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Defining, Teaching, and Learning Ethics in Medical Education

Our society, and the medical profession, is faced with the reality that it “is not a good time for physicians; physician morale is at an all-time low” (Kenny). Scientific advancements and increasing social demands appear to have made us lose sight of the “fundamental essence of medicine” (Kenny). This, according to Nuala Kenny, Professor of Paediatrics and Director of Bioethics Education and Research at Dalhousie University, is “the vulnerability and fragility of that fundamental endeavour whereby physicians and patient together seek to relieve suffering.” For instance, physicians are now expected to guarantee results, rather than promise to do their best to treat the patient and ease suffering. Because of what Kenny speaks of as “a persisting moral vulnerability accompanying illness”, it is her view that today’s physicians are in more need of ethical training than those of past generations. In her critique of the Canadian Medical Association’s Code of Ethics, she states that it cannot be the only source of assistance to physicians dealing with ethical issues. She further contends that there is a need for an interdisciplinary response in providing a better code and training in bioethics. Medical ethics is a “moral” issue that cries out for the help of those who have made morality their concern and expertise: philosophers, ethicists, theologians, and to some extent, psychologists and psychiatrists. As Kenny has said, “at the heart of the therapeutic relationship are the patient’s trust and the physician’s promise to do his or her best.” In other words, it is about promises, not guarantees. A clearer focus on ethics in medical

training could re-align new doctors with what it means to practise medicine, giving them a sense of the foundation behind the guidelines and some perspective and hope for the struggles being felt by the profession. Ethical responsibilities and obligations speak directly to the idea of a physician's promise to the patient and to society in general.

In attempting to identify, for the purposes of my Interdisciplinary Masters in Humanities in Interpretation and Values, the role of the humanities disciplines in undergraduate medical education, I realized that the importance of the ethics discipline is most obviously expressed by virtue of the development of ethical reasoning as an essential component of the medical curriculum.

Arguably, the increased interest and research in ethics and implementation of ethics curricula at medical schools can lead one to assume that medical education is not currently meeting optimal standards in addressing the training of physicians in the application of an ethical framework in their day-to-day clinical decision-making process. The medical community at large acknowledges the importance of the humanistic side of practicing medicine in addressing the areas of communication and ethics in the CMA Code of Ethics. This is contrary to the historical approach that seemed to expect that ethical reasoning would be a natural, inherent ability of all physicians. In fact, all medical schools in Canada now include ethics in their curricula. However, the initiatives in how to teach, learn, and assess these skills as part of a medical education program, whether at the undergraduate or post-graduate level, are in their early stages (Singer, Cohen, Robb & Rothman 23). A series of standardized ethics scenarios developed by a team at the University of Toronto appears to be one of the few examples of such

initiatives. The researchers on this team explained that they were responding to inadequate research as to how to validate the students' learning of ethical decision-making.

It is my sincere and humble goal that this practicum report contributes to the Northern Ontario School of Medicine's (NOSM) innovative Case-based Approach to teaching and learning and its potential of benefiting from the humanities-related themes in the curriculum, at both the institutional level and the student level. More specifically, I hope that this report will support the achievement of the institutional goal to graduate high calibre, patient-centered physicians who are interested in, and capable of, practicing in more challenging Northern and rural communities. Therefore, in my report, I will present my assessment of how the humanities' focus is communicated in the learning objectives, curriculum delivery, and assessment tools, and how the curriculum and teaching model facilitate the development of ethical reasoning.

I will begin by addressing the question of ethics in NOSM's curriculum. With the exception perhaps of Theme 4, The Foundations of Medicine, ethics is integrated in all the curriculum themes of the program by virtue of their learning objectives. However, as Theme 4 involves the clinical application of the sciences, and the Clinical Skills in Health Care Theme addresses the application of practical skills in an ethical framework, we could consider the application of ethics as integrated in Theme 4 as well.

