, as well as formal courses in ethics, and allowing students and physicians to approach moral concerns

individually. Chapter I illustrated that there are indeed significant moral issues in the medical field. The question of whether or not to allow physicians and students to approach such concerns individually becomes a question of whether or not this approach will best deal with moral concerns.

In the next chapter, we will see that in numerous studies, several individuals exhibited the higher stages of moral reasoning. Undoubtedly, few of them had ever taken specific courses in ethics to promote this development. Koh;berg's theory is based on "observations" of moral reasoning used by people, a number of them children, who had never taken formal courses in ethics, and yet they exhibited varying degrees of moral development, from the lowest stage to the highest. If such development can take place throughout one's life without the aid of specific courses in ethics, why, it can be asked, should cpurses in ethics be a more valuable approach to resolving moral and ethical conflicts in the clinical setting than merely allowing people to approach such conflicts individually with their own resources?

One answer to this argument is that although moral development does take place in people who have not had specific courses in ethics, such development cannot be supposed, particularly at higher stages, in all people. Although it is not suggested here that courses in ethics will assure moral development in all students, it is proposed that such courses

will at least provide a more consistent opportunity for moral development than that which is offered in the daily lives of most people.

Another important argument is that physicians deal with moral concerns in the clinical setting that are, in many instances, unique to those experienced in the lay-person's life. The situations surrounding the expression of many moral issues in the medical settinf are often complex given the focus of medicine on the technical aspects of patient care. Moral issues tend to become somewhat obscured in this atmosphere. Courses in ethics would serve more visibly, to enforce the presence and importance of moral concerns in the clinical setting, even to those whose moral development is at the highest stage.

It must also be noted that the attainment of a certain level, particularly the highest level, of moral development, does not therefore mean that the student or physician requires no further education, whether it be through experiences in daily life or through formal courses in ethics. Even those who have reached the highest stage of moral development must be challenged and questioned, and in turn continually challenge and question their beliefs and arguments.

This chapter concludes therefore, with the recommendation that ethics courses, as opposed to codes of ethics or individual approaches, provide the best framework within which to deal with and resolve medical moral concerns. These

courses should focus on cultivating students' dispositions toward moral behavior as well as cultivating their abilities of reflective consideration and rational justification of their actions.

Chapter IV will focus on the implementation of such courses in the medical school curriculum as well as on empirical justifications and evidence for this approach in improving moral behavior. The chapter will close with some concluding remarks on the purpose of ethics courses in the medical profession.

CHAPTER IV

IMPLEMENTATION OF ETHICS COURSES

In Chapter III, two main goals were proposed for ethics courses: (1) the cultivation of students' dispositions towards moral behavior, and (2) the cultivation of students' abilitites to support their actions by reflective consideration and rational justification. The focus of this chapter will be on the implementation of these courses into the context of the medical school curriculum.

Before this is done, the question of whether or not the development of moral reasoning can be related to the development of moral behavior must be explored. This is a necessary question to ask and answer, given the dual purpose of the proposed courses. Is a person likely, at a higher or more refined level of moral judgment, to behave in accordance with that reasoning?

Psychologist Lawrence Kohlberg has focused on the development of moral reasoning and the problem of correlating moral behavior with moral reasoning, and much of the research in this area of moral development is dervied from the schema of moral development which he constructed. Because of the impact of his theory in this field, it will be the focus of this discussion.

Kohlberg developed what is now known as the structural-developmental approach, which focuses on a person's moral

behavior within the context of their moral judgments.

> Rather than focusing on the particular behavior as viewed by an outside observer, the ways in which the individual defines the behavioral situation and his or her choice in that situation are concentrated on. Moral behavior, then, can be studied as a developmental dimension which parallels moral reasoning, since particular behavioral choices are examined in terms of the structural-developmental processes which they reflect.1

Kohlberg's schema of moral development is presented on the following pages in Table I. Discussion of the theory, as well as its application to ethics courses will follow.

