A Model for Teaching Ethics in a Family Practice Residency

Donnie J. Self, PhD, and Gregory T. Lyon-Loftus, PhD, MD
Norfolk, Virginia, and Keams Canyon, Arizona

The model used for teaching ethics at the Ghent Family Medicine Residency at Eastern Virginia Medical School consists of a monthly one-hour noon conference integrating ethical principles and clinical decision making. The underlying objective is to help produce effective physicians by developing their knowledge, skills, and attitudes. The model combines didactic material and clarification of personal values in a case study format. The most important kind of learning to be derived is the self-awareness of one's own value structure and its contribution to the clinical decision-making process. Such a conference will succeed in capturing resident participation in direct proportion to faculty support. Medical ethics teaching in family medicine is appropriate, important, and consistent with the principles of a good family practice residency. An illustration of a typical ethics noon conference on confidentiality is given.

The meaning of life is the essence of medicine—how it begins, how it is lived, and how it ends. Medical education by its nature represents a community of persons that inculcates values in the medical trainee. By exposing the trainee to experiences of birth, death, pain, and cure, the medical education process allows the person an opportunity to develop values relevant to those events. In addition, medical education can provide opportunities for reflection and adjustment of a person's values. With the crowding of the medical education curriculum, there has been a loss of reflective time in the life of the medical trainee. Attention to medical ethics training can help return reflection to its proper place in value formation of the trainee.

There is increasing interest in ethics training in family medicine residency programs. The Special Requirements for Residency Training in Family Practice[1] now stipulates ethics as a topic for accreditation by the Residency Review Committee. However, there are very few reports in the literature on how to implement ethics training in family medicine. An earlier report in the *Journal of Family Practice*[2] describes a very different teaching approach of ethics training on ward rounds in contrast to the noon conference described here. A much earlier report in the *Journal of Medical Education*[3] describes a course approach to ethics training in family medicine residency but is currently somewhat out of date and inaccurate according to its author. Nevertheless, the importance for developing adequate methods for ethics training in family medicine has been clearly established.[4,5]

It is well known that values influence and guide

From the Human Values in Medicine Program, Department of Family Medicine, Eastern Virginia Medical School, Norfolk, Virginia. Requests for reprints should be addressed to Dr. Donnie J. Self, Human Values in Medicine Program, Department of Family Medicine, Eastern Virginia Medical School, PO Box 1980, Norfolk, VA 23501.

© 1983 Appleton-Century-Crofts

behavior. Everyone has certain values, and it is recognized that people have values that differ. Clarification and expression of values help one understand why behaviors, in one's self or in others, are as they are. If behavior can be understood in terms of values, it can be dealt with more effectively. Understanding and dealing with behaviors are of prime importance in the physician-patient relationship. The function of ethical principles and personal value systems is to guide choices. This paper presents one format for the expression and clarification of values that provides for an improved understanding of behavior based upon reflection on ethical issues surrounding patient care.

Format

The medical ethics program at the Ghent Family Practice Residency of the Eastern Virginia Medical School consists of monthly one-hour noon conferences. The Family Practice Residency Program maintains an ongoing educational series of noon conferences throughout the week. The educational subject matter of these conferences is typical for family practice residencies and covers topics ranging from cardiology through dermatology, endocrinology, practice management, and so on. One hour each month is assigned to the topic of ethics. The conference is attended by faculty and first-year residents, second-year residents, and third-year residents who are not assigned to conflicting clinical responsibilities. This constitutes a small group ranging from 5 to 12 persons plus a speaker and occasional guests.

Each conference is developed around one ethical principle, such as truth telling or confidentiality. The conference usually opens with a brief didactic presentation using slides and prepared comments in which certain classical distinctions of ethics are presented and any necessary vocabulary for characterizing concepts is identified and clarified. This didactic presentation itself usually generates a few questions and some discussion among group members involving clarification of the classical distinctions or expression of personal opinions. If one of the group members does not volunteer a relevant, current clinical case, a prepared typical case illustrating an ethical issue is then distributed to stimulate discussion of the issues surrounding the conference topic.

Objectives

It is the underlying objective of the Family Medicine Ethics Conference to help produce effective physicians by developing their knowledge, skills, and attitudes. Development of these traits is the function of philosophy in medical education.[6] It has been shown that there is a consistent and meaningful relationship between the development of moral reasoning and quality of clinical performance.[7]

Knowledge

The conference contributes to the basic fund of knowledge of the resident and faculty. This fund includes knowledge of the fundamental principles and vocabulary of medical ethics, such as the principles of autonomy, justice, beneficence, nonmaleficence, and confidentiality. The knowledge to be imparted also involves data concerning variables that affect the application of values in medical ethics such as physician impairment, compliance characteristics, and the traditional consensus of physicians' beliefs about certain issues. These variables contribute to an inconsistency in the application of ethical principles to clinical decisions. Perceiving an inconsistency challenges each participant in the conference to examine the consonance and integrity of his or her own value system and the consistency of its application in clinical ethical decisions. A pointedly pluralistic stance is taken by the discussion group leader in pointing out that while different people may arrive at different conclusions or make different decisions, for each person there is an appropriate and inappropriate conclusion in the application of his or her values and ethical principles to the problem.

