ENGAGING THE DISENGAGED: AN ASSESSMENT OF THE MEDICAL ETHICS CURRICULUM AND SUGGESTIONS FOR ITS IMPROVEMENT

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ABSTRACT

The medical ethics curriculum is an important part of medical education as it helps foster students to become virtuous and compassionate caretakers. The format of the curriculum is intended to expose students to ethical and moral issues early in their careers and allow them to apply their knowledge in clinical situations. However, the implementation of the curriculum is incredibly varied and fraught with challenges. This thesis explores the challenges of the current format of the medical ethics curriculum and the repercussions that will extend throughout medical school and moving into residency and beyond. It will additionally delve into potential solutions that, if implemented conscientiously, can encourage more engaged and thoughtful discussions in the classroom and the clinical setting. It is the ultimate hope that such interventions will result in students' increased moral development and shape these future physicians into better caretakers, colleagues, and leaders.

Dedicated to all past and present

medical students who felt alone

even in a room full of people.

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CHAPTER 1: INTRODUCTION

Brief History of the Development of the Medical Ethics Curriculum

The past few decades have witnessed the rapid development of a medical ethics education in an effort to acknowledge the changing societal and ideological context of healthcare. Indeed, more and more, we are recognizing that social determinants of health, bias, psychosocial factors, and the relationship and trust between doctor and patient are paramount to health care, and that awareness of these moral, legal, and ethical issues that arise in healthcare is critical to introduce early on in a physician's career (1). In response, the medical school education system is increasingly incorporating ethical and social topics such as social determinants of health, racism and implicit bias, and health literacy into the curriculum. In 1985, a paper entitled "Basic Curricular Goals in Medical Ethics" (otherwise known as the DeCamp Report) was published and argued that medical ethics should be a required component in US medical schools (2). That same year, the Liaison Committee on Medical Education (LCME) declared that for U.S. medical schools, "ethical, behavioral, and socioeconomic subjects pertinent to medicine must be included in the curriculum and that material on medical ethics and human values should be presented"(3). The Association of American Medical Colleges (AAMC) Learning Objectives state that a physician must be altruistic, compassionate and empathetic in caring for patients, going on to say:

> They must bring to the study and practice of medicine those character traits, attitudes, and values that underpin ethical and beneficent medical care. They must understand the history of medicine, the

> nature of medicine's social compact, the ethical precepts of the medical profession, and their obligations under law. At all times they must act with integrity, honesty, respect for patients' privacy, and respect for the dignity of patients as persons. In all of their interactions with patients they must seek to understand the meaning of the patients' stories in the context of the patients' beliefs, and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own…(4)

Similar endeavors have been undertaken in many parts of the world, particularly in the US, Canada, and Europe, with a broad consensus on the goal of the curriculum: "to provide both the knowledge and application - particularly to recognize these scenarios in the real world and be able to do a critical self-appraisal of one's own identity and role in the medical, academic, and social system" (2,3,5,6). In order to truly achieve excellent patient care, providers must have the self-awareness, empathy, and integrity to handle ethical dilemmas however and whenever they arise.

The State of the Medical Ethics Curriculum Today

The existence of a rigorous ethics curriculum in medical education is recognized by faculty and students alike to be integral in instilling these characteristics in students (1,7–9). However, the format with which to endow future physicians with the ability to recognize and handle ethical dilemmas in medical and social contexts has not been standardized. There is incredible difficulty in imparting invaluable and complex

knowledge of these subjects, and much like the rest of the curriculum, the method of teaching these topics is left up to the discretion of the individual schools. Thus, despite mandatory ethics courses being introduced to most medical schools in the U.S., there remains no standard as to what to include in the curriculum, when to dedicate time to these subjects, and how to ensure that it is effectively enriching the students' experience (3,10–13). There are significant obstacles to effective ethical teaching that lend to this heterogeneity, notably a lack of time in the curriculum, a lack of qualified educators, and an insufficient amount of funding to an ethics curriculum (6,11–13).

The resulting effect can be detrimental to the medical students' education and ability to look outside their own worldview and relate to others unlike themselves. This is especially true in recent years as we observe increasing diversity of medical students with different backgrounds, life experiences, and values (14). Such diversity in future physicians is invaluable to patient care and autonomy, but it becomes evident that the concern now is not only how doctors can relate to and respect their patients, but how they can relate to and respect each other. Bezuidenhout postulates that student education is dependent on contextual factors such as the learning environment and the sociocultural characteristics of the student (15). Failure to acknowledge this can lead to poorer learning outcomes, increased burnout, and a sense of alienation that prevents students from forming meaningful relationships (15,16). If the ethics curriculum is not sufficient in facilitating such discourse, then students are deprived of opportunities for critical thinking and expanding their worldview. The format of the curriculum should be carefully implemented in a manner that provokes honest and thoughtful discourse that challenges the students to learn and develop to become truly ethical and conscientious

physicians. Thus, the purpose of this work is to examine the structure and format of a typical medical ethics curriculum in the United States, anticipate the challenges and potential repercussions of the format, and suggest solutions that may better facilitate conscientious and intentional learning and growth.

CHAPTER 2: EVALUATION OF THE ETHICS CURRICULUM

Methods

Written Attestations

A questionnaire was sent out to all medical students in a single institution to gather thoughts on the format and efficacy of the ethics component of the doctoring curriculum. Demographics collected from the students included age, gender, ethnicity, and socioeconomic status (SES). Students were also asked whether or not they had prior ethics education or exposure before matriculating into medical school. For each of the major threads in the ethics curriculum, students were asked to grade the importance of the subject matter, the quality of the lectures and small group discussions on the topic, and whether or not the amount and content of each topic were adequate. Students were also able to comment on what aspects of each subject matter they found particularly pertinent or were dissatisfied with. Select quotes from the surveys are included in this paper in order to effectively capture the student perspective.

