

Vanquishing Virtue: The Impact of Medical Education

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ABSTRACT

North American physicians emerge from their medical training with a wide array of professional beliefs and values. Many are thoughtful and introspective. Many are devoted to patients' welfare. Some bring to their work a broad view of social responsibility. Nonetheless, the authors contend that North American medical education favors an *explicit* commitment to traditional values of doctoring—empathy, compassion, and altruism among them—and a *tacit* commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.

They further note that medical students and young physicians respond to this conflict in various ways. Some re-conceptualize themselves primarily as technicians and narrow their professional identities to an ethic of competence, thus adopting the tacit values and discarding the explicit professionalism. Others develop non-reflective professionalism, an implicit avowal that they best care for their patients by treating them as objects of technical services (medical care).

Another group appears to be “immunized” against the tacit values, and thus they internalize and develop professional virtue. Certain personal characteristics of the student, such as gender, belief system, and non-medical commitments, probably play roles in “immunization,” as do medical school features such as family medicine, communication skills courses, medical ethics, humanities, and social issues in medicine. To be effective, though, these features must be prominent and tightly integrated into the medical school curriculum.

The locus of change in the culture of medicine has now shifted to ambulatory settings and the marketplace. It remains to be seen whether this move will lessen the disjunction between the explicit curriculum and the manifestly contradictory values of detachment and entitlement, and the belief that the patient's interest always coincides with the physician's interest.

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When “Andrea Fricchione” visited Stony Brook for her medical school interview, she radiated warmth and enthusiasm. She had graduated with honors from a prestigious liberal arts college and chosen to spend a year as a teacher with a volunteer organization in inner-city Baltimore. Andrea had a snappy-looking premed portfolio that included excellent grades and test scores, considerable health-related volunteer experience,

a wide array of extracurricular activities, experience in a research laboratory, and an imaginative but genuine personal statement.

The faculty interviewer was impressed with Andrea's thoughtfulness and maturity. When asked about her emergency room volunteer work, Andrea told stories of her interactions with specific patients, rather than making global statements about how meaningful the experience was. When asked what book she had read recently, Andrea described in detail the book and her reaction to it. She was well informed about ethical and social issues in medicine. She had organized an HIV education project on campus, and later served as a student member of her college's curriculum committee. Andrea's decision to devote a year to teaching underprivileged children was another plus—it helped prove that she had not only a sense of social commitment but also the courage to act on it.

We were pleased when Andrea chose to attend Stony Brook over the other medical schools that accepted her.

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During her preclinical years, she became an active proponent (as well as thoughtful critic) of Medicine in Contemporary Society, Stony Brook's four-year curriculum in medical ethics and social issues. A couple of months before she graduated, we asked Andrea to reflect in writing on her medical school experience, placing particular emphasis on issues of altruism, professionalism, and social consciousness. The following are excerpts from her statement:

When I arrived in medical school, I was eager to get involved. I was excited about addressing important issues because, as medical students, I was sure that we would have some clout and certainly a commitment to the well-being of others . . . However, medical school is an utter drain. For two years lecturers parade up and down describing their own particular niche as if it were the most important thing for a student to learn. And then during the clinical years, life is brutal. People are rude, the hours are long, and there is always a test at the end of the rotation. . . . After a while I reasoned that the most important thing I could do for my patients, for my fellow human beings, for the future of medicine, as well as for me, was to assure myself some peaceful time. I made a point of hoarding my extra time for simple pleasures. I had read Perri Klass' novel in which she describes how physicians must relearn the ability to appreciate the mundane. Her point is that physicians must *regain* their humanity after completing their training. For my part, I tried not to lose it, or at least to hold onto it as long as possible. So, rather than thinking arrogantly that I could improve the lives and souls of others, I decided to focus more on my own life. I figured that I would then be better equipped for dealing with human situations faced by a physician in patient encounters. . . .

In addition, I have found medical school to be profoundly humbling. I certainly understand now in a way that I never did before how people are able to change very little . . . In some sense I think activism is futile. It isn't just that there will always be more to do—it's that most projects are Band-Aid treatments and simply provide an opportunity to feel good about oneself that isn't justified . . . Furthermore, I've become numb. So much of what I do as a student is stuff that I don't fully believe in. And rather than try to change everything that I consider wrong in the hospital or the community at large, I just try to get through school in the hope that I will move on to bigger and better things when I have more control over my circumstances. On the other hand, I do believe that habits formed now will rarely be overcome in the future. So I regret not having spoken up on more issues. But I was often too tired.

