Bioethics

HOW DO WE CARE FOR OUR FUTURE CAREGIVERS? RETHINKING EDUCATION IN BIOETHICS WITH REGARD TO PROFESSIONALISM AND INSTITUTIONS

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Abstract: Background: Bioethics is an integral part of most medical curricula. It complements medical skills training to help future caregivers make morally good decisions in their encounters with patients. Principle-based concepts are commonly regarded as the mainstream approach to bioethics in today’s world. However, despite its clear merits, principlism alone is not sufficient for educating future caregivers. Hence, additional perspectives of health care education are required and will be taken into account in this paper. Objectives: Two shortcomings of typical health care training must be addressed: insufficient consideration of the nature of the health care profession and of institutional requirements. Notions and relevance of professionalism in health care have been intensively discussed in recent years. In this paper, I argue that a caring understanding of professionalism is essential for good quality care for the patient and for the physicians themselves. With reference to the ethics of care, the scope of caring professionalism and its implications for health care education are considered and placed within an analytical framework that combines the individual and the institutional context of health care. Conclusions: To educate our future caregivers, we must address aspects of professionalism more intensively in medical and nursing schools, and even more so during residencies. This is not just a task of training in knowledge or competencies, but also involves the character formation of the individual and the whole organization. Rethinking health care education from this perspective will allow us to answer the question ‘How do we care for our future caregivers?’ with an easier conscience.

Keywords: Medical Education; Professional Practice; Health Care Ethics; Organizational Ethics; Medical Professionalism; Virtues

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1. INTRODUCTION

In recent years, there has been growing interest in improving bioethical education for health caregivers. Although bioethics is well represented in medical and nursing schools and other university departments as an academic subject, there are still questions about how to teach good moral skills to future physicians, nurses and other caregivers, in addition to good technical skills. In this quest, a principle-based ethic is widely regarded as the mainstream approach to bioethics. Despite its clear merits, principlism alone is not sufficient for educating future caregivers and managing health care, as even its key proponents acknowledge. Hence, additional perspectives of bioethics are required and will be taken into account in this paper.

The first perspective is a reference to the notion of professionalism. In addition to principle- or rule-based accounts of bioethics, the term ‘professionalism’ has reemerged in recent years. By trying to define what professionalism in health care is and how it could be developed and taught, a richer understanding of what it means to be a caregiver - and of the humanistic relationship between caregivers and care-receivers - shall be accomplished.

The second perspective is a reference to institutional ethics. Although it may be right to foster professionalism, it should not be isolated to an individualistic context. Rather, we must take the economic and legal framework of health care into account as well. Hence, I will present an analytical matrix for combining the personal with the institutional perspective of care. This matrix will provide a basis for developing guidelines for rethinking education in health care ethics. These guidelines include several action options of enhancing professionalism.


2. THE FRAMEWORK OF PRESENT EDUCATION FOR HEALTH CAREGIVERS

A review of the literature and official documents on health care education identifies three core elements.

(1) Competencies: physicians and nurses are trained in competencies, which are the scientific knowledge and technical skills taught in medical schools, nursing schools and during their residencies. Although we speak of ‘scientific’ knowledge and ‘technical’ skills, such as understanding the physiological processes, measuring blood pressure or conducting an appendectomy, this does not mean that these competencies are ethically irrelevant. An incompetent caregiver fails to provide good health care and therefore violates the traditional principles of beneficence and nonmaleficence. Additionally, the conduct of many of these competencies also requires a certain attitude (e.g., respect) to be not only morally good but also effective (think, for instance, of establishing informed consent for a complex surgery). Hence, profound training in these competencies is a necessary condition for being a good caregiver. However, it is not a sufficient condition.

