A Conscience Sensitive Approach to Ethics and Teaching Caring Attitudes

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Medicine is a moral enterprise, and medical educators have a primary moral and professional obligation to students to teach, evaluate and nurture this aspect of the curriculum.

We assume our students enter medical school as persons of conscience, and that our job as teachers, in addition to helping them master facts, critical and clinical thinking and skills, is to promote their development into professionals of conscience, and eventually, virtuous physicians. Thoughtful students quickly grasp the fact that what we **can** do in medicine usually outpaces the consensus of what we **ought** to do, and one of the earliest questions these students ask is how they should go about honoring their individual moral selves in the face of patients, peers, or teachers who profess divergent values, or request services that jar the young professional's sense of moral ought-ness. Medical educators readily recognize the moral requirement to teach ethics, but struggle to engage effectively the moral reasoning of students who are inundated with basic science courses and clinical skills training (Self and Baldwin, 1994). Students appreciate hearing case stories, and recognize in the practice of case-based ethical dilemma resolution similarity to other medical problem solving processes, but are impatient with philosophical theory. Most students at our institution were biology or chemistry majors, and few have taken any courses in literature, philosophy, religion, ethics, or other humanities.

We also recognize that the experience of professional education and training is a life changing experience, which may, for some, become adverse. Personal and professional stressors and psychopathological interferences (for example, mood or anxiety disorders or substance abuse) may overwhelm inadequate coping skills and push a student away from her/his path toward flourishing practice and onto a path toward demoralization and failed beneficence. If this state is not countered, either autonomously or through external help, the student may be more susceptible to negative influence from the "hidden curriculum" and slip further toward despair or toward the development of uncaring attitudes and behaviors, perhaps even to the point of contributing to or committing a harm. This is a widely recognized phenomenon, and yet most of our professional and educational efforts, like those reported in the literature, have concentrated on *responding* to such uncaring attitudes and behaviors rather than on developing early "preemptive" educational programs.

We describe a new approach to teaching bioethics and professionalism that draws upon three unique programs at the Indiana University School of Medicine (IUSM): **The IUSM Competency Based Curriculum**; a faculty development program, **"Teaching Caring Attitudes;"** and **The IU Conscience Project**. Each of these programs will be described briefly, followed by the discussion of a new curriculum that, we believe, will help prevent lapses in caring attitude and behavior, will support and deepen the work of

the competencies, and will nurture young professionals as they travel their path of great expectations toward virtuous practice.

The IUSM Competency Based Curriculum

The literature on competency is perhaps more robust for positive youth development (for a recent review see Evans, et al, 2005) than for young adults entering the professions. The competencies considered critically important for positive youth development include these five: social, emotional, cognitive, behavioral, and moral abilities. The related literature stresses the "multidimensionality of competence" and suggests that arenas of competence ought to be subject to research to ascertain their effectiveness. (Evans, et al, 2005). Medical education traditionally stressed knowledge and skills, and although "multidimensional" competence was implied, outcomes were not usually described in those terms before the early 1990's. That certainly is changing, especially at the IUSM.

The IUSM embarked on a major curricular revision, the first in nearly 30 years, in 1992. Over several years of review, study, debate and discussion, the School's educational leaders identified the goal of graduating 'competent physicians;' that is, virtuous physicians who display competence in nine critically important arenas. We were helped enormously by earlier work done at Brown University on a competency-based curriculum, and with their help and support we adapted many of their ideas to our School. The nine competencies now required for graduation from the IU School of Medicine are: Effective Communication, Basic Clinical Skills, Using Science to Guide Learning, Life Long Learning, Self Awareness, Self Care and Personal Growth, Community Context of Health Care, Moral Reasoning and Ethical Judgment, Problem Solving, and Professionalism and Role Recognition. We identified a knowledge base, criteria for each of three levels of achievement, and assessment tools for each competency. Every student must achieve an intermediate level of achievement in each competency, and an advanced level, level 3, in at least three competencies. The competency curriculum was fully implemented with the matriculating class in 1999.[1] Responses to the new curriculum have ranged from eager affirmation to downright suspicion, but over the last few years, a generally positive regard has developed among students, faculty and administrators. For the purposes of our project and this paper, we will concentrate on three of the IUSM competencies in particular: Self-awareness, Ethics and Professionalism.

Teaching Caring Attitudes – a Faculty Development Program

Teaching Caring Attitudes grew out of work done by a diverse group of faculty members who received a generous grant from Lincoln National Life Insurance Company in 1996.

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[1] A more detailed description of the competency-based curriculum may be found in "The Indiana Initiative: Physicians for the 21st Century" publication by IU, and the Medical Education and Curricular Affairs (MECA) website (http://meded.iusm.iu.edu). In a related and helpful development, in July 2002 the American Council of Graduate Medical Education instituted a requirement for competence in 6 areas: Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice Based Learning, and Systems Based Practice (ACGME, 2002).