Andrea came to us avowing compassion, sensitivity to the needs of others, a willingness to put herself on the line, and optimism about the human condition. However, like so many other students, she found medical school "an utter drain." Andrea adopted new values, developing a narrower view of life. While she did not entirely abandon her original

motivation, Andrea now viewed her goal in a more limited and fatalistic fashion. In fact, she concluded that the only way she could achieve anything approximating her original goal was to focus first on helping herself.

Andrea's story illustrates a process that happens to most students during the course of their medical education. This essay is a commentary on Andrea's narrative, which sheds light on a number of common concerns about medical education. For example: Why don't contemporary physicians communicate more effectively with their patients? Why are patients so frequently dissatisfied with their physicians? Why don't more physicians devote themselves to community service? Why aren't physicians more concerned about inequities of our health care system?

Some critiques of medical education emphasize negative aspects of the medical school selection process, arguing that the premedical treadmill gives precedence to science majors who have high grades and test scores, and who demonstrate personality characteristics such as detachment and competitiveness. At the same time those critics say that the admission process undervalues qualitative or affective aspects of the applicants' characters and accomplishments. The applicant pool, on this account, is skewed toward individuals who might turn into good scientists or technicians, but who have two strikes against them when it comes to becoming compassionate physicians.

However, we are convinced that, like Andrea, most students who matriculate in medical school do, in fact, have the potential to become "good" doctors in the traditional sense of medical virtue.^{1,2} Their self-reported altruism and compassion are usually genuine. The situation is reminiscent of the Biblical parable about the farmer who sows good seeds on barren ground. Healthy green shoots rise quickly, but in the absence of nourishment they soon wither. We believe that our entering medical students are "good seeds." In this essay we focus on the lack of nourishment and the exposure to defoliants they encounter in medical training. How does professional socialization alter the student's beliefs and value system so that a "commitment to the well-being of others" either withers or turns into something barely recognizable?

EXPLICIT VERSUS TACIT VALUES

In medical education scientific knowledge serves as a Rosetta stone for understanding other forms of human discourse. In this context medical language largely replaces other forms of communication. The emotional (affective) and symbolic (imaginative) aspects of human experience are distanced and diminished. Technical skills emerge as fundamental, while interactive skills (if encouraged at all) are secondary. The culture implicitly, and often explicitly, devalues primary medical care and relationship-centered approaches to prac-

ting medicine. The hothouse atmosphere is psychologically and spiritually brutal, as indicated in Andrea's statement: "The people are rude, the hours are long, there is a test at the end of virtually every rotation." Student abuse includes long work hours and intense and conflicting demands, associated with a general lack of emotional support from faculty and role-model physicians.

Much has been written about professional socialization in this environment.³⁻¹⁰ As students and house officers successfully wend their ways through often-negative experiences, they gradually adopt the professional culture and its value system as their own. An important aspect of this socialization is the transfer of a set of beliefs and values regarding what it means to be a good physician. This learning process includes both explicit and tacit components. The *explicit learning* component of professional development includes courses, classes, discussion on rounds, advice, or other teaching that is overtly intended to instill professional values. Medical ethics courses frequently address issues of professional identity and medical virtue. Humanities courses typically articulate the virtues or attributes associated with being a "good" physician and the special moral obligations that arise in the physician-patient relationship, as well as the role of physicians in society. Additional explicit learning occurs in the clinical setting, where attending physicians offer more informal but no less direct cautionary statements about how to behave in medical practice. Ideally, these explicit elements of the curriculum would be consistent with the tacit learning that occurs throughout medical training. However, the evidence to date indicates that they are not.

What we call *tacit learning* includes all those aspects of the curriculum and the socialization process that instill professional values and a sense of professional identity, but do so without explicitly articulating those issues. Thus, tacit learning arises from what Hafferty calls the "hidden curriculum"⁴ in medical training or from Hundert's "informal curriculum."⁶ Hafferty's concept is more inclusive, however, because "it includes the hidden transmission of the dominant culture during formal classes, whereas [Hundert's] informal curriculum is that subset of the hidden curriculum that happens outside classes, hospital rounds and the like."⁴

The tacit socialization process goes on continuously, day after day, throughout medical training. Tacit learning is more powerful than explicit learning not only because it is reinforced more frequently but because it relates to *doing* rather than *saying*. As an example of this process, consider basic notions of how compassion manifests itself in the care of patients. The explicit curriculum stresses empathy and associated listening and responding skills, the relief of suffering, the importance of trust and fidelity, and a primary focus on the patient's best interest. Tacit learning, on the other hand, stresses objectivity, detachment, wariness, and distrust

of emotions, patients, insurance companies, administrators, and the state. Andrea Fricchione, who began her education with a high level of personal and social concern, concluded after years of tacit socialization that her own needs must come first, since activism is "futile" and she had to conserve her energy to deal with patient interactions. This conflict between tacit and explicit values distorts medical professionalism.