Conversations

In-person interviews were also conducted with volunteers to discuss the topic of the ethics curriculum in an unstructured conversational format. Participants were initially prompted to share their thoughts on the quality of the ethics curriculum, and the subsequent exchange was largely undirected. Questions were prepared to help guide the conversation, taking care to do this without steering the participant to any particular view. Select quotes from discussions are included in this paper as well.

Clarifying Language

For the purposes of this paper, the ethics component refers to all medical ethics topics, but with a particular focus on the topics of social determinants of health, implicit bias, and different forms of identity (e.g., race, gender, etc). The term "participants" refers to the students at this institution who participated in completing the surveys or in-person conversations. The term "minority" refers to those individuals who identify as underrepresented in medicine (URM), defined as "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population (17)." The terms "URM" and "minority" are used interchangeably in this thesis.

CHAPTER 3: CHALLENGES AND REPERCUSSIONS OF THE MEDICAL ETHICS CURRICULUM

Implementation of the Ethics Curriculum

There is considerable variation among medical schools in how the ethics curriculum is structured (3,9,13,18). Most schools, including this institution, follow the traditional curriculum of having two pre-clinical years followed by two years of clinical rotations. The doctoring curriculum is spread mainly throughout the preclinical years, with expected reinforcement of the topics in the clinical years to follow. Many schools differ in their learning objectives, but the majority cite that these courses should familiarize the students to various medical ethical issues and develop in them ethical reasoning and problem-solving skills (13). This curriculum should include ethics topics such as social determinants of health, informed consent, disability, vulnerabilities, implicit bias, and cultural humility, usually in 1-2 hour sessions. Small group discussions are shown to be more effective methods of increasing moral reasoning skills, as they intend to create cognitive dissonance and stimulate growth throughout the moral stages when participants with differing positions are obligated to confront each other (19,20). Most institutions utilize this small-group format in the ethics curriculum or a combination of lecture and small-group sessions. Topics are taught either using clinical case studies and patient simulations (such as in the case of discussing resource allocation), or in an abstract or theoretical manner (such as when discussing different ethical principles) (6,21). Students are generally graded by their class participation and examinations.

This paper's primary goal of recognizing the weaknesses of the curriculum and theorizing ways to improve is not an entirely new endeavor. Several studies have commented on the format of the curricula and the observed obvious variation in its implementation across medical schools. Researchers Dubois and Burkemper, for example, recognized this heterogeneity and attempted to formulate a standardized medical ethics curriculum. Their survey of the ethics syllabi in US medical schools revealed a total of ten different course objectives, four teaching methods, thirty-nine content areas, two methods of assessment, and 1,191 distinct recommended readings. There was a significant overlap of the objectives being taught, but a substantial amount of weaknesses and discontinuities were identified that needed to be addressed (13). The present survey results convey similar opinions as those in the literature, with an acknowledgment of the importance of the subject matter in their education and future healthcare careers, but frustration with several aspects of the format and method of teaching (8,22). Despite the noted heterogeneity in the curriculum, similar drawbacks have been observed in several studies and within this institution. These include the inconvenient timing of the sessions, the lack of depth to the conversations, unqualified preceptors, and an obvious lack of priority of the content, which we will go through in more detail.

Challenges

Sporadic Timing

One challenge commonly encountered has been centered around the timing of the ethical discussions. As mentioned above, the current format of the ethics curriculum is

formatted in such a way that many of the sessions are 1-2 hour long lectures or small-group discussions and scheduled randomly throughout the first two years (5,6). Often, these sessions are centered around topics pertaining more to the conventional curriculum and fit in where there is availability. Additionally, the total amount of time dedicated to the ethics curriculum amounts to very little relative to the traditional medical courses, in some schools comprised of less than 2% of the traditional medical curriculum (23). While a survey of US medical schools by Silverberg et al revealed substantial variation in the number of hours dedicated to ethics sessions, the majority of schools reported 40 hours or less (10).

A major issue presented by this limited and sporadic scheduling of bioethics topics is that it leads to very short, out-of-context discussions, where the student is temporarily displaced from their studying before returning them once again to their "prioritized education." With this format, at best the student views the bioethics session as a "break" from studying (thus not viewing it as an important or necessary part of their professional development). At worst, the student is disengaged and waiting for the session to conclude, paying lip service to get out quickly and resume their "real studies." One interview volunteer thought that the sessions were not genuine discussions and that facilitators are waiting for the "woke" students to have the answers: "I know almost all the time what the person is looking for as an answer, and most people would have a hard time saying what they do not want to hear." This student goes on to express his frustration with how this format discourages genuine conversation: "Most people would have a hard time saying what [other students] do not want to hear, so how are we going to have the real discussions on what students believe?" Another student expressed this same

frustration. "It's not interactive," he claims, "you don't need to use your brain. You just look for buzz words." Indeed, many participants have confessed their hesitancy in speaking out and engaging in more honest and nuanced conversations and note a distinct lack of inclusivity in the sessions.

