In Focus Article

The Moral Domain of the Medical Record: The Routine Ethics Evaluation

Alfred I. Tauber, Center for Philosophy and History of Science, Boston University, Boston, MA

The structure, content, and orientation of the contemporary medical record inadequately reflect the appropriate influence of patients' rights and bioethics on health care. Most tellingly, the medical chart reveals a remarkable absence of attention to medical ethics, except in the case of crisis management. But medical ethics informs both crisis decision-making and virtually all clinical interventions. Indeed, clinical care embodies a complex array of choices influenced by individual and cultural values, themselves reflecting religious beliefs, personal histories, psychologies, and social mores. But the typical medical chart, which records clinical descriptions, analyses, and rationales for treatment, rarely identifies or accounts for this value-laden dimension of care and thus both over-simplifies and distorts the depiction of a patient's illness and its treatment. To better reflect the complex moral domain of clinical care, and assist in organizing its complex structure, a systematic procedure is proposed here to evaluate the ethical status of every patient: As a *routine* part of the clinical evaluation, in a designated *Ethical Concerns* section of the medical record, an "ethics work-up" is designed to serve as a moral 'diagnostic' analogous to its scientific counterpart. Adapted to the needs of individual patients, such evaluations should identify ethical problems, coordinate related data, resources, and opinion, and define the rationale for choices made and actions pursued. In establishing improved integration of the 'epistemologies' of care and the 'ethics' of care, the goals of a more humane, patient-centered medicine may be better met.

Keywords

Medical ethics
medical record
ethics work-up
ethics education
patient care

INTRODUCTION

This paper arose from discussions at my home institution, Boston University School of Medicine, about how to teach medical ethics more effectively to students and house staff, which led to perhaps an even more daunting challenge: How to increase the *explicit* exercise of moral reasoning among our clinical faculty. Thus, my proposal begins with the premise that making ethical concerns more central to patient care is laudable, and given my perspective as a physician, the strategies I am advocating are primarily directed at altering the doctor's behavior. The moral posture espoused here does not go uncontested, but without the endorsement, and leadership of physicians, the well-meaning efforts of bioethicists will remain peripheral to health care. I hasten to add, however, that the reform described below is hardly restricted to disciplining physician behavior, but is designed to provide a forum by which all members of the multi-disciplinary health care team can participate more effectively in the care of the patient.

Simply, this proposal describes a vehicle by which the moral domain of care may be explored as a *routine* matter. A designated portion of the medical record, an *Ethical Concerns* section, is designed to assemble all relevant data and coordinate decision-making that relates to the social and psychological dimension of care. This effort brings the moral domain, the space in which value judgments derived from the patient's perspective, to prominence. A deliberate effort to define such "patient-centered" care demands that articulation of the patient's personal concerns be given full voice. Thus improved communication between patients and the health care providers (HCPs), as well as better clinical coordination (with better integration and quality of care), are expected from adding an ethics work-up as a regular part of clinical evaluations.

The American Journal of Bioethics, 6(4): W1–W16, 2006

ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265160600843544

The discussion begins with a review of contemporary medical ethics training in the United States, specifically the status of curricula (irregular), the rationale for such education (disputed), and the empirical basis for claiming effective interventions (fragmentary and indecisive, at best). In short, the purpose, content, teaching methods, and means to measure the success of ethics education are contested and extensively debated despite a general consensus on its overall goals (Culver et al. 1985). The confused state of medical ethics education reflects the absence of a widely subscribed mandate for ethics, which in turn reflects the unsteady status of ethics at the bedside despite the enormous advances made over the past thirty years to protect patient rights. I do not believe that the typical efforts of curricular reform can satisfactorily address the underlying resistance to placing medical ethics on a firm grounding in the *ordinary* care of the patient. To do so, a shift in physician attitudes must be made. This will not be accomplished by revamping ethics readings, adding ethics conferences, or facilitating ethics consults, each of which assigns ethics a supportive role to care (e.g., Glaser and Miller 1993). Not to disparage these efforts, support from ethicists is typically sought at times of crisis, and within that extraordinary context, the role of "ethics" is narrowly regarded as a means to negotiate confounding dilemmas. Crisis management is obviously important, but I seek to place medical ethics at the center of patient care as a *routine* matter. In short, I want to move medical ethics training from the classroom and conference to the bedside.

Instead of seeking pedagogic reforms, I propose focusing efforts on altering basic attitudes about the relation of medical ethics and patient care: By proactively identifying ethical concerns as a routine part of the diagnostic process, explicit moral reflexivity will become a constitutive element of day to day life in the clinic and hospital. To do so, I suggest abandoning the status quo of "ethics as crisis management," and instead, fix "moral reflexivity" in the foreground of *praxis*. To place ethics in the customary evaluation of illness requires a significant shift in professional attitudes and a mechanism for cognitive disciplining. Various philosophies describing patient-centered care have been espoused, and some have made tentative progress. This proposal may be regarded as contributing to that effort in a direct and simple fashion: On one hand, the Ethical Concerns section of the chart deepens data-gathering of what should be a routine sort; on the other hand, by making such an effort more deliberate, complete, and central to clinical decision-making, a shift from a bioscientific focus to a more comprehensive biopsychosocial attitude is facilitated. In short, a means is provided to make the value structure of decision-making explicit and deliberate.

TAKING MEDICAL ETHICS SERIOUSLY?

The agenda of medical ethics is still contested. With virtually no detailed guidelines from governing boards, the reforms sought at every level of medical education cannot follow simple directives by those who seek a more comprehensive moral education. Despite new general goals issued by various medical education governing boards, the failure to adequately address ethics education or more effectively make medical ethics a central concern of HCPs continues to frustrate those who advocate an increased commitment to ethics education.[1] With the majority of US medical schools undergoing major curricular reform in 2001 (Barzansky and Etzel 2001), re-thinking on this matter seems opportune.

Addressing the challenge of enhancing the role of medical ethics in daily practice ranges from emphasizing the practical necessities of dealing with ethical issues in an increasingly demanding profession to moral self-reflection as a virtue of professional performance. In the first instance, the typical advocate cites the steady and powerful advances of medical technology, which have spawned new ethical dilemmas. In this arena, educators must prepare clinicians to face difficult predicaments resulting from an ever more sophisticated technology. A variant of this position concerns the pragmatics of care: Some have suggested that clinical performance is linked to moral judgment. Doctors who possess more developed moral reasoning skills may be more competent in the clinic (Sheehan et al. 1980), and this moral awareness is putatively correlated with

1. Although calls for enhanced ethics training began in the 1960s (Guttentag 1960; Jonsen 1998), standardized medical curricula in the United States still do not exist. In recent surveys of US medical schools, at least 39 different topics are covered, and only six content areas were taught in a majority of schools: informed consent (85%), health care delivery (75%), confidentiality and privacy (67%), quality of life/futility/provision of treatment (67%), death and dying (66%), and euthanasia and physician assisted suicide (60%) (DuBois and Burkemper 2002). Of the 1,191 ethics readings used by US medical schools, only 8 are used by more than six schools, and no reading is used by more than ten schools, which dramatically illustrates that there is no consensus on the relevant literature! (ibid.). But these statistics only reflect a portion of the deep imbroglio about medical education in this area.

moral education (Harvan 1993, p. 361). The optimistic conclusion of such studies promotes the view that education fosters morality, which in turn develops more effective physicians. These views are not universally supported; in fact, the empirical basis of correlating ethics training with clinical effectiveness is hardly impressive.[2]

So an almost choreographed debate unfolds: Those skeptical about the value of ethics education hold that if the medical school curriculum must include liberal arts, not enough time will be left for science. Already, the traditional four-year course of study is often thought inadequate to prepare students for the highly technical and scientific demands of medicine in the twenty-first century. The response is that ethical reasoning skills figure prominently in the clinical decision-making process (Pellegrino and McElhinney 1982, pp. 34–5). One might refer to this debate as weighing the "epistemological" and "moral" claims for physician attention, or viewed from a somewhat different perspective, the struggle over defining the physician's true virtues: Critics see little value in moral sensitivity as a tool of clinical care, while advocates of moral sensitivity believe that discerning and integrating patients' values into clinical care is essential to competent clinical practice. This latter position consists of two defenses, one based in moral philosophy and the other in medicine's epistemology.