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[1]Myra Windmiller, Nadine Lambert, Elliot Turiel, Moral Development and Socialization, Allyn & Bacon, Inc., Boston, MA., p. 108, 1980

Table I. Levels and Stages in Moral Development

Levels	Basis of Moral Judgment	Stages of Development
I.	Moral values reside in external, quasi-physical happenings, in bad acts, or in quasi-physicial needs rather than in persons and standards.	Stage 1: Obedience and punishment orientation. Egocentric deference to superior power or prestige, or a trouble-avoiding set. Objective responsibility.
		Stage 2: Naively egoistic orientation. Right action is that instrumentally satisfying the self's needs and occasionally others'. Awareness of relativism of value to each actor's needs and perspective. Naive egalitarianism and orientation to exchange and reciprocity.
II.	Moral value resides in performing good or right roles, in maintaining the conventional order and the expectancies of others.	Stage 3: Good-boy orientation. Orientation to approval and to pleasing and helping others. Conformity to stereotypical images of majority or natural role behavior, and judgment by intentions.
		Stage 4: Authority and social-order maintaining orientation. Orientation to "doing duty" and to showing respect for authority and maintaining the given social order for its own sake. Regard for earned expectations of others.
III.	Moral value resides in conformity by the self to shared or shareable standards, rights, or duties.	Stage 5: Contractual legalistic orientation. Recognition of an arbitrary element or starting point in rules or expectations for the sake of agreement. Duty defined in terms of contract, general avoidance of violation of the will or rights of others, and majority will and welfare.

Table 1 (continued)

Levels	Basis of Moral Judgment	Stages of Development
		Stage 6: Conscience or principle orientation. Orientation not only to actually ordained social rules but to principles of choice involving appeal to logical universality and consistency. Orientation to conscience as a directing agent and to mutual respect and trust.2

[2]James John Jelinek, Editor, The Teaching Of Values, The Arizona Association for Supervision and Curriculum Development, Tempe, Arizona, pp. 123-124, 1975

In this table, six stages of moral development have been drawn out, corresponding with three levels of moral development. Level one has been termed as the preconventional level. At this level, people are concerned only with the direct consequences of the actions - recieving either reward or punishment. Right and wrong are defined at this level in terms of the consequences of the action. Within this level, Stage I reflects the obedience/punishment attitutde with the avoidance of punishment, and the obedience to superior power being the basis of moral judgment. Stage 2 reflects an instrumental attitude of reciprocity for one's own benefit, not as a reflection of any other principles such as fairness or justice. Level II is termed the conventional level of moral development. In this level, one is concerned with living up to others' expectations and of maintaining the present social order out of loyalty to it. Stage 3 reflects behavior which is approved by other members such as family and friends. Stage 4 represents the orientation toward rules and sociak order, with right behavior reflected in respect for authority.

Level III is what is known as the post-conventional level, also known as the autonomous level. It is here that the person, by Kohlberg's scheme, is judged to be at the highest level of moral development. Authority and majority opinion no longer define what is right/wrong at this level. An effort is made at this level to establish moral principles which are independently valid from authority and majority rule. Stage

5 reflects right action in terms of individual and societal rights as well as relevance of personal values and opinion. The legal viewpoint prevails and is represented by the American Constitution. Stage 6 reflects right action in terms of the universal principles of morality. They are principles of justice and respect for individuals.

Kohlberg claims that everyone goes through stages in moral development, each stage higher than the one preceeding it. Everyone begins at the lowest stage and reaches a different level at different times during the course of their lives, but Kohlberg insists that this development takes place by all people, at all times, in all cultures. Not everyone will reach the highest level (indeed it has been argued that the sixth stage is merely theoretical and cannot be reached as a stage of development), nor will people of the same age necessarily have the same level of moral development. Nor do different decisions about the same case necessarily reflect a difference in the stages of morality between people.

The theory is complex and we must be cautious of too simplified an interpretation. Although it provides a structure for examing correspondence of moral behavior to moral reasoning, it does not merely state that to understand a person's reasoning will enable a prediction of their subsequent behavior. If this were so, utilization of the same level of reasoning would always give rise to the same type of behavior in similar situations. This however is not generally the rule:

> For example, Kohlberg (1969a) refers to the person at law-and-order Stage 4 who decides to participate or not participate in acts of civil disobedience depending on the definition of the situation by the authorities. When the social order is against civil disobedience, the person probably will not participate; if the authority is on the side of civil disobedience, it is unclear what the person will do. A further example, an individual reasoning at Stage 3 may offer to help someone in distress in one situation, but not in another because approval considerations may work in opposite directions in the two situations.[3]

Does this discrepancy therefore indicate that the connection between moral reasoning and moral behavior is only an ideal and in actuality there is little correspondence between the two? This is one interpretation, but further evidence points to another conclusion.

