The Formation of Medical Imagination
A Formação da Imaginação Médica

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RESUMO
O autor discute a importância e a possibilidade do ensino das Humanidades no curso médico, a partir de sua própria experiência na University of Texas Medical Branch at Galveston. A utilização da literatura estimula a sensibilidade do indivíduo, aguçando sua capacidade de atenção, percepção e reflexão. As humanidades exercitam tanto a imaginação como também o intelecto. Este é um valioso hábito mental para ser compartilhado com medicina. Deve ser reconhecido que as humanidades enfrentam seus próprios problemas, sendo o principal deles o risco de obscurantismo, que pode ser evitado lembrando-se que o cultivo do intelecto, imaginação, e sensibilidade não é a seu próprio serviço, mas sempre é feito para a melhor compreensão prática.

ABSTRACT
The author discusses the importance and possibility of teaching the humanities as part of undergraduate medical education, based on his own experience at the University of Texas Medical Branch in Galveston. Use of the literature stimulates individual sensitivity, sharpening one’s capacity for attention, perception, and reflection. The humanities exercise both imagination and intellect, as a valuable mental habit to be shared with medical training. It should be acknowledged that the humanities face their own problems, especially the risk of obscurantism, which can be avoided by remembering that cultivation of the intellect, imagination, and sensitivity are not ends in themselves, but are always part of an effort at better practical understanding.

Thirty years ago Paul Ramsey recorded some provocative ideas about the purpose of humanities in the medical curriculum. Ramsey said, “... unless we mean to make medical education more literate, indeed more literary, ethics can find no proper place in it. Ethics is... an intellectual inquiry. Therefore, education in medical ethics must necessarily be primarily literate.” To be literate is to possess the skills necessary for communicating in a particular language—in this case, the language of morality. The mastery of such literacy, according to Ramsey, is a minimum requirement of medical education. But he goes further: “... unless we mean to make medical education... more literary, ethics can find no proper place in it.”

Why is literacy of this sort—the cultivation of moral imagination and such habits of mind as the disciplines of perception, attentiveness, and reflection—a precondition for the responsible practice of medicine? Because without a sensibility attuned to what peoples’ lives are like, to what matters to people before they get sick and after they get well, the best efforts of physicians to heal the sick are likely to be morally compromised. Contemporary principalist
bioethics in the United States has been insufficiently mindful of this fact. Its discourse is curiously disembodied. The doctors and patients who populate its case discussions tend not be full-blooded characters but stand-ins for ethical concepts. One does not come away from a consideration of current debates in bioethics with the impression that patients, or doctors for that matter, have moral lives.

Reading stories, and paying studied attention to patients’ stories prepares one for more stories. It primes our imagination, enlarges our capacity to imagine, and shapes our sensibility. Writers, poets, and dramatists tend to be astute observers of human nature and discerning interpreters of human experience. By means of metaphor and the cognitive devices of literary expression, they probe experience for the possible sense it makes. Experiences of illness, injury and disability are no exception. This is what I want to argue this afternoon. I will bolster this claim in the course of my remarks with reference to examples of both imaginative literature and clinical cases.

I will begin with Franz Kafka, and return to him later. First from his story The Country Doctor, an epigram to set the tone and direction of my remarks: “To write prescriptions is easy, but to come to an understanding with people is difficult.” One would be hard put to say more succinctly than this what the high calling of medicine is about: to come to an understanding with people about what ails them, about how to remedy the ailment, and about how to bear up when illness is irredeemable.

Coming to an understanding with people has always been at the heart of medical care. At times when medical morality was more settled than it is today, one could count on novices acquiring this art by observation and imitation of accomplished mentors. Imitation is still central to much clinical medical education but it can no longer be taken for granted in a medical enterprise that is increasingly mechanized, institutionalized and bureaucratized. Educators are no longer certain about whether medical students and trainees are being adequately prepared to practice the human dimensions of their profession. And so the art of medicine must be singled out for special attention. Modern doctors are too often left to their own devices in negotiating the moral straits of medical care, and patients are bewildered (and, alternately dazzled) by medicine’s powers, both real and imagined. As a result, doctors and patients often talk past each other and sometimes are at odds.

Proposals for remediating this situation are various and range from the adversarial (“empower patients to drive a hard bargain”) to the beneficent (“restore to medicine its sense of responsibility for patient well-being”). Each such proposal captures a partial truth (“patients are not well-informed about what medicine can and cannot do,” “doctors are challenged by the knowledge explosion in biomedicine, new technological developments, and by the pressures of market forces.” Contemporary bioethics can be seen as one response to this situation. The prevailing approach of bioethics as principilism sets out from principles considered sufficiently general to evoke broad assent. These principles are to brought bear as “action-guides” on morally problematic medical situations, usually via rules derived from the agreed upon principles. The medical situations are commonly quandary cases that require resolution. It is believed that the application of such principles as those of autonomy, veracity, nonmaleficence, utility, and the like will help solve the problem. The challenge is to pick the relevant principles, put them in order and, where they conflict, reconcile them with each other to arrive at an ethically satisfactory solution.

Bioethics so conceived provides medicine a language for articulating and adjudicating moral problems, and it has much to recommend it. But its limits are those of every procedural approach, an approach that assumes that moral responsibility is tantamount to rule responsibility. What is essential is that there be rules governing behavior, and principles to serve as arbiters when rules conflict. This view informs the social contract theories that are prevalent in principlist bioethics today. The idea of a contract is well-suited to negotiations between powerful professionals and informed, demanding public. But by implying as it does that self-interest is fundamental to social relations and by associating freedom with the freedom not to be interfered with, it does not equip doctors and patients for a relationship in which trust and generosity play a significant part. nor, at the level of social interaction, does a contract view elicit public-spiritedness from the profession of medicine and its institutions. On a social contract account, we may seek out a doctor because we hurt, but in the relationship then established we would never let our guard down. This explains why the principle of autonomy occupies a place of privilege in bioethics. Such a view of social reality does not adequately account for the experience of many patients and professionals, an experience filled with sympathies and admirations.

The root of the trouble reaches to a different level. It is the relationship between doctors and patients itself that is troubled and in need of reflection and fresh focus. Viewing the matter thus has implications for medical education and accounts in large measure for the growing presence of the humanities in medical curricula.

The approach of the medical humanities, of which bioethics as a technique of moral reasoning is an important part, is broadly philosophical. It aims at applying settled knowledge from the various disciplines of the humanities to medicine but at engaging medical educators and students in sorting through morally perplexing aspects of their practice. Teaching in the medical humanities is predicated on the view that because moral problems are perceptual as well as conceptual in origin, understanding must begin in a tutored appreciation of experiences of illness. Training in making sound judgments begins in
educating the moral imagination which, in turn, qualifies how we think and act. John Stuart Mill remarked on this process a century ago as knowledge was becoming compartmentalized and professionals were beginning to specialize. What professionals should gain from a university education, Mill thought, was not only professional knowledge but “that which should direct the use of their professional knowledge, and bring the light of general culture to illuminate the technicalities of a special pursuit... Education makes a man a more intelligent shoemaker, if that be his occupation, not by teaching him how to make shoes; it does so by the mental exercise it gives, and the habits it impresses.”