Edmund Pellegrino and David Thomasma have presented the most compelling arguments for the virtue of fostering moral sensitivity as an end in itself, not for its epistemological or practical utility, but for its moral value (Pellegrino and Thomasma 1988, 1993). This position advocates empathy and self-reflexivity as inherent and self-evident values. Ethics training then becomes a central component of education not as a "tool" of effective care or a means of risk reduction or even of applied medical jurisprudence, but rather as the moral guidance system of clinical practice itself, and thus an integrated component of care. In short, "medical ethics" becomes part of the larger humane profession of "doctoring," which is based on the set of abiding moral commitments made by physicians to their patients. On this view, the rationale for ethics training rests on the need to offset the epistemological conceits and professional posturing of physicians as distanced observers and facile technocrats (Spiro 1993). Because medical students are assumed to enter medicine at least in part to address the needs of others, the teaching of ethics aims to restore, or perhaps rejuvenate, one casualty of professional training, namely empathy.[3]

Proponents for a more empathetic ethos, the "humanists," argue against those I will label as "positivists," who maintain that ethics training is not

2. Little progress has been made in evaluating the claims made by education reformers. Though standardized vignette exams (Savulescu 1999) and Kohlberg-based tools (a schema that tracks the sequentially sophisticated stages of moral reasoning [Kohlberg 1984]) have been utilized [Sheehan et al. 1980]), the goal of making students "more humane" is not easily quantified, and the goals of such education have not been clearly defined. Although some studies suggest that even a relatively short amount of time in ethics-oriented course work favorably influences moral reasoning (e.g., Sulmasy et al. 1990), a more concerted effort on the teaching wards is probably more effective (Carmel and Bernstein 1986). In any case, training directed at fostering ethical sensitivity remains an unresolved issue, at best, because a dearth of proper evaluation methods plagues what is already a confused issue (Arnold, Povar, and Howell 1987; Self et al. 1989; Goldie 2000).

3. Even among some sympathetic supporters of a humane ethos, a disturbing demurral is introduced: If one embraces moral sensitivity and its various appendages as integral to good care, can such values be taught in medical school and beyond? The deep permeation of ethics in the personality structure of the HCP supplies the critics of formal ethics training with a salient objection: If ethics and moral views are 'caught' not 'taught,' if they already reside in the deep crevices of moral agency, then students have already acquired their values by the time they reach medical school through family life, church, and societal interaction. Consequently, formal teaching will be unable to modify these pre-established beliefs (Pellegrino and McElhinney 1982, p. 35). Following this line of reasoning, critics of humanities education in medical school almost scoff at the notion that such course work will have a salutary effect on physician behavior. They maintain that compassion and empathy spring forth from the child's earliest socialization and is supported or altered by the vast cultural influences of a society that may or may not foster such precepts. Even the most ambitious humanistic education cannot alone promote increased moral self-consciousness (Roochnik 1987).

Nevertheless, measures must be sought to offset the loss of empathy most students experience as they progress in their training (e.g., Self 1993; Bissonette et al. 1995). On this view, the crucial question becomes, How to reawaken the compassion that inspired (at least in part) students to become doctors in the first place? Those who advocate a more robust moral education argue that the potential gains include "increased care for persons," "increased self-critical attitude" on the part of the physician, "increased capacity for personal growth," "enhancement of patient autonomy," a better understanding of "norms of professional conduct," and finally, "contribution to public policy debates," all due to a heightened humane awareness hopefully achieved through a curriculum devoted to enhancing such qualities (Pellegrino and Thomasma 1981, p. 73–4).

an essential part of medicine, because the aim of the current medical curriculum is to foster objectivity and dispassion, not empathy (Landau 1993). This detachment provides doctors with the proper skills required to deal with patients and their diseases. In the first encounter with the cadaver in the anatomy laboratory, the student is introduced to the stark realities of the clinic, where human suffering is reduced to scientific scrutiny. The ability to exclude personal and subjective feelings functions as a potent psychic defense mechanism, which allows physicians to cope with the traumatic aspects of the clinical encounter (Landau 1993; Cody 1978, p. 54). Objectivity, from this perspective, is both necessary and sufficient for modern care of the patient. Indeed, the values governing clinical objectivity are the foundation of modern medicine and cannot be compromised. On this view, emotional detachment is valuable, for it encourages, and perhaps actually enables, sensible, objective choices. In short, desensitization is both practical and effective.

And, to be sure, for some patients, this detached (de-empathetic) attitude corresponds to their own sense of privacy, and perhaps even their own understanding of the contractual arrangements of contemporary health care. Without the overlay of inter-personal intimacy, the doctor-patient relationship comprises a simpler directive of utilizing expertise, applying technical tools, and leaving the humane supportive elements to the clients and their families. Surveys deny that this "hands-off" position is popular. In 2004, the vast majority of Americans (85%) appear to place more importance on doctors' interpersonal skills than on their medical judgment or experience (!), and failing to establish effective communication is the overwhelming factor that drives patients to switch doctors (WSJ 2004). In that cache of "interpersonal skills," empathy reigns as an ordering principle. Of course, the issue is not either/or, but rather how to attain a more humane care in the face of dehumanizing technology and corporate administration.

THE AMBIGUITY OF MORAL AGENCY

The positivist attitude has a long and distinguished heritage, and a realignment of its values is still resisted in many professional quarters. The Flexner Report of 1910, in advocating a scientific curriculum for American medical schools, also established the clinical-scientist ideal as the model of the twentieth century physician (Tauber 1992). According to that vision, medicine as a science requires that the physician must remove himself from the complexities of emotional attachment in order to achieve optimal objectivity. Indeed, excessive self-reflection is counter-productive to the task at hand, scientific scrutiny. While emotional involvement and even compassionate commitment may be appropriate in another setting, medicine is governed by a different ethos: Proper scientific evaluation, diagnosis, and treatment call for detached objectivity, and, accordingly, empathy interferes with professional conduct. Even if one dismisses this professional portrait as a sorry caricature, few would doubt its influence on the self-image of many physicians. I believe that the resistance to giving medical ethics greater attention resides in this powerful attitude, one that will not be changed easily.

Philosophically, this positivist position rests on making a strict distinction between facts and values: Facts are the province of science (nature has no value, only what humans project upon Her) and values are reflections of human experience—social mores, culture's historical contingencies, and individual psychology. Contemporary philosophy of science has little patience for what is now regarded as a false dichotomy between facts and values (e.g., Putnam 2002). The distinctions are easily collapsed, especially at the bedside. Biomedicine is, despite its putative ambitions, a normative enterprise, which means that clinical science is governed by varying standards and a spectrum of values, which attain their status within a context of health (Richman 2004; Tauber 2005a, 2005b).

'Health' has many parameters, meanings and interpretations, so the clinician is constantly challenged to integrate factual findings with the health needs of the patient. Simply, normative values are embedded in medical practice, so that decisions made in the context of health-seeking are, by definition, determined by individual needs and circumstances. So clinical facts always reside in a complex array of systems that confer specific and often unique meanings to any finding. An integration of unsteady norms and the intuitive inference arising from the individuality of disease expression require that judgments order facts into their proper placement for *each* individual patient. And beyond this relaxed view of objectivity, clinical care must also incorporate judgments arising from the patient's (as well as the physician's) social and psychological realms that are seemingly removed from scientific concerns. Together, these various kinds of value judgments erect the scaffold of clinical assessment and care, in which a more complex "moral epistemology" emerges.

This epistemological observation about medicine's scientific character has far-reaching implications for justifying the placement of medical

ethics squarely in the middle of medical practice (Tauber 2005c). The doctor cannot retreat into some positivist enclave. The 'facts' are unstructured without the ordering conferred by the health goals of the patient. These may be simple or complex, but in every case the context of the individual determines the meaning of the clinical facts. In short, care cannot be administered without acknowledging the fusion of objective assessment of disease with the personal values of both the patient *and* the physician. So, when those who advocate a stark objectivity in dealing with patients, the rationale cannot reside in medical epistemology. Instead, they must seek rationalization for their behavior in response to the emotional demands of clinical engagement, a psychological prescription, not one based either on the ethics of medicine, nor its science. The rejoinder, of course, is classic: "If you can't take the heat, get out of the kitchen!" Technical expertise may suffice in certain clinical settings, but not in those situations where doctor-patient communication plays an important role in their encounter. In that intimate setting, the physician must draw upon multiple resources, including the emotional extension of oneself to another.

