The Need for Medical Ethics Education in Family Medicine Training

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Professional and accreditation organizations have endorsed medical ethics as a fundamental component of education for family medicine trainees. Yet various obstacles combine to work against the continuation of formal medical ethics education beyond medical school and into residency training. This article reviews the current consensus on the scope and objectives of medical ethics education in the context of family medicine training. The need for, and outcomes of, medical ethics teaching are analyzed on the basis of the available evidence. Recent trends in medical education that potentially influence graduate medical ethics training are also discussed (specifically ethics training in medical schools and the priority given to training in professionalism). This review shows a strong evidence-based need to provide medical ethics education for family physicians in training, a need that is apparent on many levels. The current reliance on medical school ethics education and emphasis on professionalism does not answer this need. A well-constructed course in medical ethics for family medicine trainees can teach an array of competencies stipulated by professional and accreditation agencies as important in the practice of family medicine. Educators must strive to overcome barriers and provide formal medical ethics programs to better prepare family physicians for modern professional roles.

Medical ethics education for family medicine trainees currently presents a conundrum. Graduate education accreditation bodies and professional organizations in family medicine agree that knowledge of medical ethics and the practical application of clinical ethical reasoning skills are essential components of what it means to be a family physician. Yet, there are strands of evidence to suggest that medical ethics education is not provided in many family medicine training settings. This article reviews the current consensus on the scope and objectives of medical ethics education in the context of family medicine training. The need for medical ethics teaching is analyzed on the basis of the available evidence, and proven outcomes are summarized. Recent trends in medical education that potentially influence graduate medical ethics training are also discussed (specifically ethics training in medical schools and the priority given to graduate training in professionalism). This updated appraisal of the value of medical ethics training for family physicians provides a springboard to defining the future direction of medical ethics education for family medicine trainees.

Broad Scope and Clinical Relevance of Medical Ethics

Medical ethics as a discipline has roots in philosophical principles. These principles in turn form the basis of societal and moral values, professional codes of conduct, and laws integral to the practice of medicine. Because of this broad foundation, ethical issues arise in, and have implications for, many aspects of medical practice, from the intimate dynamics of the doctor-patient relationship to the expansive reaches of social justice and health policy. This means that medical ethics has a broad scope and far-reaching clinical applicability (Table 1).

Over the last 3 decades, medical practice has been increasingly complicated by the emergence of moral conflicts in medical care and clinical research, an increased emphasis on patient centeredness in the doctor-patient relationship, the development of sophisticated medical technology, and the influence of legal and health system factors on clinical care. For these reasons, medical ethics is now considered a key foundational component of...
Medical ethics education must change to custom fit hierarchical status within the medical team, new clinical environments, such as the physician’s changing working environments, such as the physician’s different stages of medical training. This is related to education beyond medical school. It is also recognized that ethical challenges vary at different stages of medical training. This is related to changing working environments, such as the physician’s hierarchical status within the medical team, new clinical experiences, and heavier clinical responsibilities. Medical ethics education must change to custom fit learning needs at each stage of training to enable the student to adapt to stage-specific ethical challenges. During specialty training, medical ethics education must further evolve to prepare the trainee physician for those specialty-specific ethical problems that commonly occur in their chosen field. As stated by many commentators, training in medical ethics should build upon the foundational knowledge learned in medical school and continue into postgraduate and continuing professional development, integrated horizontally and longitudinally throughout medical training.

The Need for a Continuous Learning Process

Is this foundational knowledge enough to carry a graduate physician into clinical family medicine? Unfortunately, knowledge in ethics gained in medical school is well documented as suffering from variability in content, quality, and consistency. Since newly qualified physicians have varying levels of confidence and competency in dealing with ethical dilemmas, it is important to provide continuing and reinforcing ethics education beyond medical school.