The humanities exercise the imagination as well as intellect. This is a valuable habit of mind to be shared with medicine. It must be acknowledged that the humanities face their own problems, chief among them being the risk of obscurantism, with specialists splendidly knowledgeable about a filed of study but divorced from a living culture. In my experience it is in no small measure thanks to the renewed dialogue with physicians and other professionals and participants in public affairs that the humanities themselves are being reinvigorated. The humanities can avoid obscurantism by remembering that the cultivation of intellect, imagination, and sensibility is not for its own sake but is always done in the service of practical understanding. To recall Kafka’s country doctor, in medicine this means an understanding of people and with them.

The understanding that is required for relating to patients is different from though not unrelated to, the kind of knowledge required to get a diagnosis. The skilled diagnostician must see beyond the patient’s distinctiveness to the regularities by which diseases are recognizable. But morally sound medical practice requires that the subtraction of the patient for purposes of the diagnostic hunt be temporary and instrumental to patient care. The move from diagnosis to prognosis and treatment remains incomplete until the doctor enters a relationship with the patient in ways that are sensitive to subjectivity and alert to the dramatic, storied character of experience. The knowledge required to understand a patient is more life self-knowledge or the knowledge we have of a friend, his character, the nuances of his personality, his feelings and ideas. Here it is not the world of nature but the world of culture that requires interpretation. These two worlds, though analytically separable, are fundamentally the same. It is just that they cannot be known in the same way. Gaining access to the human world requires the emotional and intellectual capacity to sympathetically enter into the experience of others.

The late Isaiah Berlin drew the distinction I’m making between knowledge about and knowledge of this way:

A medical chart or diagram is not the equivalent of a portrait such as a gifted novelist or human being endowed with adequate insight—understanding—could form; not equivalent not at all because it needs less skill or is less valuable for its own purposes, but, because if it confines itself to publicly recordable facts and generalizations attested by them, it must necessarily leave out of account that vast number of small, constantly altering, eversoent colors, sense, sounds, and the psychical equivalents of these, the half noticed, half inferred, half gazed at, half unconsciously absorbed minutiæ of behavior and thought and feeling which are at once too numerous, too complex, too fine and too indescribable from each other to be identified, named, ordered, recorded, set forth in neutral scientific language. And more than this, there are among them pattern qualities—what else are we to call them?—habits of thought and emotion, ways of looking at, reacting to, talking about experiences which lie too close to us to be discriminated and classified—of which we are not strictly aware as such, but which, nevertheless, we absorb into our picture of what goes on, and the more sensitively and sharply aware of them we are the more understanding and insight we are rightly said to possess. This is what understanding human beings largely consists in.

Sometimes Berlin refers to imaginative insight as a gift, implying that you either have it or you don’t. However, he also speaks of it as an achievement, implying that it can be learned. Perhaps it is best thought of as a capacity that can be cultivated, a capacity to imagine something of what it must be like to be experiencing the what the patient sitting opposite you in the exam room or lying in the hospital bed before you is experiencing. Not to know for sure, not to identify with another’s experience (that is the Romantic fallacy), but to come to some sense of what it must be like. As when Berlin writes,

When the Jews are enjoined in the Bible to protect strangers ‘for ye are heart of a stranger, seeing ye were strangers in the land of Egypt,’ this knowledge is neither deductive, inductive, nor founded on direct inspection, but akin to the ‘I know’ of ‘I know what it is to be hungry and poor.’

I said when I introduced my remarks this afternoon that we would return to Franz Kafka. And this mention of an understanding the reaches beyond moral reasoning and empirical investigation brings me to Gregor Samsa, Kafka’s strange protagonist in the novella, “The Metamorphosis.” Gregor’s transmogrification is sudden and unexpected. He awakes one morning to find himself transformed into a gigantic beetle. It is no dream but a waking nightmare, and by telling the tale from Gregor’s point of view the author takes us inside the sufferer’s experience. Gregor struggles desperately to free himself from the bed, and the condition, that hold him captive. Anxious to find out what his family may think of him thus changed, he is disheartened when they recall in disgust at the sight of him. Gradually, unwittingly, they begin to treat him as something
not human and menacing, though "he felt no disability." Kafka keeps the pressure on us, confining us inside Gregor’s inescapable shell, so that when, at the novella’s denouement, Gregor’s father nearly kills him in a fit of rage, we rationally comprehend the Samsa family’s frustration and revulsion, but we sympathize with Gregor. (I invite students to ask themselves what this parable can reveal to us about the experience of disabling, disfiguring illness and human reactions to it.)

As "The Metamorphosis" testifies, parables have an arresting quality that etches them deep in memory. Based on things seen, they evoke vivid images which are seen in the mind’s eye. Because parables engage the visual and visceral imagination, they penetrate deeply into experience. But they have the power to do more than arrest attention: they provoke more than curiosity. They arouse something deep within by calling up and focusing what the hearer vaguely senses is so. This is appropriated knowledge, not a knowing isolated in the intellect but involving the feelings, the heart, and shaping the will, a knowing that engages the knower. It is not a knowledge one can possess but a knowing that yields understanding and that demands a response on the part of the knower, a response that reaches beyond the requirements of contractual obligations.

Let me give an example of what I mean by reference to a father’s account of his son’s struggle with cancer. Receiving the news of his son’s first relapse, Terry Pringle reflects, "We child always knew there were boundaries. A bully could chase me, but would stop at the front door. My father might beat me, but would stop short of killing me. We are subject to illness, but it can always be cured. We are safe within these boundaries. And when I see the boundaries are imaginary, I feel sick.” And, months later, “I want my son to live. I have never begged for anything in my adult life, but now I am begging.”

Early this moving narrative, Terry Pringle introduces readers to Dr. Pope, the small town pediatrician who is to execute the medical decisions of the specialists in a distant city responsible for Eric’s treatment. At first, Dr. Pope seems to Brenda Pringle “insufficiently concerned” about her son. There are some miscommunications between the specialists and the pediatrician regarding drug dosages and it is Eric’s mother, not the doctors, who sorts it out. But Dr. Pope persists, stays in touch with Eric and his parents. The father writes: “The words he speaks aren’t nearly so important as the effort he makes. We need at least one doctor to confirm that Eric is important to him, that he is thinking as well as acting, that he recognizes the treatment comes from a standardized schedule but our son is not compilation of statistics and probable responses.”

