

Special Section: 30 Years of The Journal of Clinical Ethics

Clinical Medical Ethics: Its History and Contributions to American Medicine

Mark Siegler, Guest Editor

Editor's Note

We wish to recognize and express our appreciation to Mark Siegler as guest editor. All articles in this issue of *JCE* were invited by Mark. Additional invited articles will appear in *JCE* throughout the year. We thank all contributors.

ABSTRACT

In 1972, I created the new field of clinical medical ethics (CME) in the Department of Medicine at the University of Chicago. In my view, CME is an intrinsic part of medicine and is not a branch of bioethics or philosophical ethics or legal ethics. The relationship of patients with medically trained and licensed clinicians is at the very heart of CME. CME must be practiced and applied not by nonclinical bioethicists, but rather by licensed clinicians in their routine, daily encounters with inpatients and outpatients. CME addresses many clinical issues such as truth-telling, informed consent, confidentiality, surrogate decision making, and end-of-life care, while also encouraging personal, humane, and compassionate interactions between experienced clinicians and patients.

The goals of CME are to improve patient care and outcomes by helping physicians and other health professionals

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identify and respond to clinical-ethical challenges that arise in the ordinary care of patients. As Edmund Pellegrino, Peter A. Singer, and I wrote in the first issue of *The Journal of Clinical Ethics*, 30 years ago: "The central goal of CME is to improve the quality of patient care by identifying, analyzing, and contributing to the resolution of ethical problems that arise in the routine practice of clinical medicine."¹ Similar to cardiology and oncology consultations, ethics consultations are a small component of a much larger field, and the process of consultations is certainly not at the core of cardiology or oncology or CME.

In this article, I intend to discuss the origins of the field of CME, its goals and methods, the relationship between the broad field of CME and the much narrower practice of ethics consultation, the contributions of the MacLean Center at the University of Chicago in developing the field of CME, and, finally, how CME has improved the practice of medicine in the United States.

INTRODUCTION

The field of clinical medical ethics (CME) was started in 1972 in the Department of Medicine at the University of Chicago.² Clinical medical ethics is an intrinsic part of daily medical

practice. CME is not a branch of bioethics or philosophical ethics or legal ethics or theoretical ethics. Rather, it is a central component of clinical care that must be practiced and applied by licensed clinicians in their ordinary encounters with patients. During the past 47 years, CME has become integrated into medical education and medical practice. CME has become a transformative field in medicine that aims to improve the clinical and ethical quality of routine care that clinicians provide their patients and also to improve patient outcomes. Although bioethicists may provide theoretical insights to clinicians, bioethicists cannot practice medicine or examine patients or provide care to patients. In daily practice, CME addresses clinical ethical issues such as truth-telling, informed consent, confidentiality, surrogate decision making and end-of-life care, and also encourages personal, humane, compassionate, and fair interactions between doctor and patient.

I am honored to have been invited to serve as an author and as the guest editor of this special issue of *The Journal of Clinical Ethics* on its 30th anniversary. I have warm memories of being invited by Norman Quist in 1990, along with my great co-authors, Edmund Pellegrino, from Georgetown University, and Peter A. Singer, from the University of Toronto, to discuss the field of CME in a series of five articles that were published in the first volume of this journal.

In this essay, I will discuss the following issues relating to clinical medical ethics (CME):

1. What were the origins of the field of clinical medical ethics?
2. What is CME and what are its goals and methods?
3. What is the relationship between the larger field of CME and the more limited practice of doing ethics consultation?
4. How has the MacLean Center at the University of Chicago contributed to developing the field of CME?
5. How has CME changed and improved the practice of medicine in the U.S.?

WHAT WERE THE ORIGINS OF THE FIELD OF CLINICAL MEDICAL ETHICS?

In 1972, when I joined the University of Chicago faculty, the Chair of Medicine, Alvin Tarlov, asked me to establish and direct our hospital's first Medical Intensive Care Unit (MICU). In those days, there were very few

MICUs, in part because there were very few effective ventilators, and the specialty of critical care medicine did not yet exist. In fact, while the Society of Critical Care Specialists was formed in 1970, the first American Board of Internal Medicine certification exam in Critical Care Medicine was not held until 1987—15 years after we had opened our MICU. In time, MICUs would become one of the great medical and technological advances that saved many lives, prolonged many lives, and in the process raised new ethical questions that clinicians had never before faced.