The original intent of this group, the Health Ethics Leadership Program (HELP), was to facilitate the teaching and practice of healthcare ethics throughout our institution, with the overall goal that consideration of ethical issues eventually would be part of every teaching and therapeutic encounter within our hospitals, clinics and classrooms. This was a little grandiose: The IU School of Medicine is the second largest medical school in the country, with about 1100 students total, plus hundreds of persons in residency and fellowship training. At the time of the first HELP meeting, in 1996, there were about 4 full time faculty members (out of several thousand!) who had any formal training in medical ethics, and a handful more who had substantial training in related fields of communication, education, psychology, and others. Our HELP group included physicians in medicine, psychiatry, pediatrics and dermatology, a professor of pharmacology, the vice chair of family medicine who held a PhD in psychology, and a staff member who had a masters degree in ethics. As we began to know each other and to try to put our lofty goal into some sort of workable program, we told many stories about why we thought we needed such a program. The stories usually involved incidents of disrespect for patients, disrespect for learners, lapses of judgment or attitude often in circumstances of exhaustion, anxiety, hunger, grief or other unexpressed emotions. What often seemed clear from the stories, and from our own personal and painful experiences, was that a lapse in behavior did not necessarily mean that the offender was a "bad" person, or resident or student, and that an educational intervention, rather than a punishment, was needed. A review of the literature revealed that most incidents of uncaring attitudes or behaviors, including 'black humor,' referring to patients as 'dirtballs,' 'frequent flyers,' 'cabbage patch kids,' or 'gomers,' usually went ignored by the others in the group, including the faculty or senior resident." Other responses often used by teachers with questionable success included humor, which might backfire, nonverbal disapproval, and judging or moralizing, which might lead to learner resentment or frustration (Bogdewic, 2000). It was also, lamentably, not uncommon in the collective memory of the group that the most senior folks were those displaying the uncaring attitudes. We honestly could not figure out how to take on some of the most senior faculty members whom we knew engaged in this kind of behavior, but we felt that we could begin offering support and specific skill training to those who do most of the teaching at our School, the residents and younger faculty. This led to our faculty development program, which we called "Teaching Caring Attitudes (TCA)."

The heart of the TCA program is the CARE LAPSES model, which describes behaviors clinical educators can use when confronted with learner anger, hostility or disrespect. The HELP members generated the model through mutually told stories of challenging encounters with learners, and ensuing discussion of the interventions --what worked and what didn't.

> "**C**" stands for '**Clarify**,' to understand what the student meant. Sometimes a student may say something disrespectful and immediately wish to recall it.
> "**A**" reminds us to '**Assess**' the learner's situation (e.g. post call, sick herself) and motivating behavior.
> "**R**" refers to '**Repeat**,' to simply repeat the disrespectful word or phrase. Repeating is a subset of clarification, and the intonation, for example in the

form of a question or statement, may help the learner to really 'hear' and experience the impact of the objectionable word.

"**E**" refers to '**Empathy**' for the learner. Although empathy is an emotional experience rather than a verbal technique, empathy may be expressed verbally and by body language.

"**L**" cues us to '**Listen**' actively which involves paraphrasing and tracking of the conversation.

"**A**" refers to the '**Acknowledgment**' of the learner's emotions verbally. For example: "That patient really seems to upset you," or "That smell seems to be eliciting a strong reaction of disgust from you."

"**P**" prompts us to '**Ponder**' the impact of learner's behavior on patient or family, on the learner herself, on the medical care provided, and finally on medico-legal implications.

"**S**" refers to '**Stimulate**' self-reflection by having the learner reflect on his/her own motivations, desires or goals. This may reveal inconsistencies or behavior incongruent with the physician and person the learner hopes to be.

"**E**" refers to '**Educate**' the learner, specifically related to the learner's attitude, not toward facts that do not impact on the unprofessional behavior.

"**S**" this time in the mnemonic reminds us to '**Stop**' the learner's behavior.

Philosophically, the HELP group agreed that most challenging attitudes and behaviors would best be met through a firm, supportive, educational intervention, i.e. the CARE LAPSES approach, rather than a punishment meted out in the form of eliciting shame or assigning blame. However, a few behaviors might occur sufficiently offensive or persistent that a teacher might resort to confrontation and/or termination of the interaction, hopefully scheduling a follow-up conversation in the not too distant future, for example: "Please stop calling the patient a sleazeball. Let's talk about your reaction to this patient after conference today."

TCA helps persons recognize a lapse in caring attitude and offers a variety of strategies with which to counter or respond to the learner in a way that fosters the learner's self awareness and empathy. The TCA model has been presented at several local workshops and at national meetings, including the Society for General Internal Medicine in 1998. Further details may be found in the literature (Cottingham, Marriott, Litzelman, 1998; Srinivasan, Litzelman, Seshadri et al, 2004). The HELP group met regularly for 5 years and for most of us, this shared work was one of the most satisfying experiences of our professional lives. Yet, we realized that our practical TCA program turned out to be quite different from the grander vision with which we started. As currently employed, TCA models a way of *responding* to uncaring attitudes and behaviors, some of which may lead to harms being committed, rather than providing a truly innovative educational model that would help young persons develop the necessary knowledge and skills to flourish and grow into the best physicians they can be.