In particular, tacit learning favors the development of three characteristics, or traits, that make it difficult to be a caring physician. The first is *detachment*. In their clinical education students become cynical about the value of tenderness and virtue because they learn that they can better survive their clinical training by developing an "us versus them" mentality. The notion that detachment is a prime requisite for objectivity is questionable.^{11,12} Good medical practice can better be characterized as a tension between engagement and detachment. The emphasis on detachment encourages physicians to discount the affective and imaginative aspects of their work, while focusing exclusively on the cognitive and technical aspects. Because so much of one's self is invested in the professional milieu, one's affective skills may atrophy, resulting in a state of emotional numbness. In the first chapter of his *Medical Ethics* (1803), Thomas Percival enjoins physicians to "unite tenderness with steadiness" in their care of patients.¹³ By the term "steadiness" we interpret Percival to mean the intellectual virtue of objectivity or reason, along with the moral virtues of courage and fortitude. By the term "tenderness" we interpret him to mean humanity, compassion, fellow feeling, and sympathy. Elsewhere Percival contrasts the "coldness of heart" that often develops in practitioners who do not cultivate such virtues with the "tender charity" that the moral practice of medicine requires. We believe that the emphasis on detachment in medical training promotes such "coldness of heart."

The second characteristic is a strong sense of *entitlement*. Physicians-in-training have every right to believe that the social utility of their work demands respect. However, the duration, rigor, intensity, and abusiveness of today's medical education also engender a sense of entitlement to high income, prestige, and social power. In essence medical students believe that physicians have to pay very high "dues"—tuition, long hours, deferred gratification, great responsibility—which then warrant very high benefits in return, the cultural equivalent of "MD" license plates.

The third characteristic fostered by contemporary medical education is a phenomenon we call *non-reflective professionalism*. This is a belief system by which physicians consciously adhere to traditional medical values, while being (relatively) unaware that they base much of their behavior on beliefs at variance with these values. Among young physicians, adopt-

ing such a non-reflective professional identity is perhaps the most frequent method of reconciling the conflicting messages of tacit and explicit learning. (More about this trait follows.)

RESOLVING THE CONFLICT

Conflating Values

In non-reflective professionalism, students and young physicians hold that behaviors reflecting the tacit set of values are, in fact, the best way to manifest the explicit values. Thus, young medical professionals become convinced that the most effective way to show compassion for a patient is to take a clinically detached approach. Likewise, the non-reflective professional identity tends to conflate self-interest with the patient's interest. Physicians convince themselves that behaviors favored in the hospital's culture of survival do, in the long run, best serve the interests of their patients. In general, this involves substituting technologic intervention for personal interaction. Because culturally we associate benefit with "providing the best" and "being aggressive," patients usually expect (or at least accept) their physicians' predilection toward performing too many, rather than too few, interventions. Until the recent managed care revolution, this pattern of aggressive diagnosis and treatment also resulted in economic and social benefits for the physician. In other words, non-reflective physicians could view themselves as championing patient-benefit practices while at the same time pursuing doctor-benefit practices.

Andrea Fricchione's statement demonstrates some of these characteristics. First, she says she became convinced that giving of herself to improve the lives of others was a type of "arrogance." This arrogance was defused by the "profoundly humbling" experience of medical school, which conveyed the (tacit) message that people can't change, so she was wasting her time. In this situation, how could she best achieve her original goal? The only solution was to focus on her own needs ("hoarding my extra time for simple pleasures.") This strategy would leave her "better equipped" for the frustrations she faced—presumably the best result in a bad situation. Andrea hadn't abandoned her explicit values ("the best thing I could do for my patients, for my fellow human beings. . ."), but she had decided that by decreasing her personal involvement with them, or her professional commitments in general, she would, in fact, benefit them more.

