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Medical ethics education: to what ends?

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Abstract

The goals of medical ethics education comprise several dimensions: legal duties to secure informed consent, tell the truth and protect confidentiality; objective competencies that include an understanding of DNR regulations and surrogate decision-making procedures; discursive moral skills such as moral sensitivity, reciprocity and moral development that combine into the capacity for moral dialogue and debate; and finally, behavioural goals that challenge moral education to nurture a more humane, sensitive and communicative physician. Part one of this paper describes each of these goals, together with some of the inherent difficulties affecting implementation. Part two presents survey data from medical ethics instructors ($n = 126$) who were asked about the importance of each goal and their ability to successfully achieve each aim. While each goal is highly rated, only those goals associated with legal duties and objective competencies are thought to be achieved with any degree of relative success. Goals associated with character transformation, unique to medical ethics education, are among the most difficult to achieve. Additional empirical data corroborate these impressions. Moreover, it is not clear that medical ethics education has much to do with good care. Empirical data are scarce and the conceptual relationship between ethics and care remains highly problematic. Part three offers a number of divergent interpretations of care and concludes that they have little to do with medical ethics. There is no reason to expect that medical competence should be affected by moral competence. Medical ethics therefore might then be viewed as an educational enhancement: unnecessary for healthy doctoring but desirable among a small percentage of the profession who maintain an interest in ethical problems.

Introduction

The goals and methods of medical ethics education continue to remain elusive. It is not yet clear what should be taught, how to teach what has not yet been clearly defined and how to know whether, in fact, we have accomplished what it is we hope to achieve. Finally, and perhaps most important, it remains questionable whether ethics education has any effect on patient care. Each of these questions is considered in turn. Part one addresses the problems of the goals associated with medical ethics education, part two uses survey data collected from medical ethics educators to explore the difficulties of attaining these goals, while the last section raises a general concern about the fundamental relationship between moral education and medical practice.

The problematic goals of medical ethics education

Medical ethics education seems to be fundamentally different from other fields of ethics instruction. To

one teaching moral and political philosophy, for example, the thought never arose to try and make students better citizens by encouraging them to vote more often, support voluntary organizations or write letters to their elected representatives. Instead, the purpose of teaching moral and political philosophy is both informative, that is, to supply the necessary grounding in the principles of moral theory and political justice, and didactic, that is, to enhance critical thinking as students are encouraged to articulate, expound and defend their own moral and political viewpoints. This is an enormous achievement, if and when it is accomplished.

The goals of medical ethics education, on the other hand, are considerably more ambitious, ranging from informative and didactic aims to far-reaching aspirations of character transformation. At one end of this spectrum are a series of concrete, quotidian goals that reflect a list of mostly legal duties to secure informed consent, tell the truth and respect confidentiality. Often enshrined in a code of ethics, this is a rather modest form of ethics education that entails little more than a knowledge of rudimentary 'dos' and 'don'ts'. Physicians are taught how members of their profession ought to behave. Once taught to behave paternalistically, physicians are now taught – thanks to contemporary developments in political philosophy that assert consumer rights – to respect patient autonomy, often under threat of legal sanction. This is the most basic form of professional ethics education. Should time allow, further instruction may address what can be termed 'objective competencies': a working knowledge of the rules and regulations relevant to the practice of bioethics, such as DNR regulations, the role of advance directives and living wills, surrogate decision making, factors affecting patient competence for decision making, and the legal precedents, not to mention hospital policy, that dictate the appropriate conditions for the withdrawal of life support.

As will be noted below, most ethics instructors are fairly confident that they can instill this kind of moral education. Nor is there any doubt that this kind of instruction has been effective, insofar as physicians are sometimes more inclined to respect the autonomy of their patients and hear them out. However, it is not moral education nor is it instruction in moral philosophy. It is professional education and an attempt to ground medical practice in the social, moral and (mostly) legal *milieu* of the times. While one might pause and ask why this is not a sufficient aim for any modern profession, medical ethics education pushes further towards goals that were not always the purview of medical education on one hand nor of moral education on the other, and they are considerably more difficult to accomplish.

Medical ethics education as philosophical discourse

One strong component of instruction in moral philosophy, suitable perhaps for medical ethics education, is the ability to engage in discourse (Pellegrino 1989). This speaks to both an affective and cognitive component of personal development that when evenly woven together enhances one's ability to undertake moral dialogue. Affective development reflects ethical sensitivity and mutual reciprocity, and points to the necessary preconditions of successful moral discourse. Cognitive development, on the other hand, demonstrates the ability to cogently argue from premises to conclusions, defend one's argument and frame one's point of view in terms that are universally objective rather than narrowly parochial.