Traditional Ethics in Medical School

Practitioners of modern medicine encounter moral issues multiple times each day, from the most straightforward discussion of informed consent to the most intimate details of end of life consultation. Indeed, every encounter with a patient, family member, healthcare team member or related person is an ethical encounter, an "interplay of values," but young physicians and trainees arrive at medical school with varying levels of information, interest and comfort related to the ethical dimensions of patient encounters. As mentioned in the introduction, medical educators struggle to find the most effective and interesting ways to teach medical ethics to this varied group of learners. There is some consensus (Branch, 2000; Eckles, Meslin, Gaffney et al, in press) that case based discussion, usually involving dilemma resolution principles, is the format most palatable to medical students, in part because it mirrors medical case consultation. But, learners need some background knowledge of ethical language and theory in order to identify and engage ethical problems in a thorough, intellectually rigorous, and empathic manner.

There are several approaches to ethical decision making in medicine. One familiar to most practitioners is the approach using the **major moral principles** of *autonomy* (respect for persons), *beneficence* (do good, promote good and prevent harm), *non-maleficence* (refrain from doing harm), and *justice* (consideration of fair distribution of burdens and benefits, or consideration of what is due or owed others) (Pellegrino, 1993). Another approach is to apply an **ethical theory** to a moral problem in medicine. Three major theories commonly apply: *consequentialism*, *deontology*, and *virtue-based ethics* (for excellent reviews of each see: **A Companion to Ethics**, 1993). *Consequentialism*, also referred to as teleology, utilitarianism, or ends-based reasoning, resolves a dilemma through consideration of what would bring about the greatest good for the greatest numbers. Unflattering commercial description and language related to this theory include "the ends justify the means," and "bottom line considerations." *Deontology*, also known as rule-based reasoning, approaches an ethical dilemma by asking, "What is the highest principle (rule) that should be followed?" or "What is the one principle that should never be violated?" Deontologists believe that acts are right or wrong in themselves, and not because of any related consequences. *Virtue based ethics* and virtue theory consider first the moral actor rather than the choice or action, and ask "What would a good physician (teacher, parent, lawyer, etc.) do in this circumstance? (The "care-based" approach is closely related to virtue theory and considers what the decision maker would want done herself in a similar circumstance).

As a practical matter, conscientious people use some or all of these principles and theories every day, choosing the approach that best fits the situation at hand. Formally, the 'best fit' method is called **casuistry**. Casuistry describes the process of analyzing a moral dilemma or case by comparing it to other well-known and ethically scrutinized scenarios, so-called 'paradigms'. Is this present case before me more like Case A, about which I know, or like Case B about which moral consensus has developed? Paradigm cases serve as ethical guideposts in a sense, similar to precedent cases in the law and classic medical presentations; as noted earlier, medical students feel generally more comfortable with case-based ethical discussion than with formal didactic presentations on

principles and theory, and often are surprised when they realize that they are invoking those principles and employing those theories as they grapple with cases. (for comprehensive reviews of casuistical traditions see: Jonsen and Toulmin, 1988; Kirk, 1999).

Each of these approaches has value, but is insufficient to respond to all ethical dilemmas; something is missing. What happens when two prima facie duties conflict? For example, a competent person refuses life saving surgery, thus exercising his autonomy, despite the surgeon's earnest urging which reflects beneficence. Or, a patient with a "Do Not Resuscitate" (DNR) agrees to palliative surgery but insists that the DNR order remain in effect. The anesthesiologist is concerned: she believes that procedures that might be considered 'resuscitative measures' at any other time or in any other place are actually 'routine' during the operative and perioperative periods, and thus in order to fulfill her professional and moral duties she wishes to be able to exercise her full therapeutic options on behalf of the patient, even procedures the patient has specifically declined in arriving at his DNR status. Another example involves the issue of physician-assisted suicide which, at least on one level, seeks to balance an autonomous person's request for relief of suffering with professional obligations to do no harm, to preserve life. In other words, what **should** a virtuous physician do in the face of his patient's terrible suffering? The principle approach is insufficient to resolve the competing claims of autonomy and beneficence. Consequentialism's 'the ends justify the means' may be attractive (the patient is dying anyway and this will make it more comfortable), but deontology would counter that killing is wrong. How does a physician reconcile the certainty that whatever he chooses, he will cause or allow harm to his patient and violate at least one of his sworn duties?

This is the point at which medical students (and even seasoned clinicians) falter. Our School, like many others, provides a rigorous basic science curriculum in the first two years, emphasizing facts, evidence, proofs, objectivity, and employs the language of science, 'value neutrality'. Scientific language is a necessary acquisition of all medical practitioners, but it is not sufficient to fully explore ethical issues in medicine. Ethical problems usually are messy, not susceptible to neat black-and-white solutions. What is needed for a full exploration of the complex human drama that engenders ethical dilemmas is moral imagination, which is difficult to retrieve, activate or even describe with scientific language (although the science of developmental psychology strives to make this description). Moral imagination allows a physician to imagine committing harm and the aftermath. Can one prevent the harm, and if not, how does a good physician respond? Is reparation possible, forgiveness or healing? Moral emotional responsiveness raises issues that are not addressed by traditional ethical principles or theories, and certainly not by the basic science curriculum. Moral language is required, the language of values, virtues, choices. At some point, moral language becomes personal: '**I** choose to do this because of the values I hold, in accordance with the image I have of myself as a good person.'