Numerous studies have indicated that the higher an individual is in his or her developmental stage, the more consistent the relationship between the stage of moral reasoning and his or her moral behavior. Kohlberg states that evidence indicates that "adult change is not only toward greater consistency of moral judgment, but toward greater consistency between moral judgment and moral behavior."[4] Of these studies,

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[3]Windmiller, op. cit., p. 116

[4]Lawrence Kohlberg, R. Kramer, Continuities and Discontinuities in Childhood and Adult Moral Development, Human Development, 12, p. 107, 1969

the most famous perhaps are those conducted by Stanley Milgram[5] and utilized as well by Kohlberg.

In the Milgram experiments, a group of volunteers were told that they were participating in an experiment designed to test the effect of punishment on altering learning behavior. In actuality, the experiment was a contrived circumstance to see how far these volunteers would go in their actions, on the command of someone in authority.

A large number of volunteers were obtained through an advertisement in a New Haven newspaper. These volunteers were from a broad spectrum of class backgrounds and had a wide range of occupations. A learner was given tasks to perform and when a mistake was made, the volunteers were to administer an electrical shock to the subject. In actuality, the "learner" was a collaborator in the experiment and although the volunteers were led to believe that they were administering electrical shocks, no such shocks were being felt by the learner. The volunteers were placed in front of the shock generator which was clearly labeled with voltages ranging from 15 to 450 volts. In addition

> the following verbal designations were clearly indicated for groups of four switches going from left to right: Slight Shock, Moderate Shock, Strong Shock, Very Strong Shock, Intense Shock, Extreme Intensity

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[5]Stanley Milgram, Obedience to Authority, Harper and Row, N.Y., N.Y., 1975

Shock, Danger: Severe Shock. Two switches after this last designation were simply marked XXX.[6]

To authenticate the experiment for the volunteers, each volunteer received a sample shock of 45 volts on the wrist from the third switch of the generator.

The volunteers were instructed to shock the learner each time a wrong response was given and to advance one higher level on the shock generator each time a wrong answer was given. To insure that the volunteers realized the increasing intensity of the shocks they were "administering" they were instructed to announce the voltage level each time a shock was to be administered. In many instances throughout the experiments, the volunteer would turn to the experimenter (also a collaborator in the experiment) and ask whether he or she should continue. The experimenter responded with one of four statements, using as many as necessary to get the volunteer to continue.

Prod 1: Please continue, or, Please go on.
Prod 2: The experiment requires that you continue.
Prod 3: It is absolutely essential that you continue.
Prod 4: You have no other choice, you must go on.

The prods were made in sequence: Only if Prod 1 had been unsuccessful could Prod 2 be used. If the subject refused to obey the experimenter after Prod 4, the experiment was terminated. The

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[6]Ibid., p. 20

experimenter's tone of voice was at all times firm, but not impolite.7

In the initial experiment, the learner was placed in an adjacent room and strapped into an "electric chair" apparatus while the volunteer (or subject) watched. The subject was then taken to his room where the learner's answers would be designated on a control panel of silently flashing lights. No voice feedback was used from the learner in the initial experiments because "it was thought that the verbal and voltage designations on the control panel would create sufficient pressure to curtail the subject's obedience."[8] Surprisingly however, this was not the case. "In the absence of protests from the learner, virtually every subject in the pilot study, once commanded, went blithely to the end of the board, seemingly indifferent to the verbal designations."[9] Voice feedback from the learner was then initiated into the experiment but "even the strongest protests from the victim did not prevent many subjects from administering the harshest punishment ordered by the experimenter."[10] As the shocks were increased

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[7]Ibid., p. 21

[8]Ibid., p. 22

[9]Ibid., p. 22

[10]Ibid., p. 22

in intensity by the volunteer, the learner increased the intensity of his verbal complaints. At 75-volts, the learner grunted, increasingly so until the 120-volt shock whereupon he shouted that the shocks were painful. As the voltage was increased, the intensity of the learner's cries and protests would increase until finally at 315 volts, the learner screamed violently and refused to provide answers. (No answer indicated an error so the learner continued to be shocked whereupon he shrieked in agony.) At 330-volts, the learner was not heard from at all.