Skills

The conference contributes to the development of skills of critical reasoning and the ability to work toward clarity in decision and thinking and exactness in articulation. The conference format and practice encourage each person to "hear out" another person's position and then elicit evidence which supports that position. This ability to analyze and pursue a line of reasoning is important in the realm of values as well as in the realm of facts. Through the analysis of values the conferences

help residents develop interpersonal skills enabling them to listen, explore, and support other people's values with constructive criticism. Through the articulation of their own values, the conference participants bring to awareness inconsistencies within their own value system, which has been shown to lead to efforts at improved integration or consonance. Evidence also suggests that practice at hearing and expressing value-based statements leads to improved performance in these behaviors during times in which physicians are under high emotional strain. In addition, the ability to discriminate between judgments based on the weight of evidence and disguised value judgments is improved with practice.

Attitudes

The conference is intended to contribute to the development of attitudes of openness and tolerance and conceptual excitement. Openness is facilitated by the supportive acknowledgment of expressions of one's own values, including observations of consistency and acknowledgment of decisions that retrospectively appear to be inconsistent with ethical principles. Openness is facilitated also by practicing tolerance of other persons' value expressions. Tolerance for pluralistic values is modeled by the group leadership; furthermore, the legitimacy of tolerance is emphasized in the requirement for integrity and internal consistency without requiring conformity. It is worth noting that the classical conflict in medicine between personal involvement in caring and professional distance is well expressed in a medical ethics context of tolerance for each individual's values, subsumed by a respect for ethical principles. It has been the common experience of students through the ages that an exploration of substantive issues of values and meanings generates excitement. Harnessing that energy and diverting it from the "beer and bull session" to an organized conference that proceeds from principles, through cases, to personal awareness has a rejuvenating effect on medical practitioners of all ages.

Example of Medical Ethics Conference on Confidentiality

The following material is an illustration of a typical ethics noon conference.

Objectives

At the conclusion of the conference the resident should be able to do the following:

1. State the criteria for a sound ethical decision
2. State the basis of the principle of confidentiality
3. Compare the various medical codes on the issue of confidentiality
4. Discuss the act vs rule distinction in ethics as it applies to the issue of confidentiality
5. List the three generally accepted exceptions to confidentiality
6. State the conditions appropriate for a breach in confidentiality
7. Apply these considerations of confidentiality in a discussion of case studies.

Confidentiality is the foundation of the physician-patient relationship. Later you will be asked to make some ethical judgments about case studies involving confidentiality. Therefore, consider briefly the criteria for a sound ethical decision.*

Criteria for a Sound Ethical Decision

1. The decision must be rationally arrived at, not just gut feelings. You can give reasons and justifications, sometimes better or worse, for choosing one alternative over others.

2. All relevant data must be fairly considered. The decision must not be biased any more than you can help, ie, the data must be objectively considered. You must be willing to be persuaded by the data or be open minded. Can you put yourself in the opposite position empathetically and still conclude that the decision is best even though you do not like it?

3. The decision must be universally applicable. You would be willing for all physicians to do likewise under relevantly similar conditions. This is generally considered a cornerstone of Western morality. Examples come to us from Immanuel Kant (Categorical Imperative: Do those acts and only those acts which you could will to become universal law) and from the Judeo-Christian ethic (Golden Rule): Do unto others as you would have them do unto you.

4. The decision must be coherent and consis-

*This particular set of criteria was first brought to the author's attention in personal conversation with Dr. Larry Churchill of the School of Medicine of the University of North Carolina.

tent, ie, fit in well with other moral beliefs you hold and preferably with the moral beliefs of others.

Basis for the Principle of Confidentiality

The principle of confidentiality is based on the right to privacy and the notion of privileged communication. This is incorporated into the state laws, although it varies slightly from state to state. The principle of confidentiality is also incorporated into most codes of medical ethics. State laws give a legal basis to confidentiality, and medical ethics codes give a moral basis to confidentiality.

Comparison of Confidentiality in Codes of Medical Ethics

1. *World Medical Association.* A doctor owes to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.

2. *Declaration of Geneva.* I will hold in confidence all that my patient confides in me.

3. *Hippocratic Oath.* Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

4. *British Medical Association.* It is a practitioner's obligation to observe the rule of professional secrecy by refraining from disclosing . . . (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient. . . . On certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding consideration must be adoption of a line of conduct that will benefit the patient, or protect his interest.

5. *American Medical Association Principles of Medical Ethics.* A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of his patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the society.

But what if the best interest of the patient is illegal or prevents justice? What counts, and when is it sufficient to breach confidentiality? Either one of two approaches is usually taken.

Act vs Rule Distinction

Act Utilitarianism—The person determines the utility of each individual act, then the act with the greatest utility is obligatory. This emphasizes the particular: *this* act in *this* situation. The principle of utility applies directly.

Rule Utilitarianism—The person determines the utility of performing one *kind* or class of act in a *type* of situation. The utility of following one rule is compared with that of alternative rules. The principle of utility applies indirectly.