(2) Ethics: training in ethics is commonly regarded as an essential part of health care education. Among other characteristics, modern biomedical ethics can be described by two attributes: First, it works in a pluralistic society and, accordingly, has diverse approaches to moral problems. And, second, as a consequence, it often operates from a ‘thin basis’, avoiding more substantive assumptions about the good life or the ends of medicine. Instead, modern bioethics aims at empowering caregivers and others by teaching them to use


commonly accepted tools such as general principles or guidelines. Equipped with those tools, moral problems shall be recognized and resolved. Perhaps the most prominent representative of this type is a principle-based concept of ethics formulated by Beauchamp and Childress⁹. By its four benchmarks—autonomy, beneficence, nonmaleficence, and justice—principlism is indeed a powerful concept for clinical decision-making. A principle-based concept of ethics is advocated by diverse moral theories and in many cases helps people to make good decisions. However—and this is not a fault of Beauchamp and Childress—principlism is faced with the danger of becoming an ethical approach that is too thin, formalistic, or even legalistic, or, as some have noted, a mantra¹⁰ that is recited without consideration of the difficulties of implementing it in daily routines. Training in bioethics could therefore become just that: training that is similar to the training given for other competencies, such as those mentioned above. What is missing is the adequate ‘spirit’ of health care that can be addressed more intensively from an ethical point of view¹¹.

(3) Professionalism: what does it mean to be a health care professional? Is it just completing training in medicine or nursing and training in ethical competencies or is it more than that? Do health care professionals continuously strive to improve, both technically and morally, and if they do, does this mean it becomes more a way of life than a job? And if so, how could it be taught? This problem addresses the heart of education, for education is not merely training but also developing a person; it is character formation¹²,¹³. Personal development of health care professionals is, however, harder to define, teach or assess than academic knowledge or practical skills. Nevertheless, it is critical that we find ways to encourage professionalism in health care, for it

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will determine whether our future health care is truly caring. Thus, I will elaborate on the notion of professionalism in the following section.

3. PROFESSIONALISM AND CARE

First, the word ‘professionalism’ has several meanings. Today, it is regularly used to describe any kind of due job fulfillment; anyone who is not explicitly an amateur, dilettante, or greenhorn declares herself, or is regarded by others, as professional. Second, professionalism can also refer to an organized group having more or less homogenous interests. One speaks of ‘professional associations’, which often indicates and implies lobbies or pressure groups. Third, professionalism can have a more substantive, moral implication. It then refers to the aforementioned question of how to be a good caregiver. This understanding of professionalism includes the premise that one duly and competently fulfils their task (as in the first meaning of professionalism); but it goes beyond that when looking at the motivation and personality of the caregiver. Self-regulation in associations (as in the second notion of professionalism) is encompassed by the morally substantive professionalism, too. However, this autonomy is regarded as a consequence of due job fulfillment and moral integrity, and not as a self-evident entitlement.

To summarize the three meanings of professionalism, one can speak of a technical, an unreflective, and a compassionate and responsive professionalism. The last one, compassionate professionalism, is a major theme of recent discussion about health care education. There are several questions to answer in this discussion: What does ‘professionalism’ mean in this ethical sense? Should it be part of health care education? How can it be developed? What is a supporting environment for it? How can it be assessed?


In this paper I argue for the presumption that professionalism is an integral part of health care and health care education and hence will concentrate on the question of how to shape an adequate framework for developing and fostering professionalism. Before doing so, it is necessary to mention some of the key components of contemporary professionalism theory in health care to allow a better understanding of an institution’s tasks.

The ethical concept of professionalism has close ties to virtue ethics and ethics of care. Professionalism can be regarded as a form of being rather than merely of doing (e.g., fulfilling clinical tasks) or knowing (e.g., knowledge about ethical theories). Hence, it is not the isolated act that is of interest to professionalism (e.g., Is it legitimate to withhold the truth from an individual patient in a specific situation?), but the fundamental way of being of the involved persons. For example, is the physician a truly caring physician, one who respects others, strives for the best, and is, at the same time, aware of specific circumstances, or does she struggle with various guidelines and norms on informed consent, and, as a result, forget the humane aim of such institutional rules? However, individual acts are relevant to professionalism because acts become routines, routines become virtues or vices, and virtues and vices form character. Therefore, the genuine exhibition of professionalism is found in daily routines rather than in singular dilemmatic decisions. Consequently, the task of professionalism has also been described as a challenge of “microethics”.