This is **not** comfortable for most physicians, and our youngest students recognize that moral language is not the vernacular of their new profession. Indeed, we have heard third

year clerks say with great confidence, "**I** will never make that mistake," or "I will never make that **mistake**." Those who can scarcely imagine making "mistakes" (a term already more acceptable to them than "harms") may also find it hard to imagine seeking forgiveness, which, together with gratitude, may be found in a fuller, richer repertory of moral emotional responsiveness. They may miss in part or even entirely the transformation of moral connectedness from personal to professional, essential in attachments to patients, peers, and teachers, and motivational for virtuous behaviors such as seeking help from colleagues and soliciting peer support and encouragement.

Conscience Theory

A theory of conscience formation and functioning was initially developed to account for empirical findings from a study, begun in the early 1980's, of the moral developmental psychology of children and adolescents. The Stilwell Conscience Interview (SCI, Appendix A) was the principal instrument used to engage the child in her awareness of aspects of her moral identity. After completing their initial work on normal development of conscience (Stilwell & Galvin, 1985; Stilwell, Galvin, Kopta, 1991; Stilwell, Galvin, Kopta, et al, 1994; Stilwell, Galvin, Kopta, et al, 1996; Stilwell, Galvin, Kopta, et al, 1997; Stilwell, Galvin, Kopta et al, 1998) the investigators began to describe conscience development and functioning in abused and neglected children (Galvin, Stilwell, Shekhar, et al, 1997; Galvin, Stilwell, Adinamis, et al, 2001). There was also collaboration on an international project examining the effect of a natural catastrophe, the devastating 1988 earthquake in Armenia, on the conscience functioning of young adolescents (Goenjian, Stilwell, Steinberg, et al, 1999).

There are three major aspects of **Conscience Theory**: *developmental stages of conscience*, five *domains of conscience*, and the recognition that for each domain there exists a corresponding *intrinsic (bedrock) value*. The *stages of conscience* are invariant, and move from something posited by the preschool child in the locus of external authority to something internalized, personified, and eventually integrated into the personality as a moral organizer by the older adolescent (Stilwell, et al, 1985; 1991). Five *domains of conscience*, including conceptualization, have been described. In the conceptualization domain, a person provides a basic definition of what governs his or her moral life. The person's consciousness of how he or she is composed as a moral being is elicited, through the SCI, in a deliberate effort that allows for the emergence of a personal definition, distinct from his or her generalized definition of 'conscience.' Conceptualization anchors the developmental features of four other domains. In turn, any of the domains may be salient in current conscience functioning and formation, thereby imparting distinctive character to the person's overall conscience concept: these are the **contours of conscience,** characteristic of the individual and not susceptible of staging. The other four domains are: *moral emotional responsiveness, moral valuation, moralized attachment, and moral volition.* In the domain of *moral emotional responsiveness*, transitions occur in the ways emotions are perceived as regulating moral behavior in response to an "am good-feel good" set point on a personal moral emotional barometer. Moral emotional responsiveness ties morality to physiology. Deviations from the set

point create uncomfortable feelings that motivate prosocial behavior, inhibit harmful behavior, and motivate the processes of reparation and healing after wrongdoing (Stilwell et al, 1994). Discrete emotions theory (e.g. Izard, 1977), aspects of temperament theory (e.g. Kagan, 1989; Kochanska, 1991; 1993) and concepts of stress (Chrousos and Gold, 1992) contributed to the construct of this domain.

The domain of *moral valuation* describes the transitions that occur in the process of defining, prioritizing, and justifying moral rules on behalf of values. The moral rules originate in, and sustain respect for, values that are seen in a relational context, referred to as the valuation triangle: rules related to authority, to self and to peers. Both moral reasoning and psychological defenses operate in the domain of moral valuation, and transitions in processing moral dilemmas correlate with stages of conceptualization (Stilwell, et al, 1996).

Moralized attachment is the domain that holds processes and activities of the other domains within the bonds of human relationship: that is, internalization of another's moral presence in one's own conscience concept, one's moral emotional experience of others via empathic and sympathetic arousal, creation of rules that value others' needs, establishment of relationship hierarchies and fairness among equals and, in the domain of moral volition (see below), the transformation of agency into advocacy for others (Stilwell, et al, 1997). Attachment theory (e.g. Bowlby, 1988) and the developmental stage theory of empathy (e.g. Hoffman, 1991) contributed to the construct of this domain.

Moral volition is the domain in which autonomy and will are coordinated with the felt obligation to restrain or take action. Autonomy is the recognition of the self as independent; will is the way an independent person intentionally chooses and directs his/her behavior. In this domain two processes are involved: self-evaluation in the light of external and internal standards reflecting moral values, and conscious choosing to refrain from antisocial behavior and to engage in prosocial behavior (Stilwell et al, 1997).

The third aspect of conscience theory is the idea that for each domain of conscience there corresponds an *intrinsic (bedrock) value* that may be seen as exerting a developmental push and an ethical pull on the person of conscience. These bedrock values, respective to the above domains, are: moral meaning-making (composing a good life), balance or harmony, worthiness (with respect to authority, self and others), moral connected-ness and freedom.