In considering the Themes that the students at NOSM will be studying, particularly the ones addressing Northern and Rural Health and the Personal and Professional Aspects of Medical Practice, the curriculum has a unique opportunity to

deliver an educational experience that will allow students to develop their skills and knowledge in the field of ethics—perhaps to a greater degree than that of other medical schools. Its distinctive Case-based structure offers occasions, throughout the curriculum, for students to be guided to assess their knowledge, do research, build their skills, and become increasingly proficient in ethical reasoning in circumstances they are likely to encounter as professionals. One Theme in particular, Clinical Skills in Health Care, has a large component of objectives relating to the humanistic skills in regards to communication. These objectives include listening skills, patient-centered interviewing, and oral and written communication. These abilities are crucial components of the graduates' ability to fulfill their ethical responsibilities in their roles as physicians. The Theme of Northern and Rural Health outlines learning objectives relating to Northern and rural communities including distinct cultural groups, scope of practice, personal awareness, community life, women's health, the inter-professional team, and technology in the delivery of health care. In theory, this should better prepare students to make judgments that are more ethically informed in a variety of cultural and demographic contexts. Theme 3, Social and Population Health, plays a particular role in the development of ethical reasoning in the domain of research. Personal and Professional Aspects of Medical Practice is the Theme that is most commonly identified as the ethics “course” of the curriculum. It outlines components of the patient-physician relationship, such as the ethics of medicine, confidentiality, consent, truth telling, research ethics, advocacy, personal conduct, professional responsibilities, the legal aspects of practicing medicine in regards to the patient, consent, confidentiality, negligence and liability,

competence and conduct, medical records, self-regulation of the profession, and interprofessional issues. It provides the framework within which graduates will function as physicians using the best ethical judgment possible in all situations.

It is important to maintain the teaching and learning of the above-mentioned topics throughout the curriculum and not minimize the distinctive process of developing ethical reasoning. Ethics are involved in all aspects of a physician's role. We cannot assume, however, that graduates will know how to analyze a situation and make an appropriate ethical judgment when faced with a decision that is outside of day to day ethical issues. For instance, physicians may encounter difficulties in dealing with ethical dilemmas because, as Kenny explains, although the CMA Code of Ethics is a good guide concerning the physician's competence, standards of practice and communication, and informed patient consent, it is not strongly responsive to "virtue ethics," the traditional ethic in medicine, which would give it a stronger foundation. It states the theoretical standard by which the physician is obligated to the patient, reflected as far back as the Hippocratic Oath in Greek history, which is, at its core, "what ever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice" (qtd. in Kenny). However, since the oath is not defined in ethical terms, documents such as codes of ethics attempt to proclaim a physician's promise to patients and society rather than describe ideal moral behaviours and attitudes.

Nevertheless, in order to set standards for the specialized skills and knowledge needed to be considered a good physician, such documents must be capable of "demanding adherence to those standards and authorizing sanctions against bad medical

practice” (Kenny). At present, the CMA Code has shortcomings in the area of ethical judgment, particularly in how to prioritize ethical ideals or principles, in conducting peer review, and resolving conflict of interest (Kenny). In addition, Kenny writes, it does not address specific ethical issues such as abortion, physician assisted suicide or euthanasia. It appears to address only those everyday situations in which ethical issues arise and minimizes the process by which a physician must deal with ethical dilemmas, for example, situations in which two ethical principles are in conflict or an ethical principle is in conflict with the law. The Code, or another similar guideline, needs to outline the values, virtues, and duties essential to the practice of the profession - the principles by which a physician could stand that would represent the ethical thought of the community of physicians. As Beauchamp and Childress explain, in order for codes to be justifiably prescriptive, they need to address normative ethics of the profession: “*General normative ethics* is a form of inquiry that attempts to answer the question, ‘Which general moral norms for the guidance and evaluation of conduct should we accept and why?’ ”(2). This standard, according to these bioethics experts, is the one that codes of ethics should strive for and maintain.

As a school, the Northern Ontario School of Medicine could forgo the wait for ethics tools such as the CMA Code of Ethics to become more directive and adequate as ethical guidelines. It could be equipping its graduates with a strong foundation in ethical knowledge, analysis, and resolution. These are difficult skills that are acknowledged as essential to the practice of medicine, but that have not been easy to develop in medical education. This institutional objective could contribute towards getting students started

on the practice of standing on principle rather than finding themselves torn between the demands imposed on physicians, their personal and financial interests, and their professional obligations.

So far, NOSM should be praised for the ethics dimensions of some of its initiatives and what they offer as opportunity for further developments in building on ethical reasoning related educational goals. Examples of these initiatives are the School's purchase of "Harvey," a commitment to integrate ethics stations in Objective Structured Clinical Examinations (OSCEs), and symposia on topics including the history of disability, considerations surrounding a patient's wish to die, and other ethical issues.