There is wide consensus on the essential characteristics of a health care professional. It includes the professionalism attributes described by Swick, and reported by various empirical studies on being a good health care giver, as follows:


- demonstrating a continuing commitment to excellence (medical/nursing excellence);
- adhering to high moral and ethical standards (moral excellence);
- evincing core humanistic values such as integrity, caring, compassion, altruism, empathy, and respect for others (virtuosity);
- exercising accountability for oneself and for one's colleagues (responsibility);
- responding to social needs, reflecting a social contract with society (solidarity);
- exhibiting a commitment to scholarship and to advancing one's field (scholarship and curiosity);
- subordinating one's own preferences to the interests of others (self-effacement);
- dealing with high levels of complexity and uncertainty (courage);
- reflecting upon one's actions, decisions, and behaviors (self-reflection);

The ethical heart of professionalism lies in a notion of care as it has been developed in recent ethics of care papers. 'Care' refers to a mindful, compassionate, and engaging firm attitude that is also thoughtfully reflected (and not merely an emotion) and realized in the praxis of everyday life. Ronald Epstein has described this as 'mindfulness', stressing the self-awareness of a professional. It includes, among other characteristics, actively observing oneself, the patient, and the problem, with critical curiosity, adoption of a beginner's mind, the humility to tolerate awareness of one's areas of incompetence, and

compassion that is based on insight\cite{28, 29}. Others, like Edmund Pellegrino, try to describe the caring dimension of professionalism by referring to classical virtues and the concept of humanism, which they regard as essential for being a good physician, nurse, or other caregiver\cite{30, 31, 32, 33, 34, 35}. Although this kind of professionalism is widely acknowledged as an integral part of health care, the puzzling question of how to develop professionalism remains. Some commentators also express their fundamental concerns regarding character formation in medical schools, nursing schools, and during residency. Robert Veatch, for example, points out that truly compassionate, dedicated professionals could get health care wrong: goodwill does not guarantee a good result\cite{36}. It is therefore important to remember that professionalism and its education is not the detached solution to every clinical problem. As with training in competencies and medical ethics, it is a necessary but not sufficient part of health care education. It is clear that education in professionalism is different from, but complementary to, training in health care skills or ethical guidelines. Formal courses about the meaning of professionalism are far less effective than are, for instance, classes in pharmacology or in analyzing the legal prerequisites of

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an informed consent\textsuperscript{34}. The following approaches are far more influential for developing the professionalism of the individual caregiver and health care organization:

\begin{itemize}
  \item role modeling, apprenticeship, mentoring\textsuperscript{29, 34, 37, 38, 39, 40},
  \item narrative-based health care\textsuperscript{16, 41, 42},
  \item small group discussions\textsuperscript{34, 38, 40},
  \item engaging in community health services\textsuperscript{43, 44},
  \item rituals such as white coat ceremonies\textsuperscript{45},
  \item using examples from pop culture, such as television or literature\textsuperscript{46, 47},
\end{itemize}

In a nutshell, hour-long medical ethics classes about good patient–physician relationships can be ruined by a mindless senior attending physician or faculty member who treats a patient in a disrespectful, humiliating way in front of students and residents. It may be that the erosion of the students’ and residents’ professional conscience is not caused by a single incident, but it could occur if the senior’s behavior represents a personal or organizational pattern. It is true, theoretically, that this so-called ‘hidden curriculum’ could be challenged by the ethical principles the students and residents have learnt in their respective courses. In fact, this is the essential function of those ethical theories: to serve as benchmarks of critique for one’s own and others’ actions and behaviors.

However, this theoretical assumption faces a somewhat brutal clinical reality, determined by traditionalistic hierarchies, restrictive policy frameworks, economic pressures, and health care teachers who cannot maintain their professional demands or are unwilling to do so. Resisting these forces by referring to ethical codes or principles is almost illusionary for novice health caregivers. Hence, our attention concerning the development of professionalism shifts to the framework, which may support the individual in her striving to become professional in health care. In the following section, this framework will be analyzed by using an analytical matrix that provides starting points for practical action.

4. A FRAMEWORK FOR FUTURE EDUCATION IN HEALTH CARE

The framework for future education in health care must respect all three dimensions of education: competencies, ethics, and professionalism. It should also take into account the interdependencies of the individual’s behavior and the institutional setting. The matrix shown in Table 1 could help to analyze this task.