Repetitive and Superficial Discussion

Another problem presented by infrequent and random scheduling is that the same topic is often presented multiple times without introducing much more depth to the discussion over time. For example, in the first year of medical school, students participate in a lecture on the very relevant topic of social determinants of health (SDH). However, the topic is revisited the next year, so far removed from the first introduction that a significant portion of time is spent reminding students of the basic concepts of SDH. Of course, the subject of SDH is brought up multiple times throughout the years, but arguably not in a structured manner that facilitates a deeper understanding of our role in it. Rather, there seems to be a repetition of the words and definitions over and over again without allowing ourselves to have the uncomfortable conversations about why they exist in a historical context and how we can use our roles to mitigate them. Students and preceptors spend so much time talking about how so many problems exist (one survey participant described it as "overkill"), but not enough time talking about how to address them on a personal and systemic level. These lectures were described by one respondent as "condescending and simplistic." Another participant, a white male, alludes to this phenomenon in the race and implicit bias thread of the ethics curriculum, noting that words like "institutional racism" are used many times, but are not understood beyond

that. This particular phrase is thrown around a lot to the point that it "seems too big to stop - like the whole world is stacked against [people of color] and we have not been told what a doctor's role is in that, and what are the solutions we can take." This sentiment was echoed by other students as well, one individual saying, "it's hard to hear these issues because it felt like I could not do anything to really help or change the situation." The knowledge of the issues of today is integral to a physician's training, but the repetitive manner in which it is mentioned without accompanying discussion of ways to address it is bound to bring about a pervasive sense of hopelessness that quickly becomes overwhelming. This is not to say that students should be expected to figure out concrete solutions to the complex social, political, and economic problems that have existed for many years, but - to again quote Giubilini - they should at the very least be encouraged to do a "critical self-appraisal of one's own identity and role in the medical, academic, and social system."(5). In the curriculum's current state, they lack the opportunity to do so effectively.

Lack of an Integrated Format

For most medical schools, the ethics curriculum is essentially finished when students complete the preclinical years, with the expectation that students apply this knowledge in the following clinical years (5) However, these clinical years offer little to no additional instruction on ethical matters. Miles et al. stressed that an ethical curriculum should be integrated, both vertically and horizontally, throughout preclinical and clinical training - a sentiment that was echoed by many scholars (1,18,19,24,25). However, within this institution, except for a few days when the entire MS3 and MS4

classes are excused from clinical duties to attend mandatory themed “Academic Fridays” or voluntary vertical classrooms, there is no ethical education incorporated into the students’ clerkships. Students briefly revisit these topics in this setting but are essentially abandoned when they reach any practical portion. There is often no avenue for students to apply their learning or be guided through decision-making on a more personal level (1). Students come to learn that there is a clear dichotomy between what is taught and what actually happens in a real-life setting. While the classroom scenarios are made to reflect the daily dilemmas that take place in healthcare, discussing these issues in an isolated classroom setting is entirely different than encountering them on your own with little to no guidance. In fact, in the present survey, several students experience a sense of helplessness and isolation when on clinical rotations and confronted with real moral and ethical scenarios.

Compounding this lack of reinforcement of the ethics training is the existence of the “hidden curriculum" (5,26–28). As opposed to the formal didactic framework that explicitly states the goals and objectives of a given healthcare topic, the hidden curriculum is unspoken, unacknowledged but universally experienced. It is a socialization process in which trainees come to unconsciously inherit from their teachers the values, norms, and attitudes that are understood to be measures of what a good physician should be. There is a remarkable benefit that comes from observing the practices of more seasoned caretakers; students are able to attain skills such as empathy, resilience, and communication skills that cannot be taught in a classroom setting. However, the process is so remarkably subconscious that it can easily become flawed when biases, prejudices,

and unethical behaviors are also internalized in the impressionable trainee (5,26,28). Hafferty says this about the curriculum:

> [It is] more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques. In fact, what is 'taught' in this hidden curriculum often can be antithetical to the goals and content of those courses that are formally offered. The result is a progressive decline of moral reasoning during undergraduate medical school training. (26)

Hilton asserts that the hidden curriculum is "probably the most important factor influencing development of professionalism," and yet there is no active counter-measure to its effects (29). The hidden curriculum and the medical ethics courses are diametrically opposed forces, and without continued reinforcement, the formal ethics education students receive early on can be counteracted - if not completely overwhelmed - by this informal curriculum.

The inability to delve deeper into moral and ethical concepts is persistent even in residency, and the ability to discern ethical behavior from unethical behavior in our teachers does not appear to get any easier (30). Upper-year students on their clerkships can attend grand rounds and other residency conferences, many of which are presented on socio-ethical issues. Several have expressed surprise at the fact that these sessions were focused on *defining* concepts such as microaggressions and implicit bias instead of delving deeper into how to actively and specifically combat them. Such sessions were facilitated by older attendings who seemingly have no vested interest in the subject

matter - an attitude that is inherited and imitated by the residents. This is not just a medical school issue, it is a widespread problem.

Lack of Qualified Faculty

Another glaring problem with the state of the medical ethics curriculum is the distinct lack of ethics faculty. A lack of funding towards an ethics department or ethics-trained individuals has been a noted phenomenon among many schools, and the effect can be detrimental to student's education (12,23). Medical educators have an obligation to create clinically competent physicians, but to help foster professionalism by encouraging cognitive and moral growth. This institution has the privilege of having some esteemed ethicists that will introduce ethical and social topics to the entire class before delving deeper into them in smaller group settings. However, there are often several of these smaller discussions happening simultaneously and across different days, and because there aren't enough trained faculty available, many of the sessions will be precepted by physicians who are certainly well-intentioned but are not well-versed in the topic at hand. This was a negative aspect noted by many survey participants, with students commenting that the SDH sessions were "taught very poorly by unqualified individuals," who "weren't really prepared to respond to the issues that came up." Another student noted that they oftentimes had "facilitators who fundamentally didn't understand the topics at hand and let the discussion run away in the wrong direction." An ethics expert can guide the conversation in a manner that encourages diverse and intentional thinking. But an untrained facilitator, especially one with their own

viewpoints, can unconsciously direct the conversation in a way that is reductive and detrimental, as evidenced in this situation.

