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Indiana University School of Medicine

## CONSCIENCE SENSITIVE MEDICAL EDUCATION

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### Introduction

Medicine is a moral enterprise, and young people who enter professional school are presumed to be morally astute, as well as intellectually capable. Thoughtful students quickly grasp the fact that what we **can** do in medicine usually outpaces the consensus of what we **ought** to do, and one of the earliest questions these students ask is how they should go about honoring their individual consciences in the face of patients, peers or teachers who profess divergent values, or request services that jar the young professional's sense of ought-ness. Medical educators readily acknowledge the need, indeed the moral requirement, to teach ethics, but struggle to ascertain the most effective, efficient and compelling way to present the material and engage the moral reasoning of students who are already inundated with basic and advanced science studies (Self & Baldwin, 1994). Students appreciate hearing about case stories, but do not want much in the way of philosophical theory. Most students at our institution have backgrounds in biology or chemistry; few have taken any courses in literature, philosophy, religion, ethics or other humanities. The handful of lectures and small-group case-based discussions related to ethical dilemmas in medicine offered in the curriculum are helpful, but often fail to prepare the young physician adequately for a life in which moral questions daily will present themselves.

We are piloting an approach to moral teaching in medicine based on an examination of conscience formation and functioning, and the understanding of the intersection of personal conscience with professional medical and ethical values. We believe that conscience theory and language may be a useful addition to the traditional approaches to dilemma resolution that involve principles, theories, and case based reasoning. In this paper we will explore traditional ethical resolution methods, give a brief history and overview of Conscience Theory, and then show through case example how

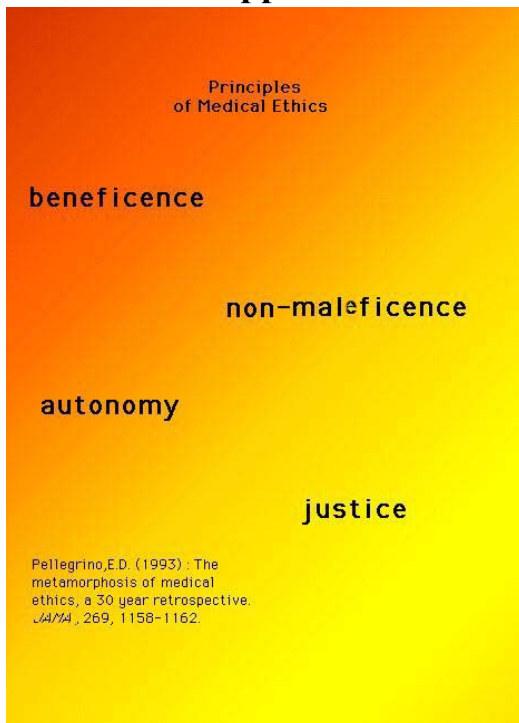
using Conscience Theory may allow a richer examination of the most poignant and troubling dilemmas physicians face.

## Case Illustration

For several years in an introduction to medicine course, the following clinical/ethical scenario was one of several used to stimulate discussion about dilemma resolution possibilities. Respondents were asked to describe the dilemma and their approach to it, using whatever methods seem most appropriate, and to defend their proposed resolution (**The Patient-Doctor Relationship, course syllabus, 1993**).

**A 26 year old man with Crohns disease presents to the emergency department with toxic megacolon and a lower GI bleed. His hemoglobin is 6.4, white cell count is 16.7. He is alert, oriented and appears competent. Despite resuscitative procedures, he continues to bleed. Emergent total colectomy is scheduled. However, the young man states that he is a Jehovah's Witness, and that he will not accept blood transfusions under any circumstances. His wife and family (parents) reinforce his decision. The anesthesiologist is torn, but states she will not transfuse the patient during surgery, even if it results in his death. The senior surgeon states that he has an obligation to do everything he can for the patient, and that it would be wrong to stand by and let a man under his care die unnecessarily. The surgeon will not operate under these conditions. The patient will likely die without both surgery and transfusions.**

## Traditional approaches



There are several respected and effective approaches to ethical decision making in medicine. One can utilize **major moral principles** of *autonomy* (respect for persons), *beneficence* (do good, promote good or prevent evil), *non-maleficence* (refrain from doing harm), and *justice* (consideration of fair distribution of burdens and benefits, or consideration of what is due or owed others) (Pellegrino, 1993).