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Table 1

Broad Scope and Clinical Applicability of Medical Ethics Education

(1) Informed consent and refusal of treatment: why respect for autonomy is so important, adequate information, treatment without consent, competence, battery, and negligence.
(2) The clinical relationship: truthfulness, trust, and good communication: ethical limits of paternalism; building trust; honesty, courage, and other virtues in clinical practice; narrative and the importance of communication skills.
(3) Confidentiality: clinical importance of privacy, compulsory and discretionary disclosure, public versus private interests.
(4) Medical research: ethical and legal tensions in doing medical research on patients, human volunteers, and animals; the need for effective regulation.
(5) Human reproduction: ethical and legal status of the embryo/fetus, assisted conception, abortion and prenatal screening.
(6) The new genetics: treating the abnormal versus improving the normal, debates about the ethical boundaries of and the need to regulate genetic therapy and research.
(7) Children: ethical and legal significance of age to consent to treatment, dealing with parental/child/clinician conflict, child abuse.
(8) Mental disorders and disabilities: ethical and legal justifications for detention and treatment without consent; conflicts of interests between patient, family, and community.
(9) Life, death, dying, and killing: the duty of care and ethical and legal justifications for the nonprovision of life, prolonging treatment and the provision of potentially life-shortening palliatives; transplantation, death certification, and the coroner’s court.
(10) The duties of doctors and medical students: public expectations of medicine, the need for teamwork, the health of doctors and students in relation to professional performance, professional regulation, clinical mistakes, whistle-blowing.
(11) Resource allocation: rationing and the fair and just distribution of scarce health care; the relevance of needs, rights, utility, efficiency, desert, and autonomy to theories of equitable health care; boundaries of responsibility of individuals for their own health.
(12) Rights: what rights are and their links with moral and professional duties; the importance of the concept of rights, including human rights, for good medical practice.

Source: The Core Curriculum in Medical Ethics and Law for United Kingdom Medical Schools.

Research Issues Occur Commonly in Family Medicine

Specialty-specific training in ethics is especially important for family physicians. Ethical challenges not only occur frequently in everyday family practice but can also be potentially complex. In one study conducted in a primary care office, almost one third of patients presented ethical problems that influenced their health care. This ethical complexity is related to the very aspects of the job that define it as family medicine. These characteristics of family medicine entail inherent uncertainties, conflicting responsibilities, and “pervasive moral dimensions,” all of which underscore the need for medical ethics education for trainees.
Ethical Issues Cause Errors in Medical Practice

There is no doubt that ethical issues cause physicians difficulty in clinical practice. Recent studies have shown evidence of errors in physicians’ judgment related to ethics-related subject areas such as informed consent,1,12 end-of-life care,13 and the provision of information to patients regarding certain morally difficult medical procedures (such as terminal sedation in a dying patient or abortion after failure of contraception).14

In several studies, primary care residents,5,15-17 and practicing physicians18,19 have themselves identified a curricular need for more medical ethics education training. For example, in one study by Kenny and colleagues, physicians recognized that they lacked a systematic approach to the identification and analysis of ethical issues and explicitly expressed a need for more training.19 These studies provide further support for continuing training in medical ethics.

Changing Roles of the Family Physician

Family physicians are often in the front line of organizational and social change and must be able to adapt to the increasing complexity of medical care options, expectations of personal and professional accountability, the predicted increase in cultural diversity of patients, and the constant evolution in health system organization. The attributes taught in medical ethics (the ability to identify, analyze, and balance complex ethical conflicts at the patient and health system level, and to explicitly justify decisions) provide a foundation for these roles. This expanding role of the family physician in the future health care environment is another compelling reason to ensure a commitment to quality education in medical ethics.

Professional Organizations and Society Expect These Skills

The need to provide an expanded and specialized training in ethics for family medicine trainees has been recognized by graduate accreditation bodies and other professional organizations internationally. The Royal College of General Practitioners (RCGP) in the United Kingdom, the College of Family Physicians of Canada (CFPC), and the American Academy of Family Physicians (AAFP) have all published specific learning objectives for medical ethics course content for family medicine trainees.20-22 The Canadian College has gone as far as producing a 30-page Family Medicine Bioethics Curriculum to “facilitate ethics education in family medicine training programs.”23 The perceived importance of medical ethics education in family medicine training is demonstrated by the inclusion of questions on medical ethics in the RCGP and American Board of Family Medicine certification exams. The RCGP and CFPC23 further stipulate that work-based competence in medical ethics must be demonstrated before trainees are allowed to practice as family physicians.

