Teaching Virtue

San Francisco Medicine September 2005

Can virtue be taught? This is the age-old question that has haunted philosophers and parents since the dawn of civilization. Plato takes up the issue in his dialogue between Socrates and Protagoras. In this account, Hippocrates, not the famous physician of Cos, but the son of Appollodorus and the brother of Phason, announces that the famous Sophist Protagoras has arrived in Athens and, for a considerable fee, is willing to teach his pupils wisdom. Hippocrates, thirsty for knowledge, has agreed to sign up and asks Socrates what he thinks. Soon Protagoras, perhaps the first "concierge philosopher" enters the scene and begins a protracted dialogue with Socrates. They agree that wisdom represents a virtue and then begin to enumerate others such as courage, self-control, justice and piety. After a meandering and, at times, tangential discussion they arrive at the position that the ultimate virtue is knowledge. And since knowledge can be transferred through teaching, perhaps virtue can be taught after all. Having reached this position, they both agree that they need to further explore the nature of virtue beyond its transferability and part recognizing that their conclusion is unsatisfying. One of the things that distinguishes Protagoras is that Socrates is not clearly the winner in the debate, reflecting Plato's own uncertainty about teaching virtue.

I would agree with Plato that a better understanding of virtue is necessary to answer the question definitively. I too am unsatisfied with the idea of knowledge as the ultimate virtue and offer a contemporary example to make my point. If you were to provide the inmates of San Quentin with a course of instruction in law, would those who successfully complete it be law-abiding citizens, or lawyers?

Since 1980, I have been lecturing in Medical Ethics at California Pacific Medical Center. Topics have ranged from the metaphysical ("The Nature and Bias of the Scientific Method") to the practical ("Dealing with Requests for Nonbeneficial Treatments"). To say that I have been teaching "ethics" requires a more precise definition of the term. In my opinion ethics is quite different from morality. I consider morality as a state of character which is inclined to choose the "good" or "right" path when called to act. Ethics, on the other hand, is the discipline which attempts to study and define what that choice is all about. Ethics includes the language used to define the issues, a recognition and description of the circumstances and imperatives that define a moral choice, and the theories and systems which have been developed to assist individuals when faced with moral choices. By this definition, ethics is knowledge and therefore it can be taught, but are we thus producing moral physicians or, as I asked above, simply teaching law to the inmates?

The data that exists is not very encouraging. Donnie Self, at the University of Texas in Galveston, and others have, for years, been studying the effects of ethics programs on medical students. Most researchers have been administering standard written instruments designed to measure levels of ethical reasoning and judgment such as James Rest's Defining Issues Test (DIT). Although advancement in the level of ethical

decisions has been demonstrated in many other postgraduate fields, Self has reached the startling conclusion that medical students do not make measurable progress in their level of moral development… This conclusion can be explained in only three ways. Either medical students have already attained such a level of ethical sophistication that further development is not possible; medical students are morally inert, and, unlike their contemporaries in other disciplines, lack the capacity for moral change; or, thirdly, the instruments of measurement have been set up
like cameras along the wrong parade route, measuring the wrong things or using instruments that are inadequate to the task.
Rest's, own evaluation of his instrument has demonstrated that higher educational levels show less change in moral development, perhaps because they have already learned the "right" things to say when confronted with moral dilemmas. This might lend support to the first explanation, that medical students are moral agents without peer, but it is still hard for me to accept in light of my own experience or that of others.

In 1995, my colleague Richard Sprott, Ph.D., a developmental psychologist at Cal State East Bay, and I began to explore the third hypothesis. We wanted to see if, by using a more medically specific survey instrument, we could demonstrate change in the moral values of physicians in training. Like many naive researchers, I thought we would have answers in three or four years. Ten years and 250 subjects later, we are just beginning to glean some sense from our data. Instead of medical students, we have chosen first year medical residents for our study. This choice was based on both the availability of medical residents at CPMC, and my belief that stress and adversity challenge an individual's value system and thus are more likely to precipitate change. What could be more predictably stressful than the first year of medical residency?

The instrument initially consisted of five, and now three, medical case vignettes which have reached the point of a decision dependent on the moral values of the decision maker. The cases involve conflicts between respecting the values of patient autonomy, duties to promote health and reduce harm, and obligations to social justice. Each resident was asked to complete the questionnaire on the first day they arrived at CPMC, and again in the last month of their first year of training. Although all the residents were offered a series of lectures in medical ethics, this was not considered an intervention. The intervention was the experience of residency which they all received in abundance. Our goal was simply to see if we could document change in the values and decisions of those studied.

As we assemble our data for publication, a few significant points are emerging. First, value changes do occur and can be measured. The changes are subtle and would easily be missed by a generic measure of moral reasoning such as the DIT. They can only be demonstrated when the case is very specific to the actual experiences of the resident, what we call "context specific". Residents at CPMC spend a lot of time dealing with patients who have little chance of meaningful survival. When they are asked how aggressive to be in a patient in the ICU with a limited chance of survival, as a group, the residents clearly demonstrate a willingness to be less aggressive in treatment at the end of the year than they did at the beginning. In situations measuring attitudes toward social justice or respecting patient's wishes, aggregate change is not demonstrated. Our

explanation of this finding is that social justice and making medical decisions based on patient autonomy are not things the resident faces in his or her everyday world. These are areas that are often deferred to the attending and therefore have less impact. This is not to say that the residents do not have opinions or values about other things. Just that we cannot demonstrate that, as a group, these values change.

When you leave the group analysis and start looking at individual responses, other findings begin to emerge. First, the residents are not homogeneous in their medical values in the first place. Individuals place very different emphasis on values such as promoting health, avoiding harm, respecting patient wishes, distributing medical benefits justly, and even the limits of their own altruism. Individual residents also show changes when compared to their previous responses. Even if the actual decision remains the same, they often site different reasons for making the decision and weigh the factors going into that decision differently. Given the variability of values entering the residency it is not hard to understand why group change is difficult to document even if there is moral turmoil in the individuals.

In short, physicians in training enter their residency with a fairly well-established set of moral values. Some are more focused on patient welfare, others value objective data and tend to reject the subjective, and some are clearly more interested in their own advancement and reward. Since, as Donnie Self tells us, these values did not develop in medical school, where did they come from?

Moral education of the toddler is not the purpose of this paper, but the significance of mentoring and role modeling in medical education is one that needs further investigation. I would only note that role modeling seems to be taking a back seat in medical education in favor of outcome-based analysis, a process that is clearly a utilitarian one and one that offers no respect for virtue.

So, I return to the question, can virtue be taught? My answer is no, at least not at the postgraduate level, and barring an intervention more cataclysmic than the internship. Doctors-to-be enter their training with a fairly fixed set of moral values and virtues. Some, who are predisposed, can have their moral positions refined and sophisticated by ethical training but most adapt the circumstances to fit their moral view. Thus, if the purpose is to establish virtuous physicians, the task should fall to medical school admission committees and not the curriculum committee.

8/3/05

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