Another approach is to apply one or more **ethical theories** to a moral problem in medicine. Three major theories readily apply: *consequentialism*, *deontology*, and *virtue-based ethics* (for readily manageable reviews of each see: **A Companion to Ethics**, 1993).

**CONSEQUENTIALISM**  
(OLDER TERM : TELEOLOGY)

The view that whatever values an individual or institutional agent adopts, the proper response to those values is to promote them.<sup>1</sup>

Consequences alone should be taken into account when making judgements about right and wrong.<sup>2</sup>

*Consequentialism*, also referred to as teleology, utilitarianism, or ends-based reasoning, would resolve the dilemma through consideration of what would bring about the greatest good for the greatest numbers. Unflattering commercial description and language related to this theory include "the ends justify the means," and "bottom-line considerations."

Some Types:

Some identify utilitarianism with consequentialism, some say it is a kind of consequentialism, some say the term 'utilitarianism' should be reserved for consequentialism with the assumption that only pleasure (alternatively: well-being or preference satisfaction) has intrinsic value.

Some advise that the distinctions should be 'utilitarian vs. non-utilitarian' and 'consequentialist vs. nonconsequentialist'.<sup>3</sup>

Hence deontology is nonconsequentialist, virtue-based ethics are consequentialist (invoke teleology) but may or may not have a utilitarian component.

1. Pettit, P. (1993): Consequentialism. In *A Companion to Ethics*, P. Singer (ed.) Blackwell Publishers Inc., pp.230-240.  
2, 3. *A Dictionary of Philosophy*, T. Mautner (ed.) Blackwell Publishers Inc.; Cambridge, Mass., 1996.

**DEONTOLOGY**

Moral theories according to which the rightness or obligatoriness of an action is not exclusively determined by the value of its consequences.<sup>1</sup>

"The end does not justify the means,"

*Deontology*, also known as rule-based reasoning, on the other hand, approaches an ethical dilemma by asking, "What is the highest principle (rule) that should be followed?," or "What is the one principle that should never be violated?"

Some acts are right or wrong in themselves. To act rightly, agents must first of all refrain from doing things that are known to be, before the fact, wrong. The particular requirements are called, variously:

- \* rules
- \* laws
- \* deontological constraints
- \* prohibitions
- \* limitations
- \* proscriptions
- \* norms

Deontological constraints are

- 1) negatively formulated as "Thou shalt not's"
- 2) narrowly framed and bounded
- 3) narrowly directed, attaching to agent's decisions and actions rather than the consequences of their choice or action.<sup>2</sup>

1. *A Dictionary of Philosophy*, T. Mautner (ed.) Blackwell Publishers Inc.; Cambridge, Mass., 1996.  
2. Davis, N. (1993): Contemporary deontology. *A Companion to Ethics*, P. Singer (ed.) Blackwell Publishers Inc., pp. 205-218.  
Also see:  
Rawls, J. (1971): *A Theory of Justice*. The Belknap Press of Harvard University Press; Cambridge, Massachusetts.

## VIRTUE ETHICS

Ethical theory in which the concept of virtue is fundamental, in contrast to rule- or duty-based moral theories.<sup>1</sup>

Also uses terms such as 'integrity' or 'character'.  
What does a good person do in real life situations?  
The Virtue-theorist does not necessarily reject utilitarianism or rights-based theories, but believes these theories ignore ordinary moral life involving character.<sup>2</sup>

## *Virtue theory*

is first concerned with the moral actor rather than the choice of action and asks the question,

"What would a good physician (teacher, parent, lawyer etc) do in this circumstance?"