But beyond the "foreclosure of feeling" (Cody 1978, p. 46), or what I would call the "epistemological" conceit of objectivity (Tauber 2005a, 2005b), a second potent force arises from the "sociology" of practice, specifically the economies of everyday demands on time and energies. Achieving heightened interpersonal sensitivities seems too often to impair the efficiency of practice, which is learned by following the busy role models of the profession. While they teach clinical skills and profess the various lessons of enhancing the doctor-patient relationship, mentors also instruct a "hidden curriculum" (Wear 1998). The Hidden Curriculum is a course of study not found in any catalogues, but to function effectively in the contemporary environment of health care, doctors-in-training are taught how to deal with saturated schedules, onerous administrative details, and an incentive system that rewards productivity, not personalized care. Add to these demands, the lurking fear of medical malpractice and the defensive attitudes it spawns, we then readily recognize that powerful and pervasive determinants easily compromise a more humane medicine.

The Hidden Curriculum offers skills that enable the harried physician (or nurse) to effectively navigate in these institutional waters. Yet all too often, effective only means efficient, and efficiency may easily conspire to rob the best of intentions. In short, efficiency may define effectiveness in one dimension, but it also may sap the resources from which empathy, compassion, and patience are drawn. Of course, compassion and competency are not conflicting values. They are, in fact, complementary, but the practice of "efficient" care does not always discern the quiet questions, "What are we doing?" and "Why?" Again, we discern the powerful influence of the emotional demands made upon physicians that heavily contribute to a "defensive" posture, one that recedes from contact, avoids exposure, acts evasively.

The sociology of the profession, the perceived virtues of its professionals, the psychological dimensions of the doctor-patient relationship, and the epistemological ideals of the profession, each contribute to defining the place of medical ethics in the complex matrix of our health care system. So it is not surprising that the purpose and goals of ethics training, its practical application, its role in shaping professional practice are in dispute. I have given this short overview (no doubt over-simplifying the convoluted and complex tributaries that converge on defining the role and expectations of medical ethics training), because it so clearly reveals the obstacles to the integration of moral reasoning into *routine*, contemporary medical practice. Educators committed to enhancing ethics training must overcome complex social and epistemological attitudes that resist moral assessment and self-reflection—attitudes rooted in the 'positive' value placed on the cognitive power of the scientific ideal, the 'negative' value of activities that make over-burdened physicians less efficient, and perhaps most insidiously, the emotional stress of dealing with the infirmed and the dying. In the end, contemporary medical practice allows neither enough time, nor sufficient perception of rewards for efforts to raise moral awareness and develop skills in moral assessment.

A MODEST PROPOSAL

Because formal ethics instruction seems to play only a minor role in ethical growth, I do not advocate increasing curricular efforts (Johnson 1983; Roochnik 1987). Instead, I believe the scope and aims of medical ethics training should be understood as fulfilling the same educational goals as those of any other pre-clinical course of study: Ethics instruction should provide the basic vocabulary and essential concepts for application in the clinical setting. With that limited agenda, we must now devise the means by which moral sensitivity may be better exercised in the day-to-day routine of health care. Specifically, How might the inherent empathy of

health care givers achieve better expression? or in another venue, How might medical ethics contend for its rightful share of professional attention?

The ongoing debate concerning the role of medical ethics in medical education, and more broadly in daily practice, reflects its perception as occupying a peripheral place in medical reasoning. Most HCPs have a general awareness of medical ethical concerns, but these are generally subordinated to the other more pressing immediate issues of efficiency and the competent application of medicine's tools of care. We need a vehicle by which medical ethics might be centered into the routine of daily practice. To do so, I suggest that physicians, doctors-in-training, and nurses apply an analogous evaluative model to the ethical dimension of patient care as they do to diagnosing and treating organic dysfunction. In short, I suggest that an "ethics work-up" become a required standard part of the clinical evaluation of *every* patient. That assessment should be routinely documented in the medical record as are findings concerning the heart, the lungs, and the abdominal organs.

The rationale is simple: To place medical ethics more firmly into medical practice, we must devise an *explicit* focus of attention on moral concerns by the entire health care team. To redress the missing input of ethics, a separate section of the medical chart devoted to identifying and dealing with ethical issues should be established. Fully integrated with various clinical evaluations and on-going progress notes, this section would become the identified site in which HCPs would clearly articulate both the obvious and the less apparent ethical issues pertinent to each patient. This so-called *Ethical Concerns* section is designed to proactively identify such problems and thereby raise these issues as part of ordinary evaluation and care. This section of the medical record would then join the open forum for the communication of findings and opinions that is crucial for the effective treatment of a patient's illness in all of its dimensions. I have previously outlined this proposal (Tauber 2002a, 2002b), and here I more fully explain its rationale and the context of its need.

'Ethical' in this instance encompasses all those matters related to the value-based decisions, which are constantly made when caring for a patient. What options are exercised and how they are implemented are more than technical decisions or strategies to deal with efficient use of clinical resources. Clinical decision-making by patients, families, and physicians must be integrated within broad societal and psychological concerns. As these decisions require physician guidance, the doctor should be aware of his or her own value system—one that may be in harmony or in conflict with those of the patient. Self-reflection and empathy thus become important moral faculties in addressing the myriad challenges that appear in the exercise of effective care. Specifically, the value-laden character of decision-making must be made explicit in order to protect patient dignity and autonomy, and, perhaps no less importantly, to better protect the physician's own professional identity as a care giver as opposed to a technocrat or gate-keeper.

Broadly speaking, there are two domains where value judgments are prominently at work: The first concerns the implementation of knowledge: In considering and applying the scientific and technological tools of clinical medicine, the question arises, What should be done for a patient in the context of the personal and social contexts of the illness? (Pellegrino and Thomasma 1981). (Note, the use of 'illness' as opposed to 'disease;' the latter is a biomedical designation for pathologically defined dysfunction, while 'illness' refers to the entire constellation and experience of a person being sick, i.e., the patient's emotional, social, spiritual, and cognitive response to his or her experience of disease and life-disruption.) The second domain concerns how physicians, beyond the exercise of their clinical science, participate in the patient's life story (Hunter 1994). These issues, as crucial as they can be, are rarely voiced in the medical record and thus remain conspicuously muted. Discerning and integrating them into medical treatment may be implicitly achieved, for better or for worse, or explicitly articulated and thus available for scrutiny and discussion. The latter approach would seem more effective in protecting patient dignity and rights. After all, an evaluation that addresses the ethical dimension of care is prima facie evidence of such an effort.

An *Ethical Concerns* section of the medical record would provide for a recognition and synthesis of personal, social, and ethical issues related to the effective care of the individual patient. There, medical students, physicians and other HCPs would address problems, which range from decision-making in crisis to more mundane details of support for the ill during the hospital stay and after discharge. In making deliberate efforts to identify such issues in the context of the patient's life history and future goals, the heath care team might more effectively deal with those concerns closest to the patient's own experience of illness. More than a scientific and legal

document, the medical record might then become a more comprehensive construction of a person's illness.

WHY THE MEDICAL RECORD?

Because the medical record is a narrative of a particular sort, it tells a story—in its current format, a story of disease. What is included in that story formulates, structures, and thereby interprets. Standardized along prescribed lines, the medical chart may be perused quickly by anyone conversant with current practice. Such a document displays information uniformly, and (perhaps more subtly) the logic and ethos underlying practice—how care is thought of and ultimately delivered. But the record is more than a *reflection* of practice and thought, it is also a *determinant* of what kind of care is given, because the record functions in structuring clinical thinking. Doctors are trained to fulfill the template of the record's divisions and sub-divisions, to obtain data relevant to the particular problems that require attention, as well as to address unsuspected disease. If questions are not asked, answers cannot be given. If tests are not performed, the best intentioned scrutiny will not suffice. Similarly, if inquiry is not made into the welfare and support of a patient, the physician will not identify current or potential problems. And while there is an increasing sensitivity to gleaning such insight in the clinical interview (the "patient profile"), there is as yet no formal place in which to situate and organize such information. By specifically addressing the moral or value-based concerns of the patient as part of the medical encounter, HCPs will have a straightforward means to consider such matters. By demanding that the busy physician ponder this dimension of his patient, ethics will be given appropriate standing for attending to the concerns of the ill that too often are bypassed or forgotten.