In the original experiment, there were 40 volunteers and 26 of the volunteers "administered" the voltage increasingly from the starting voltage of 15-volts to the highest voltage of 450-volts. Variations were then tried on this experiment. Experiment #2 incorporated vocal feedback from the learner and 25 of the 40 "volunteers "adminstered" the maximum shock to the learner. Experiment #3 placed the learner in the same room as the volunteer (proximity experiment) and 16 of the 40 "administered" the maximum shock. Experiment #4 was identical to experiment #3 except that the learner recieved a shock only when his hand rested on the shock plate. When the learner refused to place his hand on the plate (usually around the 150-volt level) the experimenter ordered the volnteer to force the learner's hand on the plate (touch-priximity experiment). Of the 40 volunteers, 12 complied to the maximum shocl level. Milgram noted that as the learner was

brought closer to the volunteer administering the shocks, obedience to the experimenter diminished.[11]

Kohlberg's results based on experiments designed from Milgram's experiments yielded interesting results for the correlation of moral reasoning and subsequent moral behavior.[12] Briefly, of those volunteers administering shocks who were determined to be at a Stage 6 level of moral development, seventy-five percent overrode the authority figure and terminated the experiment, rather than continue to harm the learner. Of those under the Stage 6 level, all but thirteen percent continued to shock the learner to an extensive degree. Inclusive in this group were those at a Stage 5 level, which seems to be contradictory to what their actions should have been. But Kohlberg points out that Stage 5 is the social-contractual stage and that the individual feels he has entered into a contract (and feels the learner has likewise entered into a contractual agreemen to perform the experiment) and must therefore fulfill the commitment. At Stage 5 the individual is not equipped to resolve the dilemma outside of the principles of social contracts, rules, and laws. It is only when the Stage 6 level is reached that social contract and

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[11]Ibid., p. 35

[12]Lawrence Kohlberg, Indoctrination versus Relativity, Harvard University, Eighteenth Summer Conference, Institute On Religion in an Age of Science, Star Island, N.H., 1971

accepted authority no longer are the constraints on action.

What therefore does this particular study (supported by a number of other studies as well) indicate for the relationship between moral reasoning and moral behavior? It indicates that although the early stages of moral development are ambigiously correlated with moral behavior due to the situational factors involved in making the decision of how to act, the correlation between moral reasoning and moral behavior tends to become more clear as the individual progresses into higher stages of moral growth. Situational factors decrease in influence and principles of rationality take over. Given the opportunity to develop morally therefore, it would seem that moral reasoning would influence and guide an individual's behavior as he or she reached the higher stages of moral development.

One interesting implication should also be noted. When Milgram performed the various experiments, he noted that as the learner was brought in closer proximity to the volunteer "administering" the shocks, obedience to the experimenter decreased and the volunteers refused more readily to give the shocks. Milgram puts forth several factors that may be at work in this situation - empathic cues, denying and narrowing of the cognitive field, and reciprocal fields. For example,

> in the Remote and, to a lesser extent, the VoiceFeedback conditions, the victim's suffering posses an abstract, remote, quality for the subject. He is aware, but only in the conceptual sense, that his

> actions cause pain to another person; the fact is apprehended but not felt.13

As the learner is brought closer, the conceptual sense of causing pain to another becomes more visible - more tangible. The volunteer becomes increasingly less willing to proceed with the shocking. In this instance, empathic cues are at work. For the factor of denial

> the Remote conditions allows a narrowing of the cognitive field so that the victim is put out of mind. When the victim is close it is more difficult to exclude him from thought.14

Finally, for the factor of reciprocal cues, "possibly it is easier to harm a person when he is unable to observe our actions than when he can see what we are doing."[15] It would seem, given these observations that as the learner was brought closer, the conceptual fact of causing pain or harm to another person becomes a tangible one, resulting in a decrease in inclination to continue the experiment by the volunteers. Another way of stating this is that the limited sympathies of the volunteers, defined by Warnock as the natural tendency of human beings "to be more concerned about the satisfaction

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[13] Milgram, op. cit., p. 36

[14] Ibid., p. 38

[15] Ibid., p. 38

of their own wants, etc., than those of others,"[16] were expanded as the learner were brought in closer proximity to the volunteers. However, Kohlberg's experiments indicated that those whose moral development was at the Stage 6 level terminated the experiment rather than to continue to harm another person. It is a possibility that at this stage, these volunters were able to expand their sympathies to incorporate the conceptual fact that they were harming another person and therefore terminated the experiment without necessarily needing to have those conceptual facts made tangible by the actual presence of the learner, as did those at lower stages of moral development. Given Warnock's statement that it is the proper business of morality to expand our sympathies, Kohlberg's results would certainly seem to indicate that those at a higher stage of moral development had more expanded sympathies and were therefore able to make decisions regarding another person more readily.