Let us start with Harvey, a highly advanced cardiopulmonary patient simulator developed by the Center for Research in Medical Education at the University of Miami, School of Medicine. Harvey is an example of the School's sensitive use of technology in their approach to ethically responsive learning experiences. Traditionally, students learn the pathophysiological characteristics, the diagnostic signs and the methodologies of clinical applications related to heart conditions and then apply this knowledge using simulated or real patients in order to practise and refine their clinical skills in the detection, diagnosis, and treatment of heart disease and heart conditions. According to Dr. Issenberg, one of the lead researchers in the use and development of Harvey, the simulator allows "learners [to] make & detect errors without consequences; instructors focus on learners; [its use creates] 'teachable moments'; [using Harvey for teaching and assessment] reflects [an educational] 'culture' focused on ethical training."

The use of Harvey has the potential to address some ethical issues involved in the

learning process. First, students are much more likely, through the appropriate use of Harvey, to attain a higher level of knowledge and skill. This obviously reduces the risk of error on real patients and increases the students' ability to assess a medical situation, inform patients and their families more accurately, and make appropriate treatment recommendations and decisions, a process intrinsically linked to ethical reasoning. Second, simulated, volunteer, and real patients are not made to endure repeated physical examinations. Consequently, a sick patient's level and feeling of well-being will not be compromised by repeated encounters with students and the students' lack of experience and confidence. The physical exams of sick patients will come at a time in the students' learning process in which these experiences will serve as a re-enforcement of the previously acquired skills and knowledge. Third, studies show that students who are more confident in their skills are more able to deal with interpersonally sensitive situations, such as the cardiovascular examination of women, decreasing the need for more invasive or expensive diagnostic examination techniques (Issenberg).

These important benefits reinforce what is considered by Dr. Issenberg as the "privilege to practice medicine", the invaluable doctor-patient relationship that allows doctors to lay on their hands and treat their patients. In addition, Harvey's link to the "Umedic" software supports learning in the sense that students can learn and practise with the use of this technology with little or no help from faculty, creating a pedagogically rich opportunity for students to make mistakes and to refine their knowledge and skills on their own in a non-threatening environment. For example, Dr. Issenberg stated that 90% of what students need to memorize in cardiology are the

pressure and volume curves in the heart, a difficult concept to grasp without practical application. Since Harvey mimics the pressure and volume curves, students are able to explain them and, through repetitive practice sessions, relate them to the various heart sounds. The integration of Harvey accords with the well-known Chinese proverb, “Tell me and I shall forget. Show me and I might remember. Involve me and I shall understand” (qtd. in Issenberg).

NOSM is justifiably proud to be the first medical school in Canada to purchase Harvey, demonstrating its commitment to having the best resources possible for its students. In fact, NOSM students, using Harvey, will have the advantage of being acquainted with a component of the Royal College of Physicians of Canada high-stakes certification examination tools, since the College is presently using videos of Harvey and exploring ways to use this technology for assessing hands-on examination skills during these certification exams.

Another initiative that demonstrates the School’s commitment to teaching and learning ethics is its intention to benefit from the University of Toronto’s development and openly shared resource of 14 scenarios using standardized patients to teach and evaluate bioethics. This tool was piloted by Singer, Cohen, Robb, and Rothman using OSCEs to assess the physician’s ability to respond to an ethical-clinical situation. The researchers define this response as the “ability to identify, analyse, and attempt to resolve ethical problems arising in the care of a particular patient” (23). The pilot took place at the Pre-Internship Program OSCE for sixty-nine foreign medical graduates, candidates of the University’s Pre-Internship Program. The researchers in this study aimed to address

the seldom-examined reliability and validity of assessment tools and the relevance of assessment methods to real situations. The stations were tested by expert clinicians and analyzed by a physician-bioethicist. Overall, the candidates in the pilot scored low on the ethical-clinical stations and could obviously use remediation in this domain. However, the research confirmed the validity of the content of each station as well as satisfactory inter-rater agreement, finding that “ethics OSCE stations may be suitable for evaluating the ability of medical students and residents to address selected clinical-ethical situations” (Singer et al. 23). Due to the cost associated with the labor-intensive process of developing, using and analyzing the results of new ethics stations, the University of Toronto stations will likely be reserved by NOSM for practice during structured clinical skills sessions and for summative, high-stakes assessment OSCEs.