All of this implies that there are occasions in which it is appropriate to breach confidentiality. If so, what are the exceptions to be?

Generally Accepted Exceptions to Confidentiality

1. When the law requires it (eg, gunshot wounds, infectious diseases, suspected child abuse, dog bites)

2. When it is in the best interest of the patient (eg, to prevent suicide)

3. When it is in the best interest of society (eg, Typhoid Mary-type cases or the patient is planning a homicide)

What if the best interest of the patient is illegal or prevents justice and is not required to be reported by law? If there are to be exceptions, under what conditions do you breach confidentiality?

Conditions for Breach of Confidentiality

The principle of confidentiality should not be breached unless *all* the following conditions are met simultaneously:

1. Its maintenance would clearly result in damage that outweighs the damage done by the breach

2. There is *no* other way that does not involve a breach of confidentiality to avoid the damage

3. The breach is the least possible that will prevent the damage or is the one with the least harmful consequences to the patient

4. The patient is informed, preferably before the breach

Now consider some case studies and determine what you consider to be the appropriate course of action regarding confidentiality.

At this point a current clinical case might be offered by a conference participant or a typical case from the literature would be discussed. In either event emphasis would be placed on applying

the foregoing didactic material to the case. Typical cases from the literature might include a bus driver with a heart condition,[8] gonorrhea and the unknowing spouse,[9] or genetic counseling of relatives.[10]

Conclusions

Given that medicine is practiced in a pluralistic society, marked by rapid progression and shifts in societal concern, the derivation of definitive answers to the ethical questions of medicine would seem impossible. Therefore, the most important kind of learning to be derived from the Family Medicine Ethics Conference is the self-awareness of one's own value structure and its contribution to the clinical decision process. The Ghent model of combining didactic material and vocabulary with case references and clarification of personal values constitutes a process that can occur in many settings. In the experience of the authors, several things contribute to success in this endeavor. The ethics conference setting is perceived by residents to be equivalent to other educational settings within the same environment, that is, it is seen as a component part of a larger process of patient care. Consensus and conformity of opinion regarding values and ethical decisions are not considered preferable to logically and consistently derived differing personal opinions. The participation of a clinician sympathetic and conversant with both the principles and vocabulary of ethics serves as a bridge between the practice of medicine and the study of medical ethics. Such a "straightman" or "catalyst" transforms the conference attendees from an audience to participants by modeling and exhorting the application of didactic material and ethical principles to personal issues and current clinical problems. This immediacy enables the conference to avoid dwelling on such theoretical distinctions as act vs rule utilitarianism except in a context of a particular case or perhaps most importantly in the identification of a personal style preference. The role of the ethicist is similarly important in that he or she serves not simply as a "discussion leader" but as a trained and experienced expert able to demonstrate the characteristics of openness, tolerance, and conceptual excitement.

Medical ethics teaching in family medicine is appropriate, important, and consistent with the principles of a good family practice residency. It is worth doing with adequate attention to presentation of ethical principles, selection and presentation of provocative case material, and facilitation and support of exploration of personal values. Such a conference will succeed in capturing resident and student participation in direct proportion to faculty support. The participation of an experienced practicing clinician improves the functioning of the group by demonstrating the application of the abstract ethical principle to current clinical problems as well as by modeling open expression and articulation of values and tolerance for other opinions. This model represents a method for the inclusion of medical ethics in the ongoing curriculum for the education of medical trainees. It is based on the perspective that medical ethics is a component in medical practice in the same sense as is cardiology, neurology, or financial management. The format requires a tolerant milieu and an ethicist knowledgeable in ethical theory, comfortable in articulation of personal values, familiar with clinical settings, and tolerant of other's values. It functions best with a clinician who is experienced with the translation of ethical principles into clinical decisions and able to translate ethical vocabulary into the context of patient problems.

Acknowledgment

This work was supported in part by a Human Dimensions in Medical Education Grant from the W. K. Kellogg Foundation.

References

1. Essentials of accredited residencies. In Directory of Residency Training Programs. Chicago, American Medical Association, 1982
2. Carson RA, Curry RW Jr: Ethics teaching on ward rounds. J Fam Pract 11:59, 1980
3. Keller AH: Ethics/human values education in the family practice residency. J Med Educ 52:107, 1977
4. Geyman JP: Expanding concerns and applications of medical ethics. J Fam Pract 10:595, 1980
5. Dickman RL: Family medicine and medical ethics—a natural and necessary union. J Fam Pract 10:633, 1980
6. Clouser KD: Philosophy and Medical Education. In Self DJ (ed): The Role of the Humanities in Medical Education. Norfolk, Va, Teagle & Little, 1977, pp 21-31
7. Sheehan TJ, Husted S, Candee D, et al: Moral judgment as a predictor of clinical performance. Eval Health Profess 3:393, 1980
8. Brody H: Ethical Decisions in Medicine. Boston, Little, Brown, 1976
9. Pence GE: Ethical Options in Medicine. Oradell, NJ, Medical Economics, 1980
10. Veatch RM: Case Studies in Medical Ethics. Cambridge, Mass, Harvard University Press, 1977