Conscience Sensitive Ethics and Medical Education – A New Curriculum

As we have endeavored to teach bioethics to learners of various levels of experience and interest, we have noted several recurring challenges. Learning about and becoming a virtuous physician involves personal as well as professional development and growth, and the traditional approaches described earlier do not necessarily help a medical student or resident who is struggling with time pressures, worried about the survival of intimate relationships during medical training, or experiencing profound anxiety because of inadequate knowledge and skills. As already illustrated above, there are some specific

instances in which the application of ethical principles and theories may not adequately resolve the ethical dilemma at hand. Moreover, none of the traditional approaches really addresses the personal conscience of the medical professional. Finally, we often are involved in "remediation" programs for students and residents who have behaved in an ethically or professionally inappropriate manner with resultant harm to a patient or colleague.

The approach we are using now involves a 'paired learning experience': first year medical students in the Introduction to Clinical Medicine (ICM I) course, i.e. the developing professionals of conscience, are matched with residents of the Children's Bureau Retreat in Indianapolis. Retreat is a secure residential facility for persons aged 5-18 who have experienced significant adversity in their lives, including break up or loss of family, failed foster care placement, struggles with police or school authorities, substance abuse, etc. Working within and expanding upon the framework of the ICM I curriculum, we have developed specific teaching modules aimed at responding to the limitations of traditional bioethics teaching, fostering the integration of personal and professional moral lives, and preventing lapses in caring attitudes and behaviors. The interactive experience helps the medical student understand personal/social development in the early lifespan and promotes non-judgmental inquiries into values, choices and moral emotional responses, as well as self-awareness. It also provides a conceptual framework for professional conscience development, basic for ethical discourse and for life-long virtuous practice.

We begin the first session of ICM I by giving the students a case history that involves a man who is a Jehovah's Witness and who needs and requests life saving surgery, but requires a promise from the surgeon and anesthesiologist that no blood products will be given at any time, even to save his life. We answer questions related to the medical facts of the case, and then invite the students to describe what they think ought to be done and why. They are free to imagine all possibilities. We collect this exercise and repeat it at the end of the educational intervention – a pre-test and post-test.

During the initial visit to Retreat, we spend the first 90 minutes asking each medical student to describe and draw a picture of his/her own conscience. This reflects questions 1, 2 and 11 of the Indiana University Conscience Autobiography for Healthcare Professionals (I.U.CAP), a modified version of the SCI for healthcare professionals (Galvin, 1998, Appendix B). Each student then shares his/her own definition and drawing with the class and at the end of the period, the preceptors help point out features of the 'composite conscience' of the group. This exercise in moral imagination usually reveals all of the domains of conscience, and allows the students to begin to appreciate diversity and similarities within their group. As soon as we finish, we pair the medical students with the Retreat children and adolescents, and ask the medical students to help their young partners do the same thing. During the last half hour, medical students share their impressions of their partners' drawings. The struggles and life stresses of the Retreat members are foreign to most medical students who come from relatively advantaged families, but even at this early stage, medical students can perceive some of the effects such hardship has on moral development and functioning. At the end of our time

together, the Retreat drawings are collected and held in reserve to be used in group therapy the next day. (Galvin, Gaffney and Stilwell, 2005).

The second visit, usually 1-2 weeks later, focuses on moralized attachment. For this we use a "triple-pass genogram" or "moralized genogram." The first pass records the biological connections, as in a traditional genogram. The second pass records emotional attachments, and the third pass records the moral attachments, the people who care most about their moral lives. Emotional and moral attachment figures may or may not be biologically related. I.U. CAP questions 6-10 explore attachments and also help the learners recognize and describe transmission of values across generations. The medical students share their genograms with each other, and afterward return to their young partners to repeat the exercise. This often is the most poignant of the sessions. Broken and twisted biological connections confuse and stun medical students, who have no experience with incest, rape or abandonment. Retreat residents often cannot identify emotional or moral attachment figures other than their present caregivers.

At this time in the fall semester, the ICM I schedule provides a high school visit as part of the developmental thread of the curriculum. At the high school we help the medical students explore the teenagers' moral values using the image of a "valuation triangle" showing developmental shifts among authority-derived, peer-derived and self-derived values. I.U. CAP questions 12 -14 pertain to the medical students. An especially useful and interesting heuristic device for this work is the "Value Matrix," which applies grids to rules in order to elicit values and to discern the 'best value'- 'basic motive' gap for either abiding by or rejecting rules.

The Value Matrix is an organizational schema to represent the dynamic process in which the educator facilitates the person of conscience's self-examination of the valuational contents of her conscience.

Operationally defined, for any 'don't' (or 'do') x, **base motives** are usually the first (i.e. **base**line) responses a person makes to an inquiry in the form:

If you (a person) went along with x, it would be *because* ---- (fill in the blank).

The educator records this '*because*' as a starting point for the dialogue but then stretches the person's moral imagination by hypothetically blocking the motivational power of whatever was put in the blank in order to assist the person of conscience in eliciting another *because*. The person of conscience adduces another '*because*' and then is asked to *evaluate* the first '*because*' with respect to the second '*because*' in terms of which is *better* (the educator makes clear that what is meant by '*better*' is not '*stronger*'). This may turn out to be an iterative process, the end result of which will be the person of conscience's **best reason(s).** The person may then be asked to judge the relative *strengths* of all the '*becauses*' she has differentiated into **best reasons** and **base motives**.

