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David C. Thomasma

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Medical Ethics: A Clinical Base

David C. Thomasma, Ph.D.

The author is a professor of medicine and philosophy and director of the medical humanities program at Loyola University Stritch School of Medicine.

A recent mini-symposium in the *Hastings Center Report* (April, 1981) was devoted to the topic of philosophers in the clinical setting. This paper is intended to contribute further to the issues raised in that symposium, especially those raised by William Ruddick and Mark Siegler.

Various views exist about the role and scope of medical ethics. Ingelfinger,¹ Shelton,² and MacIntyre^{3, 4} argue that medical ethics is dangerous or useless. Hare,⁵ Morgenbesser,⁶ and Callahan⁷ are among those who ascribe to a non-clinical view of medical ethics, namely, that it is a branch of philosophical ethics applied to medicine. Marquis⁸ and McKee⁹ question the validity of clinical medical ethics, though for different reasons. Siegler,¹⁰ Siegler and Pellegrino,¹¹ Pellegrino¹² and Jonsen¹³ all argue for the appropriateness of a clinically-based medical ethics. The last-named all argue for this position for practical reasons, the most important being the complexity of modern medicine and the fact that clinicians must be involved in setting policies which would otherwise be left to outsiders.

The cause of such diversity lies, in part, with the newness of the discipline. Medical ethics has not yet proved itself. Part, too, is occasioned by a different view of the aim of medical ethics. Should it aim at practical consideration^{14, 15, 16} or should it be an application of more theoretical ethical labor to medicine?^{17, 18, 19, 20} The process of applying theory to practice represents a more deductive view of ethics in general, and medical ethics in particular, than the tack taken by others who prefer to operate inductively from cases to resolutions. Finally, objections are raised against medical ethics on grounds that it usurps the decision-making requirements of medical practice without either sufficient knowledge²¹ or proper authority.^{22, 23}

I shall add my voice to those calling for a clinically based medical ethics by attempting to clarify the confusion which exists about the role and presence of medical ethics in the heart of medicine. The problems are either posed in the literature or stem from my experience as a philosopher in the clinical setting. First I will raise three important objections to the clinical presence of philosopher and attempt to answer these objections. In the second section, I will out-

line the tasks of a philosopher developed from experience spanning eight years.

Three Objections

The three objections which have been or can be raised to a clinically based medical ethics and the presence of philosophers on rounds are that they constitute outside interference in professional judgment, that ethics can best be taught by role models in medicine who can infuse moral character in students, and that philosophers sell out their discipline by participating in clinical decisions. Each objection will be taken in turn.

1) Outside Interference

The first problem medical ethics faces is the accusation that it is a power grab by philosophers, theologians and lawyers who are meddling at best and counter-productive at worst. A strong sense of paranoia infuses the view, as medical ethics is frequently listed among the many other outside interferences which make professional judgment in medicine so difficult today.

Just to cite paranoia is not to answer the objection that philosophers are out of place in the clinical setting, however. In the main, if resistance occurs for this reason, the objection seems to vanish after some experience with philosophers in the clinical setting. Physicians, such as Victor Sidel, note that the comments of outsiders such as philosophers are tolerated if they help clinicians do their work. In addition, philosophers can assist in the formulation of policy as needed by the institution.²⁴ As the large number of programs relating ethics to medicine now attests, some easing of the "outsider" objection has occurred.²⁵

However, if the objection is formulated in a stronger mode, it is not so easy to dismiss. Ingelfinger's concerns go to the heart of the matter and deserve a more careful response.²⁶ The challenge he poses is how clinical ethics and all other humanities can actually improve the quality of patient care. After all, medicine is aimed at making good decisions with patients and handling patient management problems. In this respect, clinical judgment is the guiding force of practice.²⁷ Given this pragmatic, patient-oriented approach, how can philosophers at the bedside be actually said to "assist" in patient care?

Further, the objection is strengthened when one considers the qualities of philosophers. They are normally argumentative, have a penchant for abstract discussion, love to pose theoretical cases to illuminate some obscure point, are loners, and as William Ruddick remarks, are more interested in truth and autonomy than in patient care.²⁸

What, then, can the philosopher add to the patient care judgments of a morally sensitive physician? Granted the above description of philosophers might be a stereotype, the question still stands.