The relationship between the child and the physician grows over time. Eric tells his parents that Dr. Pope is as skilled as the specialists at doing a spinal tap. On another occasion, Eric objects to having to lie down to receive an injection. “Okay,” the doctors says, “We’ll do it your way.” Whenever there is a choice between physicians, Eric wants Dr. Pope.

As the Pringles begin to run out of medical options and decide to try an experimental drug, they call their pediatrician. “He asks Brenda how we are doing. ‘Fine,’ she said. ‘Now tell me how you’re really doing.’” A friend tells us later that the doctor had asked if anyone had heard from us; he had thought about us all day.” When it becomes clear that cure will not come Terry Pringle breaks down. “Once loosed, the sobs are unstoppable. I sit on the coffee table with my head in my hands; Dr. Pope crosses the room and pulls me up, embracing me. I understand instinctively the move he has made. We don’t know each other well; he is as reserved as I am. And I know the steps across the room were long ones for him, not only to me, but out of a role that protects him. The doctor prays: ‘Lord, this hurts.’”

While the Pringles are able to decide about next steps, the doctor listens. Do they want Eric hospitalized? Not, they wish to keep him home. From then until the end, Dr. Pope attends Eric at home. When Eric’s parents are overwhelmed by the burdens they bear, the doctor takes charge, gently but firmly. It is a kind of sad, beautiful dance with one partner leading for a time and then the other.

The father phones Dr. Pope in the middle of an October night to tell him that Eric is dead. Pringle writes, “We is there within a few minutes and sits beside Eric for a long time, rubbing Eric’s arm and head. Before looks for a heartbeat, he performs the same ritual he always has—rubbing and rocking on the stethoscope to warm it before touching it to Eric’s chest.”

symptoms that corresponded to none of the results of routine tests, Frank learned from a specialist he had not met before that he may have testicular cancer.

By then I felt less terrorized by the idea of cancer than validated by a recognition that I was seriously ill…. Even though my worst fears were realized in what he said, the physician showed, just by the way he looked at me and a couple of phrases he used, that he shared in the seriousness of my situation. The vitality of his support was as personal as it was professional.12

Emboldened by these signs of recognition, Frank could get down to the business of dealing with his illness and, as important if he was to survive whole, he could keep sight of himself in his illness. If the recognition he needed at the point of diagnosis was an acknowledgement of the seriousness of his situation, recognition’s form would change as treatment began. Although in becoming a patient he had to learn dependence, he also worked at his role as lead actor in the drama of his illness. It was that for which he now desired recognition. This required a role reversal of considerable dimensions in a theater dominated by doctors, but it was necessary if Frank was ever to relinquish the role of patient and go into remission.
In his probing investigation into the nature of responsibility, Hans Jonas wrote that “ethics has an objective side and subjective side, the one having to do with reason, the other with emotion. The two sides,” he noted, “are mutually complementary and both are integral to ethics.” I have said that in my view, contemporary bioethics debates too often concentrate on issues of formal responsibility, that is, on accountability to principles and adherence to rules and procedures, to the neglect of material responsibility. It goes without saying that in the absence of rules of right action and warrants for those rules, arbitrariness may prevail. And it stands to reason that, with the bureaucratization of medicine, procedures were bound to proliferate. It is also the case, however, that as Jonas puts it, “Without our being, at least by disposition, responsive to the call of duty in terms of feeling, the most cogent demonstration of its right, even when compelling theoretical assent, would be powerless to make it a motivating force.” In addition to teaching sound moral reasoning, we must cultivate in our students the virtues of respect, regard, imagination, sympathy and compassion. These are the moral instruments they will need to take good care of the sick.

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6. This quotation and those that immediately follow are from Pringle T, This Is the Child. New York: Alfred A. Knopf, 1983.


8. Ibid., 142.

9. Ibid., 163.


12. Ibid., 26.

The Health Services Experience: an Alternative to the Classroom-based Model for Moral Development of Health Professionals

A Experiência no Serviço: uma Alternativa ao Modelo Baseado na Sala de Aula para o Desenvolvimento Moral de Profissionais de Saúde

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RESUMO

Os autores apresentam uma descrição crítica do modelo de ensino de ética nos cursos de graduação médica nos Estados Unidos, destacando seus riscos inerentes. Apresentam duas experiências de ensino desenvolvidas pela University of Texas Medical Branch em Galveston com comunidades carentes: Mulukukú, Nicaragua e Rio Grande Valley, Texas. Estes dois projetos buscam o engajamento dos estudantes da área da saúde em atividades práticas que possibilitem experiências concretas de tomadas de decisões éticas, contribuindo para o seu desenvolvimento moral.

Os autores concluem que a ética precisa afetar o comportamento e não apenas desenvolver processos sofisticados de reflexão. Ainda que os princípios éticos podem requerer algumas vezes a não intervenção, o objetivo do ensino desses princípios deve ser o de demonstrar aos alunos a como atuar ativamente demonstrando responsabilidade e respeito pelos seus pacientes, em uma relação engajada.

ABSTRACT

The authors present a critical description of the teaching model used in courses on ethics in undergraduate medical training in the United States, emphasizing the model’s inherent risks. They discuss two teaching experiences developed by the University of Texas Medical Branch in Galveston in low-income communities: Mulukukú, Nicaragua, and Rio Grande Valley, Texas. These two projects aim at student involvement in practical activities in the health field which foster concrete ethical decision-making experiences, thus contributing to their moral development.

The authors conclude that ethics should affect actual conduct and not merely develop sophisticated reflection processes. Although ethical principles may sometimes require non-intervention, the purpose of teaching such principles should be to show students how to actively demonstrate responsibility and respect for their patients in a relationship involving commitment.

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3 Resumo elaborado pela Comissão Científica do Simpósio
Moral development involves more than ethical reasoning skills; it involves processes of leadership, advocacy, action, and personal commitment to justice and beneficence. Educators have discussed at length the need to "humanize" medical students, to engender social responsibility and encourage moral development in a way that enhances meaning and understanding, but few proposals have emerged that are designed to do this. This presentation describes a model for moral development of medical and other health professions students that uses a service-oriented, experiential approach.

Introductory medical ethics courses are meant to teach personal and interpersonal processes of ethical deliberation and reasoning, and to prepare students for life-long moral development.* Although such courses intend for students to translate these skills into ethical behavior and action in the clinic, they rarely give students opportunities to internalize and exercise ethical commitments. But ethics, like medicine, is not only a discipline but also a practice. Consequentially, skills in ethical deliberation are developed and refined through use. Without encouragement and opportunities to consciously take moral action, the moral development of caregivers can stagnate. And while we can teach professional etiquette as well as identification and standard resolution of clinical ethics issues, moral responsibility and commitments are less "taught" than they are "engendered."