Directing the MICU from 1972 to 1977 changed my career and encouraged me to establish the field of clinical medical ethics. Our seven-bed MICU received the sickest adult patients in the hospital. Our mortality rate was over 60 percent. Each day, my team and I confronted ethical issues such as rationing beds, negotiating informed consent, deciding when we needed surrogate consent, deciding whether we could stop a treatment once we had started it, and communicating a truthful prognosis to the patient or the family. My previous training in medicine had not prepared me for this set of problems, problems that would arise every day in the MICU.

Faced with these recurring issues, I soon discovered that there was no place to send my house staff and students to find answers. The medical literature and textbooks did not discuss these matters. Although in the 1960s there was a new, emerging literature in biomedical ethics, written largely by nonclinicians—that is, by philosophers, theologians, legal scholars, and social scientists—this literature rarely addressed the practical concerns faced in the MICU by medical students, residents, nurses, and physicians. The language of biomedical theory was different from the language of clinicians, and bioethical theory was often not helpful in resolving the practical dilemmas clinicians faced while caring for sick and dying patients. One repeated clinical ethical challenge in our seven-bed intensive care unit involved when, if ever, was it clinically and ethically appropriate to transfer a patient already in the MICU because a new patient had a better chance of benefiting and surviving in the unit. Because MICUs were so new at that time, there was little clinical guidance for such daily clinical ethical challenges. Furthermore, in the early 1970s, very few clinicians were even aware of the bioethics move-

ment, and those who were often reacted negatively and sometimes with hostility to bioethics and to non-physician bioethicists.

At that time in 1972, I first realized that if we were to improve the care of patients in the MICU and throughout the hospital, it was essential that doctors, nurses, patients, and families become more closely involved in discussions about these relatively new and difficult clinical and ethical questions. Physicians and patients needed help to better understand the ethical issues in daily clinical practice so that they could incorporate ethical analysis into their clinical decisions. It was these insights that led me to change my career goals. In addition to caring for patients, I would also direct my career to develop and expand the new field of CME. I would do so by involving practicing physicians, nurses, and patients, with the goal of improving medical care and patients' outcomes.

I was fortunate that in the 1970s, four distinguished pioneering bioethicists worked at the University of Chicago: James Gustafson (theology), Richard McCormick (theology), Stephen Toulmin (philosophy and the Committee on Social Thought), and Leon Kass (the Committee on Social Thought). I found myself frequently seeking guidance about ethical dilemmas from these experts, especially from Gustafson and Toulmin. In all of these encounters, I was struck by how relevant for medical practice these new bioethical insights were, while at the same time, I was troubled deeply by the general absence of clinicians from these discussions and by the widespread ignorance among clinicians about the fields of bioethics and about the recently established field of clinical medical ethics. I believe the creation of clinical medical ethics in 1972 encouraged clinicians to become involved and aware of ethical challenges that arise in routine clinical situations.

I came to believe that clinical medical ethics could not be an elective area of study for physicians. Rather, it was an essential field that physicians had to learn in order to practice good medicine. I also soon realized that clinical medical ethics was far more closely aligned to clinical practice than it was to bioethical theory.

My central point is that intensive care physicians and, in fact, physicians in general, routinely encounter many ethical issues and that dealing with these clinical-ethical issues is an intrinsic part of reaching clinical decisions and providing good clinical care to patients. For this

reason, it was imperative that we create and develop the new field of clinical medical ethics, a field that prepared and assisted clinicians who were caring for patients and making clinical-ethical decisions each day.

In 1996, Daniel Callahan, the cofounder of the Hastings Center, attacked the field of clinical medical ethics in an article published in the *Hastings Center Report*. The article was entitled "Does Clinical Ethics Distort the Discipline?" Callahan wrote:

In one of my first articles on bioethics, I wrote that the principal aim of the field should be to help the medical practitioner deal with concrete cases. While I would hardly want to overlook the needs of the practitioner, I now wonder if that is the right place to center our attention. . . . Does reality lie in the particularity of individual cases where most clinicians think it does—or in a more general, abstract and universal realm no less real but just more hidden.³

Callahan's views certainly differ in a major way from the goals of clinical medical ethics, which are to improve the care and outcomes of individual patients.