Students will obviously need other learning and assessment activities to measure their progress and set their learning objectives in their ethical reasoning development process. Other methods could include reflection, research, and assessment of situations presented in the curriculum cases with the assignment of tasks appropriate to their level of learning, via guided open discussion (synchronous or asynchronous), self-assessment and reflection.

A third example of the School’s response to the inclusion of ethics in its institutional and student goals was its hosting of a symposium on January 20th, 2005, entitled: *When a Patient Asks for ‘Help’ to Die: Ethical Considerations*, given by Dr. William F. Sullivan from St. Michael’s Hospital Family Medicine, Surrey Place Centre, and the University of Toronto. With the use of contemporary, well-known case examples

like Sue Rodriguez, he spoke of the difference between euthanasia, physician-assisted suicide (PAS), and allowing someone to die—very important distinctions. These issues bring up ethical dilemmas such as: who decides if one's life is worth living and when (i.e., before requiring life-support), sustained life versus quality of life, and physical suffering versus emotional suffering. He explained that the patients' request "for 'help' to die ... [usually comes from] ... unacceptable symptoms, loss of function, burden of living (i.e., in the context of medical interventions) and lack of meaning and purpose in life." There are different theoretical approaches in assessing such situations, such as the benefit versus burden assessment, as opposed to the quality of life versus the vitalist assessment. A point that Dr. Sullivan makes is that a request to die expresses the patient's view that life is not worth living and PAS affirms this judgment. He stated that "understanding these requests is a task for philosophy ... and psychology", the disciplines that study such notions as autonomy, informed choosing, human desire and values (the process of choosing values). To proceed ethically, physicians must be able to identify the facts of a situation and make a value judgment based on those facts. Sullivan added that people's feelings are involved in the cognitive access to values, underlining the need for personal experience and self-reflection to be taken into account in forming value judgments.

Dr. Sullivan promotes the idea of reframing a patient's request to die into a way of helping the patient live well even while dying. This reframing involves informing patients of the facts relevant to their situations, of the prognosis, and of the real possibilities. He also says that doctors need to attend to the patients' (and families')

feelings in order to formulate responses to their values. Lastly, he recommends that physicians encourage their patients to attend to the good aspects of the present and make the choice to enjoy them. He believes that “the ethical care of vulnerable and dying patients involves: a process of knowing his or her good; and choosing to promote this good by means acceptable to the patient, physician, and community.” Important to note is that Dr. Sullivan speaks not only from a professional perspective, but he also incorporates into his thinking his personal perspective; he cared for his wife while she died at home. The learning opportunity offered by such symposia is not only evidence of the School’s commitment to promote an interdisciplinary, humanistic approach to medicine, it also confirms the benefits of its experiential approach to teaching and learning. Dr. Sullivan’s book, *Eye of the Heart: Knowing the Human Good in the Euthanasia Debate*, is an excellent example of the types of resources students will be encouraged to seek out. NOSM also would do well to capitalize on the sponsoring of such symposia by highlighting the ethics dimensions and the opportunities for the related reflection and dialogue they offer.

The collaborative learning model at NOSM, in which students work through realistic cases in small groups, abundantly provides opportunities for students and faculty to engage in a process of identifying ethical issues, reflecting on how to react to the problem, drawing on theories and principles, exploring options, and formulating ethical points of view. Students will have several community placements and community learning sessions in which they will be faced with real situations, working environments, and patients that present them with occasions to enhance and develop ethical reflection

and consideration of their ability, or inability, to respond to situations in an ethical manner. Opportunity, though, is just the beginning. A process of mentoring and providing feedback that responds to those experiences will provide crucial support to students' learning.