Thus, to take medical ethics seriously in current practice, namely, to treat the ethical issues of patient care as a crucial component of evaluating and treating illness, the medical record is the natural home for that evaluation. Informal understandings, silent consensus, assumed discussions do not suffice for management of disease (the pathophysiological domain), and they cannot suffice for the care of the ill. The medical record is the only locus for assembling this assessment, for the chart depicts health care and also has a role in structuring that care and its governing logic. In its narrative, the chart identifies clinical problems and the efforts to diagnose illness, and records therapeutic interventions. The medical chart also proscribes the ways each of these processes is performed and ultimately records the rationale for the decisions which are made. In short, the record reflects the structure of clinical thought and action, and less obviously expresses the values embedded in clinical practice.

One might well wonder why an ethics section has not already been incorporated in everyday assessments. Considering the widespread attention in health care organizations to respecting patient dignity, privacy, autonomy, and rights, one cannot but be struck with the incongruity of paying homage to such precepts while simultaneously ignoring them as part of the medical record of care. If the record indeed records the clinical encounter, why are organic concerns separated from the moral ones? Why does the current chart carefully record the former and only in an *ad hoc* fashion acknowledge the latter? The moral dimensions of care are constitutive of that care. So why not make an effort to identify how that domain is understood for each patient, and why not explicitly record how the patient as a person (as opposed to a disease) is understood and treated?

History provides useful insight to answer these questions. When the format for keeping medical records was last revised about thirty-five years ago, an effort led by Lawrence Weed (1969), reform was largely in response to a new appraisal of how physicians thought about their patients. The problem-oriented medical record was a deliberate attempt to re-organize the chart according to clinical problems. Because of the explosion of medical technology in the 1960s, the patient's comprehensive health needs risked being lost among the competing interests of one subspecialty perspective or another. The revised chart helped the doctor to identify all the medical issues at hand, assess each individually, and then integrate them to ensure that the patient received comprehensive care.

But the aspiration of integrated care remains unfulfilled in a health care system too often seen as dehumanizing. As my colleague Daniel Dugan observes (personal communication), Weed was writing in the late 1960s, so his vision and point of view pre-dates the emergence of 'patients' rights' and bioethics (Jonsen 1998). Weed's efforts to better articulate the purposes of the medical record, to "organize" medical care around "all of the patient's problems," to be a tool of communication, and to provide a basis for quality improvement, are still valid. Indeed, Weed's fundamental thesis seems commonplace now: The obligation to

address all the patient's problems, and to enlarge the patient profile in service of treating problems in their full context, serves the goal of being a 'whole physician' in service to the 'whole patient.' But what is different today is that the scope of clinical care now encompasses newly articulated patient rights. Indeed, the emergence of patients' rights and bioethics during the past thirty years requires an enlarged definition of *all* of the patient's problems. The medical chart must be revised to address this expansion, not only in service to informed consent and protection of patient autonomy, but also to acknowledge the larger ethical dimension of illness.

William Donnelly (1997) has shown how the medical record employs language that obscures, or even ignores the personhood of the patient and his or her experience of illness and medical care. The physician typically describes the sick person as a biological specimen, uses rhetorical devices that enhance the credibility of clinicians and laboratory data against the patient's own testimony, and subordinates the patient's subjective perspective and wishes relative to the doctor's value structure. Building on a rich literature, he recommends several revisions of the clinical language used in record-keeping, including, personalizing the clinical narrative; relating some of the case history in the first person singular; composing a two-perspective history—one of the illness, the other of the disease—since neither perspective alone is the whole story and each complements the other; and including the patient's perspective as an integral part of the case history. That proposal, in line with other previous critiques, e.g., Fischbach et al. (1980), Smith and Hoppe (1991), Delbanco (1992), Matthews, Suchman, and Branch (1993), has recently been amplified to include a restructuring of the patient narrative in the chart as constitutive to the clinical record (Donnelly 2005).

Donnelly's approach is laudable, but I believe my proposal might be achieved immediately without a major overhaul of the medical interview that his would require. On pragmatic grounds alone, an Ethical Concerns section will more likely be adopted and thus contribute to the our shared goal of a better balanced patient-centered medicine. Although I am also advocating more comprehensive care, part of the on-going trend towards a biopsychosocial clinical medicine, the proposal suggested here is an intermediate step towards that reform (Frankel et. al 2003). In short, I am suggesting a 'supplementary' reform, not a radical one.[4] Evaluating a patient's social history and psychological state, as well as identifying the patient's prior decisions and current values regarding health care

4. The biopsychosocial model demands a wider horizon of concern and different resources of inquiry than the commonly appreciated technical skills of clinical medicine (Frankel, Quill, and McDaniel 2003). Formally introduced by George Engel in 1977, its essential precept is that "emotional, behavioral, and social processes are implicated in the development, course, and outcome of illness" (Engel 1977). On this view, disease occurs in a complex context that is only in part—sometimes greater, sometimes less—"biological." Accordingly, there is no isolated locus in which physicians might function as applied biologists—geneticists, biochemists, biophysicists, or whatever. On this view, the physician also assumes the mantles of the sociologist, psychologist, priest, and humanist (Chapman and Chapman 1983). Proponents of this patient-centered approach would expand the focus of professional interest from the disease, its diagnosis and treatment, to also encompass the multiple social and psychological dimensions of a person who is ill. This revised responsibility recasts physician identity by advocating a more comprehensive vision of what it means to heal.

The crucial *moral* element in this rendering of the medical scenario is that a patient-centered, holistic approach is adopted. By holding onto her personhood, the patient resists the reduction of illness to disease. Instead of unilateral treatment, collaboration between the two parties prompts the patient, guided by the doctor, to take personal responsibility for attaining health (Barbour 1995, 34). Interestingly, this model of care fosters patient autonomy, and not surprisingly so: If the one-way approach of a scientific attitude is adopted, the patient becomes an object of scrutiny; in the biopsychosocial model, the ill person becomes a collaborator and thus intimately involved in her own care. So it is not "what the doctor does *to* the patient" that serves as the therapeutic goal, but rather an expanded agenda that includes the doctor's capacity to help the patient understand the specific personal sources of the problem and the effects of the disease. Person-centered care medicine sets different criteria for care and provides the moral framework in which patient autonomy and physician responsibility might easily co-exist side-by-side to achieve the same ends, the attainment of health. This theme is more fully explored in Tauber (2005c).

This revised role of the physician would require a major revision in medical education. Person-centered evaluation requires a broadened approach to determine relevant factors in an individual's illness beyond abnormal clinical data. The initial dialogue is crucial, for not only does it establish the ground rules for the doctor-patient relationship, but the all-important task of attaining trust is approached. Critical to the successful navigation of these often troubled waters is to listen to the patient discuss her illness, and approach the problem from her perspective before a translation is made to understanding the symptoms and signs as manifestations of disease.

In a recent review of the status of biopsychosocial medicine, the exhortation for this approach is made

are already important elements in patient evaluations. I am advocating a re-organization plan, albeit somewhat expanded. As a reform of data gathering and organization, what is already *implicit* will become *explicit*. In systematizing the ethical concerns of patient care, HCPs will have a template for the ethical reflection often required for comprehensive, empathetic care. Doctors, medical students, nurses, social workers, clerics, and other HCPs undoubtedly will supply complementary information that reflects their particular professional orientation; in their combination, a portrait of the ethical status of the illness will emerge.