In 1997, a year after Callahan's article was published, the *Lancet* published an editorial that strongly endorsed my earlier views about CME and directly challenged Callahan's views. The *Lancet* editorial stated: "Ethics needs to be rooted in clinical practice and not in armchair moral philosophy. Debate on ethical matters is as much an integral part of everyday doctoring as choosing the best treatment for patients. Departments of ethics that are divorced from the medical profession, wallowing in theory and speculation, are quaintly redundant."⁴

As I stated previously, I changed my career goals during the five years that I directed the MICU. I dedicated my career to developing the new field of CME and to improving our care of patients by training physicians and other clinicians to apply the concepts of CME in their daily work.

The first paper I wrote related precisely to an important issue in clinical medical ethics, that is, telling the truth to patients and their family members. The paper was entitled "Pascal's Wager and the Hanging of Crepe," and referred to the fact that my younger associates in the intensive care unit had been telling all patients who had been admitted to the ICU (or their fami-

lies) that the patient would certainly die during this admission. When I first learned of this situation, I quickly corrected it and then wrote a paper highlighting that the routine deceit of patients and families was unethical and was clinically unacceptable.⁵

In the spring of 1973, Alvan Feinstein, the late renowned clinician-scholar and Sterling Professor of Medicine at Yale University, reinforced my choice of the term “clinical medical ethics” when he and I met at the annual American Society for Clinical Investigation/Association of American Physicians (ASCI/AAP) medical meetings in Atlantic City. Feinstein called his own work “*clinical judgment*” and “*clinical epidemiology*,” because, unlike traditional studies, his clinical and epidemiology studies were based directly on his clinical care of patients. Similarly, Feinstein regarded the work that I had started at the MICU at the University of Chicago as “*clinical medical ethics*,” which he vigorously distinguished from what he called theoretical, ivory-tower, biomedical ethics. By 1973, Feinstein considered my program at the University of Chicago to be the birthplace of the new field of clinical medical ethics.

In 1974, James Gustafson, Ann Dudley Goldblatt, and I wrote a grant to the U.S. Department of Health, Education, and Welfare (DHEW) entitled “Clinical Ethics and Human Values.” As far as I know, this was the first grant application, federal or otherwise, that used the term “clinical ethics.” The grant was approved, and we received three years of federal support to develop a multidisciplinary program in clinical medical ethics at the University of Chicago.

In 1978, I published a paper in the *Journal of the American Medical Association (JAMA)* entitled “A Legacy of Osler: Teaching Clinical Ethics at the Bedside.”⁶ As far as I know, this *JAMA* article was the first to use the term “clinical ethics” in the medical literature. This article noted that the advantages of teaching clinical medical ethics at the bedside included dealing with actual cases to maximize the physician’s personal accountability, reinforcing the relationship between clinical practice and ethical decisions, and helping to decrease the widespread resistance at that time by the medical profession to bioethics. The following year, in 1979, I started the first section of clinical medical ethics in an American medical journal, the American Medical Association’s *Archives of Internal Medicine*.⁷

In 1983, Arthur Rubenstein, the Chair of the University of Chicago’s Department of Medicine, and I received approval from Hanna H. Gray, President of the University of Chicago, to organize a center for clinical medical ethics at the university, a center that is now in its 36th year of operation.

With encouragement from President Gray, Arthur Rubenstein, and I developed a clinical, research, and financial plan for the new center. We secured initial funding from several leading foundations, including the Andrew W. Mellon Foundation, the Henry J. Kaiser Family Foundation, and the Pew Family Trust. I am also deeply indebted to the late Dorothy Jean MacLean and to Barry and the late Mary Ann MacLean, and to the MacLean family, for their continuous support of our program and their unwavering commitment during the past 36 years to the MacLean Center and its goals.