(Closely related to virtue theory is the 'care-based' approach which considers what the decision-maker would want done himself/herself in a similar circumstance).

## SOME TYPES:

Medicine has a moral tradition in which physicians lives can achieve a certain unity or 'narrative'. They can look backwards (and forward) and see how their lives made (make) a difference.

Moreover, medicine has its internal 'practices' which allow for intrinsic pleasure beyond its extrinsic rewards: the deft surgical hand, the perspicacious diagnosis, the esteem of a great teacher by students....<sup>3</sup>

Contemporary representatives:  
Elizabeth Anscombe  
Alasdair MacIntyre  
Phillipa Foot

1. *A Dictionary of Philosophy*, T. Mautner (ed.) Blackwell Publishers Inc., Cambridge, Mass., 1996.  
2, 3. Pence, G. (1993): *Virtue Theory, A Companion to Ethics*, P. Singer (ed.) Blackwell Publishers Inc., pp. 249-258. Also see:  
MacIntyre, A. (1984): *After Virtue*, second edition. University of Notre Dame Press, Notre Dame, Indiana.

Each of the aforementioned approaches, used singly have contributory value but also limitations. Each is important but not sufficient.

## KIDDER'S MORAL DILEMMAS

TRUTH VS.  
LOYALTY

INDIVIDUAL  
VS. COMMUNITY

SHORT TERM  
VS. LONGTERM

JUSTICE VS.  
MERCY

Kidder, R. (1995): *How Good People Make Tough Choices*. Firesidel Simon and Schuster, New York.

An integrated approach to dilemma resolution, involving care-based and duty-based ethics as well as greatest good inquiries, has been described by Rushworth Kidder in his book **How Good People Make Tough Choices**. During many years as a columnist for the Christian Science Monitor, Kidder collected human interest stories and was fascinated by the range of difficult, poignant and sometimes tragic decisions ordinary people encountered every day. Despite diverse situations, professions, or perspectives, though, the moral

choices tended to fall into one (or more) of four dilemma paradigms, also referred to as 'right vs. right' dilemmas : truth vs. loyalty; justice vs. mercy; individual vs. community; and, short term vs. long term. None of these pairs contains an obvious easy moral choice, and indeed, under most circumstances a moral person would affirm the goodness of being both truthful and loyal, merciful and just, concerned with individuals and also communities, and respecting both short and long term goals. But Kidder's point is that there are moments of moral choice in which it is not possible to do both (e.g., be merciful and just), one has to act, and often there is not much time to analyze options (Kidder, 1995).

KIDDER'S  
RESOLUTION PRINCIPLES

1) ENDS-BASED: "WHAT'S THE GREATEST GOOD ?"

2) RULES -BASED: " WHAT IS THE HIGHEST RULE THAT SHOULD BE FOLLOWED ?"

3) CARE-BASED: " WHAT WOULD WE HAVE DONE UNTO OURSELVES ?"

Kidder, R. (1995): *How Good People Make Tough Choices*. Firesidel Simon and Schuster, New York. pp. 161-2

As a practical matter, conscientious people use some or all of these principles and theories every day, choosing the approach that best fits the situation at hand. Formally, the 'best fit' method is called **casuistry**. Casuistry describes the process of analyzing a moral dilemma or case by comparing it to other well-known and ethically scrutinized scenarios. The consideration is whether the present case is more like case A which we know about, or case B, also well discussed and about which moral consensus has emerged. These paradigm cases serve as ethical guideposts in a sense, and resolution of a new case may proceed along the lines of reasoning employed in earlier situations ( for comprehensive reviews of casuistical traditions, see: Jonsen & Toulmin, 1988; Kirk, 1999).