The overall aims of this training, as defined by the RCGP and Canadian College are presented in Table 3 (AAFP’s list of learning objectives, while providing an extensive description of specific objectives, does not delineate overall goals). Similar objectives have been stated in studies describing ethics education in family medicine24,25 and in primary care training programs (which include family medicine, internal medicine, and pediatrics).6,26 Additional goals identified as essential include recognition of the scope of ethical issues in medicine,27,28 an understanding of ethical issues related to distributive justice, health resource allocation, and managed care27-29 and the ability to “be prepared to take responsibility for shaping some part of the health care system in accord with your own values.”25,30

The aims of medical ethics education in family medicine therefore tend to fall into the following domains: (1) recognition of the scope of ethical issues in family medicine, (2) awareness of values (self/patient/societal/professional/conflicting), (3) development of analytical and reasoning skills based on knowledge of ethical principles, professional obligations, and the law, (4) development of communication skills to enhance the doctor-patient relationship and to resolve conflict, and (5) an understanding of health resource allocation.

Table 2

Characteristics of Clinical Family Medicine That Generate Ethical Problems

- The emphasis on the patient as a psychosocial being, presenting in the context of culture, family, and community.
- The existence of social and cultural diversity in the patient population.
- The involvement in decision-making processes of multiple stakeholders, more than one of whom may be the physician’s patient.
- The interaction of the physician with vulnerable patient populations such as minors and the mentally disabled.
- The physician’s responsibility to manage the full spectrum of health conditions.
- The involvement of patients of all ages in the patient population.
- The pressure of conflicting duties on the family physician due to health care system organization and change.
**Table 3**

Aims of Medical Ethics Education in Family Medicine Training, United Kingdom and Canada

<table>
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<tr>
<th>Royal College of General Practitioners</th>
<th>College of Family Physicians of Canada</th>
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<td>Recognize the ethical dimension of every health care encounter. Understand the nature and impact of values in health care, including personal values.</td>
<td>The teaching of behaviors that reflect the values, attitudes, and character traits required of a good family physician—emphasizing empathy, compassion, caring, and critical self-reflection.</td>
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<tr>
<td>Demonstrate moral reasoning skills in choosing a course of action or resolving conflicting values.</td>
<td>The teaching of analytical skills in a systematic and comprehensive manner suitable to the identification and resolution of ethical issues inherent in family medicine.</td>
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<tr>
<td>Knowledge of the professional ethical guidelines and the legal framework within which health care decisions should be made.</td>
<td>The teaching of a knowledge base of the relevant bioethics and medico-legal literature pertaining to ethical issues inherent in family medicine.</td>
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<tr>
<td>Demonstrate the knowledge, skills, and attitudes for effective communication in eliciting and understanding the values of patients, negotiating an acceptable course of action and justifying that course of action.</td>
<td>The teaching of interpersonal communication skills to reflect these attitudes, promote an effective physician-patient relationship, and facilitate conflict resolution.</td>
</tr>
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Bold text added to emphasize common attitude, knowledge, and skill domains.

Source: Royal College of General Practitioners and College of Family Physicians of Canada\textsuperscript{20,21}

Distributive justice, and the role of the physician in advocating for organizational change.

These objectives are the product of research by opinion leaders as well as task force discussions by professional organizations and include input from patient groups and other stakeholders in medical education. As such, these reflect the knowledge, skills, and attitudes expected from family medicine training by the profession and by the many sectors that constitute the public. These professional and societal expectations provide additional validation of the need for medical ethics training for family physicians in training.

**Outcomes of Medical Ethics Education**

Methodological difficulties preclude the design of studies to assess the effect of medical ethics education on patient satisfaction and health outcomes. Is there any evidence that an education in medical ethics does, in reality, provide the expected knowledge, skills, and attitudes?