Another experiment that indicates a correlation between moral reasoning and moral behavior was performed by Krebs and Rosenwald. The focus of this experiment was on people who were at Kohlberg's Stage 3 and 4 levels of moral structural development. These volunteers answered an ad in the newspaper that offered to pay them three dollars to take part in a testing experiment. When the group assembled in the lecture hall,

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[16] Warnock, op. cit., p. 21

they were told that the test would take an hour and a half to complete, but that unexpectedly, they could use the hall for only one hour. Therefore, they would only be asked to do part of the test in the hour and then be given the rest of the material to complete at home. The person leadin the group stated that it was extremely important that she have the materials returned to her within one week or her grade in her course (she identified herself as an undergraduate) would be in jeopardy. Each volunteer was given the necessary materials as well as a pre-addressed, post-paid envelope within which the form was to be returned. During the hour in the lecture hall, the volunteers took the Kohlberg developmental test. They were then paid their money and urged to mail the remaining material back within one week.[17] The results are as follows:

> An analysis of the scores on the Kohlberg test indicated that 83 percent of the subjects were at the conventional level. Altogether, despite the great emphasis on the importance of having the questionnaire back on time to avoid jeopardizing the leader's grade, 39 percent of the participants did not return them within the week. Of that group, 23 percent never returned the questionnaires and 16 percent managed to get them in, but after the deadline. The completed forms of all stage 4 and 5 participants were promptly returned and in the hands of the leader within the time frame requested, with one exception. Among stage 3 subjects, 40 percent were on time, 33 percent were late, and 27 percent did not

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[17] Hugh Rosen, The Development of Sociomoral Knowledge, Columbia University Press, N.Y., N.Y., pp. 112-114, 1980

> return their questionnaires at all. There were only three stage 2 subjects in the population. One of them returned the questionnaire and the other two did not return them at all. All of the questionnaires that were returned late came from stage 3 subjects. In brief, the higher the stage, the more likely the questionnaires would be returned; the lower the stage, the less likely that they would be returned.18

A brief analysis of this data supports the theory of a relationship between moral stage and moral action. Thise at the higher stages of moral development (stages 4 and 5) recognize a commitment to rules. The payment represented a contractual duty that must be fulfilled, and was promptly done so. Those in stage 3 however, once out of the experimental (group pressure) setting, were not pressured to conform to any norm of behavior and were therefore disinclined to act accordingly. Those at the stage 2 level terminated the relationship at the end of the hour. Nothing more was to be gained and more importantly, no harm would come from not sending in the questionnaire.

Although beief, this overview of these empirical studies of moral development indicates that there is a correlation between moral reasoning and moral behavior, most notably and consistently at the higher stages of moral development in Kohlberg's schema. The studies, particularly the Milgram

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[18]Ibid., pp. 112-113

experiments and the ones that Kohlberg fashioned after the Milgram experiments, also furnish valuable insights into other aspects of moral behavior. For example, in the Hastings' report on the teaching of ethics in higher education, the Hastings' Committee makes the statement that the primary purpose of professional schools is to "provide students with those specialized skills, bodies of knowledge, and attitudes needed for them to work as professionals in society."[19] They then state that "the ultimate test of the value of the education is technical competence."[20] Milgram's study however, points to a very sobering and cautioning observation. Within the experiment, when trying to determine why so many people continued to obey the experimenter after harm to another individual was so apparent, Milgram observed that there was a

> tendency of the individual to become so absorbed in the narrow technical aspects of the task that he looses sight of its broader consequences. The film Dr. Strangelove brilliantly satirized the absorption of a bomber crew in the exacting technical procedure of dropping nuclear weapons on a country. Similarly in this experiment, subjects became immersed in the procedures, reading the word pairs with exquisite articulation and pressing the switches with great care. They want to put on a competent performance, but they show an accompanying narrowing of moral concern. The subject entrusts the broader tasks of setting

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[19]Callahan, op.vit., p. 36

[20]Ibid., p. 36

> goals and assessing morality to the experimental authority he is serving.21

Given this indication, educational institutions would do well to reassess their objections to shifting the focus away from mere technical competence to incorporate a broader perspective on the effects of students' actions within the society in which they serve.