The curriculum, through its cases, aims to model the realities of Northern and rural environments in which the School hopes the graduating doctors will choose to practise medicine. In these settings, I believe, one is perhaps faced with greater ethical challenges due to isolation, lack of resources, and a more intimate involvement with the population. While Northern and rural communities offer great opportunities for physicians to be invaluable members of society and play a positive role in serving as leaders in those communities, there is also a concomitant increase in responsibility. There is often no one else, or few others, on whom to fall back for guidance and support in making difficult decisions. Resources and access to diagnostic equipment, emergency care, and specialized care are examples of limitations imposed by rural settings. These limitations place the physician in the position of judging the best options for the involved patients regarding issues such as who gets the care, the hospital bed, and transportation to the nearest emergency unit. Consequently, the physician must be skilled at a decision-making process that reflects the "ethics of care," essentially, the founding principles and obligations of her or his role. This role includes fairness, equality, open communication, mutual respect, freedom, cooperation, competence, and protection (Lakoff), with added consideration of the most widely agreed upon bioethical principles: beneficence, nonmalevolence or nonmaleficence, respect for authority and justice (Beauchamp &

Childress 7).

In addition, the collaborative Case-based approach is centered on providing opportunities for students to self-direct their learning in the identified learning objectives in all themes of the curriculum. Ideally, students will consider all aspects of medical practice, as expressed in the Themes of the curriculum, whether in a whole group session focused on the anatomy of the brain or in a topic-oriented, small group session focused on a patient experiencing phantom pain due to an amputated limb. In order for students to gain medical ethics skills and abilities through this educational experience, though, in the same way that ethics are expressed in the objectives of all curriculum themes, ethical aspects must also be highlighted in all aspects of the School's innovative approach to Case-based teaching and learning. After all, ethics is part of all aspects of practicing medicine. The danger is that the curriculum Themes will be so thoroughly integrated that, next to the basic sciences and clinical skills, the ethical aspects will be almost invisible. Unless ethics are highlighted in all appropriate class sessions and the difficulty of ethical decision-making is acknowledged, students and faculty might underestimate the critical importance of ethical reasoning as an essential tool of a good physician. The idea, as applied to ethics for instance, is that student discussion in small groups allows them opportunities to express their beliefs (derived from morals), and how they would approach a medical situation. Because all cases will involve people (with age, gender, culture, medical, social, and emotional issues) set within a community (often rural), students will need to consider the multifaceted influences and characteristics of the situation. Students, in all likelihood, will each bring different perspectives to the

discussion, encouraging reflection, evaluation, and analysis of each situation. In turn, individuals will be faced with the challenges of listening to other views, re-examining their own, and hopefully, researching and re-assessing principles and theory to refine their ability to make ethically sound judgments and decisions in regards to their medical practice.

NOSM, through the unique and practical approach of its curriculum, has the opportunity to instil this ethics focus now, in its developmental phase, by seeking out experts and by supporting their research in how to incorporate the teaching and learning of ethics into the curriculum. As an example, experts could develop approaches in which students can enhance their ability for critical reasoning through dialogue and journaling. Experts could find ways to promote the pedagogical qualities and values of dialogue and journaling, which are already being considered as assessment options, to develop reasoning skills and critical thinking. I acknowledge the legitimate concern that in a four-year program there is not much time to add on to the already tight demands of an undergraduate medical program. However, as the integration of Themes 1 through 3 becomes clearer and more focused, the ethics issue could stand out as a stream to integrate other issues in those themes such as culture, isolation, resources, population health, advocacy, research, and continuing education. These are all topics that could evoke ethics issues and potentially come together to represent the virtues, values, and ethics of the profession.

Dr. Richard Paul and Linda Elder from the Foundation for Critical Thinking have studied the process by which one attains the skills and abilities of ethical reasoning. They

wrote *The Miniature Guide to Understanding the Foundations of Ethical Reasoning*, a booklet based on *Critical Thinking: Concepts & Principles*, in which they explain: “skilled ethical reasoning presupposes the same range of intellectual skills and traits required in other domains”(Introductory Remarks). One must be skilled in breaking reasoning down into its component parts. One must be proficient in assessing reasoning for its clarity, accuracy, relevance, depth, breadth, and logicity. One must be intellectually humble, intellectually perseverant, and intellectually empathic” (Paul & Elder, Introductory Remarks). The authors also state that the process of becoming ethical is a personal one that takes a long time and much practice. In order for this learning process to be addressed by a curriculum, students not only need to learn the knowledge associated with ethical reasoning, they also need to experience situations that require ethical assessment and have opportunities to present the breaking down of the component parts of ethical dilemmas. These experiences need to be done with openness to criticism, to the possibility of being wrong, and with the willingness to improve and to try to be empathetic to the various situations. The difficulty lies in that ethical principles, essentially one’s moral position, must be demonstrated not just in words but in behaviours, which require intellectual skills and insights (Paul & Elder 2). For example, “ethically motivated persons must learn the art of self and social-critique, of ethical self-examination” (3). Students cannot be expected to go on this journey of acquiring the ability of ethical reasoning on their own; they need experts to guide them and direct their progress. Paul and Elder stress, “only the systematic cultivation of fair-mindedness, honesty, integrity, self-knowledge, and deep concern for the welfare of others can