### **Limitations of traditional approaches**

In the medical arena, respect for a patient's free choice necessarily invokes the principle of autonomy, and a physician's professional duty to treat his/her patient with the best medical therapy available reflects beneficence. Sometimes, though, a physician's relationship with a patient might also require a choice between professional duty and respect for the person's wishes: the moral question of how to negotiate a competent patient's DNR (do not resuscitate) directives when that patient undergoes an operation is an example, not far removed from the case that was introduced

earlier. Does a DNR necessarily restrict a surgeon and/or anesthesiologist in the care they provide during the perioperative period? Are 'routine' operating room procedures considered 'resuscitative' measures at any other time or place? Reverting to principles does not help here, as both autonomy and beneficence/non-maleficence are prima facie duties, morally obligated under ordinary circumstances; and, neither ethical theory or principlism suggest an easy way of resolving conflicting autonomous claims of patient and physician.

Another example involves the moral question of physician-assisted suicide which, at least on one level, seeks to balance an autonomous person's request for relief of suffering with professional obligations to do no harm, to preserve life. Put in more personal language, this dilemma asks what is the morally right and good response of a virtuous physician in the face of her patient's terrible suffering? Again, an appeal to principles will be insufficient to resolve the competing claims of autonomy and beneficence. Consequentialism's 'the ends justify the means' may be attractive, but deontology would counter that killing is wrong. There are no paradigm cases yet, although a few scenarios have been debated publicly and even presented to the U.S. Supreme Court. Kidder's framework suggests that mercy requires physician compliance with the request, but the long term consequences of this action, particularly if codified, are unpredictable and possibly unacceptable.

## **Language**

Medical language has aspired to be a language of science, facts, objectivity, and so-called 'value neutrality'. The acquisition of medical language requires years of rigorous scientific study and dedication to minute, non-subjective data. The relentless pursuit of objective observation, itself driven by specifiable values, may nonetheless silence the larger language of values. Moral imagination, essential for ethical dilemma solving in the clinical setting, becomes hard to retrieve and activate. Moral language is the language of values, virtues, choice. At some point, moral language becomes personal: 'I choose to do this because of the values I hold, in accordance with the image I have of myself as a good person'. Physicians, confronted with a moral choice, sometimes seem unable to describe adequately what is happening both externally (that which could be considered 'objective' and verifiable) and internally. Application of principles or theory to a medical

ethical dilemma may be appropriate but insufficient, leading to an unsatisfactory 'resolution' for all parties involved.

In the case of the Jehovah Witness, most medical students and teaching colleagues framed the dilemma as a conflict between the informed patient's right to choose and the physicians' obligations to provide effective and compassionate medical care. In short, the case discussions became very brief indeed, with a cursory discussion of patient autonomy and physician beneficence, and an occasional appeal to a judge to decide if treatment could be ordered. Students complained the case was too easy; everyone knew the patient had a right to decide against treatment so what was the problem?

## Conscience Theory

If limiting medical-ethical deliberations to principles and theories sometimes leaves physicians, patients and families with unresolved concerns, it may be helpful to enlarge the scope of the deliberation to acknowledge the fuller context of the patient's life through considerations of connectedness, emotional harmony, and values. Conscience language and theory may act as a bridge here, linking traditional ethical theory, principles, dilemma resolution processes, and the profession and practice of medicine. A theory of conscience formation and functioning was initially developed to account for empirical findings from a study of the moral developmental psychology of children and adolescents, begun in the early 1980's. The principal instrument used was the Stilwell Conscience Interview (SCI) to engage the child in her awareness of aspects of her moral identity. After completing initial work on normal development of conscience (Stilwell & Galvin, 1985, Stilwell, Galvin, Kopta, 1991, Stilwell, Galvin, Kopta, and Norton, 1994, Stilwell, Galvin, Kopta and Padgett, 1996, Stilwell, Galvin, Kopta, Padgett and Holt, 1997, Stilwell, Galvin, Kopta and Padgett, 1998) the investigators began to describe conscience development and functioning in abused and neglected children (Galvin, Stilwell, Shekhar, Kopta, and McKasson, 1997; Galvin, Stilwell, Adinamis and Kohn, 2001), and collaborated on an international project examining the effect of a natural catastrophe, the devastating 1988 earthquake in Armenia, on the conscience functioning of young adolescents (Goenjian, Stilwell, Steinberg, Fairbanks, Galvin, Karayan, Pynoos, 1999). Initial investigations highlighted the normal **developmental**