Table 1: Analytical matrix for framing future education in health care

<table>
<thead>
<tr>
<th>Individual context</th>
<th>Rule-based approach</th>
<th>Care-based approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>acting according to…</td>
<td>being aware of…</td>
<td></td>
</tr>
<tr>
<td>• training in health care skills</td>
<td>• virtues</td>
<td></td>
</tr>
<tr>
<td>• training in ethics (e.g., decision making referring to principles of biomedical ethics)</td>
<td>• character</td>
<td></td>
</tr>
<tr>
<td>• prejudices</td>
<td>• asymmetries of power</td>
<td></td>
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<tr>
<td>• …</td>
<td>• …</td>
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</table>

<table>
<thead>
<tr>
<th>Institutional context</th>
<th>framed by…</th>
<th>remaining mindful of…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• guidelines for admission curricula</td>
<td>• hidden curricula</td>
<td></td>
</tr>
<tr>
<td>• standard operating procedures (SOPs) mission statements declarations, oaths budgets, incentives legal provisions</td>
<td>• spirit and end of policies, oaths, and other norms</td>
<td></td>
</tr>
<tr>
<td>• interpretation and leniency</td>
<td>• organizational culture</td>
<td></td>
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<tr>
<td>• …</td>
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The matrix vertically distinguishes the individual from the institutional context. The individual context refers to the knowledge, skills, acts, and behavior of a person. This person is not an isolated self but an autonomous human being in social relationships. The institutional context refers to the ‘rules of the game,’ that is, legal, economic, and organizational norms guiding or determining the individual’s acts. Both contexts can be approached by either a rule-based or a care-based mentality, which is the horizontal distinction of the matrix. A rule-based approach concentrates on formal elements such as curricula, principles, policies, budgets, and scientific guidelines. They are the benchmarks for individual actions and organizations. On the other hand, a care-based approach critically examines the ‘spirit’ behind these formal elements, addresses the motivation and aims of the individual’s act or of the institution, and searches for the overall picture, thereby applying systems-thinking to health care. This analytical tool can be applied to health care education.

**Quadrant I** contains the individual’s engagement with training in health care skills and in medical ethics (e.g., principism). This task can be conducted in medical and nursing school classes and clinical practices. There, the students and residents are equipped with the tools necessary for curing diseases, palliating suffering, duly treating the patient and other persons, such as relatives, and critically examining their practices.

At the same time, this task is framed by an institutional setting, which is placed in **quadrant II**. The criteria for admission to medical school seek to identify prospective students capable of becoming good health care professionals. Curricula are designed to pass on the essential skills and ethical orientation in an effective and efficient way. Declarations, oaths, and mission statements express what it means to be a good doctor, a good nurse, or a good health care organization. There are standard operating procedures for clinical routines. Economic considerations, such as medical school budgets, determine the scope and intensity of training. Additionally, in many countries, medical students are burdened with extensive financial debts that must be compensated for by adequate salaries later in their careers. Finally, economic institutions, such as health maintenance organizations, set the limits of cure and care. With these

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interdependencies between the individual and the institutional context, it would not only be illusionary but also cynical to demand technically or ethically better behavior from an individual health caregiver if this would, at least in the long term, result in self-damage because of insufficient institutional support or an ethically hostile environment. In many cases, a change of the individual behavior to support the desired behavior is not justifiable until a change of the institutions has been accomplished.

However, this does not mean that formally establishing an adequate training and complementary institutional setting suffice for becoming a health care professional. Here, the care-based column of the matrix comes into consideration. An individual who performs well technically and a corresponding institutional setting will fail to produce professionalism if they miss the caring mentality described above.

**Quadrant III** of the matrix therefore addresses the need for considering and developing this caring professionalism in the individual context. This task is one of life-long learning, and occurs in the words by tackling role modeling and reflecting one’s own state of mind and emotions when confronted with other people and their problems. In terms of virtue ethics, it is a continuous struggle of improving one’s honorable habits and restricting one’s deficient habits, while acknowledging that both belong to human life. The care-based approach to the individual context of health care education leads, therefore, in essence, to character formation. This is, however, not only a demanding task but also a perilous one. Historically, there are numerous examples in which the formation of a righteous and virtuous character, which emphasizes, for example, courage, honesty, or humility, has resulted in deeply inhumane regimes of oppression, passed on from generation to generation of health caregivers. Therefore, care has to be a reflective and critical undertaking that also encompasses, for example, aspects of self-care and gender-related sensitivity.