THE ETHICS WORK-UP

In addressing the ethical concerns of patient care, both routine and exceptional, a systematic approach is required. As in the evaluation of disease, a stepwise protocol provides a basic template in which to gather data, structure its evaluation, and organize decision-making. What might such an "ethics work-up" section of the medical record entail? Should a series of specific questions be asked or a prescribed format followed? What, indeed, are the limits of such an inquiry? Or better, How comprehensively should one attempt to address such concerns? Where should it appear? Clearly, different patients have different requirements and different questions dominate different clinical settings. But no matter what the particularities of any given case may be, a self-conscious consideration of the patient's values must be considered; no less important, the HCP's self-awareness of the values guiding his or her own choices and actions also must be understood. Defining the value structure of both the patient and the HCP, and making them explicit, provide the basis by which the clinical encounter remains a consensual and cooperative effort. Because the 'moral space' of clinical decision-making is constructed by a complex confluence of values, sometimes in perfect alignment, and sometimes not, an ethical work-up must enunciate and ultimately encompass the values of the patient *and* the values of the clinician in the setting in which he or she operates. In other words, there is an on-going negotiation as to what *can* be done, what *should* be done, and *who* decides those choices for each patient (Pellegrino and Thomasma 1981). In making this deliberation explicit—articulating the basic ethics which will guide and inform clinical decision-making—the HCP is enacting what might otherwise remain a silent dialogue.

Under this scheme, doctors and nurses would fully explain therapeutic options to their patients (already routine), and in doing so, make more apparent the ethical norms and the meta-ethical assumptions underlying those choices. To determine mutually agreed upon therapeutic goals, the physician must be aware that the decision is an adjudication of perspectives, where embedded values often silently determine what is seen, what is believed, and what is advised. The point of the exercise is to deliberately address potential conflicts of value *before* they arise, and, as in any negotiation, to understand both points of view.

Surprisingly, scant attention has been given to formulating a comprehensive "ethics work-up," although both general guidance (Lo 1995), as well as specific protocols have been devised for certain problems, such as palliative care (Lo, Quill, and Tulsky 1999; Karlawish, Quill, and Meier 1999). This is due in part to the competing systems of medical ethics (e.g., axiomatic, consequentialist, consensual, or pragmatic ethics [Murphy et al. 1997, pp. 23ff.]), the sheer complexity of the issues involved, and the restrictions imposed by the particularities of individual cases. Nevertheless, a fourfold practical approach has been devised (Table 1), which offers an orderly review of the ethical issues (Jonsen et al. 1998). An alternative schema is offered in Table 2 (Thomasma 1978). With such a database, the ethical issues may be extracted, discussed, and acted upon. While other more detailed schemas have been proposed (e.g., Myser et al. 1995; Fletcher and Moseley 2003), these two examples illustrate the logical development of the ethics evaluation, namely, first, to gather data for the moral evaluation; second, proceed to the ethical evaluation proper (with its decision-making process), and, finally, develop strategies for implementation and re-evaluation.

---

primarily on pragmatic grounds of patient satisfaction, physician competence, and general promises of increased effectiveness. Indeed, proponents might take some satisfaction in recognizing that while the evidence is still rudimentary, by the early 1990s, the biopsychosocial model of disease had a firm place in many medical school curricula (Sperry 1991), and more recently it has found a place in some resident training programs (Schmidt 1998). But a ripple effect is evident throughout American medical school education, inasmuch as interviewing skills have become an almost universal component of pre-clinical education and explicit training in Engel's formulation occurs in a significant proportion (Frankel, Quill, and McDaniel 2003). With Richard Cooper, I have argued for even more radical change (Cooper and Tauber 2006).

Table 1. Four Step Ethics Evaluation (Adapted from Jonsen et al. 1998)

1. **Medical Indications**: Define clinical problems, goals of treatment, probabilities of success, and plans for therapeutic failure; delineate cost/benefit ratios of care.
2. **Patient Preferences**: Maintain patient's right to choose by determining preferences for care; assess competence of patient and ability to cooperate with medical treatment; if incompetent, is there health-care proxy or Advance Directives?
3. **Quality of Life**: Specify prospects, with or without treatment, of patient's recovery; define physical, mental, and social consequences of treatment success; explore plans for care in event of treatment failure.
4. **Contextual Features**: Clarify family or provider issues that may influence clinical decisions, including allocation of resources, financial restraints, and religious or cultural factors; describe possible legal implications of treatment decisions, e.g., clinical research or teaching; establish the scope of confidentiality.

Whether done in one of the formats presented above or by some other formulation, fact gathering of relevant information concerning the psychosocial and moral features of the case is key. The critical modification of current practice is both obtaining more comprehensive information, and placing the deliberative process on a coordinate system that includes both the patient's values and those of the health care provider. Thus the ethics work-up is directed toward understanding the patient's needs, resources, and values, and coordinating these elements with the clinician's efforts, which are themselves guided by a set of values and priorities, both personal and institutional. The *self-reflective* elements of the ethics work-up make this portion of the clinical portrait different in kind from the rest of the chart, which is oriented *from* the examining doctor or nurse *towards* the patient. In the *Ethical Concerns* section, a true dialogue is encouraged.

OBJECTIONS AND REBUTTAL

Since medical practice already addresses the psychosocial setting of the patient's experience of illness, why is this modification in record-keeping required? Simply stated, the clinical priorities as a function of the wider life concerns of the patient are rarely described in current chart documentation. Perfunctory notes about marriage status and employment typically constitute an acceptable social history, and only ancillary psychiatric or social worker narratives provide a more comprehensive picture of the patient in the home and community settings. By deliberately addressing this aspect of care, the HCP must define the moral space within which care is administered. In so doing, medical ethics will be firmly placed in the chart, thereby powerfully directing and self-consciously justifying the mode of professional behavior.

As usually considered, most cases require little or no ethical reflection or problem-solving. Certainly ethics discussions, conferences or consultations to assist with and resolve questions and decisions for those facing end of life decisions, code status determinations, interpretations of living wills, autopsy requests, and uncertainties or disagreements about health care proxy authority are frequent features of current health care. The dramatic issues of transplantation, in vitro fertilization, abortion, and prenatal genetic testing hardly need comment here, because the ethical concerns of such

Table 2. Six Step Ethics Evaluation (Adapted from Thomasma 1978)

Step 1	Identify the significant human factors in the case. Demographics (age, occupation, education, family status, home setting, etc.), behavior history (psychiatric history, criminal record, substance abuse), religious and political attitudes relevant to health and medical care.
Step 2	Explicitly define related value factors (medical, professional, or human) present for the patient, health care professional and other relevant persons involved in the case.
Step 3	Delineate all ethical choices and major value conflicts.
Step 4	Set priorities for values which are in conflict and give reasons for holding a position.
Step 5	Identify the criteria by which a decision is made, considering underlying ethical norms and meta-ethical assumptions (How was *this* decision, based on *that* value, moral?)
Step 6	Critique the assumptions underlying the decision made in step 5 and present the final opinion and strategy for dealing with the moral issues identified.

decision-making are integral to these clinical problems. The 'ethical extremes' of the medical practice spectrum are not my primary concern.

What needs attention is the more ordinary case, where determination of choices must be made in the context of a patient's values that are not easily articulated, and are frequently overlooked. In one report, almost one in seven patients suffered a moral dilemma unrecognized by the ward team (Lo and Schroeder 1981). While much depends on the patient population examined and the moral "index" adopted, I suspect further study will reveal this figure as conservative. However, these fractions do not address the essential challenge: *Every* patient demands an ethical response, because of the primary moral character of care (Tauber 1999). Whether acute and demanding, or minimal and subtle, the specifics of clinical care are fundamentally shaped by ethical considerations; the science and technology follow.

I acknowledge that significant objections to this proposal may be raised. The primary objection arises from the "economic" realities of contemporary medical practice—the economics of time and professional priorities. On this view, physicians are already over-taxed in their commitments and do not have the time to obtain the information called for here. A second objection (one already described) comes from a deeper source and is more difficult to address: While physicians may wish to be humane, they, by and large, function as technocrats and thus are rarely called upon to exercise moral sensitivity. Consequently, the patient in the typical setting does not expect to discuss values and beliefs, and only in the most pressing of circumstances do such deliberations take place.