Another critique of the ethics curriculum has to do with the woefully small number of minority faculty available to take part in the discussions. Faculty diversity has been deemed, especially by minority students, as a positive factor in medical education. Studies consistently show that faculty who are underrepresented in medicine positively contribute to better quality of care, improvements in medical education, and in achieving awareness of cultural differences (31,32). They are also essential in mentoring and serving as sources of inspiration to minority students aspiring to one day be in their positions. The lack of minority individuals in this setting, with whom minority students can relate, can only contribute to the feelings of isolation and alienation. However, although the diversity of medical students has been increasing, the diversity of medical faculty has not been keeping up (14). There is a disappointingly small number of minority faculty in academic positions, and even less at senior rank levels (33,34). This is due in part to the fact that compared to their white counterparts, minority physicians are less likely to pursue academic medicine for a variety of reasons not limited to discrimination, elitism, and the feeling of isolation in academic medicine. Even as minority faculty are recruited, many leave these roles just a few short years later ((32,35,36) There is a clear lack of effort to mitigate this glaring pitfall of medicine, contributing to a self-perpetuating cycle of exclusion and cynicism that subverts the very foundation of ethical education.

Repercussions

Simplified and Binary Discussions

The outlined challenges lead to their own direct repercussions, but can also have very personal and long-lasting effects on the students and the patients they will eventually care for. The combination of all the above disadvantages ultimately lends itself to students participating in simplified and binary discussions without much room for introspection and critical thinking. The answers offered by the students are often ambiguous enough to not be construed as positive or negative at all. Their comments or questions are broad in a way that is universally agreed upon, and the responses that may conflict with another's opinion are often not challenged. One current student notes of the small group discussions: "some people, if they have different beliefs, will stay in the background… they'll say the part they think people will agree with and leave out the nuances." There is a distinct absence of proactive inquiry, in which students are asked "genuine questions about the situation [which] convey respect for the person and their contributions to the situation and allow the team to learn" (28). Instead, facilitators and peers ask questions for which they already know the answers, and participants do not feel as if they can speak their opinion or ask their own questions without admonishment or judgement. If students are not encouraged to engage in difficult conversations, they cannot build upon the basic ethical foundations that have been laid down. The result of this disengagement is an inability to recognize and comprehend the nuances present in everyday moral dilemmas.

Standardization of Experiences

This is dangerous not only in the fact that it silences many counter-perspectives but also because it leads to a standardization of certain experiences. The nature of the conversations leads to a consensus on how certain experiences should be viewed and how an individual should react in a given situation. One example of this was a workshop conducted a few years ago on sexism in healthcare. Students were given scenarios about sexism and sexual harassment in the workplace, then asked to raise their hands to indicate how severe that scenario was on a scale of not severe at all to extremely severe. It naturally led to the majority of the room converging to agree on a single "right" answer on how the affected individual should have responded. It was found by many students to be incredibly offensive and invalidating of so many women's feelings. One student writes:

> The idea of presenting sexism, bias and bad behavior in a clinical setting by rating severity is tone-deaf. It leads to a mob mentality and diminishes the individual experience. Bad behavior is bad behavior regardless of severe vs mild.

This sentiment was echoed by many others, along with comments on the tactlessness of having some sessions led by male preceptors who some students noted were themselves perpetrators of sexism.

While this may be a particularly egregious example of the tone-deaf environment that may result in group discussions[i], this "herd mentality" is subtly pervasive in several doctoring sessions and the clinical setting, assisted by the hidden curriculum discussed above. Salzburg et al. state that "the expected transition into higher levels of moral reasoning when looking at ethical cases does not appear to be present," largely in part due to the students being more preoccupied with following the rules and respecting the hierarchy (21). As a result, the roles of clinical competence and ethical knowledge become conflated and so intertwined that any failure in the clinical setting is perceived as a deficiency in their ethical and moral reasoning (21,26).

Mental and Emotional Toll

Another negative effect is the mental and emotional toll on the students. Many individuals end up feeling frustrated about the way topics are discussed, especially those with lived experiences in those subjects. It may lead to a feeling of isolation and prevent these students from speaking at all because of concern of embarrassment or ridicule for their vulnerability. In other words, they do not have a sense of psychological safety - the concept of feeling comfortable in a setting to share ideas, opinions, perspectives without fear of ridicule, judgement, or punishment (37). One URM participant recalled constantly feeling particularly uncomfortable in the small group discussions on race and implicit bias, stating that issue isn't having these conversations at all, "it's feeling othered in your classroom, it's hearing people minimize certain situations, it's hearing people feel tired about having these conversations when we [people of color] do not really have the option

[i] It should be noted that this particular session was not repeated in following years.

to be tired, we have to keep going." These students sit in the same rooms as their peers, but still manage to feel incredibly alone. For underrepresented minorities, this lack of psychological safety is often compounded by a sense of tokenization. There are very few URM students in each class, a paltry percentage relative to the population average, and thus there may be only one or two, if any at all, minority students in a small group discussion. When having conversations about issues such as race and implicit bias, there is an almost unconscious framing of the single URM student in the room as the "case study" where their experiences and identity are examined and used as fodder for conversation.