provide foundations for sound ethical reasoning” (4). An ethical person is able to do what is right despite the effect on one’s own desires and interests.

Doctors also need to be able to strike a balance between respect for culture and ethics. This balance is not easy. The influence of cultural experiences, traditions, habits, and customs of our social and cultural groups, passed down over generations, take on a force of their own, leading individuals to believe that theirs is the only reasonable way to be and to act. It is on one hand important to respect the individual in that belief; however, it does not always reflect what is ethical. The curriculum “should foster the intellectual skills that enable students to distinguish between cultural mores and ethical precepts, between social commandments and ethical truths” (Paul & Elder 10). Based on the assumption that an unethical act is one that denies an individual of an inalienable right, there is basic required knowledge to be taught, which includes being able to identify acts that are in-and-of-themselves unethical. This understanding does not come to us naturally. We must first be able to identify our own beliefs and the ideas through which these were formed, and further, to become aware of the way we experience the world. We must then learn alternative ways of thinking and alternate worldviews. Appropriate education can foster this process of distinguishing right from wrong ethical decisions and can allow students to gain the ability to make judgments and interpret situations in an ethical manner.

This ability of judgment and interpretation is critical in the field of medicine where individuals are often faced with ethical situations in which two ethical principles are in conflict. For example, a physician can be caught between the principle of

beneficence, the unethical nature of murder (or nonmalevolence), and the canons of professional medical ethics. In such cases, the doctor is challenged with the need to “engage in a dialogical reasoning between conflicting ethical perspectives” (Paul & Elder 21), clearly a skill that would not come naturally, and that must be developed over time, through experience. More importantly, the process of analyzing the situation must be done with intellectual humility and without judging the situation based only on our moral principles. One must seek to “respect the rights of others, including their freedom and well-being, to help those most in need of help, to seek the common good and not merely our own self-interest and egocentric pleasure, and to strive to make the world more just and humane (Paul & Elder 21).” As a society, we tend to hold physicians to a higher moral ground than the average person. This higher standard may actually be a contributing factor in physicians’ low morale, mentioned earlier. It therefore stands to reason, as much for the benefit of the physician as for the benefit of their patients and society as a whole, that medical students need to be provided with adequate, appropriate training that cultivates the logic of developing ethical thinking as an integral part of her or his introduction to the profession.¹

As suggested earlier in this report, now is the time to plant the ethics focus in the foundational documents of the Northern Ontario School of Medicine’s curriculum and continue to work towards a pedagogical approach that will allow students to develop their ethical reasoning skills and abilities without impeding the scientific and clinical aspects of the curriculum. The School has made a good start with the multidisciplinary character of symposia, the instructional design of the Case-based curriculum, the selection of good

physicians to guide the clinical development (incorporating related ethics), and its commitment to providing students with instructional tools such as Harvey.

In closing, it is my sincere belief that as NOSM continues to develop as an institution and makes the appropriate adjustments to the way in which it defines and teaches ethics, and the way in which students learn the ethical component of the curriculum, it could arguably rise above traditional medical education with its contemporary response to a contemporary concern: bioethics. A strong delivery of the ethical reasoning component of the curriculum could have a life-long impact on the quality of graduates and the care they will provide to our Northern and rural communities. A foundation in the principles that guide bioethics, beneficence, non-malevolence, respect for autonomy and justice would implant in students feelings of pride in the profession, and boost their morale as physicians. These qualities would, in turn, empower the graduates to improve the morale of the profession as a whole and to contribute positively to the body of ethical thought in the medical community.