As for the first concern, the economics of time and commitments currently divide the professional day according to certain expectations and standards of conduct. If physicians were expected to devote more professional effort in getting to know their patients, then the time it took to accomplish that objective would be acknowledged as important and factored in appropriately. The skeptic will not be calmed by proleptic reassurances that the increased work this new activity will command is manageable, or effective. Admittedly, I have eschewed discussing implementation, but whether this effort is worthwhile must be decided after we concur that the merits of the proposal are worthy of study and trial. That justification, to be plain, is based on the need for counter measures to offset patient mistrust: In our health care system, patients too often complain that their concerns are left unidentified; their fears ignored; their true opinions disregarded (Tauber 2005c, 2006).[5] The measures advocated here address these problems. Whether the effort effectively addresses the challenge may only be studied empirically. Indeed, a preliminary study is underway.[6]

---

5. I refer to two dimensions of mistrust: The first concerns confidence in professional ability and judgment. Given the increasing evidence of physician error (Institute of Medicine 1999; Berwick 2003), and, perhaps even more important, the growing sophistication of patients understanding the controversies and uncertainties that plague the science of medicine (i.e., the debates that arise as new advances are made in diagnostics and therapies), doctors are increasingly facing an informed consumer, who often presents a skepticism toward medical authority. The second concerns the growing incorporation of medicine into HMOs. Physicians in the corporate environment do have conflicts of interest, which may give rise to patient mistrust. Patients are aware of these competing agendas (Shortell et al. 1998; Jacobson and Cahill 2000; Illingworth 2000) and physicians have been noted to compensate for their corporate affiliations—sometimes lying to extract benefits for their patients (Freeman et al. 1999; Wynia et al. 2000) and sometimes not offering potentially useful services because of perceived coverage restrictions (Wynia et al. 2003).

Clearly, trust is highly correlated with patient satisfaction (Anderson and Dedrick 1990), and while many theories thrive as to why trust has been eroded, few measures and little data can accurately ascertain the general impression of trust's decline in the clinic (Pearson and Raeke 2000). To quantify this problem is difficult, inasmuch as the categories of assessment are not standardized (Hall et al. 2001). The kinds of questions that must be addressed include how thoroughly clinical problems are evaluated, how well health care providers understand and empathize with a patient's individual experience, and how effectively they communicate and successfully build a relationship with their patient that is both honest and respectful (Thom and Campbell 1997). When the corporate character of contemporary health care is added, the trust question becomes exceedingly complex. Perhaps the most interesting formal response to the challenge of split allegiance has been made in the Charter on Medical Professionalism (Blank et al. 2003), a broadly adopted code of ethics, which holds that beyond the specific responsibilities to advance the well-being and dignity of their patients, physicians are enjoined to improve patient quality of care, access, and more equitable distribution of resources as part of their moral code. This code of ethics clearly places the physician's loyalties squarely with the patient.

6. In July, 2004, the first specified "Ethics" section of the medical record was inaugurated at Emanuel Medical Center (EMC) in Turlock, California under the supervision of Dan Dugan, a medical ethicist consultant, and Tom Johnson, the Chairman of EMC's Ethics Committee. They are preparing a preliminary report of its function and outcomes. The proposal of an *Ethics Work-up* to be

As to the second objection, perhaps more effort devoted to establishing the moral relationship between doctor and patient is unnecessary. Why should the physician move beyond serving as technocrat to a more complete care giver? After all, is not medicine ultimately a scientific discipline, ever more beholden to technological applications? On this view, technical proficiency is paramount and attention to humane values will come into play only as required, and in a minimal expression. Others on the health care team—nurses, social workers, clergy, administrators, psychiatrists, ethics committees—can deal with ethical complications as they arise.

The rebuttal begins by observing the fundamental difference between the physician and the other members of the health care team: The doctor holds a privileged position. In concert and collaboration with the patient, physicians yield an authority that has a more powerful influence than other HCPs. The decision-making calculus is hardly simple, but suffice it to say here, that the doctor cannot abdicate responsibility for defining, at a minimum, the various options for care and advising the selection of one or another. To perform that task adequately, physicians must *know* the patient beyond a biomedical description, for in the end, clinical choices are made within a more complex universe than described by clinical parameters divorced from the patient's individual personal reality. The goal is the individual's *health*, not simply disease elimination (Richman 2004). On this critical point, I end my argument:

Although medicine's moral calling is compelling enough to demand more attention to ethical concerns (Pellegrino and Thomasma 1988, 1993; Tauber 1999), I believe an even better argument arises from understanding medicine's epistemological construction (Tauber 2005c). After all, we may reasonably disagree about moral beliefs, but there is less room for argument about the character of the clinical enterprise in which we all share. Note, I might have rested my rebuttal on the tenet that scientific (positivist) ideals must be *balanced* with the humane values of empathy and compassion (the values residing at the foundation of medical care), but I do not. That strategy has proven weak against those who argue that medicine is a technocratic enterprise, because their underlying understanding leads to a predicted outcome: They begin by falsely separating clinical facts and values into separate domains. Once divided, some (doctors) will address the facts and others (ethicists, social workers, clerics) will deal with the values. Split the problem and split its solution between specialists for each. But this configuration, as already discussed, may only be defended by distorting the character of medical practice. The 'facts' of care disallow the severe distinction in which the divided formulation begins. So instead of seeking better "balance" between (scientific) facts and (human) values, I argue for acknowledging their inextricable linkage (Tauber 2005a; b). And in light of that understanding, we possess a powerful rationale for taking medical ethics seriously by *all* HCPs.

incorporated into an *Ethics Concerns* section of the medical record is being considered at several medical schools and hospitals as of October, 2004: Boston Medical Center, Boston, MA; Brigham and Women's Hospital, Boston, MA; Swedish Covenant Hospital, Chicago, IL; Columbia-Physicians and Surgeons, New York; Tufts University School of Medicine, Boston, MA.

CONCLUSION

My goal is to make ethics more explicit in the day-to-day practice of medicine, and thereby enact the precept that medicine is fundamentally ethical (Tauber 1999). To enact that understanding, physicians must remind themselves that clinical science and its applications are tools for fulfilling their fundamental and defining moral responsibilities to patients. Further, they must better balance the claims of a nineteenth century scientific ideal of objectivity with a twenty-first century appreciation that clinical science in service of patients is value-laden. Values have a wide expanse: Clinical decision-making is a dialectical process of doctor recommendation and patient understanding and choice; respect for patient autonomy is more than informed consent and demands from us an ever-present effort to preserve patient dignity; and the economies of practice must balance efficiency with efficacy, which in turn depends on some measure of empathetic, personalized care.

Not only must mentors *teach* the skills requisite for such behaviors, they must *practice* them and thereby *show* doctors-in-training that professionalism includes certain humane behaviors. The lasting lessons are learned at the bedside, not in the classroom. The tools for practicing an ethical medicine may be obtained in lecture; the enactment must occur with the patient. (In fact, empirical research has amply shown that students are more deeply influenced by the behavior of role models than by the material presented in course work [Glick 1993; Goldie 2000].) In short, the moral encounter occurs in the intimacy of the doctor-patient relationship.

Contemporary practice requires a directive, and a means, to enhance that relationship.

In espousing a deliberate emphasis on ethics in daily practice, I seek to recover an intimacy in the doctor-patient relationship that many find lacking. Recently, the unsteady standing of trust has received increased attention as commentators have focused on both the macro-social factors and micro-inter-personal elements that seem to have adversely affected this relationship (Annison and Wilford 1998; McKinlay and Marceau 2002). The health care dyad, traditionally one characterized by trust on the part of the patient, seems too often plagued by doubt (see footnote #5). Sown by cynicism and cultivated in a climate of social wariness, patient autonomy assumes its defensive character in a climate of unsteady relationships. Putting aside the degree of patient confidence in their physician's technical ability and the prestige of medical science, a deeper, and perhaps more menacing question looms concerning the ethics of care: In the corporate setting of an HMO, in the emergency ward of a municipal hospital, and even in a private doctor's office, patients increasingly wonder, "Will my doctor do what is best for me?"

A general ambiguity has replaced the traditional trust characterizing the patient-doctor relationship, and the sources of this misalignment are deeply embedded in contemporary society (Tauber 2005c, 2006). Physician accountability is one way of reassessing this vanishing ideal. A myriad array of studies, regulations, legislation, and reactive risk management measures now mark a profession that until quite recently conducted its business with little concern for maintaining its own professional standards of behavior (Shortell et al. 1998). The shadowed presence of others at the bedside to protect the patient is a symptom of patient mistrust. As Francis Fukuyama observed, "people who do not trust one another will end up cooperating only under a system of formal rules and regulations, which have to be negotiated, agreed to, litigated, and enforced, sometimes by coercive means" (1995, p. 27). Neither informed consent nor regulations can substitute for primary trust.