The rule-based approach, on one hand, can provide benchmarks for this reflection by referring to ethical principles or legal standards such as antidiscrimination policies. The care-based approach, on the other hand, can fill those rules with meaning and encourage creative handling that is context and relation sensitive.

The care-based approach of professionalism is not restricted to the individual context, however. As shown in **quadrant IV**, the institutional dimension of professionalism is also a focus of analysis. As with the individual context, the
care-based approach asks for the caring mentality and the end of health care institutions. It makes a difference how an institution is approached, executed, or, in a deeper sense, lived. For example, the white coat ceremony practiced in many U.S. medical schools\textsuperscript{51,52,53,54} is controversial. If this ritual is approached with a thin rule-based understanding, it loses its meaning, namely to encourage professionalism from the very beginning of health care education. It may degenerate to an act of entitlement by assuming that the student or resident is invested with the full authority of the health care profession\textsuperscript{55}. A care-based approach acknowledges that rituals such as the white coat ceremony can be an effective vehicle for fostering professionalism. At the same time, it critically recalls the dark side of history that is also connected with the white coat; it addresses the asymmetry between those who wear the coat and those who expect help from the person wearing the coat; and it tries to uphold the mindfulness needed to asymptotically approach the professional virtues that the coat represents. In essence, professionalism in this context means handling institutions in the same careful way that this ritual is handled. Furthermore, the care-based approach in health care education not only focuses on the students and residents but in the same manner requires mindful management of policies, mission statements, and other norms. It keeps the managing actors aware of the fact that institutions are not always self-evident and self-executing; that they need interpretation and often leniency; and that they do not only bind others but should also be self-binding. Hence, rethinking health care education also means rethinking what good management of health care and its education mean. In this sense, it is a central task for the management of medical schools and health care organizations to develop and maintain an organizational culture that provides a safe institutional environment for professionalism\textsuperscript{41,56}.


Having illustrated the four quadrants of the matrix, it is important to see the interdependencies and complementarity of the individual and the institutional contexts as well as the rule-based and care-based approaches. The complexity of education in general and health care education in particular makes it inadequate to speak of a ‘master plan’ while looking at the matrix, and rather advises the use of the term ‘ecology’ when talking about professionalism. Education, in contrast to pure training, is a challenge with far more variables and unknown elements. Despite this complexity, enhancing professionalism in health care should not be restricted to vague assumptions. In the final section of this paper, I will present some action options to fulfill this task.

5. Action Options for Enhancing Professionalism in Health Care

The practical agenda for enhancing professionalism is a Herculean task because professionalism cannot be taught like health care skills or ethical reasoning. Nevertheless, it should be possible to create a safe institutional environment in order to develop professionalism on individual and organizational levels. Methods such as mentoring, role modeling, and narrative-based medicine have already been mentioned above. In general, education in health care and bioethics has to take place at different venues such as classrooms and clinics, and during apprenticeships. Thomas Inui has developed a long agenda of concrete tasks to enhance professionalism. This agenda includes, among other actions:

- confronting deans, chairs, and chief residents with professionalism;
- providing professional development in small groups (Balint groups) for undergraduate, graduate, and continuing medical education students;
- developing enhanced mechanisms for focusing and remediating residents’ stress and burnout.


creating cases for discussion that are focused on students’ and residents’ ethical dilemmas (e.g., how to introduce myself when learning a new procedure; how to describe a procedure that will cause pain); and encouraging measurements that focus on ‘life experience’ (narrative-based approach) for students and residents\textsuperscript{14};

- critical incident reporting as part of the assessment of the curriculum, professional development of trainees, and key information for institutional management; teaching how to frame ‘medical errors’ constructively, and ensuring continuous improvement\textsuperscript{61};

- creating mechanisms for making exemplary behaviors and achievements more visible (e.g., ‘Teacher of the Month’ awards)\textsuperscript{62};

- introducing observational measures designed to generate formative feedback for students and residents on behaviors related to professional values\textsuperscript{63};

- creating a visible source of assistance for avoiding or resolving conflicts of interest\textsuperscript{64}.

The crucial point about these tasks is that those who teach and manage them must also live them. This will often require courage, self-effacement, creativity, open-mindedness, and compassion, but supporting efforts to enhance professionalism through health care education and management will allow us to answer the question ‘How do we care for our future caregivers?’ with an easier conscience.


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