For example, a rule might be: Do not use drugs. A student is asked to provide a 'because' for following the rule, and a 'because' for not following the rule. The reason for following the rule might be "I don't want to go to jail," or "I don't want to get expelled." The educator 'blocks' those, reassuring the student that neither will happen, and again asks the student to identify his/her best reason for not using drugs (following the rule). Students recognize that often their best reasons are NOT their strongest motives for either following or rejecting a rule; this process of identifying and then refining the reasons may lead to a narrowing of that gap.

The high school experience prepares our medical students for their last visit to Retreat a few weeks later. At Retreat, the established pairs explore the younger persons' moral do's and don'ts, using the value matrix, and in a preliminary fashion, explore changes in the residents' inner states (moral emotional responses) under conditions of doing good or experiencing lapses in right-doing. At the close of this session, the medical students discuss the overall experience with the Retreat residents; often, the students express a desire to stay in contact with 'their' residents.

The following week we revisit the Jehovah's Witness case. Again, the students are invited to respond to the case and we look for evidence that conscience-related considerations, especially of connectedness and moral emotional responsiveness, are making their way into the students' written responses. [2]

The Study

The purpose of the study was to measure the degree of change before and after the above-described educational intervention. The responses were collected over a two-year period from the first year medical students participating in the ICM I small group piloting the study. Each of 16 ICM I students responded to the case before and after the educational intervention. Conscience sensitive criteria were developed which expanded upon the Brown University (now IU) competency criteria related to Moral Reasoning and Ethical Judgment, level 1 (Appendix C). Responses were transcribed and coded so that the scorer was blind to the identities of the students. The average responses pre and post were 6.7 and 10.7 respectively, representing a positive change of 4.1 with a standard deviation of 4.9. The median pre and posttest scores were 6.5 and 9.8 respectively. The minimum change was –5 (only one student actually dropped; see further commentary below), and

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[2] While we were preparing this paper we realized that the timing of the 'posttest' for the Jehovah's Witness case is not optimal; we have been doing that second response during the ethics session at the end of the first semester of the ICM I course, which makes some sense, but at that point we have not completed the entire conscience-sensitive educational intervention. The last related session actually occurs early in the second semester and is followed immediately by a session on professionalism. We plan to move the posttest response to the ethics case into the professionalism session.

the maximum was +12. The sample size was not deemed large enough to do a meaningful test of statistical significance. [3]

The following illustrates the change in a particular student's response:

Pre test:
"Must-   Seek an alternative option if one is available. Possibly the pt could be enrolled in a study where an investigation blood substitute could be used to replace HGB and still be acceptable to the pt. Another pt option would be to use surgical techniques such as " cell-savers" to minimize the pts blood loss. The pt must be consulted to determine if any option is acceptable to him and also to ensure that he fully understands the consequences of his decision.
May-   If necessary if no suitable option can be agreed upon, hospital administration may need to replace the surgical staff with equally skilled surgeons that are willing to respect the pt's wishes and still accept the responsibility and challenge of performing the surgery. If the surgery is successful, the pt could then be started on EPO."

Posttest:
        "The pt has made the decision to not receive blood transfusions. At this time the pt is of sound mind and able to make decisions regarding his own health. The pt has the autonomy to make his own decision. The pt's moral values namely his religion inhibit him from receiving blood transfusions. The patient able to balance his belief in his religious practice vs. his likely fear of dying and still fears the potential of death is not enough motivation for him to ignore the value of his religion. His moral connections to other individuals namely his wife and family agree w/ his decision. If the surgeon were to have their way, the surgeon would be depriving the pt of his autonomy. The pt's religious leader should be consulted to see what medical interventions to increase Hgb would be allowed by the religion. The pt has no chance of life if surgery is not performed. The surgery should be done w/o blood transfusion to give the pt a chance to life. Other medical measures would be used to compensate for the blood transfusion such as epo.
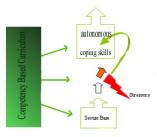If the surgeon is not comfortable than another should be found to perform the surgery to prevent depriving the surgeon of their autonomy."

     The final related ICM I session occurs early in the second semester and is entitled "Young adulthood: your life as a medical student." The standard curriculum asks the students to:
   1. Identify current stressors and personal stress responses; and,
   2. Identify the coping skills they employ to manage those stressors.

See Figure 1.

As we discuss these stressors, we actively invite students to identify the resources they have to respond to stressors. As the discussion unfolds, the students realize that each one already possesses significant personal coping skills that have delivered them safely so far.
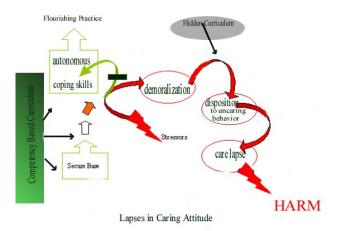
The conscience sensitive approach to this session specifically assigns the students four more tasks:

3. Prefigure the connections soon to be made between personal conscience and professional conscience;
4. Make explicit their own healing values which they will retrieve in conditions of demoralization;
5. Nurture and enrich their competencies by addressing moral emotional responsiveness skill building; and,
6. Develop a strategy involving an active help-seeking mode to survive lapses in caring attitudes.