Ethical sensitivity marks the ability to recognize the ethical dimensions inherent in a clinical setting. The first step necessary to resolve any bioethical quandary is to first recognize that a problem exists. One of the foremost goals of ethics education, therefore, is to generate an awareness that ethical difficulties really arise in clinical situations and, indeed, infuse medical practice. While educators often rate this goal among the highest of all (see below), attempts to measure sensitivity in any formal way have met with mixed success (Hebert *et al.* 1990)

Ethical reciprocity directs ones attention to one's adversary or partner in dialogue and embraces an awareness that recognizes the moral worth of an opposing position (although one might not agree with it). It, too, is less a moral reasoning skill than a condition for successful ethical discourse (Gross 1997). Without reciprocity there is no attendant possibility that one can grasp the moral perspective of an opponent, change one's mind (or one's opponents) and adopt an alternative position. Without

reciprocity true moral dialogue is impossible and potentially interesting ethical debates are reduced to grandstanding. While reciprocity can be nurtured through classroom dialogue and dilemma discussion, it is also the product of a natural process of moral development (see below). Reciprocity, together with sensitivity, set the stage for moral understanding and ethical argumentation.

Ethical understanding is a reasoning skill and indicates the ability to clearly state and understand the moral principles underlying one's position. Ethical understanding does not necessarily require a grasp of formal ethical principles. Instead, it reflects a capacity to articulate one's position in terms of general moral norms (truth telling, fairness, equality, etc.) and be prepared to successfully defend one's viewpoint. Ethical understanding also reflects the wherewithal to locate a particular moral dilemma on a map of relevant paradigm cases. These provide additional rules of thumb for clarifying morally relevant clinical issues. *Ethical argumentation* follows naturally from ethical understanding and points to one's ability to not only articulate one's viewpoint but to refute common objections and persuasively defend one's point of view. Ethical understanding and argumentation reflect the oft-repeated objective of educators to cultivate the ability to cogently and convincingly argue one's position, successfully utilizing conventional moral norms and values. Ethical argumentation reflects moral competence and the ability to successfully engage in moral discourse.

In addition to its being a skill, moral competence also reflects one of the fundamental underlying goals of cognitive development. In the hands of educational psychologists moral competence points to an enhanced ability to use increasingly universal and less parochial moral principles (Kohlberg 1984). Universal or post-conventional moral principles are those anchored in autonomy, fairness or the common good (general utility) and do not favour the rights or welfare of a specific group or interest. Moral development works through stages, the lowest of which is anchored in rank egoism and the highest of which embraces respect for universal rights and common welfare. The end goal of moral development is a morally competent individual, inclined to act on his or her considered moral judgment and respectful of the moral integrity of other individuals in the community. Post-conventional moral development marks the culmination of ethical reciprocity, sensitivity, understanding and argumentation.

Though a product of a great many psychosocial, economic and educational forces, moral development is sensitive to classroom intervention, particularly through discussions of hypothetical or student-chosen dilemmas and clinical confrontation with on-the-job moral challenges (Self & DeWitt 1994; Self & Davenport 1998). However, in one of the strange twists of medical education, moral competence – that is the ability to articulate autonomous moral principles and respect the moral integrity of one's adversary – seems to regress among students during medical school, a finding unprecedented in any other field (Self *et al*. 1993; Lind 2000). Active intervention may forestall this regression but enhanced moral development remains elusive, particularly when aimed at adults rather than adolescents. Moreover, the evidence that cognitive moral development significantly affects moral behavior has never been weighty and in fact may even impede collective forms of moral action (Gross 1997). These considerations should give pause for thought when considering the appropriateness of moral development as a goal of medical ethics education and certainly make us cautious about using moral judgment tests as a criteria for entrance to professional schools as some have suggested (Self & Davenport 1998).

Although it might be obvious that a philosophy instructor should instruct her students in the art of moral discourse, it may be true that moral discourse skills like moral development are inimical to medical ethics education. When one educator once complained that his fellow physicians do not get involved intellectually and emotionally in ethical problems, one of his colleagues actually took this to be a compliment. Asked to comment on the ethics of withdrawing and withholding treatment, a senior thoracic surgeon wrote to me, 'Since I find myself to be on the front lines and not in the academic arena of Socratic discussions, I can honestly say that I have never actually given this question much thought. Soldiers are not expected to think . . .'.