The kinds of moral commitments we are talking about are not controversial and are generally held to be virtues among ethics educators and health professionals alike, and largely revolve around promoting patients' health interests. The most respected and admired moral exemplars of our time demonstrate their strength of character and moral commitments through their actions, often responding to injustice through public service and making personal sacrifices in their professional lives. These role models not only have behaved responsibly when confronted with challenges, but also have sought opportunities to display moral responsibility not as an obligation but as a desire. They took a proactive role in establishing themselves as admirable professionals.

Two projects developed for U.S. medical and health professions students present real potential for heightening the moral development of students in the health professions, and provide opportunities for proactive moral development and internalization of ethical behavior. Designed as service opportunities, the projects attend to students' moral development by putting them in circumstances that provoke reflection, test assumptions, develop empathy, supplement abstract understanding, and reveal how moral meanings of situations and decisions can change according to patients' social, political, and economic environments.

During these projects, students learn not only to recognize ethical issues and develop appropriate responses, but also to realize problems in a more complex sense by engaging in the process of solving problems within a particular context. In our experiences, these projects capture students' moral imagination and engender their interest in a way that classroom learning and even clinical experiences often do not. They teach a broader base of ethical issues than classes often do, including the responsibilities of physicians beyond their clinical responsibilities to individual patients and the necessity of a proactive approach in the ethical practice of medicine. Such an approach contrasts that often found in U.S. hospitals, where students abandon the process of coming to difficult moral decisions to the "ethics experts," who can often be called upon to step in and take responsibility for such decisions. The two projects developed using this alternative model are described below, as are some of the features that define the model. In order to better contrast this pedagogical approach to standard U.S. approaches for teaching ethics to medical students, a brief description of the standard model is first provided.

THE STANDARD MODEL IN THE U.S.: DEVELOPMENT OF ETHICAL REASONING SKILLS IN MEDICAL STUDENTS.

U.S. medical schools routinely offer some kind of ethics course in their curricula, which is often the most significant opportunity for building a foundation for moral development that students receive during their medical education.

First, a brief note about the most common structure of medical education itself in the U.S.: after 4 years at an undergraduate university, students enter medical school, which usually consists of two years of class work with a small amount of exposure to the clinic, and two years rotating through clinical departments. Recently, some programs have moved to problem-based learning pedagogies modeled on apprenticeships, but such programs are not common.** Three- to seven-year residency programs follow medical school, depending on the specialty chosen. No public service is required after graduation.

Introductory medical ethics courses are typically offered in the first year over the course of one semester, or at most two semesters, with classroom meetings for an hour each week. Some schools incorporate ethics rounds during the third and fourth years, where students meet to discuss cases. Some schools offer further exposure to ethics through elective courses during the fourth year, although again, most are classroom-based, abstract experiences.

*Although this article focuses primarily on medical ethics pedagogies for the purpose of drawing contrasts, the alternative model presented is equally useful for the moral development of other health professionals, in much the same ways presented here.

**Problem-based learning places students in the clinic from the beginning of their medical education and focuses on learning through experience. Such an approach holds more potential for supporting the moral development of students, but only if attention to ethics and moral development is specifically integrated into the pedagogy.
Clinical experiences during the third and fourth years are expected to provide the practical context to extend reasoning skills into moral development, and students are expected to use this environment to develop their own ethical practice skills. Although the realization of moral development opportunities depends largely on mentors' skills, ethical issues are not always discussed or even acknowledged explicitly in the clinical context. Further, positive role models for medical competence and ethical competence do not necessarily overlap, which can send mixed messages to students regarding the profession's commitment to the ethical practice of medicine. Consequently, despite the potential opportunities presented by the clinical setting, if ethical implications are not brought to the surface, examined explicitly, and responded to, they may not make a contribution to the student's moral development. Typical service projects, such as clinics for the poor, present opportunities for moral development. But often these projects must be actively sought out by students, are not well supervised, are not attractive to students, or do not focus on ethical issues or students' moral development.*

In terms of time, structure, and academic rigor, the introductory medical ethics course is often the most significant ethics instruction that students receive during their medical education. Introductory course curricula generally focus on the profession's ethical foundations by reviewing codes of conduct and oaths, and by discussing the accepted principles and frameworks for analyzing issues that are likely to arise in the clinic, such as truth-telling, confidentiality, informed consent, the use of life-sustaining treatment and end-of-life care, and conflicts of interest, to name a few. Legal issues and professional requirements are usually included in discussions. Finally, courses may discuss other topics such as dealing with difficult patients, communication issues and skills, and cross-cultural issues. Macro ethical issues involving the structure of health systems, distributions of resources, human rights, and issues of social justice are rarely brought up, much less placed at the center of ethics discussions.

Background reading on each of the topics is provided, and given the growth of the field of medical ethics in the U.S. over the past thirty years, there is a great deal of quality literature from which to choose, including journal articles, textbooks, and anthologies, which address a variety of ethical issues and approaches. Respected authors apply their training in various disciplines, though mostly philosophy and theology, to the context of medicine. Literature and history usually supplement the disciplinary understandings of issues.

Introductory classes often take a didactic approach, with group discussions of the issues intended to clarify personal values. Grades often depend on a combination of class participation, short essays, responses to case studies, and/or research papers. Given the limited time amount of time budgeted for such courses and the breadth of topics usually covered, it is difficult to spend more than an hour of class time on any particular topic, which makes it virtually impossible to examine issues in depth or have time for reflection.

The course is expected to provide students with a vocabulary through which to communicate their own and others' values and thought processes, introduce them to common interpretations of ethical situations, and provide feedback to guide legitimate interpretation and resolution of these issues. Students learn through guided repetition of tasks, often presented in the format of case studies, in which they recognize and apply the relevant ethical principles to various clinical scenarios.

Most schools use a principlist approach to moral reasoning that focuses on autonomy, beneficence, non-maleficence, and justice, although other approaches such as Feminist Bioethics or a Care Ethic might also be discussed. That approach is placed within a secular bioethics framework, which emphasizes tolerance for pluralistic values demonstrated largely through respect for patient autonomy and non-coercion. At times, students can get the impression that because they should not force views and values on patients, they cannot engage patients: "non-coercion" becomes "non-interference." This can have the opposite effect on the doctor/patient relationship than intended, leading to isolation and lack of interpersonal understanding. Students' perception of moral action can become a highly proceduralist approach to resolving ethical issues in the clinic, focused on following the patient's wishes, without a strong duty to engage in a process of dialogue or discovery. Taken to the extreme, a secular bioethics blunts moral agency, because in order to discredit the appropriateness of enlightenment philosophies in multicultural environments, it presents arguments against the possibility of resolving conflicting beliefs and values and emphasizes non-interference—a "safer" posture than non-coercion above any particular virtuous practice. It is this extreme that concerns those who wish to encourage the moral development of students. Secular bioethics should not be translated into non-engagement; rather, students should be taught how to discover and focus on common goals and foster mutual understanding with patients both by listening and learning as well as by talking. By contrast, the service experience model encourages respectful engagement based on the professional responsibility of the physician to the patient with a conscious recognition that a core value of the Western medical tradition is moral agency.