This early support enabled us initially to train 15 physician-leaders from the U.S. and Canada in the new field of clinical medical ethics and to launch our CME Fellowship Training Program. Twelve of our early leading physician-fellows—Susan Tolle (Oregon), Peter A. Singer (Toronto), Alvin Moss (West Virginia), Jay Jacobson (Utah), Robert Walker (South Florida), the late Douglas Kinsella (Calgary), Joel Howell (Michigan), Eric Kodish (the Cleveland Clinic), Christine McHenry (Cincinnati Children’s Hospital), Robert Orr (Loma Linda), John La Puma (University of California), and Laura Roberts (New Mexico)—returned to their home institutions to become the original directors of clinical medical ethics programs in the U.S. and Canada.

In 1990, I was invited, along with the late Edmund Pellegrino and Peter A. Singer to introduce the new field of clinical medical ethics in a series of five papers that we published in volume one of a new journal, *The Journal of Clinical Ethics*.⁸

WHAT IS CME AND WHAT ARE ITS GOALS AND METHODS?

As noted in the introduction, CME is a new *medical* field, an intrinsic part of clinical medicine. The goals of CME are to improve patient care and outcomes by helping physicians and other health professionals identify and respond to clinical-ethical challenges that arise in the daily care of patients. As Edmund Pellegrino, Peter A. Singer, and I observed almost 30 years

ago: “The central goal of CME is to improve the quality of patient care by identifying, analyzing, and contributing to the resolution of ethical problems that arise in the routine practice of clinical medicine.”⁹

The doctor-patient relationship, along with the nurse-patient relationship, are at the heart of CME. The central focus of CME is individual patient-physician decision making. CME helps patients, families, physicians, and other health professionals reach good clinical decisions by taking into account, while recognizing all the uncertainties, the medical facts of the situation (including the differential diagnosis, proposed diagnostic and therapeutic interventions, and treatment choices), the patient’s personal preferences and values for diagnostic interventions and therapeutic management, as well as related ethical considerations involving the wishes of the family, financial concerns, and research and teaching activities in academic institutions. Unlike biomedical ethics, CME is not a theoretical undertaking; rather, it must be practiced and applied every day, by licensed clinicians (rather than by unlicensed bioethicists, humanists, or social scientists) in order to provide excellent clinical and ethical care to patients.

In 1982, Albert Jonsen, William Winslade, and I wrote a book entitled *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. The book, now in its eighth edition, strongly supported the practical application of CME to patient care and the regular use of clinical medical ethics to help patients and physicians make good decisions relating to the care of the patient. The book states, “Clinical ethics is inextricably linked to the physician’s primary task, deciding on and carrying out the best clinical care for a particular patient in a particular set of circumstances.”¹⁰ As Al Jonsen wrote in 1988, “*Clinical Ethics* proposed a method of analysis that was closer to the reasoning of clinicians than to the speculation of philosophers.”¹¹

The foreword to the first edition of *Clinical Ethics* was written by the late Robert Petersdorf, MD, one of the most powerful and influential medical leaders of his generation. In the foreword, Petersdorf wrote,

Despite the increasing importance of ethics in medicine, few clinicians spend the time and effort it takes to read a book on ethics. All too often, these books have been couched in weighty philosophy and abstruse theory.

This little book handles ethical problems in medicine quite differently. Jointly authored by an ethicist, a clinician and a lawyer, it attacks ethical problems in real-life terms. . . . This is a very useful little book, primarily because it is so helpful to the “working doctor.”¹²

WHAT IS THE RELATIONSHIP BETWEEN THE LARGER FIELD OF CME AND THE MORE LIMITED PRACTICE OF DOING ETHICS CONSULTATION?

Beginning in the mid-1970s, the University of Chicago Hospitals pioneered the development of ethics consultations to assist patients, families, physicians, and the health team. MacLean Center faculty and fellows wrote much of the early literature on clinical ethics consultations, including the first book on the topic of ethics consultations.¹³