Both remedial and proactive responses are required to strengthen the weakened personal bond between doctor and patient. I contend that placing medical ethics firmly into the heart of the medical chart, as a constituent part of the medical evaluation, is a mechanism that represents an important step in that process. The routine articulation of ethical concerns may provide the most direct way of pulling medical ethics from the periphery of the medical landscape into its very center where it belongs, for there it reminds caregivers of the values and premises at the core of their professions. Teaching ethical principles, moral theories, medical jurisprudence, and the other components of medical ethics may be seen as the tools of this enterprise. A robust curriculum is required, but let's put the horse before the cart: Make identifying and addressing ethical concerns a part of the *routine* clinical evaluation through an ethics work-up. Just as the student learns to use a stethoscope to auscultate the heart, he or she should learn the basics of moral reasoning and apply them to the clinical scenario. I suggest that only by a self-conscious effort will moral sensitivity be highlighted in a way that will tilt the doctor-patient relationship towards the empathetic ideals most would endorse.

In the end, I make this proposal not to argue for more recognition of "medical ethics" as an area of knowledge and skill. As important as this discipline has become, and as much as it still requires support, I advocate the *Ethical Concerns* section of the medical record as a means to better ground an *ethical medicine*. The difference is telling. Enhancing awareness of medical ethics as belonging to the core of day-to-day practice is the means toward that larger agenda. More than judicial directives, risk management, and academic debate, the morality of medicine defines the very foundation of practice, the moral substrate upon which clinical care is built. One might see most choices and actions—even the most mundane—as enacting some underlying value system, but such moral self-consciousness is not ordinarily part of clinical practice. In adopting serious efforts to assure that medical ethics does not become another sub-specialty, but rather flourishes as an integral component of every physician's training, conduct, and practice, the profession should begin to embed moral self-consciousness, as an *explicit* exercise, in the medical record.

As long as medical ethicists are perceived as practicing another "subspecialty,' medical ethics itself will be regarded as "somebody else's" expertise and responsibility, and consequently the discipline and its practitioners are easily marginalized until dire circumstances call for rescue. But if the discussion is raised to the moral plateau it deserves, the pursuit of an ethical medicine then encompasses not only medical ethics, but also includes the wide constellation of patient-centered activities that contribute to a humane medicine. Establishing an *Ethical Concerns* section in the medical record makes

ethics the business and responsibility of every HCP. Medical ethicists should be able to help in that effort, and perhaps even lead the venture.

ACKNOWLEDGMENTS

This paper is dedicated to Dan Dugan, who was the first to embrace this proposal and lead the efforts to make it an effective contribution to the care of patients. His helpful criticisms of this paper were invaluable in finalizing its argument, and I gratefully acknowledge his suggestions. The proposal presented here is more fully developed in Tauber (2005c).

REFERENCES

Anderson, L. A., and R. F. Dedrick. 1990. Development of the Trust in Physician scale: A measure to assess interpersonal trust in patient-physician relationships. *Psychology Reports* 67: 1091–1100.

Annison, M. H., and D. S. Wilford. 1998. *Trust matters. New directions in health care leadership*. San Francisco, CA: Jossey-Bass Publishers.

Arnold, R. M., G. J. Povar, and J.D. Howell. 1987. The humanities, humanistic behavior, and the humane physician: A cautionary note. *Annals of Internal Medicine* 106: 313–318.

Barbour, A. 1995. *Caring for patients: A critique of the medical model.* Stanford, CA: Stanford University Press.

Barzansky, B., and S. Etzel. 2001. Educational programs in US medical schools, 2000-2001. *JAMA* 286: 1049–1055.

Berwick, D. M. 2003. Errors today and errors tomorrow. *New England Journal of Medicine* 348: 2570–2572.

Bissonette, R., R. M. O'Shea, M. Horwitz, and C. F. Route. 1995. A data-generated basis for medical ethics education: Categorizing issues experienced by students during clinical training. *Academic Medicine* 70: 1035–1037.

Blank, L., H. Kimball, W. McDonald, and J. Merino. 2003. Medical professionalization in the new millennium: A physician charter 15 months later. *Annals of Internal Medicine* 138: 839–841.

Carmel, J., and J. Bernstein. 1986. Identifying with the patient: An intensive programme for medical students. *Medical Education* 20: 432–436.

Chapman, J. E., and H. H. Chapman. 1983.*The psychology of health care. A humanistic perspective*. Monterey, CA: Wadsworth Health Sciences.

Cody, J. 1978. The arts versus Agnes Duer, M.D. In *The role of the humanities in medical education*, D. J. Self (ed.), 45–61. Norfolk, VA: Bio-Medical Ethics Program, Eastern Virginia Medical School.

Cooper, R. A., and A. I. Tauber. 2006. New physicians for a new century. *Academic Medicine* In press.

Culver, C. M., K. D. Clouser, H. Brody, J. Fletcher, A. Jonsen, L. Kopelman, J. Lynn, M. Siegler, and D. Wikler. 1985. Basic curricular goals in medical ethics. *New England Journal of Medicine* 312: 253–256.

Delbanco, T. L. 1992. Enriching the doctor-patient relationship by inviting the patient's perspective. *Annals of Internal Medicine* 116:414–418.

Donnelly, W. J. 1997. The language of medical case histories. *Annals of Internal Medicine* 127:1045–1048.

Donnelly, W. J. 2005. Patient-centered medical care requires a patient-centered medical record. *Academic Medicine* 80: 33–38.

Dubois J. M., and J. Burkemper. 2002. Ethics education in U.S. medical schools: A study of syllabi. *Academic Medicine* 77: 432–437.

Engel, G. 1977. The need for a new medical model: A challenge for biomedicine. *Science* 196: 129–136.

Fischbach, R. L., A. Sionelo-Bayog, A. Needle, and T. L. Delbanco, 1980. The patient and the practitioner as co-authors of the medical record. *Patient Counselling and Health Education* 2: 1–5.

Fletcher, J. C., and K. L. Moseley. 2003. The structure and process of ethics consultation services. In *Ethics consultation. From theory to practice*, M. P. Aulisio, R. M. Arnold, and S. J. Youngner (eds.), 96–120. Baltimore, MD: The Johns Hopkins University Press.

Frankel, R. M., T. E. Quill, and S. H. McDaniel, (eds.). 2003. *The biopsychosocial approach. Past, present, future*. Rochester, NY: The University of Rochester Press.

Freeman, V. G., S. S. Rathmore, K. P. Weinfurt, K. A. Schulman, and D. P. Sulmasy. 1999. Lying for patients: Physician deception of third party payers. *Archives of Internal Medicine* 159: 2263–2270.

Fukuyama, F. 1995. *Trust. The social virtues and the creation of prosperity*. New York, NY: Free Press.

Glaser, J. W., and R. B. Miller. 1993. A paradigm shift for ethics committees and case consultation: A modest proposal. *Healthcare Ethics Committee Forum* 5: 83–88.

Glick, S. M. 1993. The empathetic physician: Nature and nurture. In *Empathy and the practice of medicine. Beyond pills and the scalpel*, Spiro, H., Curran, M.G.M., and St. James, D. (eds.), 85–102. New Haven, CT: Yale University Press.

Goldie, J. 2000. Review of ethics curricula in undergraduate education. *Medical Education* 34: 108–119.

Guttentag, O. E. 1960. A course entitled 'The Medical Attitude.' An orientation in the foundations of medical thought. *Journal of Medical Education* 35: 903–907.

Hall, M. A., E. Dugan, B. Zheng, and A. K. Mishra. 2001. Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *Milbank Quarterly* 70: 613–639.

Harvan, R. A. 1993. An assessment of ethical sensitivity: Implications for interdisciplinary education. *Journal of Allied Health* 22: 353–362.

Hunter, K. M. 1994. *Doctors' Stories. The narrative structure of medical knowledge*. Princeton, NJ: Princeton University Press.