In response, it must be said straight off that there is no medical necessity for philosophers to accompany clinicians on rounds. Their presence depends on educational and consultative objectives. However, I will argue that their presence can contribute to improved patient care decisions.

The appropriateness of having philosophers accompany physicians on rounds stems from the nature of medical ethics as a discipline. First, the proper aim of medical ethics is to contribute to the resolution of medical dilemmas.²⁹ Medical ethics labors which do not have this perspective as a goal are better labeled ethics of medicine and left to academic discussion. Since most of the dilemmas posed by modern medicine lie in making moral decisions about patient care or the distribution of care, medical ethics must have a clinical base in order to understand properly the realities of clinical practice, otherwise medical ethics will be condemned to artificial generalizations and incompetent conclusions. Therefore, while there is no medical necessity for philosophers to make rounds with clinicians, there is a necessity for the growth of medical ethics as a discipline.

The distinction between medical ethics and ethics of medicine is useful for delineating the role of medical ethics in the clinical setting. "Ethics of medicine" can be used to describe the more abstract discussion of a range of clinically posed problems as might appear, for example, in a general examination of issues in abortion or euthanasia. Such discussion is complex and would necessarily involve the lengthy examination of issues which would forestall any urgent or immediate decisions about patient care. In the clinical setting, such discussion is out of place because of the clinical imperative, making some decision about patient care. On the other hand, "medical ethics" can be used to describe a more analytic, case-oriented approach to a specific moral issue. Instead of a general discussion of the major issues involved in euthanasia, then, a specific case is discussed. The patient care objectives are interlaced in the medical ethics discussion, and some action by the staff is recommended. Instead of an exploration and clarification of principles, the goal of medical ethics as a clinical discipline is to contribute to a patient care decision in a specific clinical setting (the intensive care unit, for example).

In this respect, philosophers can contribute the insights and language stemming from their sophisticated ethics training to clarification of moral issues in difficult medical cases, as well as to the larger questions of hospital policy. In fact, if Callahan's prediction about the future of medical ethics debates holds true,³⁰ philosophers familiar with the realities, goals, and pressures of clinical practice will be allies of physicians in the forthcoming discussion of social disagreements about moral principle.

Second, it should also be noted that medical ethics has been developed by physicians as well as humanities professionals. As many physi-

cians have written about moral questions in medicine as other professionals. Medical ethics is not the special province of moral philosophers. Rather to achieve its aim, it must represent a true partnership between practicing health professionals and moralists. In order for the partnership to thrive, however, it must be based upon a real engagement between moral thinkers and physicians regarding issues in the clinical setting.³¹ Even more long-range policy discussions require at least a modicum of medical understanding and, hopefully, an audience to be effective.

Thirdly, while philosophers can and do call into question some of the moral aspects of medicine, it is not the role of medical ethicists to question medical theory, for they have no knowledge or skill in this area. Nor do they have the patient care responsibility assigned to physicians by the doctor-patient relationship. But, medical decisions relate to the broader goal of healing persons in which moral decisions do take place.³² Clinical indicators alone do not satisfy the requirements of medical decisions. In fact, clinical indicators are evaluative and normative. The patient's values, social values, institutional values, and professional values also enter each decision. These can be questioned by philosophers.

Because medical decisions are moral, i.e., involve moral values, it is important to clarify and rank these values, indicating which of them are ethical values.³³ Few physicians have the philosophical training necessary for this task. One could argue further that decisions made in patient care without attention to the ethical values fail on two counts. First, it seems unlikely that such decisions can truly be said to help heal the person who is the patient.³⁴ Healing must involve the values of the patient or it will, in some way, denigrate the patient as a person. Cure of the patient may be possible, but not healing of the person. Secondly, such decisions, even if judged to be ethical, lack the degree of reflective articulation on ethics and values in general required not only of professional judgment but also of communication about decisions with patients. Thus, Ruddick finds that the clinical presence of philosophers increases the consciousness of clinicians and philosophers about their professional assumptions and helps them both acquire a new degree of self-reflection.³⁵ This finding is borne out in my own experience.