A Self-Perpetuating Cycle

The overarching theme here is that the ethics and social curriculum is not viewed as an important consideration in medical education. An overwhelming majority of surveyed students stressed the importance of an ethics education, but many felt that it was not appropriately emphasized by the administration. Says one student:

> "Creating ethical physicians is simply not a priority in medicine based on its current structure. Also, the way that medical students approach these social topics demonstrates their lack of exposure to these conversations (as well as brings light to unreflected privileges) and their hesitation to process how social factors will undoubtedly impact our lives as people and future physicians and those of our patients."

Several more, when questioned about specific topics, do not recall receiving any sessions on some topics at all.

These effects are felt even more profoundly in the clinical years and into residency and beyond. Several studies on resident burnout and medical errors have been noted to stem from the lack of proper ethical and narrative education in medical school (27,30,38). Clearly, the time not spent prioritizing this education now, while students are still learning in medical school, is time taken away from having meaningful interactions and relationships with patients and colleagues in the future. This reductionist perspective of medical ethics follows into the work and personal lives of the nation's caretakers, and only adds to the negative effects of the ever-present hidden curriculum. The failure of this curriculum then becomes systemic and perpetuates an already patriarchal and discriminatory healthcare system that is especially oppressive to the minority physicians who have to endure daily aggressions while expected to maintain a standard of decorum and clinical expertise. The inevitable result is that students lose focus on the importance of ethics in clinical practice and go forth in their professional careers minimizing or entirely disregarding ethical principles (20). Changes must be made in order to avoid such damaging practices from continuing.

CHAPTER 4: POTENTIAL SOLUTIONS

Considerations in Implementing Solutions

The key to combating the challenges of the current curriculum lies in acknowledging the difference between the main medical curriculum and the almost entirely subjective and individualistic nature of ethical reasoning. Science and our understanding of medicine is always changing, but it is safe to say that much of what is learned in medical school is fixed, the knowledge of physiology and pathological processes consistent and universally held. We are taught the same material by experts in the given field, and it is that common knowledge that will govern and guide us in our future medical careers. The way we learn this is almost formulaic in nature. We rely on rote memorization, on spaced repetition, and outlining feedback systems. It is a process that has been perfected over the years and has rarely failed us in our journeys to medicine.

Of course, ethics is in its own way objective, particularly with its established doctrines that guide us in our decision-making and distinction between right and wrong. However, we use these philosophies to individually form our own judgements and morality, and the actual practice of these principles can be easily colored by bias (39). Furthermore, the topics covered in many medical ethics curricula are experienced (or not experienced) in many different ways by many different people. For all their intentions to be widely applicable guidelines, these ethical principles are undeniably exceptionally personal. Effective learning of ethics (and hopeful unlearning of preconceived biases)

requires a fluidity of cognition that many students have not had to practice. Clinical ethics in particular, in which the scenarios confronted have a direct effect on our lives and the lives of our patients and peers, compels us to come to the "right" conclusion while still acknowledging the drawbacks and benefits of all the alternate resolutions (3). A 1976 report by Veatch et al. remarks on the difficulty of imparting such knowledge on students but nonetheless emphasizes its importance: "Medical students should learn not only the origin of controversy but also the arguments leading to alternative moral conclusions. This will require reading, or at least listening to, differing and often opposing views" (40). It is difficult to expect our rigid mindsets to adequately process the more nuanced and unfamiliar topics in healthcare in order to make these weighty decisions, but it is imperative that we learn to be more circumspect and reflective about ourselves in relation to our patients and our peers. This will better allow us to recognize ethical issues as they arise in medical practice and effectively deliberate and decide on the morally acceptable course of action (1).

One must also take into account the cognitive biases and defense mechanisms that we as human beings all harbor. We are evolutionarily wired to simplify things in our minds for our own comfort and self-preservation (39). We tend to look for ways to rationalize injustice and bad fortune and ultimately often place blame on the individual's behavior. This "just-world phenomenon" is a defense mechanism that is used to control fear and protect self-esteem by freeing us from any complicity (40,41). It prevents people from seeing the outside forces that have contributed to others' misfortunes and is the very basis for "victim-blaming" and lack of empathy in situations of violence, poverty, disease, racism, etc. (42). It is perhaps this pervasive mindset that prevents students and

faculty from empathy and compassion and that needs to be directly addressed and dismantled for any productive growth. Additionally, it creates a dichotomy of in-group vs out-group, of friend vs enemy. We need to recognize our instincts to form immediate bias and cross the cultural chasm instead of further exacerbating it. It is an undeniably arduous challenge that cannot be solved in one step, but there are certainly steps we can take to begin to mitigate its effects.

Hiring Bioethics Faculty

The "conventional" curriculum, as mentioned earlier, is taught by experts in the field. Medical students learn about the symptoms of diagnosis of diabetes from a practiced endocrinologist; they learn about substrate-level phosphorylation from a Ph.D. lecturer whose life has been dedicated to biochemistry research. Why, then, are many of the ethics curricula not similarly taught by experts in the subjects?

The field of bioethics has been exponentially increasing in popularity since the 1960s and is undoubtedly an important part of the way we approach medicine and healthcare policy (43). The increasing body of literature in this field reflects the dedication and genuine passion of the experts in the field, many of which are especially devoted to education and teaching (43,44). These are experts who not only have extensive knowledge of the topics we are trying to learn but who are equipped to facilitate discussions, *especially* when there are differences in thought. They can encourage discomfort and challenge viewpoints without attacking. The discussion of sexism in the workplace mentioned above, for example, could have gone completely

different if all of the rooms (not just the ones fortunate enough to have one of the few trained ethicists) had a preceptor well-versed in facilitating discussion of uncomfortable topics without invalidating some students' experiences. Including bioethicists as an integral part of the doctoring curriculum as a whole is essential, as their presence is paramount to having proper discussions on difficult topics and recognizing the opportunities to integrate ethical discussions into traditionally clinical topics.