Illingworth, P. 2000. Bluffing, puffing, and spinning in managed-care organizations. *Journal of Medicine and Philosophy* 25: 62–76.

Institute of Medicine. 1999. *To err is human: Building a safer health system*. Washington, DC: National Academy Press.

Jacobson, P. D., and M. T. Cahill. 2000. Applying fiduciary responsibilities in the managed care context. *American Journal of Law and Medicine* 26: 155–173.

Johnson, A. G. 1983. Teaching medical ethics as a practical subject: Observations from experience. *Journal of Medical Ethics* 9: 5–7.

Jonsen, A. R. 1998. *The birth of bioethics*. New York: Oxford University Press.

Jonsen, A. R., M. Siegler, and W. J. Winslade. 1998. *Clinical Ethics. A practical approach to ethical decisions in clinical medicine, 4th ed.* New York, NY: McGraw-Hill, 1998.

Karlawish, J., T. Quill, and D. E. Meier. 1999. A consensus-based approach to providing palliative care to patients who lack decision-making capacity. *Annals of Internal Medicine* 130: 835–840.

Kohlberg, L. 1984. *Essays on moral development, Vol. 2. The nature and validity of moral stages.* San Francisco, CA: Harper and Row.

Landau, R. L. 1993. . . . And the least of these is empathy. In *Empathy and the practice of medicine. Beyond pills and the scalpel*, Spiro, H., Curran, M. G. M., and St. James, D. (eds.), 103–109. New Haven, CT: Yale University Press.

Lo, B. 1995. *Resolving Ethical Dilemmas. A Guide for Clinicians*. Baltimore: Williams & Wilkins.

Lo, B., T. Quill, and J. Tulsky. 1999. Discussing palliative care with patients. *Annals of Internal Medicine* 130: 744–749.

Lo, B., and S. A. Schroeder. 1981. Frequency of ethical dilemmas on an inpatient medical service. *Archives of Internal Medicine* 141:1062–1064.

Matthews, D. A., A. L. Suchman, and W. T. Branch Jr. 1993. Making 'connexions': Enhancing the therapeutic potential of patient-clinician relationships. *Annals of Internal Medicine* 118: 973–977.

McKinlay, J. B., and L. D. Marceau. 2002. The end of the Golden Age of Doctoring. *International Journal of Health Services*. 32: 379–416.

Miles, S. H., L. W. Lane, J. Bickel, R. M. Walker, and C. K. Cassell. 1989. Medical ethics education: Coming of age. *Academic Medicine* 64: 705–714.

Murphy, E. A., J. J. Butzow, and E. L. Suarez-Murias. 1997. *Underpinnings of medical ethics*. Baltimore, MD: The Johns Hopkins University Press.

Myser, C., I. H. Kerridge, and K. R. Mitchell. 1995. Teaching clinical ethics as a professional skill: Bridging the gap between knowledge about ethics and its use in clinical practice. *Journal of Medical Ethics* 21: 97–103.

Pearson, S. D., and L.H. Raeke. 2000. Patients' trust in physicians: Many theories, few measures, and little data. *Journal of General Internal Medicine* 15: 509–513.

Pellegrino, E. D., and T. K. McElhinney. 1982. *Teaching ethics, the humanities, and human values in medical schools: A ten-year overview*. Washington, DC: Institute on Human Values in Medicine.

Pellegrino, E. D., and D. C. Thomasma. 1981. *A philosophical basis of medical practice. Toward a philosophy and ethic of the healing professions*. New York, NY: Oxford University Press.

Pellegrino, E. D., and D. C. Thomasma. 1988. *For the patient's good: The restoration of beneficence in health care*. New York, NY: Oxford University Press.

Pellegrino, E. D., and D. C. Thomasma, 1993. *The virtues in medical practice*. New York, NY: Oxford University Press.

Putnum, H. 2002. *The collapse of the fact/value dichotomy and other essays*. Cambridge, UK: Harvard University Press.

Richman, K. A. 2004. *Ethics and the metaphysics of medicine*. Cambridge, UK: The MIT Press.

Roochnik, D. 1987. Applied ethics: Some Platonic questions. *Philosophy in Context* 17: 40–51.

Savulescu, J., R. Crisp, K. W. M. Fulford, and T. E. Hope. 1999. Evaluating ethics competence in medical education. *Journal of Medical Ethics* 25: 367–374.

Schmidt, H. 1998. Integrating the teaching of basic sciences, clinical sciences, and biopsychosocial issues. *Academic Medicine* 73: S24–S31.

Self, D. J. 1993. The moral development of medical students: A pilot study of the possible influence of medical education. *Medical Education* 27: 26–34.

Self, D. J., F. D. Wolinsky , and D. C. Baldwin. 1989. The effect of teaching medical ethics on medical students' moral reasoning. *Academic Medicine* 64: 755–759.

Sheehan, T. J., S. D. R. Husted, D. Candee, C. D., Cook, and M. Bargen. 1980. Moral judgment as a predictor of clinical performance. *Evaluation and the Health Professional* 3: 393–404.

Shortell, S. M., T. M. Waters, K. W. B. Clarke, and P. P. Budetti. 1998. Physicians as double agents. Maintaining trust in an era of multiple accountabilities. *JAMA* 280: 1102–1108.

Smith , R. C., and R. B. Hoppe. 1991. The patient's story: integrating the patient- and physician-centered approaches to interviewing. *Annals of Internal Medicine* 115: 470–477.

Sperry, L. 1991. Teaching the biopsychosocial perspective: A comparison of two approaches. *Psychological Reports* 68: 99–102.

Spiro, H. 1993. What is empathy and can it be taught? In *Empathy and the practice of medicine. Beyond pills and the scalpel*, Spiro, H., Curran, M. G. M., and St. James, D. (eds.), 7–14. New Haven, CT: Yale University Press.

Sulmasy, D. P., G. Geller, D. M. Levine, and R. R. Faden. 1990. Medical house officers' knowledge, attitudes, and confidence regarding medical ethics. *Archives of Internal Medicine* 150: 2509–2513.

Tauber, A. I. 1992. The two faces of medical education: Flexner and Osler revisited. *Journal of the Royal Society of Medicine* 85: 598–602.

Tauber, A. I. 1999.*Confessions of a medicine man. An essay in popular philosophy.* Cambridge, MA: The MIT Press.

Tauber, A. I. 2002a. Putting ethics into the medical record. *Annals of Internal Medicine*. 136:559–563.

Tauber, A. I. 2002b. Implementing medical ethics. *Journal of the Israel Medical Association*. 4:1091–1092.

Tauber, A. I. 2005a. Medicine and the call for a moral epistemology. *Perspectives in Biology and Medicine*. 48:42–53.

Tauber, A. I. 2005b. Medicine as a moral epistemology. In *Multidisciplinary approaches to theory in medicine*, R. Paton and L. McNamara (eds.), Elsevier. In press.

Tauber, A. I. 2005c. *Patient autonomy and the ethics of responsibility*. Cambridge: The MIT Press.

Tauber, A. I. 2006. Seeking medicine's moral glue. *American Journal of Bioethics* 6(1): 41–44.

Thom, D. H., and B. Campbell. 1997. Patient-physician trust: An exploratory study. *Journal of Family Practice* 44: 169–176.

Thomasma, D. C. 1978. Training in medical ethics: An ethical workup. *Forum on Medicine* 1: 33–36.

Wear, D. 1998. On white coats and professional development: The formal and the hidden curricula. *Annals of Internal Medicine* 129: 734–737.

Weed, L. L. 1969. *Medical records, medical education, and patient care: The problem-oriented record as a basic tool.* Cleveland, OH: The Press of Case Western Reserve University.

WSJ.com Sept. 28,2004—Doctors' interpersonal skills are valued more than training. http://online.wsj.com/article_print/0,,SB109630288893 728881,00.html

Wynia, M. K., D. S. Cummins, Van J. B. Geest, and I. B. Wilson, 2000. Physician manipulation of reimbursement rules for patients: Between a rock and a hard place. *JAMA* 283: 1858–1865.

Wynia, M. K., J. B. Van Geest, D. S. Cummins, and I. B. Wilson. 2003. Do physicians not offer useful services because of coverage restriction? *Health Affairs* 22: 190–197.