Another observation is also directly relevant to the need for the expansion of one's moral "point of view." In another variation of Milgram's experiments, the volunteer did not administer the shock, but was designated a subsidiary act to perform. "In this situation. 37 of 40 adults from the New Haven area continued to the highest shock level on the generator."[22]

> Predictably, subjects excused their behavior by saying that the responsibility belonged to the man who actually pulled the switch. This may illustrate a dangerously typical situation in complex society: it is psychologically easy to ignore responsibilty when one is only an intermediate link in a chain of evil action but is far from the final consequences of the action...Thus there is a fragmentation of the total human act; no one man decides to carry out the evil act and is confronted with its consequences. The person who assumes full responsibility for the act has evaporated.23

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[21]Milgram, op.cit., p. 7

[22]Ibid., p. 10

[23]Ibid., pp. 10-11

This view leads to a sort of counteranthropormorphism - that is, divesting something of its human origins and treating it as if it were somehow beyond human control. For example, in Chapter I, numerous factors that intersect with the practice of medicine were discussed. Technology, economic factors, the structure of health care delivery - all of these factors are human in origin (meaning that they were created by and continue to be fostered by human actions). They do not exist independently of human action and control. They are however, often viewed as such. Independent actions by individuals therefore become submerged within the larger structure of accumulated actions and responsibility for the effects of the structure which has been divested of its human origins is dissipated.

Given these observations, it can be stated that these experiments indicate that there is a relationship between moral reasoning and moral behavior, most notably and consistently at the higher stages of moral development. Kohlberg's theory of moral development is helpful in establishing this, but it must be noted that with the exception of this one experiment, Kohlberg is not specifically interested in individuals' actions per se, but in the reasoning that founds their moral judgments. The stage concept deals with what an individual thinks is right and therefore with what ought to be. It is not a person's actions that define his or her moral stage, but rather the reasoning that led him or her to choose those

actions. Two people can make the same judgment and yet be at different stages of moral development (a person who continues to perform the Milgram experiment out of fear of punishment from the experimenter, and one who continues the experiment out of commitment to a contractual agreement, are both making the same decision, but are at totally different stages of moral development).

Given the impact and implications of Kohlberg's theory, it has been subjected to many criticisms. It is not the purpose of this thesis to discuss the criticisms of Kohlberg's theory. This discussion serves as an indication that morality can be developed within individuals, and that higher stages of morality give rise to correlating moral behavior. Kohlberg himself admits that further investigations need to be done and with them undoubtedly will come further changes and refinements of the theory. The evidence to date, as well as the implications of such evidence, point to the connection between moral reasoning and moral behavior, and given this it seems that courses which focus on developing rationality as well as on conduct cannot but help students approach moral concerns with greater understanding. For instance, Chapter II discussed codes and oaths for physicians as directives for action. In light of Kohlberg's schema, we see that conformity to such codes is indicative of a stage 4 or 5 level of moral development. Behavior on this level of moral reasoning however, as was illustrated by Milgram, does not correlate

well, indicating that codes and oaths may not be effective in directing ethical action, As was stated before, moral behavior and moral reasoning correlate most consistently at the higher level of moral development. The goals of ethics courses promoted by this thesis promote the developent toward this level through increased rationality. It is quite possible therefore, given the empirical evidence just discussed, that a change in behavior could be the result of such courses.

Let us return therefore, to the question of how to implement ethics courses into the medical school curriculum. Let us focus briefly on the educational phases of the medical students in an attempt to provide the context in which these courses will be implemented.

The first two years of medical school are generally termed the pre-clinical years. It is here that medical students are exposed to thousands of facts in their biochemistry, anatomy, and pharmacology courses, which must be committed to memory at least long enough to pass the tests. Each course during these first two years attempts to introdice to the students an educated appreciation for the intracacies of the human body from the perspective of basic medical science.