Deflating Values

There are two other ways of resolving the value conflict. A second approach is for students to adapt their conceptions

of the ideal physician to fit their actual experience and the socialization process responsible for it. In other words, they discard traditional medical virtues. They become cynical about concepts such as duty, fidelity, confidentiality, and integrity. They question their own motivations and those of their patients. These physicians take on an "objective" professional identity that generally narrows their sphere of responsibility and confines it to the technical arena. Given this ethos, statements such as the following make perfect sense: "He's an extremely good doctor, but he sure is nasty with patients." "Her bedside manner is terrible, but she's the best gastroenterologist in the bowels of the city." To those who subscribe to this ethic, being a "good" doctor is a technical accomplishment that ought not to be considered compromised by lack of sensitivity, communication skills, or any professional virtue other than competence.

Maintaining Values

A third group of medical students avoids succumbing to the conflict between tacit and explicit socialization because in some sense they are "immunized" against forces that undermine medical virtue. These students progress through medical school and postgraduate training while maintaining, and even nourishing, an altruistic professional persona. In this case the seed either falls on a patch of good soil (immunizing factors in the medical school), or is a hybrid seed that thrives on adversity (natural immunity). What are the factors that help students resist becoming narrow or non-reflective physicians?

NATURAL IMMUNITY AND IMMUNIZATION

One predictor of natural immunity is continued commitment to standards or principles beyond the ideals of medicine. Such commitment tends to protect the student from the negative values instilled by tacit socialization. For example, students who identify strongly with their religious traditions and practices may find it easier to stave off detachment and fragmentation in their professional lives. The trend toward admitting more "non-traditional" applicants to medical schools may have increased the pool of students with such commitment, although the relationship is complex. Many non-traditional students are older than traditional premeds and have additional life experiences, either in earlier careers or in post-college projects (e.g., Peace Corps, teaching in low-income area schools, or public policy fellowships). Such students may have already tested their altruism and compassion in other endeavors. In some cases their post-college work may have required the courage to drop out of the mainstream to achieve a personal objective. In other cases the switch to medicine may have required the

courage to give up promising and lucrative jobs. Such non-traditional students may bring more defined and mature sets of values to the medical school mix.

Another potentially immunizing factor is being a woman. Since in our culture women are traditionally socialized from childhood to be empathic and compassionate, as a group they arguably enter medical training with a greater reservoir of caring skills and more openness to learning the affective and interpersonal aspects of doctoring. There is now considerable evidence that at least in the primary care specialties women physicians do, in fact, tend to spend more time with and communicate more effectively with their patients than do their male peers.

The family medicine, primary care, and generalist movements, which by the year 2001 have extended to almost all North American medical schools, constitute a third source of value immunization. While traditional specialties characterize those medical fields by their supposedly limited *depth* (e.g., less extensive knowledge in a given area), family medicine and generalist movements in internal medicine and pediatrics characterize themselves by *breadth* (e.g., ability to serve most health needs of most families). Moreover, these new academic fields argue that the whole is greater than the sum of its parts; caring for the whole person requires more than certain levels of knowledge and skill in various disease-oriented specialties.¹⁵ In fact, person-oriented, or relationship-oriented, care demands an additional set of knowledge, skills, and attitudes not captured in a specialist-oriented academic medical curriculum.^{16–18}

A final factor with immunizing potential is the establishment of medical ethics and humanities teaching in the majority of medical schools.¹⁹ However, the impact of such courses is generally limited.²⁰ First, ethics courses are usually too short and occur too early in the curriculum. The student learns useful information about advance directives, informed consent, surrogate decision making, and confidentiality, but this initial dose may not be reinforced, or may be suppressed, when the student enters his or her clinical life. Second, ethics courses may not address medical virtue and professionalism. While end-of-life decision making and other areas of quandary ethics are important topics, values inform every aspect of day-to-day medical practice. Empathy, compassion, attentiveness, fidelity, courage—such values are not easily communicated by “hard” ethics courses, no matter how intensive or well placed. By the same token these virtues are hard to develop “on the run” in a clinical factory in which time for reflection, interaction, and feedback is scarce. If they can be taught in coursework at all, they are more likely to be nourished in “soft” humanities courses such as literature, film, and religious studies, where analysis, reflection, and self-awareness are emphasized. Moreover, interactive skills must be explicitly taught in courses on interviewing and physician–patient communication.