There are some ethicists, especially nonclinician ethicists, who claim that the core of CME is performing ethics consultations. This perspective regards ethics consultations as being at the heart of CME. I strongly disagree with this view and consider it to be a narrow and mistaken understanding of CME. When clinicians such as I started the field of CME in the early 1970s, we viewed it as a new, improved, approach to clinical medicine that worked to integrate ethical considerations into the *entire* range of outpatient and inpatient medical practice. In 2019, to practice good medicine, physicians must know and regularly apply in their care of patients the central elements of CME, and these elements include truth telling, informed consent, respect for patients, confidentiality, assessment of decisional capacity, interactions with surrogate decision makers, pain management, appropriate end-of-life care, and many more. For clinicians today, applying CME standards in patient care is no longer an elective matter. Rather, the central principles of CME have now become the clinical, legal, and professional standard of care in the U.S. While very few U.S. physicians today are formally trained as clinical medical ethicists, all physicians are expected to routinely apply CME elements in their regular, daily work with patients.

CME applies to all clinical decisions and not just to ethical dilemmas or conflicts that may generate requests for ethics consultations. It is important to note that whereas the field of CME

started in the early 1970s, ethics consultation played only a minor role in the field until about 15 years later, when John Fletcher and Al Jonsen convened a meeting in Washington, D.C. to form a society called the Society for Bioethics Consultation (SBC). As I recall, there were about 60 participants at the meeting, the majority of whom were PhDs, with only eight physicians present. While ethics consultations remain a component of the larger field of CME, they are a relatively small component compared to all the other critically important contributions the field of CME makes on a daily basis as an integral part of patient care. I have often thought that the ultimate goal of clinical ethics consultations should be to teach clinicians enough about ethical standards that, in the future, they can resolve ethical problems by themselves without calling an ethics consultation. Although ethics consultations may be helpful in dealing with some ethical dilemmas or conflicts that arise in the course of medical practice, CME is a much broader field that has important applications throughout the entire spectrum of daily medical practice.

The difference between these views about ethics consultations and the broader field of CME can be compared to cardiology consultations or oncology consultations. The practices of cardiology and oncology are much larger and more complex and far more inclusive than merely performing cardiology or oncology consultations. While consultations are called when the primary physician seeks an expert opinion about a difficult matter, consultations play a limited role in the fields of cardiology and oncology, and clearly do not constitute the central purpose or body of clinical or research practice in these fields. Similar to cardiology and oncology, the field of CME is much larger and more encompassing and more relevant in day-to-day medical care than the relatively infrequent requests for an ethics consultation. I would speculate that whereas CME applies to *all* clinical cases, ethics consultations are requested in far fewer than 1 percent of clinical cases.

HOW HAS THE MACLEAN CENTER AT THE UNIVERSITY OF CHICAGO CONTRIBUTED TO DEVELOPING THE FIELD OF CME?

As discussed previously, beginning in 1972, my colleagues and I at the University of Chicago created, named, developed, and led the new field of CME. During the past 47 years, the

MacLean Center for CME has continued to advance the field of CME in many important ways. These advances include the following.

Established Clinical Ethics Fellowship Training

The MacLean Center's CME fellowship program is the oldest, largest, and the most successful ethics fellowship program in the world. Since beginning the fellowship program in 1981, the MacLean Center has trained more than 450 fellows, including more than 325 physicians. Some of our distinguished former physician-fellows include Peter Angelos (University of Chicago), Farr Curlin (Duke University), Ellen Fox (Fox Ethics Consulting), Richard Gunderman (Indiana University), Joel Howell (University of Michigan), Kenneth Iserson (University of Arizona), Jason Karlawish (University of Pennsylvania), Niranjana Karnik (Rush University), Eric Kodish (the Cleveland Clinic), Ira Kodner (Washington University), Alexander Langerman (Vanderbilt University), John Lantos (University of Missouri-Kansas City), John La Puma, Stacy Lindau (University of Chicago), William Meadow (University of Chicago), Jerry Menikoff (Director of the U.S. Office for Human Research Protections), Alvin Moss (University of West Virginia), Ryan Nash (Ohio State University), Lois Nora (Former President of the American Board of Medical Specialties), Robert Orr (University of Vermont), Preston Reynolds (University of Virginia), Laura Roberts (Stanford University), Gregory Sachs (Indiana University), David Scheidermayer (Medical College of Wisconsin), John Schumann (University of Oklahoma-Tulsa), Gretchen Schwarze (University of Wisconsin), Peter A. Singer (World Health Organization), Giuliano Testa (Baylor University), Susan Tolle (Oregon Health Sciences University), Alexia Torke (Indiana University), Peter Ubel (Duke University), and Bruce White (Albany Medical College).