**stages** of *conceptualization of conscience* from something posited by the preschool child in the locus of external authority to something internalized, personified, and eventually integrated into the personality as a moral organizer by the older adolescent (Stilwell, et al, 1985; 1991). In addition to the **developmental stages**, five **domains** of conscience, including conceptualization, have been described. In the conceptualization domain, a person provides the basic definition of what governs his or her moral life. The person's consciousness of how he or she is composed as a moral being is elicited in a deliberate effort that allows for the emergence of a personal definition, distinct from his or her generalized application of the term, 'conscience.' Conceptualization anchors the developmental features of four other domains. In turn, any of the four other domains may be salient in current conscience functioning and formation, thereby imparting distinctive character to the overall conscience concept. The resultant variety found among persons in their **contours of conscience** is not susceptible of staging. The other four domains are: *moral emotional responsiveness*, *moral valuation*, *moralized attachment* and *moral volition*.

In the domain of *moral emotional responsiveness* transitions occur in the ways emotions are perceived as regulating moral behavior in response to an "am good-feel good" set point on a personal moral emotional barometer. Moral emotional responsiveness ties morality to physiology. Deviations from the "am good-feel good" set point create uncomfortable feelings that motivate prosocial behavior, inhibit harmful behavior and motivate the processes of reparation and healing after wrongdoing (Stilwell et al, 1994). Discrete emotions theory (e.g. Izard, 1977), the concept that each human has an affective core under the control of the biologic processes of self-regulation, preadaptation for participation in human interactions and affective monitoring (Emde, 1983), aspects of temperament theory (e.g. Kagan, 1989; Kochanska, 1991;1993) and concepts of stress (Chrousos and Gold, 1992) contributed to the construct of this domain.

In the domain of *moral valuation* transitions occur in the process of defining, prioritizing, and justifying moral rules on behalf of values. The moral rules are categorized within a triune relational context, referred to as the valuation triangle: rules that sustain respect for authority; rules that sustain self-respect, uphold self-development, and preparation for future responsibility; and rules that sustain respect for and promote responsibility among equals. Both moral reasoning

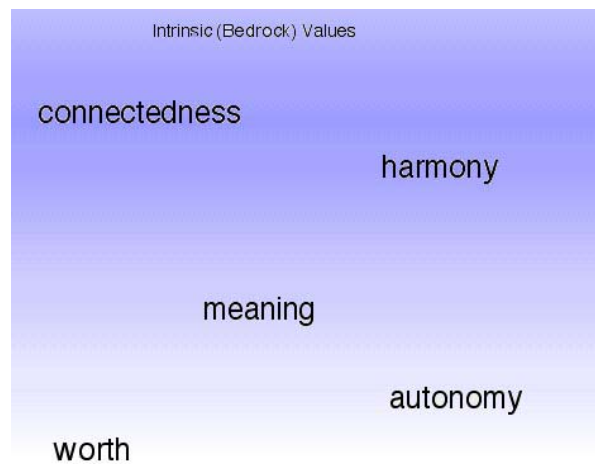


and psychological defenses operate in the domain of moral valuation. Transitions in processing moral dilemmas correlate with conceptualization stages (Stilwell, et al, 1996).

*Moralization of attachment* is the domain that holds processes and activities of the other domains within the bonds of human relationship: *viz*, internalization of another's moral presence in one's own conscience concept, one's moral emotional experience of others via empathic and sympathetic arousal, creation of rules that value others' needs, establishment of relationship hierarchies and fairness among equals and, in the domain of moral volition, the transformation of agency into advocacy for others (Stilwell, et al, 1997). Attachment theory (e.g. Bowlby, 1988) and the developmental stage theory of empathy (e.g. Hoffman, 1991) contributed to the construct of this domain.