Despite their limited support within the general medical curriculum, these introductory classes not only make an important contribution to medical ethics education, but also provide students with a foundation for ethical concepts and reasoning on which the experiential approach to

* There may be a variety of reasons the projects are not attractive, including for example that the time commitment interferes with studying, the projects do not receive significant institutional or community support, or the work seems unappreciated by patients and/or professional role models.
moral development depends for its success. Any implicit criticisms more reflect the limitations placed on such courses in terms of time, resources, and opportunities to engage and develop students’ moral lives than a failure in designing the courses per se. In fact, researchers, notably Self, have found that students who have taken such classes do move to higher stages of moral development, demonstrated through ethical reasoning.*

Self’s studies are based on Kohlberg’s theory of moral development, which is modeled on Rawls’ interpretation of justice as fairness, where the right or good is that which is most fair to all concerned. Scores for Kohlberg’s tests are based not on a student’s particular moral values, but on the reasoning behind their belief. Other theorists include Gilligan and Noddings, who argue for morality interpreted in terms of care, compassion, and responsiveness to other persons.

AN ALTERNATIVE MODEL: MORAL ENGAGEMENT OF HEALTH PROFESSIONALS STUDENTS THROUGH SERVICE

In the context of the service projects, both bases for ethical reasoning—justice and care—are appropriate and can be observed in action. The particular theory that is chosen appears to be less important for moral development than giving students a context and social understanding in which to develop moral responses, and deciding which approach is appropriate for the situation is part of the process of moral development.

Reasoning skills can also be fostered through experience. Students learned not only to recognize ethical issues but also to see factors contributing to the problem that might not be apparent to a less engaged clinician who responds according to algorithms rather than by exercising their moral capacity. But moral development also involves a proactive component, in which reasoning necessarily spurs an active response, a demonstration of moral development that has not yet been incorporated into moral development assessments.

The service experience model we have developed may present its own limitations for moral development. The model was designed to address deficits in U.S. formal and informal educational culture, and should not necessarily be interpreted as a universally successful method for engendering ethical reflection, compassion, and action. These projects were developed out of a perceived need of U.S. medical students to become familiar with how deprivation can affect patients’ experiences and perspectives. A lack of such understanding can lead to caregivers’ inability to identify with patients and to provide medical care and advice in a way that is both respectful and effective. Without understanding the social contexts of such patients’ lives, physicians feel less of a professional obligation to advocate on their behalf. With exposure to the daily struggles of deprivation, though, students often discover for themselves duties they did not previously recognize, and take the first steps to fulfilling them through participation and leadership in the service projects. We have found that many students have a strong interest in seeking opportunities for moral development, but need guidance to be taught how and when they can actively make a positive contribution rather than simply avoid moral pitfalls.

But other cultures may find other challenging issues and opportunities for humanistic formation of students. Ultimately, the value of a project will lie in its ability to offer students new understanding of their patients’ lives and how they are affected by the larger context of the community in which they live.

Rather than educating students in ethical and legal responsibilities, abstract reasoning skills, and professional etiquette, we sought to engender moral responsibility by providing students an opportunity to serve, in a personal sense. The pedagogical emphasis in this approach is less on instilling ethical competency through technical skills than a recognition that human dispositions to moral action must be nurtured, guided, and practiced. Philosophical and humanistic explorations are meant to be supplemented by real life experiences, and early opportunities to be kind, compassionate, and charitable need to be encouraged and given programmatic structure.

If these experiences are carefully supervised, guided and discussed, they can reveal the complexity of ethical problems in a way that classroom discussions and decisions cannot. Problems discussed in the classroom can be oversimplified because the context is not sufficiently developed, and it can be difficult to creatively solve problems in the abstract. When third- and fourth-year medical students begin to realize these challenges during their clinical work, their lack of practical experience in responding to the situation and dealing with the consequences is more likely to result in inaction or in unsatisfactory results. Certainly it is difficult to gain personal satisfaction, which can help galvanize commitments to moral action, from the happy but hypothetical resolution of a difficult abstract problem.

MULUKUKÚ, NICARAGUA
Alexandra Bambas

The first project was developed four years ago, after I had spent three years co-teaching an introductory medical ethics course at the University of Texas Medical Branch. I began working with a local church, which was sponsoring a medical mission to Nicaragua and had decided...
to recruit several first- and second-year medical students to help work in the clinic. The clinic is located in Mulukukú, a community in the Northwest Autonomous Zone, which was heavily involved during the Sandinista/Contra conflict of the 1980s, and the citizens of the community remain split between the two parties. The difficulties of Nicaragua’s political, social and economic situation, in combination with low levels of health and education, the high levels of violence that have become endemic, and the general political and geographic marginalization of Mulukukú, place the well-being of the community at great risk in terms of physical, mental, and social well-being. Several years ago, the government closed the only public health clinic, which was responsible for serving a catchment area of 25,000 people, and for the last ten years the privately sponsored free clinic operated by the women’s cooperative has provided the most significant access to primary care for the vast majority of the area. This grassroots cooperative is the primary force of social organization and solidarity there.

In order to make the mission trip more meaningful for the students, many of whom had never been outside of the U.S. nor worked in a deprived community, the medical director of the mission trip and I decided to offer a course for credit through the medical school, which would provide 2 weeks of class at the school, 2 weeks at the clinical site in Nicaragua, and would incorporate as a requirement participation in a public health project.* We wanted the course to be an opportunity for students not only to acquire clinical experience, but also to reflect on values not typically examined in the course of the usual semester work. We hoped the course would invigorate those ideals that influenced students to become health professionals in the first place.

Specifically, my original goal for the experience was to engender ethical decision making by teaching responsible international health practice. The theory behind this goal was that the international context provides U.S. students with a sufficiently alien environment that they are encouraged to open their minds and eyes to the subtleties of what was happening around them. Sometimes working in a cooperative context with people who are in situations and have perspectives dramatically different from one’s own can increase interpersonal understanding as well as tolerance for diverse beliefs.

**CURRICULUM**

Before students could serve in the community clinic, they had to complete two weeks of readings, didactic lectures, and small group discussions in order to prepare them for the cultural experience and alert them to the clinical and ethical issues likely to arise and of which they should be aware in order to understand the context of care in the community. Readings and discussion topics were carefully chosen to address issues rarely presented in introductory ethics classes but which have clear ethical implications for the students’ work in the community.** Macro issues included global distributions of health resources and the burden of disease, the structure of different health care delivery systems, an explication of human rights, and information on the social, political, and economic reality of Nicaragua, including how military interventions had affected the availability of local and national resources. The readings were intended to spur students’ curiosity and exploration of the meaning of medical practice in the community. Other topics introduced students to the professional responsibilities of practicing internationally, including the obligation to focus efforts around community-defined needs and the ethic of reciprocity in the mission experience. Specific health problems of the community were also presented to the students, including knowledge of tropical medicine, treatment of alcoholism, injuries due to violence, sustainable development, and public and environmental health issues.