Graduates of the MacLean Fellowship have served as directors of more than 40 ethics programs in the U.S., Canada, South America, Europe, the Middle East, Africa, Australia, and China. MacLean Center fellowship graduates have held faculty appointments in more than 60 U.S. university programs. More than 25 fellowship graduates have held endowed university professorships. Former MacLean Center fellows have written more than 180 books and

thousands of peer-reviewed journal publications. Many of the graduates of our ethics fellowship program are leaders, scholars, and mentors who advance empirical scholarship in CME and who are dedicated to strengthening the patient-physician relationship and to improving patient care. In 2016, the Johns Hopkins Institute of Bioethics presented an award to the MacLean Center that stated, "The training program established by you . . . [has] had a greater impact than any other clinical ethics training program in the world."¹⁴

Strengthened the Doctor-Patient Relationship by Introducing the Concept of Shared Decision Making

The MacLean Center's most important achievement is its support and defence of the critical importance of the doctor-patient and clinician-patient relationship. As noted earlier, these relationships are the central focus of CME. The MacLean Center is proud to have trained more than 400 clinician-ethicists (including 350 physician-ethicists). These trainees have helped to maintain and improve doctor-patient relationships. One such improvement is the introduction of the concept of shared decision making.

Shared decision making has become an essential element of the doctor-patient relationship. It was not always so. Over the last 50 years, there has been a vigorous dialogue among doctors, patients, lawyers, philosophers, theologians, and social scientists about the best way for doctors and patients to make decisions together. The complexities are inherent in the nature of the doctor patient relationship. Patients are sick, scared, and vulnerable. Doctors have specialized knowledge and societal privileges, and control access to medical resources. Doctors are supposed to serve their patients, but patients often do not and cannot know what they want or need except through the assistance and guidance of the doctor. The emergence of the field of CME in the 1970s is closely tied to the development of shared decision making in the early 1980s. Shared decision making reflects a particular view of doctors' moral obligations to both respect patients' autonomy and also to respect their fundamental commitment to use their medical knowledge to improve the clinical and ethical outcomes for patients.

CME aims to improve patient outcomes by encouraging shared decision making between

patients and physicians. In a 1979 talk to the New York Academy of Medicine and a subsequent paper based upon that talk, I introduced the concept of the doctor-patient accommodation and indicated that it was a preferred alternative to either the old model of physician paternalism or the new model of patient autonomy.¹⁵

In the 1982 report by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the President's Commission repeatedly cited my paper on the doctor-patient accommodation as an important basis for their recommendation of a shared decision-making approach in medicine.¹⁶ The President's Commission regarded the term I used, "the doctor-patient accommodation," as similar to the term they used, "shared decision-making." Both the paternalism and autonomy models imply an adversarial relationship between the patient and physician, although the models disagree on whether the ultimate power and control should rest in the doctor's hands or the patient's hands. By contrast, my model of the doctor-patient accommodation and the President's Commission model of "shared decision-making" assume that the physician and patient work together as partners or colleagues to achieve a common goal, which is to address the healthcare needs of the patient who has asked the doctor for help.

As the President's Commission stated:

The Commission's view is intended to encompass a multitude of different realities, each one shaped by the particular medical encounter and each one subject to change, as the participants move toward patient-physician accommodation through the process of shared decision making. In this report, the President's Commission attempts to shift the terms of discussion toward how to foster a relationship between patients and professionals characterized by mutual participation and respect and by shared decision making.¹⁷

Developed the New Field of Surgical Ethics

Working in close association with the American College of Surgeons, the MacLean Center has led a national effort to train surgeons in clinical surgical ethics and to encourage research on topics related to surgical ethics. During the past 11 years under the leadership of Peter Angelos, the

MacLean Center has trained more than 65 surgeons in the new field of surgical ethics.