Recruitment and Retention of Diverse Faculty

The need for increased diversity in medicine has been long argued and should rightly continue to be a priority for healthcare institutions at every level. Countless studies tout the benefits of having black and brown physicians in regard to improved patient outcomes and quality of care (31,32,35). Another underrated benefit is the impact they could have on medical education. They have different experiences than their counterparts (who are generally speaking cis, white males) and can provide a level of relatability to URM students who otherwise feel isolated. They serve as mentors and contribute so much to the comfort of the student, which can lead to more meaningful conversations (32,35). Several students have asserted that they tend to speak more and be more vulnerable, in groups in which they felt their words would be understood. The shockingly low number of minority faculty is only a disservice to the students' comfort, and state of healthcare; therefore, new programs must be developed, and existing programs should be strengthened to increase their recruitment and retention.

One such program is outlined by Johnson et al. In 1998, the University of Pennsylvania School of Medicine developed a comprehensive model for a minority medical school faculty development that spans from pre-medical students to medical students and residents, to current faculty. The goal is to develop a pipeline that supports and motivates minority individuals to pursue academic medicine as early as possible (35). At the faculty level, recruitment strategies were developed, and several areas of support are offered to the hired minority physicians. These include general career counseling, mentorship, research development opportunities, and presentation skills, all of which contribute to increased success in the promotion to associate professor. Many other institutions have followed in a similar vein of developing diversity and inclusion offices geared towards recruitment and retention of minority faculty, with great success (34,45). An important similarity in these programs is the emphasis on developing pipeline programs. Medical student diversity is one the strongest factors associated with faculty diversity and so schools must commit to addressing faculty diversity as early as possible (46).

Increasing the number of minority physicians should be a priority for medical schools in order to foster positive and healthy perceptions of medicine and academia. An important consideration here, however, is recognizing that the immense contribution that URM faculty have to education does *not* mean the responsibility of teaching the doctoring curriculum should be placed solely on their shoulders. The effect of this "minority tax" is easily witnessed by the minority students they mentor (24,47,48). In her book entitled *Faculty Diversity: Problems and Solutions*, Joann Moody postulates that minority students are aware of the burdens forced upon minority faculty, including

student mentoring and being perceived as the reigning voice for diversity at their institutions, which then dissuade minority students from pursuing careers in academia themselves (47). The administration needs to straddle the line between recognizing the valuable perspective offered by underrepresented faculty and burdening them with heading the "diversity topics" and causing further isolation. Certainly, the pipeline is important to encourage minority students to pursue academic medicine. But the effort towards retention and creating an environment in which they can flourish is just as, if not more, essential.

Integrated Sessions

In medical school, there is the concept of spaced repetition: repeating the same questions or concepts at regular intervals to increase memorization and understanding. People tend to learn from exposure. The more times something is encountered, the more likely it is to "stick" (49–51). This is universally known and practiced by medical students with the conventional curriculum and should be practiced with the ethics curriculum as well. Just as we learn by seeing the same concepts over and over again in flashcards and textbooks, so too must we be encouraged to revisit the material and have more opportunities to come back together after having a chance to sit and reflect on the topic. This would allow students to express thoughts they didn't have time to share or were not able to articulate earlier. An ethics curriculum that is integrated both vertically and horizontally is crucial to achieving this goal.

The question of course is how would this work in an already full schedule, with unmotivated students? One approach is using online discussion boards to encourage conversation and personal opinions. Online learning "offers the possibility to learn from anywhere, anytime, in any rhythm, with any means" (52). This tactic is utilized by many clerkships in the clinical years and prompts students to take their time and articulate their thoughts. In this setting, there would ideally be a long-running open forum for students to visit regularly to post and reply to each other's posts (and be prompted to do so at regular intervals). This has the added benefit of encouraging student-led discussion and centering the voices that would otherwise be stifled, a point we will revisit shortly.

As mentioned previously, in most schools, the ethics sessions are essentially finished after students complete their preclinical years and start their clinical clerkships, which leaves students without support on how to address the issues they are finally starting to encounter themselves (25,53). Students are expected to recall their previous teaching and apply it on their own, but this ongoing process of laying down ethical groundwork is undermined if there is no continued reinforcement or guidance along the process. Instead, students are unconsciously prompted to adhere to a hierarchical and binary hospital environment with its own hidden curriculum (26). Therefore, it is of the utmost importance that we encourage the expansion of the ethics curriculum into clinical years that *directly* and *intentionally* works to counteract the effects of the hidden curriculum on students and residents.

Several integrated ethics programs of note have been implemented in recent years (21,22,54). In 2020, Sullivan et al proposed a 4-year long peer-directed program that

allows students to enhance their own moral and ethical identities using a variety of different components including lunch and learn sessions, peer-facilitated ethics presentations, mentoring sessions, student ethics committee talks, shadowing a hospital ethics committee or pastoral care, and an ethics capstone project (54). As another example, Cook et al. describe an integrated model with graduated pillars of learning that involve teaching medical ethics in-person, reinforcing them through online forums, and eventually implementing their learnings in a community setting (22). This model is similar to the Masters in Urban Bioethics program that this medical school offers, which provides in-depth education to those who want to actively increase their understanding of ethics. However, these programs are voluntary and attract those who have an existing interest in advanced training. For all medical students to gain exposure to the field, a program truly integrated into the conventional curriculum is needed.