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Lectures:
- Primary care classes
- Community-Oriented Primary Care
- Role of Health Promoters and other health care workers
- Basic Nutrition; Assessment of Malnutrition
- Family Planning and Prenatal Care; Common Diseases/ Common Treatments

Public health classes
- Introduction to Epidemiology
- Conducting a Needs Assessment
- Sanitation and Water Safety
- Tuberculosis
- Immunizations: Recommendations, Status in Developing Countries
- Environmental Health
- Tropical Medicine: Water-borne Illnesses, Mosquito-borne Illnesses, Diarrheal Diseases, Rehydration Therapy, Basic Parasitology.

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*Medical curricula generally provide only a superficial look at the discipline of public health, and the public health project included in the service project was later identified by half of the project students as one of the most important factors in their decision to take the course.

** All students had previously completed the mandatory introductory medical ethics course in the general curriculum.
Background to international health

- Health Care Systems in Developing Countries;
- How the health needs of poor and wealthy communities differ;
- Panel of students with international experience in medical practice;
- Human rights;
- Activism;
- Sustainable development;
- Appropriate use of technology in clinical practice.

Political, Social, Cultural classes

- Political and Social History of Nicaragua and the service community;
- Introduction to Medical Anthropology;
- Hispanic Culture/Cross-Cultural Care;
- Cultural issues in the service community;

THE PUBLIC HEALTH PROJECT

The requirements of the course included student development of a public health project, with guidance from a public health school graduate. The project topic was chosen by local health promoters from Mulukukú and designed through consensus to serve the community’s perceived health needs. Because U.S. medical students often demonstrate less than enthusiastic interest in public health, we were very pleased that the group dedicated so much time and careful attention to the project.

Development of the community health assessment—the project chosen the first year—provided an opportunity not only to talk about the relevance of certain kinds of questions to the community’s context, but also to learn how to ask the survey questions, some of which were sensitive, in culturally appropriate and respectful ways and to be aware of that issue.

Students further recognized the difficulty of constructing a depoliticized survey that would not feel threatening to a community of people who had suffered war-time atrocities and violence, who had had their confidences broken by officials and lost trust, and who continued to be abandoned by their own society. But these were people who also recognized that strangers can be friends, and that people and their governments do not always agree.

Health promoters were able to give an open and critical response to the survey, which students recognized as an indication of trust between the groups. They suggested that it was impossible to depoliticize the survey because giving the survey would itself be seen as a political activity, but they felt the community had a trust relationship with the mission group earned through service.

After local health workers and community leaders had reviewed each question and given a final edit to the survey, students helped train community health workers to administer the survey during supervised neighborhood interviews conducted by the health promoters. Although it was a time-intensive process, we decided to train the local health promoters to use the survey not only to increase the sustainability of the survey but also to increase health promoters’ knowledge of public health issues. The visits to community members’ houses to conduct the interviews provided a comfortable opportunity for students to observe first-hand the level of deprivation in which these people lived, which students say gave them a much clearer understanding of the issues which later emerged when patients came into the clinic for care.

A Stimulating Environment for Reflection

Clinic begins each day at 7 AM and lasts until 7 PM, with a break for lunch. It is important to stress that students are required to work under the supervision of physicians and nurse practitioners at all times. Despite the intensity of the schedule, the stimulation of practicing in such an unfamiliar environment kept mission team members discussing a wide variety of ethical issues as well as the meaning of what they saw during every meal, through reflection time at the end of the day, and lingering in the hammocks long past bed time.

Several ethical issues arose in the clinical context. For instance, one of the ground rules of the clinic was that male care givers are not allowed to give pelvic exams. When students asked why, a discussion began with local health promoters which focused on the tension of gender relations in the village due to the high levels of political and domestic violence, sexual abuse, and cultural norms related to sexuality. Further, despite the mission team’s ongoing relationship with the village, patients may not be familiar with particular care providers, and many of the women had never had pelvic exams; therefore, care should be taken to provide as much psychological comfort as possible. Students were also instructed that, despite the opportunity to observe unusual medical cases, they were to remain mindful of privacy issues when discussing or observing patients’ conditions. Most of the visitors to the clinic were mothers who would bring several sick or at-risk children with them, which forced students to wrestle with how to provide care responsibly in a context where few women can read instructions but are nonetheless given multiple medications to administer to numerous family members.

Through these experiences, students began the process of creatively
searching for the ethically ideal solution given the circumstances and recognizing that simple answers that may feel comfortable in the abstract can be ethically unsatisfying in practice.

During the course and subsequent field experience, discussions often revolved around not only the ethical issues students identified in the care context, but also the responsibility involved in being invited to enter a community and work with its members. Discussions emphasized the church’s on-going relationship with and responsibility to the community; the importance of working respectfully under the direction of the local clinic director, alongside local caregivers, and with patients; how to appropriately demonstrate this respect professionally and socially; and recognition and support of the community’s high level of empowerment. When students were saddened by the lack of economic resources in the community, they were warned not to practice “miserablism”, a form of pity which can diminish energy and create apathy, but instead to recognize both the community’s accomplishments through organization as well as the support that they as health professionals could provide to the community through the clinic, public health, education, advocacy, and solidarity. The reciprocal nature of the relationship between students and the community required that in exchange for patients providing students with valuable learning experiences, students were to provide competent and respectful service to the community, including providing care under supervised conditions.

Students also extended their reflection to broader ethical issues faced by the community. They discussed with each other and with community friends the political and social history of Nicaragua, including U.S. involvement in the country’s civil war; how they perceived different national health systems as more or less just for particular societies; the influence of social and living conditions on health needs; issues of justice in regard to health resources; the political difficulty of prioritizing public health needs; the consequences of living without a political voice; various issues related to cultural sensitivity; and the limits of cultural relativism.

They also examined the meaning of their own work in the clinic: the difference between short-term acute clinical care and the long-term benefits to be had through public health programs, the prevalence of preventable disease, and the sustainability of the work being done by our group and by the community.

When students were asked to identify the major health issues of the community, they focused not on medical issues but on public health issues:

- Water
- Nutrition
- Sanitation
- Immunizations
- Organizational capacity and
- Political recognition by the government.

The general challenges for the community, they believed, were:

- Poverty
- Education
- Political safety
- Health
- Environmental health and
- “Not to lose hope”.

Recognition of caregivers’ resource limitations and of a community’s larger human development needs helps health professionals understand how they can be most effective in supporting the well-being of the community.