Surgical ethics focuses on the ethical issues in the care of patients undergoing surgery. Although the ethical issues faced by surgeons and surgical patients are not completely different from the ethical issues elsewhere in medical practice, there are nuances and practicalities of the timing of surgical care that warrant specific attention. Informed consent for surgery is not different from informed consent in other areas of medicine, but the increased vulnerability of patients in the operating room demands a greater degree of trust. Furthermore, when caring for a patient in the operating room, a surgeon may be faced with unexpected problems that raise specific ethical issues. The anatomy of a patient may be such that the planned operation is not possible and the surgeon must utilize an innovative procedure. Such innovation is not allowable in other areas of medical care; for example, drugs cannot be tried on patients outside of a clinical trial without the approval of the U.S. Food and Drug Administration (FDA). In contrast, a surgeon is fully expected to creatively solve his or her patient's problem even if it means doing a procedure that has not previously been described. Alternatively, the unexpected intra-operative findings may force the surgeon to change the planned operation in the middle of the procedure. Surgeons may be faced with deciding whether to proceed in the best interests of the patient to do a different operation or to abort the surgery and discuss this with the patient later, or even to speak with the family during the operation to obtain surrogate consent.

The goal of the surgical ethics program is to prepare surgeons for academic careers that combine clinical surgery with scholarly studies in surgical clinical ethics. Surgical ethics fellows receive training in empirical research, teaching, and surgical ethics consultations, which are similar to medical consultations except that they are done in surgical situations. Graduates of the MacLean Center's Surgical Ethics Training Program currently work in more than 30 university surgery departments in the U.S. For the past four years, the MacLean Center has sponsored a joint surgical ethics fellowship program with the American College of Surgeons (ACS), a program that has now trained nine surgeons from institutions including Harvard, the University of Michigan, Stanford University, the University

of Wisconsin, the University of North Carolina, Case Western University, and the University of Colorado. Also under the auspices of the ACS, a new textbook on surgical ethics was recently published, and many MacLean Center faculty and former fellows contributed chapters.¹⁸

Participated in the "Empirical Turn" in Ethics Research

Beginning in the 1980s, the MacLean Center and its founding Research Director, the late Carol Stocking, PhD, a distinguished sociologist, played a key role in advancing the "empirical turn" in clinical ethics scholarship. This "turn" refers to the application of the techniques of clinical epidemiology, health services research, decision sciences, and evidence-based outcomes to the study of ethical matters in clinical practice. Empirical research gathers data with survey methods or clinical studies. Empirical data that shows that a particular way of ethical practice is better than an alternative helps in the development of professional consensus and encourages changes in practice. Previously, ethics research had relied primarily on nondata-based, analytic scholarship done by philosophers, theologians, and legal scholars, and such analytic scholarship had less impact on modifying clinical practice than empirical, data-driven clinical studies.

Introduced the Concept of Research Ethics Consultations

In a landmark article in 1989 in the *New England Journal of Medicine (NEJM)*, the MacLean Center introduced the concept of "research ethics consultations," an innovative approach to the ethics of clinical and translational research.¹⁹ In our *NEJM* article, we described research ethics consultations as follows: "Research ethics consultation is a process in which the ethical issues raised by an innovative therapy are analyzed before a protocol is submitted to the Institutional Review Board. This process has been an essential part of our living liver donor transplantation program in recent years." Research ethics consultations have now been widely adopted by many research groups, including Clinical and Translation Science Award programs and also by Marian Danis and colleagues at the National Institutes of Health.²⁰

HOW HAS CME CHANGED AND IMPROVED THE PRACTICE OF MEDICINE IN THE U.S.?

In the 1960s and 1970s, the early development of biomedical ethics in the U.S. was led mainly by nonphysician bioethicists—theologians, philosophers, humanists, legal scholars, and social scientists. Physicians and other clinicians had only limited involvement in this development and the impact of biomedical ethics on medical practice, and medical education was very limited.