This sentiment is often reinforced by the perceived futility of ethical discourse. Even ethics committee meetings routinely degenerate into unfocused debates. Fairness means that each person be given a

chance to speak; civility demands that criticism be restrained. As a result, participants often speak to hear their own voice rather than confront the arguments raised by others. No effort is made to critically evaluate competing arguments and reach substantive conclusions. As a result medical students routinely complain that ethics discussions, while lots of fun, often lead nowhere. They want to see closure, just as they see when a challenging clinical case is presented. Instead they are often left with the impression that ethics can justify anything (or nothing). This is a mistake, of course, but if this is the outcome of ethics education then students might be better left to their own devices, guess work and intuition. In spite of these misgivings, moral argumentation is often supplemented with still another problematic goal of medical ethics education: character transformation.

Moral ethics education as character transformation

In spite of the vast spectrum of goals just described, medical ethics education is often construed as moral education, that is, it is expressly formulated to transform a physician's moral character. Its purpose is not simply to teach ethics or moral philosophy as an intellectual discipline but fundamentally to alter moral behaviour. Consider the following:

> Ethics education has a number of goals. Trainees should be able to understand basic ethical principles, appreciate the relationship between law and ethics, recognize ethical issues when they arise in clinical situations, identify conflicting values that give rise to dilemmas and reason critically to determine the best course of action in difficult situations. . . . The humane physician must exhibit not only a humanistic attitude and knowledge of humanistic and ethical concepts but humanistic behavior as well.
>
> (Fischer & Arnold 1994 p. 655)

Even critics of such an overtly behaviouristic goal of education assume an intimate relationship between sound moral character and medical ethics education:

> . . . A medical-ethics curriculum is designed not to improve the moral character of future physicians but to provide those of sound moral character with the intellectual tools and interactional skills to give that moral character its best behavioral expression.
>
> (Culver *et al.* 1985), p. 253

In contrast to cognitive development, which affects the way one thinks, there is an irresistible urge in medical ethics education to influence *what* one thinks and *how* one behaves. The emphasis shifts from imparting technocratic skills to nurturing humanistic traits that focus on empathy and caring together with an understanding of the uniqueness of human life and a commitment to serve the community (Glick 1993). Giving operative expression, however, to character transformation is complex. On one hand, it may mean inculcation of prosocial attitudes and behaviours such as a willingness to treat HIV patients, support universal health care, deal favourably with self-abusive patients and to work *pro bono* (Thomasma 1993). On the other, it may reflect a desire to improve communication skills between physicians and patients, skills that may range from an understanding of conflict resolution techniques to a broad respect for cultural diversity in the practice of medicine.

In all of these cases, there is a concerted effort to broaden a physician's ability to interact with his patient as a fellow human being and thereby improve the quality of care. Here, however, one must distinguish between the ethical desirability of a certain virtue or skill in the practice of a particular profession and the place of ethics education to impart these same skills. Prosocial behaviour, empathy and communication skills not only move beyond the technocratic side of modern medicine but push beyond ethics as well. While they might be ethically indicated aims for medical education it is difficult to see how they are the purview of ethics education. Methodologies reserved for psychology or counselling would probably be more suitable. As a result it is no wonder that ethics educators report considerable frustration when trying to accomplish these goals.

Accomplishing the goals of medical ethics education

If many of the goals of medical ethics are ill defined and unsuitable for either ethics or medical education it is no wonder that they are difficult to achieve. In spite of good intentions, success remains elusive.

What are the goals of medical ethics education and how well are they achieved?

These questions were posed to a random sample of medical ethics instructors across the United States. A closed and open-ended survey was distributed to 370 members of the faculty interest group of the Society for Health and Human Values in 1996. One hundred and twenty-six individuals responded to the closed-end section of the survey. Fifteen indicated that they were not active faculty members teaching medical ethics and their names were removed from the sample. The resulting response rate was 32%. However, in conversations with other members of the interest group it became clear that not all actively taught ethics. As a result, the sample is probably more representative than the response rate would indicate. Seventy-eight respondents also provided answers to the open ended questions. These asked:

- What, in your opinion, are the concrete goals of medical ethics education?
- What teaching methods do you use in the instruction of medical ethics?
- What are your methods for evaluating student progress?
- In what ways have your students benefited from ethics instruction?