Another limitation combines quantitative and qualitative features. As we have argued, the culture of clinical training is often hostile to professional virtue. Because the tacit value system of the hospital is so potent in forming the student’s view of doctoring, the explicit values embodied in ethics and humanities courses may have little impact.¹⁹ For example, in their medical ethics courses, students may have learned the components of informed consent and the ethical and judicial standards by which consent is judged. Furthermore, in their courses on physician–patient communication, students may have learned the appropriate methods of facilitating or negotiating informed consent. These topics are in the explicit curriculum. However, in their surgical clerkships they may encounter a culture in which none of this material is relevant. The surgical residents may think that consent is a formality. Their attending surgeon may boast that informed consent is a farce; he can get a patient to agree to anything he wants—“It’s not what you say, it’s how you say it.” Moreover, the pace and pressure of work are such that there is no time to spend educating patients or answering their questions. The tacit value system embedded in this medical/hospital culture is contrary to the explicit value system the students learned. Nonetheless, they are immersed in this system during the most crucial months (and, later, years) of their transformation into physicians.

Thus, ethics and humanities curricula are irrelevant unless they can produce a substantive and continuing impact on hospital culture.^{21,22} Frequent ethics rounds and ethics conferences on clinical services are a step in the right direction, but if run primarily by ethics specialists, these may have little impact. The idea, of course, is to infiltrate the culture by co-opting residents and attending physicians—first obtaining their good will, then fanning good will into enthusiasm. If an ethics program can somehow achieve a critical mass of “value-sensitive” clinical faculty, it may begin to influence the institution’s ethos.

Andrea was a non-traditional female student who began medical school with a strong interest in family medicine. She attended a school with an extensive social issues and medical humanities curriculum. However, the conjunction of several “immunizing” factors did not make her resistant to the clash of values and resultant non-reflective professional identity.

WHERE DO WE GO FROM HERE?

Medical education stands at the doorstep of profound change. Academic medical centers are already being forced to step through that door into an uncertain and potentially hostile new environment. These changes have nothing to do with scholarly analysis or self-reflection, but rather are a direct consequence of the revolution in health care financing for which we use the general term “managed care.” Among

the most important features of the new system is a corporate mentality in which much of the “fat” of traditional medical care must be eliminated and with it much of the support for medical education.

Some commentators claim that the corporate transformation of medical care may lead to the decline and death of traditional professional values, such as fidelity, altruism, confidentiality, and integrity.²³ The concern that self-interest will be encouraged in mercantiled medicine has, a priori, plausibility. Likewise, physicians’ social commitments, whether to the social dimension of patient welfare or to the community as a whole, may wither as physicians progressively adopt a business mentality.²⁴ However, since we believe that, for the last 30 years or more, the powerful tacit socialization process in medical education has *already* severely damaged doctoring, we retain some optimism that the managed care revolution cannot make it much worse. Granted, the 1980s subspecialist was trained as an *impresario* technician, rather than an *employee* technician, but he or she already lived in an environment in which traditional values were suppressed rather than enhanced, and non-reflective professionalism was rampant. Thus, the notion that managed care will diminish medical virtue seems naïve. To the contrary, managed care may gouge the heart out of certain medical vices, such as arrogance and sense of entitlement. Nonetheless, there is little question that managed care has important ethical implications.^{25–27}

What are the likely effects of the corporate transformation of medicine on medical curricula? It seems probable that the new emphasis on primary care will lead to more training in the knowledge, skills, and values associated with day-to-day interaction with patients. More of the training will take place in ambulatory settings. There will probably be fewer residency and fellowship positions in certain surgical and procedure-oriented subspecialties. In medical school the curricula will include attention to outcomes studies, evidence-based medicine, quality assessment, clinical guidelines, and health care economics. Combined-degree programs (e.g., MD–MBA and MD–MPH) might increase in frequency to meet the growing need for physician administrators.

With regard to explicit professional values, it seems unlikely that *less* attention will be paid to medical ethics, humanities, and social issues. Lectures, seminars, conferences, and courses supporting medical and social values will probably accompany the trends outlined in the preceding paragraph. Managed care has made the social *interdependence* of medicine more explicit. Physicians will come to see themselves and their patients in the context of a multiplicity of social values and institutions, rather than as isolated players. Thus, the type of curriculum exemplified by Stony Brook’s Medicine in Contemporary Society courses will remain as relevant as, if not become more relevant than, in the

past.^{28,29} From this perspective, it is plausible that 21st-century physicians will be more socially aware than today’s physicians are because they will be socialized to be more *connected*.

Given this general framework, what additional changes in medical education might realistically lessen the clash between tacit and explicit values, and allow students like Andrea Fricchione to complete their education with enhanced rather than diminished professional virtue?