In fact, there is substantial empirical evidence that medical ethics education can improve physician attitudes, awareness, confidence, knowledge, satisfaction, ethical analysis skills, and decision-making ability. Formal curricula in medical ethics for residents have resulted in significant improvements in these attitude, skill, and knowledge domains.\textsuperscript{15,31-34} In one study by Sulmasy and colleagues, in which medical house officers completed an innovative curriculum in medical ethics, improvements in knowledge, confidence, ability to recognize an ethical problem, and ability to reach a justifiable decision were sustained over 2 years.\textsuperscript{15} The ethics course in Sulmasy’s study also resulted in significant attitude changes, with an increased proportion of residents recognizing that ethics should be a required part of the residency curriculum. The characteristics of these courses for residents included: predetermined learning objectives; an explicit and planned curricular design; a mandatory requirement to participate; formal assessment of attitudes, knowledge, and/or skills; assigned faculty with responsibility for the ethics curriculum; and protected curricular time for either an intensive course in ethics or regular (usually monthly) sessions over the 2-or 3-year residency period. Case-based, small-group discussions were the preferred pedagogical method. Ethics ward rounds and role modeling by faculty were also advocated to encourage horizontal integration of learning.

Surveys of practicing physicians who had completed a course in medical ethics have shown an increased interest in, awareness and understanding of the ethical dimensions of practice, and a belief by physicians (after training) that medical ethics courses are advantageous in managing clinical dilemmas.\textsuperscript{34-36} Formal medical ethics training has also been shown to improve health professionals’ abilities to analyze ethical issues in a critical manner.\textsuperscript{37} These studies provide strong evidence that the aims of medical ethics education defined by professional organizations and society are, in fact, attainable and that achievement of these aims is highly valued by residents and physicians.

**Medical Ethics Education in Family Medicine Training: Barriers**

Despite this ostensible strong endorsement of medical ethics education in family medicine training, there
is evidence that this endorsement is not translated into a wholehearted commitment to actually provide formal medical ethics education in training settings. Instead, this vital topic is “given lip service but not substance.”

**Lack of Scholarly Debate and Collaboration**

Although it is likely that training programs do provide some form of ethics instruction, there is no published evidence as to the quality or aims of this training. A literature search of OvidMedline, conducted in September 2007 (search terms included: “family medicine,” “ethics education,” “residency,” “curriculum,” “medical ethics,” “general practice,” and “family physician”) found only two papers published in the last decade describing model curricula in medical ethics, specifically for family medicine training programs. Only one additional curriculum in medical ethics, relevant to family medicine training, has been published on curricular repository Web sites. These Web sites include the Family Medicine Digital Resource Library, the American Society for Bioethics and Humanities Syllabus Exchange Project, Medical Education Online, and MedEdPORTAL. Further, there are no recent survey data reporting on the prevalence, organization, content, quality, or assessment of medical ethics programs in family medicine training. This dearth of publications implies a lack of interest in the progression of medical ethics as an educational intervention in family medicine training.

Practical problems have long been associated with ethics education, such as time constraints, scheduling difficulties, lack of continuity, attitudes of residents, and inadequate training of faculty. Guidelines provided by professional organizations at best provide only the basic outline of a curriculum in ethics. For educators constructing a course in medical ethics, the absence of published guidance not only impedes the resolution of logistical and practical problems but also means that educators must start from scratch in developing appropriate aims, curricular content, teaching methods, relevant outcome measures, and evaluation techniques.

**Professionalism as the Priority Topic**

Recent educational initiatives to promote professionalism as a priority potentially influence the approach to medical ethics training in family medicine, especially in the United States. Professionalism re-emerged as a topic of special emphasis in 2002, when the “Charter on Medical Professionalism” was launched to counter various recognized threats to medical professionalism. Subsequently, the Accreditation Council for Graduate Medical Education (ACGME, which is the organization that accredits medical residency programs in North America) allocated special prominence to professionalism as one of six general competency requirements for graduate residency programs. For educators, faced with tough options about what to include in limited educational time, this has implied a preference for teaching professionalism over medical ethics.

However, medical ethics has a broader scope than professionalism: medical ethics-related topics actually underpin the ACGME recommendations throughout all six general competencies as “a fundamental cornerstone of recommended education for all residents.”