*Moral volition* is the domain in which autonomy and will are coordinated with the felt obligation to restrain or take action. Autonomy is the recognition of the self as independent; will is the way in which an independent person intentionally chooses and directs his or her behavior. In this domain two processes are involved: self-evaluation in the light of external and internal standards reflecting moral values and conscious choosing to refrain from antisocial behavior and to engage in prosocial behavior (Stilwell et al, 1997).

The third aspect of conscience theory is the idea that for each domain of conscience there corresponds an **intrinsic (bedrock) value** that may be seen as exerting both a developmental push and an ethical pull on the person of conscience. These bedrock values, respective to the above-mentioned domains, are: moral meaning making (composing a good life), connected-ness, balance or harmony, worthiness (with respect to authority, self and others) and freedom.



## **Conscience Sensitive Medical Education**

While research on conscience formation and functioning in children and adolescents was being conducted, the authors also continued to teach students and residents in the medical school. Daily, conversations with the learners at all levels reflected moral concerns explicitly and implicitly. It was not surprising, for instance, that students complained about time pressures, worried about intimate relationships surviving medical school, struggled with insufficient knowledge to help suffering patients, and debated the proper 'role' of a junior clerk on a team. Residents struggled with the same issues, as well as the increased burden of primary responsibility of caring for medically complex patients in acute and long-term care settings while chronically sleep-deprived, teaching younger residents and students, and attempting to understand the bewildering rules of the "business of medicine" prior to leaving residency and getting a 'real job.' These concerns, as well as others, were well-known to the authors through painful personal and professional experience, and prompted some new considerations. Initially in 1998, at the request of the I.U. Director of Residency Training in Psychiatry, a new course in ethics was developed for third year psychiatry residents. The course continues to be offered each year (Galvin, Gaffney, Stilwell, Abram, 1997). Subsequently an adaptation of the SCI, *The Indiana University Conscience Autobiography for Healthcare Professionals* (I.U.CAP; Galvin, 1998, see appendix) has been used with first year medical students to help learners employ 'conscience' questions to a medical ethical scenario.

Specifically, in a small group of first year medical students we conduct a demonstration conscience interview with a volunteer student. The interviewee is invited to respond freely at whatever level of disclosure is comfortable. The observing learners are invited to respond privately. After the interview is completed, the preceptor helps the group members identify their peer's domains of conscience through answers given to certain questions in the interview. Later sessions further explore specific domains, using question sets from the I.U. CAP pertinent to each domain.

### **Learning Activities According to Domains of Conscience**

*Moral Imagination* or conceptualization of conscience: I.U. CAP questions 1,2 & 11. We ask all students to engage in definition and then in narrative

imagery or drawing to conceptualize their conscience. Group discussion ensues.

*Moral Attachment:* I.U. CAP questions 6 through 10. An additional heuristic device is the "triple-pass genogram". We ask the students to prepare a genogram, and the first time through we look for the standard biological relationships. The second examination explores the emotional connections, and finally, we ask the students to identify who cares most about their moral lives and/or who are their most important moral exemplars. The triple pass genogram is helpful to the learner in describing the transmission of values across generations.

*Moral Emotional Responsiveness:* identification of moralized emotions, reparation, and healing. I.U. CAP questions 3 & 4 (we dub these our "rings of Glaucon questions") and question 5. In our experience, first year students discuss the possibility of 'harming' a patient more readily than do third year students or residents. One specific activity exercising the moral imagination is to construct a letter of apology to a patient harmed. We discuss the required elements in such a letter and what each party may expect to 'get out' of it. Discussion of forgiveness often ensues.