Elements of these can be adopted and implemented into the traditional curriculum, in addition to the structured presentations offered in a large group setting. One feasible option would be to require students to shadow a hospital or school ethics committee during their clinical clerkships. Another is to encourage students to identify ethical situations in their patient interactions and present their deliberation and moral reasoning for choosing the final course of action. This can be done in a similar format to the Evidence-Based Medicine projects that are completed in most core rotations. Additionally, students should be offered opportunities to have unguided ethical discussions and reflect on their experiences. Ideally, this should include the participation of residents and attendings so as to reinforce the importance of ethics across all levels of healthcare and help form healthy interpersonal workplace dynamics. There are several

other strategies that can be implemented for longitudinal and integrated learning. It should also be noted that most of these can easily be integrated into residency training as well to allow for continued invaluable opportunities for education and growth (30,55).

Student-Led Discussions

Many studies on the topic of teaching ethics in medical school have proposed student-led discussions as an effective method of instilling the goals and objectives of the curriculum to the students (22,54). This school does utilize this method to an extent, mainly within the small classroom sessions, by encouraging - but not forcing - participation. This is a difficult solution to implement, but if done correctly, it could have an immense impact on the students' understanding and critical thinking. As mentioned above, there are several students who have more knowledge of and experience in several of the topics being discussed. To not acknowledge their experiences and input would be a detriment to them and their peers.

At the same time, one must be cautious of the burden that can be placed on the students asked to speak on their experiences and "teach" their peers. If done *recklessly*, it creates an arguably more harmful environment where the student unfairly bears the responsibility of "teaching" their peers and preceptors. Such dependence on individual students to speak on their views raises the possibility of that students' experiences becoming generalized, and risks adding onto the emotional and mental toll discussed earlier. Perhaps the most important detriment to relying on students with lived experiences to guide discussions is that such sessions can border on voyeuristic. Such a

format necessitates a high level of vulnerability from the student facilitator that may become invasive and risks the student becoming a spectacle upon which their peers can gaze upon. In her 2000 article, Patricia Hill Collins spoke on the tenuous relationship between the majority group and minority individuals as a passive and ineffective in creating compassion:

> From the perspective of the privileged, the lives of people of color, of the poor, and of women are interesting for their entertainment value. The privileged become voyeurs, passive onlookers who do not relate to the less powerful, but who are interested in seeing how the "different" live. (56)

It is incredibly disrespectful to the student and may only further the sense of "othering" that minority individuals experience. It further positions the onlooking peers as the majority group, as it frames their perspectives as the dominant experience to which we compare our own relative privilege. This particular solution can only be beneficial if the perspectives of the minority students are intentionally centered. It is known that this can be impactful - it was done in the wake of the George Floyd protests last summer. The Facebook page of one class initiated their own discussion and feelings about the events and the circumstances leading up to that point, and the result was a very thoughtful, introspective, and constructive dialogue.

Of course, student leaders need not be underrepresented minorities, who are pressured to precariously steer discussions of identity that are deeply personal but will inevitably nonetheless be seen as representative of an entire community's experience.

Instead, any individual should be encouraged of their own volition to guide dialogue with a group of un-like-minded peers. Care must be taken to ensure that the students facilitating the discussion are not dominating the exchange, but instead are equally held responsible for their words and subject to challenge by their peers. Such a setting may ensure more genuine discussion and simultaneously act as a practice of humility and introspection.

In an academic setting, this can perhaps be initiated using literal round table discussions (as opposed to being in a classroom) where the students are all sitting and facing each other, cannot use their laptops, and cannot be disengaged. This guarantees face-to-face interaction and prevents avoidance of uncomfortable topics. This can be combined with the longitudinal online forums mentioned above to provide additional avenues for conversation. It is also imperative that discussions be based on individual perspectives and not allow students to speak on behalf of others, nor should the comments of one student be taken to speak on behalf of others. All students will have agency and all students will be held accountable for their own words and actions.

Bioethics Training for all Faculty

Many of the medical schools have faculty who have completed training before a medical ethics curriculum was put in place at all, and before this new socially conscious paradigm began to infuse itself into health care. It is expected that the physicians with whom students may not have much to say on the topics they are learning about. However, the faculty members that are responsible for direct education in our classrooms should be

expected to know and understand all the issues in the medical curriculum, including ethics, which is sadly not the case (57). To address this deficiency, faculty training programs should be implemented in every medical institution, and even more so prioritized in schools that do not have the resources to hire an adequate amount of ethics and law experts (58).

Throughout the years, several institutions have developed and implemented programs that focus on increasing educators' ethical knowledge and level of self-awareness. One such example was an international "teach-the-teacher" course that was implemented with the goal of motivating physician educators to recognize and analyze ethical concerns in teaching medicine. Participants were organized in small groups and discussed ethical dilemmas in case vignettes that were adapted from published examples or written by medical students. Large group sessions were also used to explore basic principles in ethical reasoning. After completing the course, the participants reported an increase in their knowledge and recognition of ethical issues in clinical scenarios, and in their recognition of their own culturally learned understanding of right and wrong (59). This format is similar to that of the students' ethics courses, and should similarly be a requirement for the faculty participants. Furthermore, this assessment should be a consistent process. Physicians are expected to continuously reinforce and update their specialty-specific medical knowledge; so, too, should they be required to regularly strengthen their ethical knowledge and enhance their ability to reflect on those moral dilemmas.