Table 4 shows the extensive number of medical ethics-related topics other than professionalism included in the specific ACGME competency requirements for family medicine residency programs. The ACGME recommendations therefore endorse the teaching of medical ethics as well as professionalism.

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**Table 4**

ACGME Requirements for Family Medicine Related to Medical Ethics

**Program requirements:**
- The ability to educate the patient and family about the diagnoses, evaluation, and treatment of the disease; to obtain informed consent; and perform appropriate procedures.
- Cost-conscious ordering of diagnostic tests and therapeutics.
- The providing of guidance to patients regarding advance directives, end-of-life issues, and unexpected diagnoses/outcomes.

**Documented on the Program Information Form:**
- Patient interviewing skills.
- Counseling skills.
- Knowledge about factors affecting patient compliance.
- The physician-patient relationship.
- Experience in developing programs to address community health priorities.
- A commitment to carrying out professional responsibilities and an adherence to ethical principles.
- Competence in the elements of systems-based practice: work effectively in various health care delivery settings and systems, coordinate patient care within the health care system, incorporate considerations of cost-containment and risk-benefit analysis in patient care, advocate for quality patient care and optimal patient care systems, and work in interprofessional teams to enhance patient safety and care quality.
- Factors associated with differential health status among subpopulations.
- Determining value in the marketplace.
- Identification of strengths, deficiencies, and limits in residents’ knowledge and expertise (self-reflection and self-assessment).
- Competence in communicating effectively with patients and families across a broad range of socioeconomic and cultural backgrounds and with physicians, other health professionals, and health-related agencies.
- Sensitivity to gender, race, age, and cultural differences in patients.
- Medical ethics, including patient autonomy, confidentiality, and issues concerning quality of life.

ACGME—Accreditation Council for Graduate Medical Education

Source: ACGME Program Requirements for Graduate Medical Education in Family Medicine Education and the Program Information Form.
Conclusions

Evidence shows that, in everyday primary care practice, ethical issues are commonplace and potentially complex. Residents and physicians are known to experience difficulty in weighing up certain clinical ethical issues; in numerous studies, these groups have recognized medical ethics training as beneficial to clinical practice. There is also an expectation that medical ethics training will equip the family physician for a future role as manager of health care resources, advocate for patients and communities, and leader for organizational change. Training in medical ethics is recognized as fundamentally important to the practice of family medicine by professional organizations, accreditation agencies, and by society.

Medical ethics education gained in medical school does not answer this need for family medicine-specific ethics training. Similarly, the teaching of professionalism alone cannot address this broad range of needs. Neither can these needs be addressed solely by a physician’s moral intuition, life experience, or common sense. Formal training in medical ethics has been shown to provide graduate physicians with essential knowledge and analytical skills that nurture confidence in decision-making abilities, at the same time providing skills of relevant practical use in the clinical world. The evidence suggests that a well-constructed course in medical ethics for family physicians in training can provide an array of competencies stipulated by professional and accreditation bodies as important in family medicine. At the same time, this training complements and reinforces overlapping areas of competency such as communication skills, professionalism, and cultural competency.

For all of these reasons, educators must find ways to kick-start or strengthen formal medical ethics courses in family medicine training. This new direction needs to incorporate scholarly debate, dissemination of pedagogical materials and research by publication and the use of Web-based curricular repositories, the sharing of curricular innovation through meetings of medical ethics educators in family medicine, faculty training in medical ethics to reinforce trainee education, and collaboration with organizations invested in family medicine education (such as the RCGP, CFPC, the Society of Teachers of Family Medicine, and the Association of Family Medicine Residency Directors) to develop a flexible model curriculum and a bank of teaching resources.

This will lead to a wider recognition of the value of medical ethics, a clearer picture as to how the teaching of medical ethics and professionalism should overlap, the beginnings of longitudinal integration of ethics training from medical school through to continuing professional development, and, above all, the achievement of an improved quality of education for family physicians in training. Medical ethics, a valuable team player in the making of future family physicians, must not be allowed to languish on the sidelines of family medicine education.

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