The results revealed a decidedly disjointed effort.

As the goals of ethics education shift from a well-grounded background in bioethics and moral philosophy towards the development of interpersonal skills such as communication, conflict mediation and cultural sensitivity, educators' expectations of success lag behind. Part of the problem, perhaps, is that educators don't really want to teach biomedical ethics as moral philosophy and find it increasingly difficult to do what it is they really want to do: transform moral character and otherwise nurture a more ethical health care practitioner.

Goals and expectations

Table 1 describes the importance ethics educators attach to each of the goals described above (column 1) and an evaluation of their ability to successfully achieve each goal (column 2). Each is rated on a five-point scale from 1 (for goals deemed not important, or not achieved very well) to 5 (for goals deemed very important or achieved very well). The importance and achievement rating attached to each goal can also be compared to yield some idea of how well one's expectations are fulfilled (mean difference, column 3). While care must be taken when comparing the two scales, the mean difference between the two can be cautiously construed as indicative of the gap between one's expectations and the reality of achieving them. There is a gap between the importance one attaches to a particular goal and the extent to which one feels it is achieved. Thus a relatively low negative difference indicates a minimum shortfall in expectations (relative to other subjects), a large negative difference marks a greater shortfall and a positive difference (although there are none) points to a happy state of affairs exceeding one's expectations.

The goals of medical ethics education: how important are they?

As the importance of each goal is compared, an interesting order of priorities emerges.

Highest rated are the affective goals of medical ethics education: ethical sensitivity, the ability to discern the ethical dimensions of clinical medicine and ethical reciprocity, the capacity to grant equal moral weight to others (particularly adversaries). Each is a precondition of moral dialogue, without which ethical discussion is well nigh impossible. It is also of interest that each is rated significantly more important by women. Similarly, women also lent greater weight to the development of interpersonal skills of conflict mediation and communication skills. Given the small number of women in the sample (27%) it is impossible to draw firm conclusions but this finding lends support to speculation that women place greater emphasis on the affective components of moral development: care, compromise and co-operation (Gilligan 1982; Held 1990).

Also highly rated are the goals associated with the legal duties and professional ethics of medicine: respect for autonomy, confidentiality and informed consent. These have been a major component of the public agenda for the last generation and it is not surprising that they remain highly rated as a bulwark against paternalism.

Goals of somewhat lesser importance are those associated with objective competence, i.e. factual

Table 1 Objectives of medical ethics education. How important are they? How well are they achieved?

	Importance				
Objective	*All S*	*Male*	*Female*	*Achievement*	*Mean difference*
Professional ethics					
Respect for autonomy	4.3	4.3	4.5	3.7	–0.60
Respect for confidentiality	4.7	4.7	4.8	3.8	–0.90
Informed consent	4.5	4.5	4.5	3.8	–0.70
Objective competence	4.3	4.3	4.6	3.7	–0.60
Philosophical discourse					
Ethical sensitivity	4.9	4.9	5.0**	3.6	–1.30
Ethical reciprocity	4.4	4.3	4.7*	3.3	–1.10
Ethical understanding	4.2	4.2	4.1	3.1	–1.10
Ethical argumentation	3.9	3.8	4.1	3.1	–0.80
Character transformation					
Moral development	4.1	4	4.3	3.0	–1.10
Character transformation: attitudinal and behavioural change					
Respect for cultural diversity	4.7	4.6	4.9	3.3	–1.40
Treat HIV patients	4.6	4.5	4.7	3.8	–0.80
Treat self abusive patients	4.0	4.0	4.2	3.1	–0.90
Support for universal health care	3.8	3.7	4.1	2.8	–1.00
Willingness to undertake *pro bono* work	3.8	3.8	3.9	2.9	–0.90
Communication skills	4.6	4.5	4.9*	3.3	–1.30
Mediate conflict	4.2	4.1	4.6*	3.0	–1.20

Data indicate mean scores. The importance scale ranges from 1 (the objective is NOT very important) to 5 (the objective IS very important) The achievement scale ranges from 1 (the objective is NOT achieved very well) to 5 (the objective IS achieved very well). *$P<0.05$ (for *t*-test) **$P<0.01$ (for *t*-test). $n=91-111$ (varies due to missing values).

knowledge of the subsidiary rules of bioethics (rules of thumb governing DNR, termination of life support, competence and surrogate decision making). These are followed in importance by moral understanding, ethical argumentation and cognitive moral development, all of which aim to increase a student's ability to comprehend, justify and utilize the rules of bioethics imparted by classroom learning. These are deemed nearly as important as objective competence.