If an authentic learning posture between clinicians and moral philosophers is maintained, the role of medical ethics in medical decisions is clarified. The philosopher learns to reject generalizations and condemnations through greater sympathy with clinical closure demands, the pressure to make decisions, professional and personal values, institutional values, and other factors which bear upon the decision. None of those are available in abstract texts, as they vary from case to case, situation to situation, service to service, institution to institution. In sum, philosophers derive from clinicians the practical wisdom they so

often lack.

On the other hand, physicians learn to trust the insights and even the recommendations of philosophers so experienced.³⁶ At least two elements are present in this trust. The first is that the philosopher truly understands the situation of the clinician and shares the latter's compassion for the patient. The second element is as important as the first. The trust is based upon an ability, by no means common among philosophers, theologians and the like, to communicate philosophical insights rapidly and clearly. In other words, knowledgeable persons in their own discipline who are able to translate insights are essential in the clinical setting. The aim of clinical discussions of ethical issues must always be targeted to the case at hand and not detract from patient care obligations with lengthy discourses on philosophical distinctions. It is this requirement which gives rise to the charge to be addressed in the third objection.

In sum, the presence of philosophers in the clinical setting can be instructive for both philosophers and clinicians, raising the degree of professional awareness of principles. The philosopher also gains the necessary clinical understanding over the years to comment on cases which represent difficult ethical dilemmas, contribute to hospital policy, and teach and write on medical ethics issues with respect for medical realities. In teaching, philosophers can help prepare a generation of medical students in the principles of philosophical ethics and process of moral reasoning which are necessary for an advanced stage of reflective clinical performance and moral decision-making, a correlation which Sheehan *et al.* have found among residents.³⁷ Finally, the patient benefits from a greater facility in the health care team for a clear discussion of the moral values in their case, and from a greater ability among students and residents to handle the complex of values in a morally sophisticated way. Needless to say, improved levels of moral reasoning do not guarantee an ethical decision. But they do lead to improved clinical performance.

Sheehan's study is one of the first to offer hard evidence that indicators of clinical performance used to evaluate residents are directly affected by medical ethics training. There were 18 indicators based on work by Cook, Margolis, Elstein and Lindenfield.³⁸ These indicators included: admits mistakes, works well with others, aware of own limits, compassionate, relates well to patients, medical knowledge, clinical judgment, accepts responsibility, seeks consultations, empathy, and responds well to emergencies. Sheehan *et al.* found that "the very highest level of clinical performance is rarely achieved by those who remain at a low level of moral thought" (p. 401). Of course, no claim can be made that the medical ethics training makes physicians more ethical.

In the clinical context, the philosopher is accountable to the managing physician. Perhaps the best way to formalize this accountability

and the duties of philosophers as part of a health care team is to establish an ethics advisory service. The partnership between philosopher and clinician is institutionally recognized. The University of Tennessee advisory service is officially approved by St. Jude Hospital, the Veterans' Administration Hospital, four units of the City of Memphis Hospital, and the University Hospital. The advisory service functions like a consultation. There are three functions. First, we offer advice to the managing physician regarding difficult cases. In the past few months we have been asked for advice, in some cases in the chart, regarding the termination of treatment for a child with cancer, a dispute among physicians regarding the use of a respirator, and the extent of care for an aged alcoholic. In some services, residents flag cases which may present ethical difficulties. Second, we help develop hospital policy regarding such things as research on children. Third, we assist physicians in their obligation to teach medical students the requirement of moral judgment as it occurs inherently in medical judgment, by accompanying them on rounds in six specialties.

Ingelfinger's objection is answered, therefore, as follows. Improved patient care can be the result of clinical medical ethics if one takes patient care to be broader than cure of organic disease. Medicine involves ethics in its decisions for patients. Improved reflection on ethics, facility with language, and moral reasoning can be expected from inviting philosophers to be clinically based educators and consultants. These improvements have a direct impact on the quality of patient care.