*Moral Valuation:* I.U. CAP questions 12 through 14. We use the image of a "valuation triangle" showing developmental shifts among authority-attributed, peer-attributed and self-attributed values. We also use the heuristic device of applying grids to rules in order to elicit values and to discern the 'best value'-'strongest motive' gap for both abiding by and rejecting the rule. Here students may explicitly refer to both externally derived rules and norms, including legal implications of activities or decisions, as well as their own internal moral motivations and references.

*Moral Volition:* I.U. CAP question 15. Inquiries are first directed to successful experiences in making caring efforts contrary to an inclination not to. Discussion of interferences in conscience functioning ensues.

## An Application to the Case Illustration

We will now return to the case illustration regarding the young man committed to the principles of the Jehovah Witness faith. We decided to apply conscience language to the case to see if the resulting discussion could uncover any other layers of considerations. We asked the students to consider three of the major moral participants, the patient, the anesthesiologist and the surgeon, as persons of conscience, and imagine the dilemma from each of their perspectives. Starting with the patient,

autonomous choosing (moral volition) applies, and specifies that the patient wants surgery but not transfusion. With respect to moral attachment and the intrinsic value of connectedness, it would be important to explore the patient's web of relations with family, friends, and co-workers, while respecting the patient's autonomous choices. What will this decision mean to each of those morally relevant persons? What may be the effects of his choice on his wife, parents, other members of his religious community, and on the physicians caring for him? The truth of his connectedness locates him within many communities bound to be affected by his choice. The values of the religious teachings are powerful external motivators, but what of his personal sense of the worth of his life? Perhaps the two are inextricably bound, but one does not know this unless questions about the relationship between physical and spiritual survival values are explored. How does the patient's attachment to the physician figure in? Hard for the physician to ask but perhaps contributing to a struggle with conscience is the question how does the patient react in terms of moral emotional responses to putting his physicians in a moral dilemma? The patient could be asked: How would you respond in terms of moral emotions if you were transfused against your will?

The anesthesiologist, bound by professional values and the principle of beneficence, nevertheless believes that the patient's choice takes moral precedence over other considerations. A particularly important question for this person of conscience is: How will you respond if the patient dies and your transfusion could have prevented the death? And how do you react to being put in this position of choice?

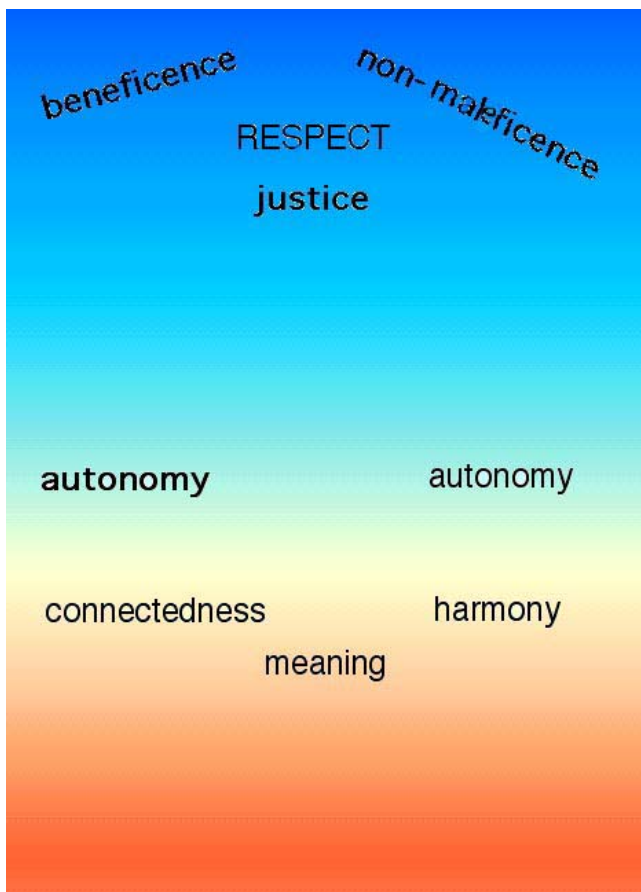
The surgeon took the same oaths as did the anesthesiologist, but holds a different understanding of medical and moral duty. Perhaps he is connected more tightly to medical principles and his community of medical peers, and values the patient's (physical) survival over the patient's religious beliefs and related right to refuse treatment. The surgeon believes that to allow a preventable death is NOT a choice for him. Perhaps the most poignant questions to put to this physician are: How will you be affected if you refuse to operate, thus ensuring beyond doubt the patient's death? Or, how will you react if you operate and transfuse the patient who survives, but accuses you of desecrating him and condemning him to eternal damnation?