One of the most consistent and long-lasting impressions of students was the solidarity of the community, especially demonstrated through the women’s cooperative. This observation was not surprising since contemporary U.S. culture pays little attention to the value of solidarity. In Nicaragua, however, a country where women have little economic, social and political power, this cooperative of thirty women—many of whom had been abandoned by their husbands—had brought together a politically divided community to work for education, nutrition, health, economic development, nonviolence, and conflict resolution. And they had done it through personal sacrifice and unwavering commitment to each others’ well-being. They served as some of the strongest moral exemplars with whom the students could have partnered.

**FRONTERA DE SALUD**

**Kirk Smith**

I started the second project, Frontera de Salud, a year and a half ago as a third-year medical student. During a clinical rotation in the Rio Grande Valley, located in South Texas near the Mexican border, I witnessed...
The reform ax has fallen hardest on non-profit institutions, in particular clinics that serve the working poor who do not qualify for public assistance yet lack the economic means to purchase insurance. The Brownsville Community Health Center, the only clinic currently serving the working poor of the area, only had the capacity to serve 14,000 of the estimated 54,000 in its catchment area, even under the best circumstances. Over the past year, the center has been forced to reduce its professional staff by 50%, leaving a staff of four adult medicine physicians, one OB/GYN physician and nurse, and two pediatricians to serve the Valley’s largely uninsured population.

Working through this health center, Frontera conducts special weekend clinics supported by medical, dental, nursing, allied health and graduate students and faculty from the Houston/Galveston area, which is approximately six hours away by car. Teams bring basic services to Valley residents, including gynecological exams, diabetes screening, pre-natal counseling, pap smears, and breast exams, using a multidisciplinary team approach. Additionally, students conduct diabetes education classes, focusing on the day-to-day of living with diabetes: diet, exercise and hygiene. This class typically has fifty attendees.

On Sunday, the Frontera team travels to the community center at Cameron Park, an impoverished neighborhood just outside the Brownsville city limits and the largest public housing complex in the U.S. At the community center, the teams set up screening and counseling stations to meet patients at the airport or bus station prior to their appointments has organized them, but nonetheless intimidating. To remedy this situation, Frontera education incorporates discussions aimed at the moral intentions of their charitable work—during clinic hours, over meals at the end of the day, during the long drives to and from the border, and in group reflection time at the close of our work on Sunday—giving thought to such topics as the health professional’s obligation to the patient and to society, social healthcare policy, the politics of wealth and its distribution, the meaning of care, etc., all delivered and given focus by experience with actual patients in circumstances of active need and relief.

Frontera educates student volunteers through campus lectures, study modules and workshops on how to perform examinations and through a Website that includes, in addition to patient education, and a medical professor discussed

Frontera is structured for students with more experience than is the Mulukuk project because it requires stronger organizational and leadership skills, at least for the small group of students with a long term commitment to the project. Continuing development of the program depends on students’ recognition of needs as well as creative and appropriate development of solutions. Since the program’s inception, students have expanded the project in several directions which demonstrate their personal commitment to the population they serve.

The identification of each of these problems and development of responses was generated by the students themselves. Students seek faculty who volunteer with Frontera for advice, support, and assistance, but students take their role in directing the activities and organization of the service project very seriously.

SOCIAL SUPPORT FOR PATIENTS

In the past, Spanish-speaking patients from the Valley referred for care to UMB have arrived overwhelmed by a system eager to help them, but nonetheless intimidating. To remedy this situation, Frontera has organized Accompáñanos de Salud to provide Spanish-speaking student escorts for Valley residents visiting Galveston. Accompáñanos meet patients at the airport or bus station prior to their appointments and stand at their sides throughout their visit to offer translation, explanation and direction through the system, as well as a calming and reassuring presence.

CROSS-CULTURAL SERVICES

When it was announced at a recent campus meeting that budgetary cutbacks of translation services would eliminate Spanish-language dia-

*More information on Frontera de Salud can be found at: http://www.sga.utmb.edu/talams/frontera.html, including one student’s experience of working with the program.
betes-management classes. Frontera volunteers called a meeting. They discussed the problem, saw its implications, reflected on their professional obligations, and responded through action. These classes have now resumed using Accompilhadores volunteers.

LINKING PATIENTS TO STATE SUBSIDIES

Although Texas has a state policy to analyze PAP smears, the state does not pay for the exam itself. The health center in the Valley no longer has the staff resources to perform the exams that would allow this especially vulnerable population to take advantage of that public subsidy, which wealthier populations who have less need for the subsidy can and do enjoy. Students decided to add this service to their responsibilities during weekend clinics.

COMMUNITY SOLIDARITY

When students began counseling patients to start a walking program to help manage their diabetes, they were surprised to learn many of these patients do not have the proper footwear to exercise. In response, students organized a shoe drive, collecting over 100 pairs of sport shoes and walking sneakers for free distribution at the clinic. They commented that this issue, which they had interpreted strictly as noncompliance and patient apathy and which had consequently caused them to be dismissive of patients’ excuses for not exercising, actually included a lack of patient resources. This realization provided a completely different emotional and behavioral response, and gave the students incentive to proactively assist patients in obtaining the resources necessary for them to comply with care recommendations.

FEATURES OF THE MODEL

Assuming that these two projects did in fact contribute to students’ moral development, we might ask what features of the projects contributed to their success, and how generalizable is the model. We don’t know all the answers to these questions, but our experiences and discussions with students as well as some of the failures of other projects with similar goals point to a number of specific features.

THE SETTING:

1. Voluntary, Service oriented

These projects were voluntary, and built around an explicit setting of charity and service ideals. Although an individual student may also be motivated for other reasons, e.g. social position or improvement of technical skills, financial gain should not be a motivation, and students should understand that moral development is an explicit educational goal of the service project.

Although the voluntary aspect of this feature could be interpreted as a weakness of the model since all students would not likely volunteer, it is possible that students who are not personally committed to the activity will not be able to fully engage their attention, especially to moral issues. Because this project seeks to develop moral leadership, it may be more useful for those students with a disposition towards those aims.

Still, it is possible that existing mandatory courses meant to foster service ideals, but which often do not succeed, could be modified so as to offer the same kinds of moral development opportunities found in these projects. For instance, Project UNI, sponsored by the Kellogg Foundation, which trains health professionals by creating university, community and service alliances in several countries in Latin America, could be adapted to more actively focus on the moral development of students. Similarly, mandatory and elective rural externships and international health projects, common in the United States, might be restructured so as to incorporate other important features of the model, and thereby reap its rewards.