Among the attitudinal and behavioural aims there is moderate support for pro-social goals associated with support for universal health care and a willingness to donate work *pro bono*.

Interpersonal skills remain one of the highest priority goals of bioethics education. As noted earlier, this is particularly true of women. In both the closed- and open-ended section of the questionnaire instructors voiced great concern for the 'human' side of doctoring. While physicians may learn ethical argumentation and progressive bioethical attitudes, moral development is essentially incomplete unless they can communicate with their patients. However, communication is only part of the story. Ethical behaviour requires personal interaction and empathy. It requires the ability to mediate in conflict between patients, family and the medical staff, an understanding of cultural diversity and a sensitivity to the role a physician can play by 'just being there'. It is not without cause that these are among the most difficult goals to achieve.

The goals of medical ethics education: how well are they achieved?

How well are these goals achieved? The data afford several answers. Of those goals defined as affective

and cognitive development, instructors feel that the most important goals are also those that are best achieved. Professional ethics and objective competence enjoy the highest achievement scores, followed by ethical sensitivity and reciprocity. Teaching objective competencies is relatively straightforward and easily measurable by traditional evaluation techniques (written tests for example) and it is therefore not surprising that they enjoy the greatest success, an impression further supported by empirical studies (Sulmasy & Marx 1997; Hayes *et al*. 1999; Angelos *et al*. 1999). It is surprising though that ethical sensitivity and reciprocity are thought to be achieved with some degree of success. Two qualifications, however, are in order. First, it is not at all clear that appropriate methods even exist to evaluate progress in this field. Secondly, it is important to note that ethical sensitivity and reciprocity suffer from the greatest expectation deficit (mean difference). Negative scores reflect a significant gap between what one wants to achieve and what one can achieve. Expectations for instilling sensitivity and reciprocity are not met as successfully as are those of other goals. Perhaps expectations are simply too high and more importance should be placed on other goals that are easier to achieve.

Goals related to moral argumentation and, particularly, moral development are not only difficult to achieve but continually fall short of expectations, a sentiment not only expressed by ethics instructors but one that is also confirmed by empirical studies (below). It may also be that students themselves remain unconvinced of the value or practicality of ethical training.

Only objective competence and the related goals associated with professional ethics are thought to be achieved with any relative degree of success. These are associated with the non-paternalistic culture that has driven bioethics for the past two or three decades. Inasmuch as students know little about them to begin with it stands to reason that they will readily assimilate these rules as the normative values of contemporary medical practice. Instructors seem confident that they can teach students to respect confidentiality, autonomy, a patient's right to know and a patient's right to die. They are slightly less optimistic about teaching those attitudes enjoying less than unanimous support: treating self-abusive patients, supporting universal health care and willingness to work *pro bono*.

The behavioural goals on the other hand, those defined as interpersonal skills, present a different picture. These are among the most desired goals of medical ethics education but among the most difficult to obtain. Importance scores are among the highest, while achievement scores are among the lowest. The resulting gap in expectations is the widest of all those goals surveyed. Inevitably this leads to frustration among instructors as their expectations are thwarted.

Much of this frustration is reflected in the data available from empirical studies. Moral development, for example, has posed a unique problem for medical ethics educators. Most often adopted as the aim of high school democratic educational programmes, some educators expected that intensive ethics education among medical students would enhance cognitive development. Control studies, however, revealed that in the absence of any intervention, medical students tend to regress as they study medicine, a finding not usually associated with moral development in adulthood (Self *et al*. 1993; Self & DeWitt 1994; Self *et al*. 1998). Active intervention then – in the form of intensive classroom dialogue – was expected to blunt moral regression (rather than promote moral development). In some settings this hypothesis has been substantiated, although it is not clear whether these results can be sustained over time, can be achieved on any large scale or have any effect, one way or another, on patient care.

Empirical data corroborate instructors' impressions about the other goals as well. In a cross-sectional study conducted by this author, the effects of ethics education are decidedly mixed (Gross 1999). Ethics education had no effect on the level of moral development among subjects in the study. Nor was objective competence affected by ethics education, although some marginal effects were observed with respect to knowledge of living wills. In an analysis of attitudes associated with termination of life support, physician-assisted suicide, aggressive treatment of anomalous newborns and treatment of self-abusive patients, no effects of ethics education were discerned. Instead religious observance proved to be the only variable that partially explained divergent attitudes. However, religious observance is a home-

grown value and reflects the inculcation of ethical norms during one's childhood and adolescence. It maintains a strong presence in the moral thinking of many individuals in the adult years and remains generally unaffected by ethics training.