These initiatives should be especially geared towards faculty preceptors who are often tasked to facilitate ethical discussions. However, similar interventions should also be implemented in the larger clinical setting, as all physicians hold an educator role to some extent, and should therefore be prompted to recognize the impact their own behavior has on trainees. The hidden curriculum too often leads to the imitation of cynical and rigid behavior that underemphasizes the importance of ethical reasoning. Nevertheless, role modeling will always unconsciously happen in a clinical setting and should be used consciously by teachers to inspire positive behaviors in their trainees. A trained physician should be able to reflect on their own values and motivations for making clinical decisions and establish communication with students and peers to encourage this level of self-reflection within themselves (11,21,60,61).

A Refined Admissions Process

Of course, the above measures (hiring bioethics faculty, encouraging peer-led discussions, etc.) can only do so much if the students in these sessions are not amenable to having their beliefs challenged and considering different perspectives. The admissions process is the first step in educating future physicians. In that case, admissions committees should more carefully select the students that are accepted. The applicants given the opportunity to matriculate into medical school should be those who are *already* of sound moral character. This is a point that has been stressed early in the development of the medical ethics course: “A medical-ethics curriculum is designed not to improve the moral character of future physicians but to improve those of sound moral character with

the intellectual tools and interactional skills to give that moral character its best behavioral expression" (2). We should not have to create moral physicians from scratch (if there was a perfect recipe to do this, there wouldn't be an issue and this thesis would not exist). Instead, the students we accept should already be virtuous, compassionate individuals with a genuine intention to learn, and the focus should be on teaching ethics and emulating ethical behavior to foster these traits (3,9,62). They should be open and willing to challenge themselves and their perspectives by having open dialogue and learning from one another (2,55,63). To this end, more emphasis should be placed on an applicant's genuine character.

In addition, schools may consider requiring specific bioethical prerequisites courses. If we expect baseline knowledge of biology and chemistry before applying, why do we not do the same for ethics (at that same level)? Why should the first time someone learns about microaggressions be in medical school? As said multiple times, the ethics curriculum should be considered as much of a priority as the conventional medical courses. Of course, this does not mean that applicants need to have taken classes on in-depth ethics, but they should at least have a basic understanding of the foundation of ethics to be built upon in medical school and beyond.

Increased Funding

Let us end this portion of the discussion by stating the obvious: there needs to be more funding for an ethics department or curriculum. While several medical ethics programs are funded by their parent institutions, it is still a paltry amount that reflects its

relative insignificance to the larger traditional medical curriculum (12,56,64). This has been a point of contention for decades. Veatch et al. in 1976 put it aptly: “Medical ethics teaching cannot survive...as a charity case, i.e., a ‘poor cousin’ of programs receiving serious internal and ongoing funding by the parent institution (53)” Medical ethics need to be prioritized, and better supported financially. Many of the solutions mentioned previously can be directly resolved by allocating money towards hiring an appropriate number of personnel who are specifically trained in teaching these topics and are *given the resources* with which to do so.

CHAPTER 5: CONCLUSION

Important Considerations

Of course, even with our best efforts, we cannot expect perfect results, to have class after class of students with equal depth of morality and common values. We are all individuals, first and foremost, with our values and experiences shaping our morals long before we first step into medical school. However, this may be viewed not only as a limitation but as a strength, for the difference in perspective and the pushback from fellow colleagues allow continued conversations and introspection. If the strength of learning lies in discomfort and dissonance, then uniformity of thought will only allow us to languish in our conformity and perpetuate a culture of rigidity and disconnect. We need to be continuously challenged in our beliefs and morals, not so that we change our core values, but so we can refine them, strengthen them, and allow them to guide us more and more in our everyday lives.

Looking Forward

The field of ethics is not just theory and abstract ideas – it extends into real life and governs how we all interact and move through the world. Clinical ethics in particular are crucial for future physicians to understand as it is inevitable that they will encounter situations that will call upon the practice of moral reasoning on an almost daily basis. The purpose of the ethics curriculum is to provide students with the tools to recognize the complexities and intersections of healthcare, patient care, and our own individual

interactions. It is imperative that these concepts are cultivated in medical students in a way that is impactful and meaningful. Prioritizing the ethical education in these students will bring about a culture change that will extend to the greater society. Therefore, medical institutions should present their ethics courses to be on par with the conventional medical courses. Applicants will often examine the rigor of the medical education at their schools of interest; so too should they closely inspect the quality of the ethics curriculum.

In recent years, many medical schools have started restructuring their conventional curricula to adopt a more comprehensive and streamlined approach to teaching medicine. There have been major overhauls and close examination of the best ways to provide students with the best possible education. This includes the factors we've discussed here, and other elements not mentioned, such as ways to assess student's learning, and how to better integrate ethics topics in the preclinical years and extending forwards. This past year in particular has redefined what education looks like. The current pandemic has forced us to reassess, readjust, and react in order to continue teaching effectively while still acknowledging the physical and emotional toll that the COVID-19 virus has taken on everyone and respecting the limitations it enacts. Face-to-face learning in small group sessions has been shown to be a more effective teaching method, but the current situation has forced academic institutions to change their strategies as they transition to online teaching (19,20,65). While there have been many obstacles encountered during this transition process, there is a silver lining: this re-structuring provides a perfect opportunity to re-examine the ethics curriculum and integrate new strategies alongside the conventional curriculum.

We have made great headway in improving the ethics education, and we should celebrate the strengths of the curriculum. Still, we must continuously be critical of its weaknesses and searching for ways to better reflect its importance in our healthcare system. Only in this way can we even hope to develop an interconnected system of genuinely ethical doctors with professional virtues and the ability to make morally sound decisions for the benefit of patient care.

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