Notes

¹ For more information regarding the specific abilities involved in ethical reasoning, Annex A provides Paul and Elder's list of ethical macro-abilities and ethical micro-skills, as well as a summary of their elements of logic of ethical reasoning. Annex B outlines a selected list of expectations listed in the CMA Code of Ethics, which in my opinion, are those that make training in an ethical decision-making process necessary if we expect these to be respected and enforced.

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ANNEX A

“Ethical Macro-abilities

- Avoiding oversimplification of ethical issues
- Developing one’s ethical perspective
- Clarifying ethical issues and claims
- Clarifying ethical ideas
- Developing criteria for ethical evaluation
- Evaluating ethical authorities
- Raising and pursuing root ethical questions
- Evaluating ethical arguments
- Generating and assessing solutions to ethical problems
- Identifying and clarifying ethical points of view
- Engaging in Socratic discussion on ethical issues
- Practicing dialectical thinking on ethical issues

...Ethical Micro-Skills

- Distinguishing facts from ethical principles, values, and ideas
- Using critical vocabulary in discussing ethical issues
- Distinguishing ethical principles or ideas
- Examining ethical assumptions
- Distinguishing ethically relevant from ethically irrelevant facts
- Making plausible ethical inferences
- Supplying evidence for an ethical conclusion

Recognizing ethical contradictions

Recognizing ethical implications and consequences

Refining ethical generalizations” (Paul & Elder 31)

According to Paul and Elder, the elements or logic of ethical reasoning are ordered in the following manner.

1. Ethical purpose: generate the ethical goal or objective (To act so as to help rather than harm other persons or sentient creatures.)
2. Ethical question at issue: formulate and raise the ethical questions related to the problem or issue (How should we act so as to help rather than harm others?)
3. Information: use the data, facts, observations, and experiences needed to solve the ethical issue (Information about our options for action, with special emphasis on the information that helps us avoid harming others.)
4. Interpretation and inferences: identify inferences and consider alternative inferences or conclusions (Judgments about what helps or harms others.)
5. Essential concepts: utilize theories, definitions, axioms, laws, principles and models to reason through the issue (The concept of contributing to, rather than undermining, the well-being of others.)
6. Assumptions: check one’s assumptions before coming to conclusions (Humans are capable of distinguishing ethics from other modes of thinking, grasping fundamental ethical principles, and acting consistently with them.)
7. Implications and consequences: determine if there is more than one ethical viewpoint that needs to be considered (If we behave ethically, innocent persons and

creatures are helped rather than harmed by what we do.)

8. Point of view: embodies one's frame of reference, perspective and orientation in the follow out of the ethical implication of one's decisions (Seeing the world as a place wherein individuals and groups often act so as to harm innocent persons and creatures; seeing humans as obligated to help, rather than harm others.)

Closely paraphrased from: Paul, Richard, and Linda Elder. *The Miniature Guide to Understanding the Foundations of Ethical Reasoning*. Dillon Beach, CA: Foundation for Critical Thinking, 2003, pp. 14-15.

ANNEX B

The following is an outline of the CMA Code of Ethics expectations that seem to most require ethics training:

The physician's role goes beyond treatment and cure, it includes care of the patient (physical comfort, spiritual and psychosocial support) even when there is no possible cure.

The physician needs to inform patients in the case where the physician's personal values influence recommended medical procedure or medical practice wanted or needed by the patient.

The physician must "take all reasonable steps to prevent harm to patients" (responsibility #4).

Physicians must recognize their own limitations.

Physicians cannot discriminate but this "does not abrogate the physician's right to refuse to accept a patient for legitimate reasons" (#17).

The physician must give patients necessary information to make informed decisions.

They must "recommend only those diagnostic and therapeutic services that [the physician] considers to be beneficial to patient or others" (#23).

They must respect a competent patient's right to refuse or accept recommended medical care.

The physician must ascertain and recognize the patient's wishes regarding life-sustaining treatment (initiation, continuation or cessation).

They must respect what a patient expressed as intentions while competent, even after becoming incompetent.

When an incompetent patient's intentions are unknown, physicians must do what they believe to be in accordance with the patient's values, when possible, or best interest.

Physicians must report colleagues' unprofessional conduct to appropriate authorities.

Source: Canadian Medical Association. *CMA Code of Ethics*. 2004. February 2005

<www.cma.ca>.