CME, by contrast, has succeeded in changing and improving medicine in critical ways that would otherwise be neglected. In contrast to the 1970s, when physicians expressed widespread resistance to biomedical ethics, CME has become so well integrated into current practice that physicians often don't realize they are actually "practicing" it, which is the goal of all ethics teaching. Applying clinical ethics precepts without being aware of doing so reminds me of the character from a play by Moliere who was surprised to learn that he had been speaking prose all his life.²¹ But physicians are practicing clinical ethics (and speaking prose) every day when they tell patients the truth, or when they break bad news, or when they negotiate informed consent for a procedure or a medication, or when they make decisions based on shared decision making, or when they decide that a patient lacks decisional capacity and turn instead to surrogate decision makers. These and other clinical ethical considerations have become so much a part of routine medical practice that they have become widely accepted as the legal and professional "standard of care." While very few U.S. physicians today are formally trained as clinical ethicists, all physicians regularly apply CME approaches in their ordinary, daily work with patients.

I would go so far as to say that these days clinicians cannot practice good medicine—that is, technically competent and ethically appropriate medicine—without some knowledge of and ability to apply the core principles of CME.

In the past 40-plus years, the changes brought by CME to medicine have been profound and have occurred without fanfare or drama. In contrast to the 1970s, today almost every medical organization has a code of ethics and an ethics committee. Similarly, every large hospital is required by the Joint Commission to have a mechanism—usually either a hospital ethics

committee or an ethics consultation service—to resolve clinical ethical problems when they occur.²² Publications on clinical ethics issues appear regularly, both in ethics journals that are infrequently read by clinicians, and in medical journals that are widely read by clinicians. Most importantly, in contrast to the 1970s, CME discussions have become a part of everyday clinical discourse and of routine clinical decisions in outpatient and inpatient settings across the U.S. This transition was critical in U.S. medicine and ethics. The physician, not the bioethicist, has the special knowledge as well as the legal and professional responsibility to assist patients in curing or caring for their illness and to assist patients in dealing with the fear, pain, and suffering that often accompany ill health. Physicians and nurses are licensed by the state and are professionally, legally, and personally accountable to the patient if they fail to adequately integrate clinical ethics into their care of patients.

The Bucksbaum Institute for Clinical Excellence at the University of Chicago

In 2011, to extend our work on the doctor-patient relationship and the application of CME, the University of Chicago established the Bucksbaum Institute for Clinical Excellence with a transformational endowment gift of \$42 million from Matthew and Carolyn Bucksbaum and the Bucksbaum Family Foundation. I was honored to be selected as the founding executive director of the new institute. The goal of the Bucksbaum Institute is to prepare and train physicians to be highly skilled practitioners as well as caring, compassionate and ethical care providers.

Bucksbaum Institute scholars—ranging from premedical undergraduates to senior physicians and master clinicians—recognize and support the institute's core goals: to improve doctor-patient communications and decision making; to apply clinical medical ethics as the standard of care; to strengthen the doctor-patient relationship; to support and extend shared decision making; to reduce health disparities; to increase faculty engagement in personal care; and to create new models for undergraduate and medical student education. The University of Chicago has created a unique undergraduate program called the Clinical Ethics Scholar Track. This program enables undergraduate students to

shadow physicians for more than 100 hours, do volunteer services in the hospital, and to enroll in courses specifically designed for this program. In its first seven years of operation, the Bucksbaum Institute has appointed more than 300 physicians and students at the University of Chicago who embrace the ideals and goals of the institute. The outstanding external advisors to the Bucksbaum Institute—Jordan Cohen, Holly Humphrey, Laura Roberts, and Arthur Rubenstein—have assisted the institute to help it improve medicine and medical practice now and into the future.

In a talk that established the Bucksbaum Institute, Robert Zimmer, President of the University of Chicago, stated, “At the heart of medical care, at its foundation, lies the relationship of a physician and patient, and this is where the art and science of medical care come together. And it is on this relationship that the Bucksbaum Institute will focus.”

The combination of the MacLean Center for CME and the Bucksbaum Institute for Clinical Excellence help the University of Chicago advance the field of CME, reduce health disparities, and improve the care of patients.

The field of CME is now nearly 50 years old. CME, which involves the close integration of ethical principles with everyday clinical practice, and requires the commitment and involvement of clinicians, has helped to improve medicine and medical practice. The field has also greatly improved patient care and patient outcomes. As we look toward the future and recognize emerging challenges to humane, compassionate, and personalized medical practice, I am confident that CME will remain a vital program that continues to defend and improve clinical medicine.

NOTES

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