The frantic pace to keep up with tomes of facts forces most students to focus on memorizing and cramming facts. It is as though with the sole accumulation of facts and manipulation of factual information, that the answer will present

itself. This approach unintentionally fosters the attitutde that medicine can solve problems that arise in the clinical setting by accumulating and manipulating facts. This however is not always the case. The medical profession operates largely around the management of uncertainty, even when all of the facts of the case have been accumulated.

The following two years of the medical students' training are known as the clinical years. The main focus here is on more fact accumulation. The emphasis is on tests, on diagnoses - in short on action. The hospitals and patients are simply more facts to be dealt with as tactile learning aids. It is during the clinical years that the student is introduced to his or her life-long partner in the practice of medicine - the patient. No longer is the student in total control of his or her own successes or failures. The patient becomes the generic term for that particular person with whom the student-physician's successes and failures are shared.

This brief outline constitutes the basic forum within which the student develops the skills and knowledge necessary to become a practicing physician. The question remains as to where in the curriculum ethics courses should be taught, and how such courses should be taught.

It is not the purpose of this thesis to outline or propose a specific educational agenda for moral education, but to point out that the need for such education is present and that formal courses will prove effective in addressing moral

concerns in the medical profession. The following comments then, concerning the instruction of medical ethics courses, and the appropriate place in the curriculum at which they will be effective, will therefore be brief. I will leave it to those in curriculum development to design more fully, those ethics courses based on the suggestions and arguments provided in this thesis.

In the discussion of Kohlberg's theory of moral development, several basic elements were illustrated as necessary to promoting effective moral development. These were mental growth, psychological growth, a broad spectrum of ideas, a wide range of human experience, and experience with conflict. In the context of medical education, a reasonable degree of mental and psychological growth can be assumed, given the rigorous selection process carried out by medical schools in terms of the students' intellectual and psychological abilities. It is therefore with the factors of ideas, human experiences, and conflict that courses in ethics should be dealing. The two stages of medical education for medical students outlined in the previous pages provide very different contexts in which to develop courses. Students in the preclinical years are more focused on the abstract concepts of patient care - the cellular structures and metabolic pathways - the science of medicine. As such, they are removed from the issues in medicine that are not resolvable through technical means or the manipulation of physical facts. In

this forum, ethics courses will have to be structured so as to give both the foundation of moral education - an overview and discussion of moral principles, values, virtues, and the like - and content to such foundations through case discussions and student experiences. The aims here parallel those of the scientific education of the student - to provide the student with theoretical knowledge which he or she will eventually utilize in dealing with patients. Before the student can begin to apply moral principles, the student should first come to a deeper understanding of them.

The clinical years provide ample illustration of human conflict, and as such, should be utilized in ethics courses. The courses should be tailored so as to allow for actual situations encountered by the students to be brought into focus.

Although brief, the aim of this section is to provide basic guidelines in the development of ethics courses in the medical school curriculum. As was stated in the previous chapter, the goals of such courses are to expand moral knowledge and increase rationality so that students will be able to <u>think</u> morally as the basis for making moral decisions. Courses should therefore focus on the mechanics of morality first, such as defining principles, understanding concepts, developing rational and consistent arguments along with the abilitites to criticize and justify, and then move on to those clinical moral situations as the forum in which to develop.

It has been emphasized throughout this thesis that the rationality which underlies all moral decisions can be improved by critical reflection and justification of those beliefs, opinions, and principles which are used in making decisions. The key theme in this suggestion is the concept of development, not indoctrination or mere conformity to ancient codes of ethical conduct. Courses should be set up such that students are faced with views that differ from their own. They must be taught not merely to tolerate others' views as the relativists and subjectivists advocate, but to evaluate and critique them, and attempt to justify their own views against them. The reasoning used in this process must be clarified and consistent, and flaws in other arguments must be pointed out. The clinical setting of the medical school curriculum offers the students the opportunities to make decisions and accept responsibility for the consequences of them. In this way, morality becomes a realistic component in the care of the patient.

In taking the them of developing morality through the suggestions just listed, how is an ethics course to be presented to medical students? To begin with, an aim must be established in order to give direction to the course. The major goal of modern medical education is to develop within the students the skills necessary to provide competent and quality health care to society. Courses in medical ethics

must necessarily recognize this aim and strive to contribute constructively to this major goal.