For all medical students, the notion of 'harming' a patient is distressing, but in our experience, first year medical students discuss this possibility more readily than do third year students or residents. We have encountered significant resistance among older students and residents in similar discussions; in fact, some deny ever having made mistakes or causing harm to patients.

A significant part of this session involves a frank discussion of psychopathological interferences with virtuous practice: substance abuse, depression and anxiety. Psychopathological interference (P.I.) may operate either to impede efforts to cope and/or impede retrieval of healing values (see Figure 2: the black bar represents P.I.).
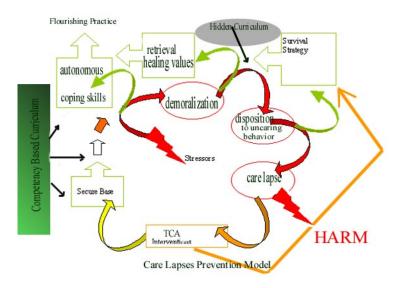
Figure 2:

We introduce the idea of the 'hidden curriculum' which often takes the form of a reduction to survivalistic values, and which they already sense as first year medical students but will not fully experience until they enter their clerkship years. We also suggest that there may come a time when autonomous coping skills will be insufficient to counter unfamiliar and extraordinary stress, or because PI has made use of autonomous coping skills too effortful. At some point, outside help may be necessary, and we discuss explicitly what form that help can take.

Recalling the TCA model and engaging moral imagination, we explore specific instances of care-lapses in encounters with patients, families, and colleagues, often using our own experiences as examples. The students recoil from some of the stories detailing disrespect, or unkindness, cheating or falsifying data, but recognize the possibilities for such behavior and readily engage in discussions of strategies to prevent them.

Nonetheless, harm happens. Otherwise there would be no need for the principle of non-maleficence. Moreover bad things can happen to a good person at the hands of a good professional. It is important that the virtuous physician develop skills in managing the moral emotions occasioned by harm to which he or she has professionally contributed. The harm done need not be further compounded by a retreat into the survivalistic values associated with the hidden curriculum nor the deliberate adoption of an uncaring attitude. Assisted in self-examination by I.U. CAP questions 3, 4, and 5 the students identify moral emotions, explore reactions to doing harm to another person, and possible follow-up (re) actions. Discussions involving forgiveness and gratitude round out the session on moral emotional responsiveness.

At the end of the session, The Care Lapses Prevention Model (see Figure 3) still remains to be personalized. Each student is asked to identify three anticipated stressors, three autonomous coping skills, three intrinsic values that can be transformed into the healing values of the profession and finally a survival strategy involving help seeking to be employed in the event of progression from a demoralized state into vulnerabilities to cause harm created by lapses in caring attitude.

Figure 3.

Care Lapses Prevention Model

Conscience Sensitive Medical Education in the Fourth Year

For four years, we have been doing a conscience-sensitive ethics module with fourth year medical students, usually 10, during a month long elective on medical ethics and

professionalism. Four weekly meetings, each 90 minutes long, follow the outline described with the first year students, but we actually have more time for discussion and activity. In the first session, we demonstrate an interview with a 'person of conscience,' usually a willing faculty member. This is very helpful as the interviewee models an appropriate level of disclosure to personal questions, and most listeners find themselves responding silently to the I.U.CAP questions along with the person being interviewed. During the session involving moral emotional responsiveness, the students construct a letter of apology for a harm committed. Usually, there is lively discussion about what constitutes 'harm,' 'mistake,' and responsibility. These nearly graduated students have a much clearer idea of harm, and enter reflectively into discussions of reparation, healing and forgiveness. We have not formally added the TCA part of this model to date, although the hidden curriculum and personal and professional stresses are freely discussed throughout the month. The Value Matrix has been especially useful in specific ethical dilemma discussions.

Final Thoughts

This conscience-sensitive approach involves a sort of delicate balancing act: we are committed to helping the students begin to understand what lies before them, positive and negative, and do not wish to frighten or overwhelm them at such an early stage of their training. We believe such an approach helps make explicit the healing values that originally impelled our students into a life in medicine and strengthens coping skills and survival strategies necessary for successful practice of the profession. Similarly, the deliberate exploration of 'personal' and 'professional' aspects of conscience is vital. This educational approach may be useful in early identification of students at risk for struggles with self-awareness or moral issues in the profession, as for example the student whose ethical sensitivity to the issues posed in the model Jehovah's Witness case actually declined over time and in spite of exposure to didactic and experiential education.

We firmly believe that this approach supports an enriched achievement of all competencies, allows deeper self-awareness, supports self-care, deepens understanding of the principles and practice of bioethics and professionalism, and ultimately nurtures our students along their paths toward the goal of becoming virtuous physicians.

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A 26 year old man with Crohns disease presents to the emergency department with toxic megacolon and a lower GI bleed. His hemoglobin is 6.4, white cell count is 16.7. He is alert, oriented and appears competent. Despite resuscitative procedures, the patient continues to bleed. Emergent total colectomy is scheduled. However, the young man states that he is a Jehovah's Witness, and that he will not accept blood transfusions under any circumstances. His wife and family reinforce his decision. The anesthesiologist is torn, but states that she will not transfuse the patient during surgery, even if it results in his death. The senior surgeon states that he has an obligation to do everything he can for the patient, and that it would be wrong to stand by and let a man under his care die unnecessarily. The surgeon will not operate under these conditions. The patient will likely die without both surgery and transfusions.