In fact, there may be good arguments for requiring students to engage in a service project of some sort during their training, specifically because it provides exposure to such activities and opportunities for moral development which they may not have sought out on their own. In any case, it is important to design mandatory service projects in such a way that students do not experience the projects as an onerous duty and resent having to participate. If the project is mandatory, there should be significant and supported opportunities for students to voluntarily initiate their own activities within the project, in order to support creative problem solving, leadership, and the sense of the rewards of assisting those in need, even when it is not strictly required. The following conditions would also apply.

2. Community cooperation

Moving students out of the institutional, highly bureaucratized environment of hospitals and putting them in the patient’s community environment serves many purposes for moral development. Perhaps the most important aspect of community work is the demonstration that ethical concerns do not end at the clinic door, but exist whenever patients are affected. The community context also helps equalize power balances between caregivers and patients, which can increase students’ sensitivity to such issues. It also teaches them to look for local resources and advantages as well as barriers that can support or detract from care interventions. Working with community leaders educates students on the environment in which they will be working. By working in environments that often have less procedural authority, flexibility and creative thinking are stimulated, and students learn to entertain other perspectives than simply the “medical” perspective. Finally, seeing patients...
in their living contexts can create a bond between students and the communities they serve that encourages personal investment in the well-being of patients.

3. Culturally unfamiliar setting

Cross-cultural settings can improve students’ cultural competence, which can contribute to the process of moral development. Cultural competence in the health development setting is that understanding which allows one to work effectively within and between cultures to help individuals or groups reach their goals. Competence involves recognizing the differences that affect relationships and responding knowledgeably and skillfully to facilitate beneficial relationships. The key to this response is recognition, both of familiar visions and new perspectives. When we say we “recognize” people, we usually mean that their faces are familiar to us. But recognition of identity has a deeper component—the recognition of another’s experience and standing in the world. It is due to this second and more profound component that, paradoxically, it is sometimes easier to “recognize” a stranger than a neighbor. Strangers stand far enough away that we can take full account of their identity without making assumptions as we do with those whose appearance and background match our own. Recognizing that identity and taking differences seriously is the first step to respecting that person; it involves the ability to understand a perspective within the context of that person’s life, an interpretive skill that requires tolerance, even as one maintains critical judgment. Indeed, it is the thoughtful accounting one takes of differences that enables sound judgment.

When people are removed from their usual environment, they are often able to observe with more open minds, without the investment they have in their accustomed perspective. Extreme cases, such as are found in circumstances of great need or drastic difference, make people aware of problems they might not have recognized as obstacles to communication and cooperation. Through such activities students gain a practical understanding of how caregiver-patient relationships differ in other cultures and how daily lives and health are affected by social, economic, and political conditions different from their own. Attention to this kind of detail improves students’ ability to build relationships and find suitable and successful approaches to meeting health needs, teaching them to listen closely to what people say and to consider how patients respond to us and to their environment. Students often return from the international setting endowed with a new perspective, enabling them to understand why patients have certain needs and make certain choices. They then become invested in working with patients on a more personal level to achieve their goals.

Cultural sensitivity and the ability to gain cultural competence are important skills in the modern world, and in health care and health promotion, these skills are clearly vital. Confronting differences in an unfamiliar setting can sensitize students to cultural subtleties in their home environment, including behaviors they may previously have found mystifying or frustrating. When they see that such behaviors may be related to cultural differences, they can respond to them in appropriate, more understanding ways.

In the U.S., patients and providers often do not share similar backgrounds, and cultural beliefs regarding the body and the practice of medicine can vary widely. Nevertheless, health is an area in which we do not necessarily need to share identical beliefs in order to achieve our mutual health goals. Staying attuned to shared goals, while maintaining an ability to appreciate and negotiate differences, is crucial to good care. Cultural sensitivity encourages qualities in caregivers that feed cooperation and communication, including an open mind, compassion, and an interest in the caregiver-patient relationship.

4. Attractive and enjoyable experience

Projects should be organized and focused to be enjoyable for students, although they may also involve hard work and commitment, in order to remedy the impression that moral agency is an onerous duty to be pursued in the face of one’s “real” desires and to encourage positive associations with service. Students may then be encouraged to continue such work in their professional practice when they discover the more personal rewards of exercising moral agency.

For our students, we knew the international aspect would appeal, as would working with poor populations. And we were very lucky to work with on-site groups who have provided invaluable support not only to our service goals but also to our pedagogical goals. Features of choosing an appropriate site will likely vary according to available opportunities as well as the specific interests of students.

THE PEDAGOGICAL STRUCTURE:

1. Preparation for the setting

Students must be adequately prepared for the social, political, cultural, and health context that created the environment in which they will be working. A lack of adequate preparation has been cited as a primary weakness for similar projects, including rural externships as well as standard international electives, because students need information to improve their understanding, to establish an open and receptive attitude, and to reduce anxiety, all of which foster ethical reflection. Students participating in the Maluku project cited the background information on the political and social history of the country and its economic context as the single most important topic to prepare them to understand what they experienced.
2. ROLE MODELS, SUPERVISION, AND ETHICAL GUIDANCE

Another weakness of other projects is that students are sometimes sent to participate in projects without someone to model ethical action and guide discussion appropriately. Finding appropriate role models may be the single most difficult factor to control, because it will depend on available resources. Role models should include health providers—not just “ethics experts”—as medical students need demonstrations of their own roles. In choosing these exemplars, the respect of students and demonstrated commitment to patients may be more important factors than “ethical expertise” as conferred by academic study, although skilled guidance in discussion can make significant contributions. Ethically insensitive caregivers pose a particular danger, as it can be very damaging to the messages we are trying to communicate when a student shadows a technically competent physician and sees that physician act unethically.

Ethical issues and challenges must be explicitly acknowledged, if not always “solved.” Given the stimulus of the environment and guidance, students’ ability to hold ethically sophisticated discussions naturally improved, they articulated prescient insights, and they began to form their own visions of moral practice and their professional responsibilities. Central themes that should be addressed in the general context of working in deprived communities include cooperation, respect for the community’s decisions, and especially sensitivity to cultural imperialism and more general exploitation.

3. REFLECTION TIME

The experience should build in adequate time to process, reflect on, and discuss the day’s events and observations. Although we never mandated participation in our discussions, our experience was that students enjoyed the opportunity. Specifically, students should not feel that there is academic pressure to “perform” or “give the right answer”, but rather that they can discuss issues and their thoughts openly without fear of punishment or risk.

FINAL COMMENTS

Ethics needs to affect behavior, not just develop sophisticated thought processes. As a society, we can’t afford to teach physicians simply not to interfere. While ethical principles may at times require non-intervention, the purpose of teaching these principles is not to engender non-intervention. We must show students how to proactively demonstrate responsibility and respect for their patients, how to be team partners in the clinic and the community, and how to function as patient advocates, whether in the hospital, legislature, or through the media. Physicians must develop a more active sense of professional responsibility—one that similarly promotes beneficence, justice, and respect for patients—through engaged relationships.

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