Why Teach Ethics?

A Philosopher's View

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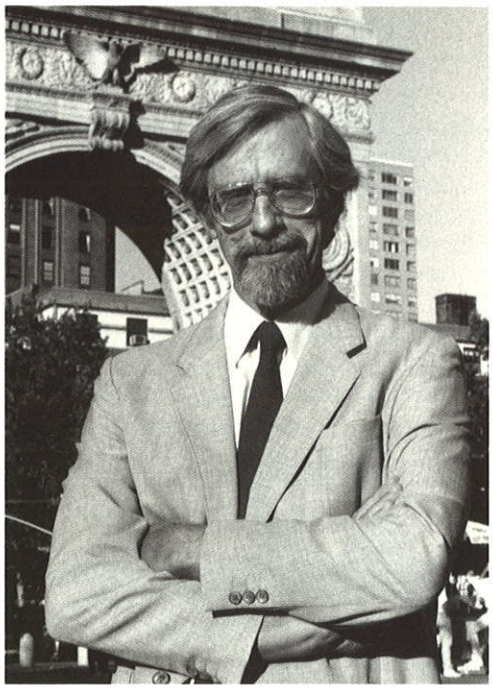

Moral character has been compared to the pituitary gland, which is fully formed and functioning by college age. On this pituitary model, a medical student's conscience is either secreting ACTH (altruistic character trait hormone) or it is not. If it is, then there is no need to study medical ethics. If it is not, the study of medical ethics is still a useless exercise; it is too late. Future patients and colleagues will have to suffer.

However, those of us who teach medical ethics favor an alternative view. We believe that moral character is more like the heart, subject to significant change through stress and exercise. On this cardiac model, the study of medical ethics is a form of moral aerobics, beneficial at any stage of life.

Our primary aim, however, is to improve students' moral discourse, not their moral character, even though tradition and training have discouraged it—Hippocrates urged physicians to say little to patients. Premedical and medical studies stress problem solving by scientific facts and clinical procedures. Sources of moral reflectiveness—literature, religion, political analysis, philosophy—have been regarded as cultural adornments at best.

Moral taciturnity is no longer acceptable to less deferential patients and staff. Physicians must become more articulate about ethical matters.

We often begin our ethical teaching by examining standard moral maxims and codes, such as the Hippocratic Oath and the American Medical Association Code of Ethics. We then examine more general principles of ethical theory, such as the utility principle and the categorical imperative.

We then ask how these maxims, codes, and principles apply to particular cases. One especially provocative case is that of a gynecologist who, at an unfaithful husband's request, lies to a patient about the venereal disease for which he is treating her. Without any prompting from the teachers, the issues of paternalism, sexism, confidentiality, and a patient's right to know a distressing diagnosis quickly arise and heatedly divide the students.

At this point, we begin to help students refine their formulation of the issues, ask for further morally relevant information, examine morally debatable assumptions, look for possible resolutions, and resist simple-minded moral relativism or individualism when no resolution is readily forthcoming or mutually agreeable. "It is up to each person to decide what is right and wrong" is not a possible standpoint for people engaged in a joint decision or project.

Even though our primary aim is not to improve character, more articulate ethical discourse may indeed have that effect. Listening and responding is such a large part of what is meant by treating patients, students, and colleagues with respect, as persons. Greater moral discursiveness enables us better to understand, listen, respect, and respond to other people, however much they differ in culture, class, race, gender, education—or ethical convictions. ■