The hospital administrator thanked you for your prompt response to the emergency ethics consultation. The administrator immediately contacted the surgeon in the case and indicated that it was her understanding, based on your recommendations, that the surgeon MUST conduct the operation without resort to using any blood products OR immediately find an alternate surgeon equally capable of conducting the surgery and willing to do so under the specified constraint. The surgeon remained steadfast in his refusal to conduct the surgery under such a constraint and also refused to nominate an alternate surgeon, declaring "I will not be party to practicing bad medicine." The hospital administrator turned to the anesthesiologist in the case and asked her to identify a surgeon who would agree to respect the prohibition on use of blood products. The anesthesiologist knew of a "Jehovah's Witness friendly" surgeon in another community hospital who, however, did not have privileges to conduct surgical operations in the hospital where the patient remained in critical condition. The hospital administrator asked the anesthesiologist if the patient could be safely transported. In the anesthesiologist's opinion, the patient was not sufficiently stable to transport. The hospital administrator arranged for the "Jehovah's Witness friendly" surgeon to be brought to the hospital and to be given emergency privileges. The "Jehovah's Witness friendly" surgeon quickly evaluated the patient, agreed to conduct the surgery without blood products of any kind and forewarned the family in the surgery waiting area that the patient's condition, already critical, had been made even more so by the delay in proceeding with the surgery. He considered the prognosis for survival to be extremely guarded. The patient's wife indicated she understood. During the surgery, the hospital administrator requested you to accompany her to the surgery waiting area to meet with the patient's wife. The patient's wife thanks the hospital administrator for her efforts but indicates, " I'm beside myself with anger right now. I can not believe the surgeon at your hospital refused to operate on my husband according to his wishes." She now asks you whether the originally assigned surgeon who refused to conduct the procedure unless permitted a resort to blood products acted in accordance with professional standards. She now wants to know, irrespective of the outcome of the surgery, if she has grounds for a complaint about a breach in the original surgeon's ethical conduct. What do you tell her? What else occurs to you to do?

Conscience Sensitive Criteria For Scoring
Discussions of the Jehovah's Witness Case

Moral Imagination

Recognition of the moral stakes involved

0   Not aware of either a moral issue or moral dilemma OR rejects taking a role as professional of conscience (e.g. "Let the judge decide.")

1   Characterizes a moral issue (Right vs. Wrong) instead of a moral dilemma

2   Aware of at least one moral dilemma (Right vs. Right).

3   Aware of more than two claims upon conscience that may conflict or interact (Right vs. Right vs. Right….).

Moralized Attachment

Recognition of the moral stake-holders involved

0   Does not identify any moral stake-holders.

1   Identifies no more than two moral stake-holders (i.e. patient and surgeon).

2   Identifies at least three moral stake-holders (i.e. patient, surgeon and anesthesiologist, and/or members of the family)

3   Identifies all of the principal persons of conscience and immediate moral stake-holders but also recognizes the import of the decision as casuistically establishing an ethical precedent affecting physicians, patients and families in the future.

Moral Emotional Responsiveness

Empathic responses to the moral stake-holders and perspective taking

0   Identifies with or expresses sympathy for no more than one of the moral stake-holders.

1   Identifies with or expresses sympathy for more than one moral stake-holder.

2   Able to take the moral perspective of each person of conscience.

3   Demonstrates concern about moral meaning, connectedness, moral emotional responses, valuational and agentic integrity for each person of conscience.

Moral Valuation

0   Does not use value language.

1   Discussion indicative of only one bioethical principle (e.g. autonomy).

2   Discussant is aware of two bioethical principles in conflict.

3   Discussant is also aware of at least one bedrock value of conscience.

Moral Conflict Resolution

0   Identifies no traditional approach to the conflict.

1   Makes explicit or tacitly assumes at least one traditional approach to the conflict (eg. intuitionism, consequentialism, deontology, virtue based).

2   Makes explicit or tacitly assumes more than one traditional approach.

3   Considers each traditional approach in turn to determine the best course of action.

Moral Volition

0   Proposes no resolution, invokes a sense of futility, or a resort to deception.

1   Proposes a resolution on the basis of the case as represented without indicating any intention of further engagement with the principal moral stake-holders (physicians and patient).

2   Proposes engagement of additional parties (eg. a Jehovah's Witness advocate).

3   Proposes re-engagement of moral stake-holders as persons of conscience in the domains of moral attachment and moral emotional responsiveness AND/OR attends to the need for reparation and healing.

Appendix A: The Stilwell Conscience Interview.

Available at http://shaw.medlib.iupui.edu/conscience/ **Conscience Works,** *Theory, Research and Clinical Applications,* 2003, 2 (1): Appendix A.

Appendix B: The Indiana University Conscience Autobiography for Health Care Professionals.

Available at http://shaw.medlib.iupui.edu/conscience/
Conscience Works*, Conscience and Ethics,* 2002,
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