2) Character

The second major objection to a clinical medical ethics stems from a notion that students imbibe moral character necessary for ethical judgments from great teachers. McKee³⁹ has raised this objection to the need for teaching ethics at the bedside originally presented by Pellegrino⁴⁰ and Siegler.⁴¹

There is little doubt that great teachers have a profound effect on students, as the latter note in their response to McKee.⁴² However, it should be noted that the major teachers of medical students in medical centers are the residents and interns, from whom students learn to manage their time, categorize patients, and make medical decisions. Only rarely do students encounter the kind of great teachers McKee envisions.

In addition, students most frequently do their clerkships in a hospital environment in which clinical indicators are emphasized to the detriment of other values of the patient. Carlton's sociological study demonstrated that unless ethics is clinically reinforced, earlier courses in the curriculum will have no effect against the "professionalization of judgment."⁴³ If, as I have argued, ethics is an inherent feature of

medical decision-making, then clinical reinforcement of this aspect of medicine is essential.⁴⁴

To be sure, great teachers can and do employ this reinforcement. My experience reveals, however, that a majority of medical educators retains an interest in medical ethics, but either do not feel comfortable enough with the language to teach it explicitly, or do not have time to keep current with the literature in the field. Then, too, some specialists seem totally unaware of the moral dimensions of the cases they attend, just as they seem unaware of the economic dimensions of their decisions. Students often raise questions which they have trouble fielding. Most attending physicians seem to welcome the medical ethics faculty on rounds because of their familiarity with clinical realities and with the medical ethics literature, albeit under the conditions of consultation already discussed.

These comments do not address McKee's major contention, however. He seems not only to hold that ethics is learned by example and not didactics, but also questions whether one can teach ethics at all. In this regard he has confused moral character with the teaching of ethics. Moral character and professional integrity *are* taught. Each year medical schools certify the latter and hopefully attest to the former. Example is a powerful means of encouraging such moral character. However, didactic teaching of the humane sciences is also a means, as recent studies on the use of Kohlberg's stages of moral development in the classroom show.⁴⁵

Clearly, McKee interprets ethics to mean moral character. They are not synonymous. Ethics is a discipline in its own right, a discipline of reasoning about ethical principles and moral practices. Medical ethics should be considered both a branch of ethics and a branch of medicine. In the former guise, it is a branch of applied ethics in which the theories and axioms of ethics are applied to medical dilemmas. In the latter guise, medical ethics is a critical reflection on the moral norms arising from the practice of medicine and a study of their reconciliation with patient and society's values.⁴⁶ In both respects medical ethics can be taught.

3) Sell-Out

The final major objection against a clinically based medical ethics comes from moral thinkers. It is levelled against those who "sell-out" their discipline by making recommendations and watering down philosophical discussions. We have also been accused of siding too much with physicians we have come to respect.

Clearly, philosophers in a clinical setting must maintain an objectivity required by their own discipline. Otherwise what they offer would be easily obtained from a coterie of admirers. But the objection that philosophers "sell out" their discipline by becoming practical and resolution-oriented is wholly without merit.

The greatest moral thinkers — Aristotle, Kant, Mill, Dewey — occupied their time by addressing real moral issues. They did not play crossword puzzles with words and distinctions. By ensuring that medical ethics keeps its feet, waist, chest and head in the realities of the clinical setting, the partnership between medicine and ethics has a decent chance to establish an equivalent greatness.

Roles of Clinical Philosophers

Possible functions for clinical philosophers in medical ethics were suggested in the previous section. However, the functions were offered from the perspective of consultation and education objectives. In this section I will briefly describe activities in which philosophers in the clinical setting engage. These are taken from my own experience and that of fellow faculty so occupied. I have identified at least eight activities.

1) **Listening:** Presence in the clinical setting allows us to listen to clinicians express their ethical concerns about a case as they develop. There is usually a cathartic moment after which initial reservations of the clinician are overcome, and after which he or she begins to develop a professional bond with the philosopher, encouraging the latter to consider a number of further problems for joint exploration. Many clinicians have explicitly stated that they prefer this bond to consults with chaplains or the social scientists. But this may only be a matter of taste and intellectual stimulation.