If anything, it is reasonable to infer from this earlier study that those of a strong religious bent seek out ethics training. This made the interpretation of some results ambiguous. For example, two factors were significantly associated with charitable behaviour: religious observance (independently of denominational affiliation) and ethics education. The effects of religious observance, most likely, result from the inculcation of altruistic norms during the course of one's early life. Here, the causal effect is probably straightforward. However, the association between ethics education and *pro bono* work is more difficult to interpret. On one hand, it appears that ethics education may affect one's inclination towards *pro bono* work. On the other, it is also reasonable to suppose that those who devote an increased portion of their practice to free medical care also demonstrate an interest in ethics education (Gross 1997).

Can ethics be taught? Should ethics be taught?

At this point it would be customary to make suggestions to improve the state of medical ethics education. If by improvement one means a better fit between one's goals and one's ability to accomplish those goals, two courses of action present themselves: trim one's goals to match one's abilities; or enhance one's abilities in order to achieve more ambitious goals.

It is more common to take the second route and offer any number of operative suggestions to improve medical ethics training. Among the most incisive have been important attempts to reconceptualize the entire idea of medical ethics education. Arguing that ethics cannot be reduced to a set of distinct 'task-oriented' skills, Hafferty and Franks (1994) suggest that ethics education in medical school is part of a much larger process of professional socialization. Ethics education will only lead to character transformation as part of an integrated programme of medical education that must first overcome the inner contradictions between the 'hidden curriculum' of medical education that advocates excessive rationality and an image of patients as 'victims of disease, objects of learning and subjects for research' and between the dictates of modern bioethics that preach much the opposite (Hafferty & Franks 1994 p. 865). This complements suggestions to integrate ethics into problem-based learning curricula, which largely dispense with formal ethics classes and integrate ethics into clinical courses through the use of ethics facilitators. While most facilitators have an interest in ethics, many volunteer their time and remain untrained in either moral philosophy or moral education.

The effects of this kind of education have still yet to be examined, although there is little doubt that forums of this kind, together with other small group venues, can benefit from the dialogical methodology and evaluation instruments already well developed and employed by moral psychologists working in the field of democratic education. Nor is there little doubt that improvements are being made to curricula to promote communication skills, teach conflict mediation and engender respect for cultural diversity (Hope 1996). Medical ethics education is a field crying out for interdisciplinary cooperation.

Alternatively, one might pursue the opposite direction and pare the goals of medical ethics education by concentrating on those goals most readily amenable to common educational methods, namely, the objective competencies and professional norms that guide the practice of medicine. The incentive for learning these competencies, however, is not so much ethical as legal. Physicians are, and probably should be, more concerned with risk management rather than moral philosophy. Ethics training, under this scenario, would be reserved for those with a special interest.

None of these alternatives, however, attend to the more compelling question: Why teach ethics at all? All the goals described earlier make the tacit assumption that knowledge of medical ethics is desirable for physicians. Moral perspicacity, whether defined as the ability to sustain moral dialogue or, more tenuously, as some kind of communication skill, is expected to enhance patient care. But does it?

How might ethics affect care? One obvious way might be that suggested above by Thomasma and Pellegrino (1993): the ethical physician is more inclined to treat self-abusive patients and donate his

time to the community. While this might indeed be true of an ethical physician, assuming ethics is defined to include a strong dose of social altruism, the evidence cited above does not suggest that ethics education does much to form character in this direction. So a practical question still remains: Does moral competence translate into medical competence? After all, we are not training casuists but doctors. The question has garnered little empirical attention but conceptually, is it not presumptuous to suggest that a physician trained in moral philosophy will offer better treatment? Can care be affected by morally incompetent doctors, those who can't recognize, much less, resolve a moral dilemma, rely on unreflective thinking and become pugnacious if not obnoxious when confronted with criticism? However much we might like to think so, the answer is not always clear, and the answer is not clear because we really don't know what 'better care' actually means.