We believe that in the preclinical curriculum problem-based learning and the trends toward integration of material across disciplines—both internal to medicine and across professions—will continue, although pure examples will probably not be adopted by most medical schools both for practical reasons and because of educational considerations. In this time of decreasing faculty resources, problem-based learning may not be feasible in many schools. Moreover, its educational advantages as a complete system are at present unclear. The basic principles—active learning in small groups—are, however, well established. In addition, the preclinical curriculum should include a substantive multidisciplinary track that deals with social issues in medicine. This offering ought to include the physician–patient relationship, traditional virtues of physicians, socialization in medical education, literature and medicine, medical ethics, health law, anthropology, cultural diversity, and health economics, especially the structure and function of the health care delivery system.

The preclinical curriculum should also include socially relevant *doing* as well as *studying*. The current opportunities for clinical exposure during the first and second years in most medical schools do not satisfy this requirement. From the students’ perspective, of course, interacting with patients in the hospital or office setting is highly desirable, but does not necessarily supplement the tacit learning environment with concepts of interdisciplinary practice, biopsychosocial modeling, and social responsibility. The American Medical Association Code (in VII) specifies that “a physician shall recognize a responsibility to participate in activities contributing to an improved community.”³⁰ In another section (III) the Code indicates that “a physician shall . . . recognize a responsibility to seek changes in [legal] requirements which are contrary to the best interests of the patient.” If these requirements are important manifestations of professionalism, they should be addressed in medical education. Ideally, students would select from a menu of available programs, choosing experiences that fit with their own interests and skills. These might include, for example, providing HIV education in local high schools, doing volunteer work in hospices, providing health services for migrant farm workers, or even working with environmental or other politically active volunteer organizations.

The clinical curricula at many medical schools have already been expanded to give students experience in a broader array of clinical settings, especially in primary care and outpatient settings. In addition to these broad requirements, curricula will need to address neglected topic areas that will enhance the relevance of clinical training to contemporary practice. Since most patients will soon be cared for under managed care contracts, it makes sense that the objectives, organization, and function of managed care be added to clinical training. In fact, health care assessment, quality assurance, and peer review—topics traditionally absent from medical training—should now be taught in concert with other respects of the contemporary management of medical services. Evidence-based medicine is another set of knowledge and skills that ought to be integrated into the clinical curriculum.

The self-contained blocks of clinical training are necessary for organization and efficiency, but there is no reason that students might not have longitudinal commitments along with their rotations and block electives. One such commitment would certainly be the opportunity to develop long-term relationships with primary care patients and chronically ill or disabled patients. Likewise, there should be an expectation that students continue their preclinical work with the same (or a different) social welfare agency or other community activity. An evaluation by their “social preceptor” should be included as part of their clinical portfolio along with clerkship grades and evaluations.

WILL THE GAP NARROW?

North American physicians emerge from their medical training with a wide array of professional beliefs and values. Many are thoughtful and introspective. Many are devoted to patients' welfare. Some bring to their work a broad view of social responsibility. Nonetheless, in this essay we have contended that North American medical education favors an *explicit* commitment to traditional values of doctoring—empathy, compassion, and altruism among them—and a *tacit* commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.

We have noted that medical students and young physicians respond to this conflict in various ways. Some reconceptualize themselves primarily as technicians and narrow their professional identity to an ethic of competence, thus adopting the tacit values and discarding the explicit professionalism. Others develop non-reflective professionalism, an implicit avowal that they best care for their patients by treating them as objects of technical services (medical care). We have illustrated this development with the story of Andrea Fricchione.

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tacit values, and thus they internalize and develop professional virtue. Certain personal characteristics of the student such as gender, belief system, and non-medical commitments probably play roles in “immunization,” as do medical school features such as family medicine, communication skills courses, medical ethics, humanities, and social issues in medicine. To be effective, though, these features must be prominent and tightly integrated into the medical school curriculum.

Changes in the culture of medicine from the 1960s until recently had their epicenter in medical schools and teaching hospitals, but they also reflected the profession's increased affluence and social power. The locus of change has now shifted to ambulatory settings and the marketplace. It remains to be seen whether this move will lessen the disjunction between the explicit curriculum and the manifestly contradictory values of detachment and entitlement, and the belief that the patient's interest always coincides with the physician's interest.

Dr. Alexandra Edelglass Stockwell is the model for “Andrea Fricchione” in this essay; only a few biographical details were changed. The authors express their sincere thanks to Dr. Stockwell for allowing them to quote her so extensively.

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