2) **Analyzing Intuitions:** I find that intuitions about the right course of action in a case are often expressed. These are analyzed and critically examined, usually after the catharsis mentioned in 1). The result of such analysis is greater awareness of the role of feelings, character, and professional style on the part of the physician as these roles enter clinical judgment. These are further separated from the ethical judgment in the case so that they may not be misconstrued for moral rules.

3) **Reconciling Accounts of Case:** Incredibly, I find that the clinical philosopher, as an arm of the managing physician, often has a clearer picture of a difficult case than many of the players in it, the patient, the house staff, the nurses, and so on. Much of our time is spent pursuing leads, analyzing intuitions, and tracing third party statements (“The student said that the nurse said that the patient was uncooperative . . .”). This function occurs because we are usually called for consultation on a difficult case which, at the very least, involves clashes in values and corresponding complex emotional content.

None of the first three functions are specifically those of an ethicist. Anyone called in on a case would encounter them. The rest are specific to ethicists.

4) **Sketch Ethical Landscape:** After the first three activities are

accomplished to some extent, the clinical philosopher begins to sketch the ethical landscape. It is not appropriate at this point to insist on one or another ethical theory. This function can best be understood as an initial description of the ethical parameters of a case. Without sufficient clinical experiences, philosophers often neglect the medical and institutional data important for this sketch.

5) Isolation of the Major Ethical Issues: This function establishes the ethical import of a case. It usually occurs when those involved are able to state that the case is one of consent, or autonomy, or the doctor's duty, or some other classification which aids in the discussion by eliminating extraneous issues. Often, at this stage, the clinical philosopher will distinguish the ethical issues from those which are legal or economic.

6) Identifying and Ranking Values: Assisting those involved in the case usually involves a struggle to wrestle with all the conflicting values. Here the philosopher can greatly aid the professionals who often lack the skills to sort out and rank these values. "Which should come first: the patient request or my duty?" "The state law says that I have to have cessation of total brain function, but it seems inhumane to keep him alive when others need his bed." In these two sentences are contained important professional, personal, legal, and ethical duties. How are they to be ranked? If the decision is made without some explicit ranking of the values, I call it a knee-jerk decision, most often colored by emotions or the last person with whom one talked. Ranking requires ethical dialogue. It also requires the next step.

7) Provide Some Theory of Ranking: Reasons are given in the sixth function for ranking certain values above others, and so reaching a decision. These reasons are actually statements of ethical principle which for personal and professional reasons should bear some consistent stamp over the course of the years. The theory of ranking a philosopher can contribute, then, directly bears on decisions to be made by the managing physician. I find that if all the other functions have been properly carried out, this theory of moral weight to be given to conflicting values most often reflects a joint decision in the case, or at least reflects an ethically justifiable claim by the physician for his or her decision.

Experience with this function can then lead the philosopher as educator to develop a process of moral reasoning to be taught the medical students, so that the process of ranking values and giving reasons for this ranking can be the basis of an educational program. We call ours an "Ethical Workup."⁴⁷ Focus on the process has the merit of providing the structure of moral reasoning without a requirement to justify one's decisions using any particular moral theory.

8) Making Policy Recommendations: Certain problems occur frequently enough to warrant the development of hospital or institutional policy. Resuscitation guidelines are just one example. These

policies do not eliminate the moral reasoning process just described for each individual case.⁴⁸ But they do attempt to develop general guidelines, like those protecting human subjects in research, which help clinicians map the moral territory of a case more quickly, because some of the reasons in 6) and the theory in 7) have been discussed ahead of time. It is, after all, the mark of educated persons to anticipate their future moral quandaries from their past experience. I find that this function is most often fulfilled in joint research undertaken by the philosopher with clinicians, perhaps because the philosopher is disposed to the realm of generalization rather than particulars.

These functions are not meant to be exhaustive. In fact they do not include interest philosophers have gained from medical practice in developing a philosophy of medicine. But they do show, I think, how inviting philosophers to function clinically can ultimately benefit the level and structure of moral decisions in medicine, and therefore, how clinical medical ethics can improve the quality of health care.

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