Consider the following:

> It is high time for a change in medical education systems in many countries. There is no doubt anymore that . . . medical education fails to foster the development of the moral competencies that medical doctors will need to become good physicians.
>
> (Lind in 2000)

Or:

> The marginalized place of medical ethics in the curriculum . . . has insidious consequences.
>
> (Hafferty & Franks 1994 p. 866)

Or:

> When we examine the daily doctor–patient relationship we find sharp discrepancies between the lofty ideals and their implementation in practice. The values are not adequately internalized by the doctors, and we still have to cover a lot of ground to increase the level of caring in the medical setting.
>
> (University of Haifa, Haifa 1998)

'Better physicians'? 'Insidious consequences'? 'Increase the level of caring'? What might this mean? None of the authors cited above flesh out, much less substantiate, this claim, one that seems to underpin all of medical ethics education. On the face of it, each assumes that lack of ethics education will adversely affect the care a patient will receive. However, this assumption demands a clear notion of 'care' that, on reflection, might mean several things, each speaking to a different ethical principle that ethics education might address.

- An uncaring physician may be neglectful. This violates the principles of professional integrity.
- An uncaring physician may fail to provide adequate care. This may result from lack of means (constrained by the limits of national or private health insurance) or lack of knowledge (constrained by lack of education). This type of uncaring may violate a citizen's right to adequate health care.
- An uncaring physician is one who will not help a patient die or get an abortion or get more money from the insurance company. The first two cases violate the principle of political liberalism, while the latter violates an amorphous norm of justice.
- An uncaring physician may fail properly to communicate with his or her patient. Communication skills have become another watchword of contemporary bioethical education. However, what does the failure to communicate mean? It also may mean several things: (a) The physician intentionally holds back information. (b) The physician does not provide enough information to make an informed choice, thereby violating patient autonomy and the right to informed consent before treatment. (c) The physician is tactless and has no flair for delivering bad news. (d) The physician is not courteous, or doesn't ask about the family. He or she is belligerent, demeaning and condescending. This violates norms of simple humanity.

The question must be asked whether ethics has anything to do with these very different definitions of caring, and the answer, 'very little', is going to disturb some medical ethicists. Caring defined relative to neglect and inadequate care is not the purview of moral theory. Any reasonable curriculum in medicine is going to condemn neglectful treatment and make every effort to impart the necessary components of clinical knowledge. Inadequate resources are, to be sure, an ethical issue. In fact, the just distribution of scarce resources is a paramount problem for administrators, legislators, judges and political philosophers. However, it is not a problem of day-to-day medicine except insofar as physicians ought to be aware of and possibly peripherally active in the budget battles going on about them.

Caring as defined by political liberalism is also not the proper purview of ethics. Ethics can't 'do' liberalism, nor should it. Good ethics does not tow a conservative or liberal line, but offers instead a sane framework of tolerance and respect for dialogue between parties of divergent moral and political traditions. Ethics cannot improve communication skills, nor teach one to be courteous, nice, affectionate, sympathetic or less belligerent and condescending. Again, psychology might be a better place to turn than ethics. Ethics might be able to convince physicians to be more forthcoming with information, but there are other vehicles for doing so that are far more promising. Informed consent can be made a principle of law punishable by some sanction, patient satisfaction can be surveyed and physicians rewarded accordingly, or physicians might be reimbursed for time spent communicating with patients. Money and law often speak louder than ethics. So what is left for ethics?

This returns us to the two traditional goals of moral philosophy. Understanding Kant and acquiring a working knowledge of Socratic inquiry will not, indeed should not, effect the standard of care, nor radically change physician behavior. In spite of what we find in many ethics curricula, moral dilemmas are often mundane, barely recognizable as moral predicaments. Some physicians will gloss over them and in many cases their patients will be no worse off. Others may recognize their dilemmas but lacking the tools to deal with them lapse into frustration and hurried decision-making based on unexamined rules of thumb and local custom. Their patients, too, will probably receive adequate care. Yet others may stop to argue with themselves, split hairs with their colleagues, confront administrators and even engage their patients. Will their patients be rewarded with exceptional care? Maybe, but then again, maybe not, but the practitioners themselves, like those in any profession, might be rewarded by the challenge of resolving a difficult issue and, in doing so, make a modest contribution to their evolving social *milieu*. Public resolution encourages discourse, discourse yields an exchange of ideas and slowly new norms may emerge that are better at quieting our moral discomfort. Ethics in medicine will continue to function as ethics in any other field: slowly, at the margins but not without subtle impact.

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