Moral valuation involves the intrinsic value of the worth or worthiness of the triune considerations of authority, peer and self. Both patient and physician seek, make, and keep values, and hold respect for self and others.

## Discussion

Ethical principles and theory may not be sufficient to resolve the most challenging and messiest moral dilemmas in medicine; the moral domains of human conscience may provide the missing links to achieving satisfying resolution of the most poignant moments of ethical conflict. Exploring these additional aspects of a seemingly "easy" ethics scenario leads to a richer understanding of the humans involved and their struggles to respect themselves and others as persons of conscience. The outcome of this case, i.e. the "answer," may be the same: autonomy trumps beneficence, but the deeper understandings gained through an exploration of conscience may have profound consequences on the moral survivors of such a difficult human intersection.

**Limitations.** Conscience theory will not resolve easily the dilemmas



inherent in issues as thorny as, for example, physician assisted suicide, but arguably enlarges and enriches the attendant dialogue and debate. Dying persons, no matter how independently and autonomously they have lived, rarely die entirely alone, and conscientious physicians rarely abandon suffering patients to professional mandates. Thus, the dilemma is incompletely framed as a conflict between autonomy and beneficence. Other values of love, loyalty, connectedness and harmony are morally relevant for both the patient and her physician. Commitment to advancing

knowledge and improving the care of dying persons compel the physician to further efforts at truly caring for the patient. Both partners, patient and physician, struggle to reconcile the competing rules and values that govern them, and strive to understand the meaning of their lives.

**Future Research and Ethical Inquiry.** What we have piloted in the educational arena raises questions susceptible of empirical research and/or ethical inquiry. First, how does conscience intersect with traditional medical ethical decision-making? Related questions are: What can an understanding of moral stakeholders as persons of conscience do to inform ethical decision-making? How would this understanding contribute to clinical ethics consultations and deliberations on clinical ethics committees? Second, what happens to a person of conscience when (s)he undergoes the rigorous process of professional education? Related questions are: Does a prospective physician's conscience have a particular contour, identifiable as such? What effect does general medical training have on a person's conscience, and is the effect similar from one person to another? Are persons with certain contours of conscience more apt to choose certain specialties? Is there an identifiable moratorium in conscience formation in medical school? If so, is it an essential part of the professional developmental process or is it contrary to optimal professional development in the form of developmental delay? Put another way, when the challenges of medical school cease to be experienced as opportunities for moral growth and, instead, emerge as adverse life events more akin to maltreatment or an earthquake, what are the demoralizing effects on, the psychopathological interference with, persons becoming professionals of conscience? Can these effects and interferences be counteracted? Can they be anticipated and prevented?

**Concluding Comments.** The questions above are posed but not answered. We believe that a young person of conscience who enters professional school experiences a molding or contouring of his/her personal conscience. As other decision-making processes become "professionalized," that is informed and shaped by professional values and norms, so also does the individual conscience. But in our experience of teaching medical ethics we have found that a focus on ethical theory or principle does not completely satisfy the students' moral inquiry. Positioned as they are between their former non-initiated selves and the new life they are in the process of obtaining, our youngest students most clearly articulate the moral question as: What am **I** to do in this situation? With this question they put their own

moral selves squarely in the dilemma, and ask for guidance to negotiate between personal and professional values. Conscience sensitive medical education is a valuable tool in this process, allowing exploration of personal values and modeling respect for different values of peers, teachers and patients.

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