The importance of ethics courses as a dimension in providing quality health care must be displayed to the students. As was stated in Chapter I in a quote from Dr. Pellegrino, 'medicine is at heart a moral enterprise.' Students must be made to see that there are ethical dimensions to the decisions that they make within the clinical setting. Dr. Glenn C. Graber of the University of Tennessee claims that

> every clinical decision -- even those which are unproblematic -- has significant value and ethical components... Eric Cassell makes a similar point: "I believe that medicine is inherently a moral profession -- or moral-technical profession, if you wish...because it has directly to do with the welfare and the good of others." Cassell adds elsewhere in the same volume: "Perhaps that would not be so if in each case there was only one right decision or only one correct course of action, but in medicine there are frequently several possible courses of action, each of which is technically correct. Or there may be only one technically proper decision but several different ways of implementing it, each of which would affect the life of the patient somewhat differently."[24]

The recognition of ethical dilemmas and dimensions in the clinical setting is a crucial objective in any course of ethics in the medical setting. If this is not first attained, further attempts at integrating ethics teaching into the daily lives of students will meet with little or no success.

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[24]Graber, loc. cit.

Students must be made to recognize and feel the need to take seriously what courses in ethics have to offer to them in providing quality patient care.

Once the need for such courses is established from the students' perspective, students should be encouraged to grapple with cases present in their every day lives. In doing so, each student's values that underlie his or her solution or opinion should be drawn out and explored. In this way, students are taught to recognize their own value systems that guide their judgments as well as recognizing those values that underlie the judgments of their colleagues.

Once students begin to recognize the values that underlie their clinical decisions, they must next be encouraged to question them critically, analyze them, and defend them against other points of view or alternative solutions. In doing so, two objectives are achieved. First of all, students are developing analytical skills needed in good decision-making, and second, they are forced to consider alternative solutions and views in evaluating and defending their opinions.

Graber also points out another skill that should be developed in the students. They should, he states,

> develop awareness of, and skill in analyzing, distinctive concepts which arise in normative thinking. An understanding of general concepts like "rights," "autonomy," "responsibility," and the like -- along with insights into the way in which analyses of these notions will embody a normative perspective -- is an important component of careful normative thinking. Further analysis of concepts like "death," "health,"

and "professiona," are essential to unravel certain key clinical medical issues.25

The goals of ethics courses, listed in Chapter III as being (1) to cultivate students' dispositions towards moral behavior, and (2) to cultivate student's abilities to support those actions by reflective consideration and rational justification, can be attained through these suggestions. Ethics courses should begin by demonstrating that there is a need within the clinical setting for the study of ethics. Once this need has been established and displayed to the students, the next step is to encourage them to discuss and grapple with problems and cases. Within this process, values should be pointed out, analyzed, questioned, defended. Students should be exposed to, and encouraged to explore, different solutions and opinions. In addition, certain concepts like those listed by Graber, should be explored and analyzed in relation to the clinical issues in which they are applicable.

The question remains as to where in the curriculum ethics courses would be most beneficial. As was stated earlier in this chapter, the key theme is development - of rationality, analytical skills, recognition of ethical dimensions in clinical cases, of hidden values underlying judgments and decisions,

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25Ibid., p. 12

of moral knowledge. The goal in the teaching of ethics is not to limit such courses to carefully controlled segments of the students' lives (and ultimately the phtsician's lives) but to integrate the knowledge and skills developed in the courses into the daily life of both the student and the practicing physician. The goal is to offer a consistent and ongoing education in this area of health care. Ideally, such courses would be most successful if they were consistently implemented throughout the four years of the medical education with the end result paralleling that of other courses in the medical curriculum - to equip the student to provide quality and competent health care to society.

This thesis has been an attept to defend the movement toward implementing ethics courses into the medical school curriculum. It is hoped that the presentation of the need for such courses, the discussion of how ethics courses are to be instructed, as well as the discussion of why ethics are best taught as formal courses in this setting, have contributed to an increased acceptance of the proposal for ethics courses.

In conclusion, it is sincerely hoped that those whose lives move them in the direction of medical service to humanity will realize the awesome responsibility placed on them as decision-makers. For regardless of how many alternatives are placed before them in making a decision, and regardless of how many philosophical discussions take place about each

argument, ultimately a decision must be made. This thesis has been an attept to advocate that the best decision be made, through both clinical competence and enlightened moral reasoning.

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