A THEORETICAL AND EVIDENCE-BASED APPROACH FOR DESIGNING PROFESSIONAL ETHICS EDUCATION

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This chapter provides a guided reflection on the state of theory, research, and practice for ethics education in the professions. We begin with an evidence-based theoretical approach to ground professional ethics education, followed by an overview of the nature of professionalism in society that includes a brief history of the ethics education movement. We then review the general status of ethics education, including changes in accreditation standards followed by current educational practices in medicine, dentistry, law, nursing, and veterinary medicine. Next, alternative options for assessing and promoting the broadly defined capacities specified by psychological theory are cited and reviewed. Last, we offer recommendations for enhancing ethics and professionalism education in the health professions and law to meet emerging accreditation guidelines that focus on outcome assessment.

A THEORETICAL APPROACH TO PROFESSIONAL ETHICS EDUCATION

Rest (1983) extended Kohlberg’s theory of moral reasoning development, first by designing an easy-to-score and administer measure of moral judgment (Rest, 1979) and then by defining the Four Component Model (FCM) of Morality to explain how cognition, affect, and social dynamics interact to influence moral action (Rest, Narvaez, Bebeau, & Thoma, 1999). Table 29.1 provides an operational definition for each component (we refer to them as capacities or abilities) and describes their interactive nature. Their particular relevance for professional ethical development is described below.

The Four Component Model (FCM): Implications for the Professions

MORAL SENSITIVITY

For individuals being socialized to professional practice, ethical sensitivity involves the ability to see things from the perspective of other individuals and groups (including other
Starting with the question “How does moral behavior come about?” Rest (1983) suggested that the literature supports at least four component processes, all of which must be activated for moral behavior to come about. The four components are a useful way to conceptualize the capacities required for effective moral functioning.

**Moral Sensitivity**
Moral sensitivity focuses on the interpretation of a situation, the various actions that are available, and how each action might affect the self and others. It involves imaginatively constructing possible scenarios (often from limited cues and partial information), knowing cause-consequence chains of events in the real world, and having empathy and role-taking skills. Both cognitive processes (perception, appraisal, and interpretation) and affective arousal (e.g., anger, apathy, anxiety, empathy, and revulsion) contribute to the interpretation of problematic situations.

**Moral Judgment**
Once a person is aware that various lines of action are possible, one must ask which line of action is more morally justified. This is the process emphasized in the work of Piaget and Kohlberg. Even at an early stage, people have intuitions about what is fair and moral, and make moral judgments about even the most complex of human activities. The psychologist’s job is to understand how these intuitions arise and what governs their application to real-world events. The educator’s job is to understand how best to promote reasoning development, especially for students who have not developed the ability prior to professional education.

**Moral Motivation and Commitment**
Moral motivation and commitment involves prioritizing moral values over other personal values. People have many values (e.g., careers, affectional relationships, aesthetic preferences, institutional loyalties, hedonistic pleasures, excitement). Whether the individual gives priority to moral concerns seems to be a function of how deeply moral notions penetrate self-understanding, that is, whether moral considerations are judged constitutive of the self (Blasi, 1984). For behavior to occur, the moral agents must first decide on a morally correct action when faced with a dilemma, and then conclude that the self is responsible for that action. One is motivated to perform an action just because the self is at stake and on the line—just because the self is responsible. Moral motivation is a function of an internal drive for self-consistency. Blasi (1991) argues: “The self is progressively moralized when the objective values that one apprehends become integrated within the motivational and affective systems of personality and when these moral values guide the construction of self concept and one’s identity as a person.”

**Moral Character and Competence**
Moral character and competence is having the strength of your convictions, having courage, persisting, overcoming distractions and obstacles, having implementing skills, and having ego strength. A person may be sensitive to moral issues, have good judgment, and prioritize moral values; but if he or she is lacking in moral character and competence, he or she may wilt under pressure or fatigue, may not follow through, may be distracted or discouraged, and moral behavior will fail. This component presupposes that one has set goals, has self-discipline and controls impulse, and has the strength and skill to act in accord with one’s goals.

It is noteworthy that the model is not conceived as a linear problem-solving model. For example, moral motivation may affect moral sensitivity, and moral character may constrain moral motivation. In fact, Rest (1983) makes clear the interactive nature of the components. Furthermore, and in contrast to other models of moral function that focus on the traditional three domains—cognitions, affect, and behavior—the Four Component Model of Morality assumes that cognition and affect co-occur in all areas of moral functioning. Thus, moral action is not simply the result of separate affective and cognitive processes operating as part of an interaction. Instead, each of the four components is a mix of affective and cognitive processes that contribute to the component’s primary function.

Source: Adapted from Bebeau (2006); Bebeau, Rest, and Narvaez (1999).
Designing Professional Ethics Education

Moral Thinking

Moral Thinking

Moral Judgment

Moral Motivation and Commitment

Moral Character and Competence

Because professional practice is essentially a moral enterprise in which new issues frequently arise with societal change and technological advances, the ability to reason carefully about the dilemmas of one’s profession is an essential capacity for practitioners. Rest and colleagues (1999) advanced the application of Kohlbergian stage theory to professional education by defining and validating three schemas associated with moral thinking in adults: the personal interest schema, characterized by decisions motivated by self-interest and/or a concern for interpersonal reciprocity; maintaining norms schema, focused on enforcement of existing norms, rules, codes, and laws; and the postconventional schema, centered on concepts of justice, fairness, duty, and the evolutionary nature of morality in society and in the professions. Recent interest in applying schema theory to professional education has centered on providing the individual with a baseline profile indicating which moral schema is predominant for the individual at entry to professional school, then providing post-test information to show whether the educational program has facilitated development (Bebeau & Faber-Langendoen, 2014). Of particular interest in professions education is the documented relation between advances in moral reasoning measured by life-span measures like Rest’s (1979) Defining Issues Test (DIT) and profession-specific measures of ethical reasoning (Bebeau & Thoma, 1999; Thoma, Bebeau & Bolland, 2008).

Moral Motivation and Commitment

Concerns for the development of a professional identity are the focus of two lines of research. One adapts Robert Kegan’s (1982) theory of life-span identity formation to professional identity formation (Bebeau & Monson, 2012; Bebeau & Thoma, 2013; Forsythe, 2005; Hamilton & Monson, 2012; Rule & Bebeau, 2005). A second flows from philosophers’ observations of models of professionalism that appear to guide moral action (Bebeau, Born, & Ozar, 1993; Thoma & Bebeau, 2013). Although applicants to the professions typically state their interest and commitment to becoming a professional, Bertolami (2004) notes that seldom during the course of professional education are students encouraged to reflect on this initial commitment to professionalism or to refine it based upon new understandings that emerge during professional education. Confirming this lack of attention to professional identity formation during professional education, Lee Shulman (2010) remarked in the preface to Education Physicians, the last of the Carnegie Foundation’s recent studies of five professions (law, medicine, clergy, engineers, and nurses) that the most overlooked aspect of professional preparation was “the formation of a professional identity with a moral core of service and responsibility around which each student’s habits of mind and practice are organized” (p. ix).

Moral Character and Competence

For the professional, technical competence, problem solving, interpersonal skills, and characterological dispositions must come together to implement an effective action. Bandura (1977) explains how cognition and affect interact when facing a challenging
A person who sees a task as “fun” or “challenging” is more likely to persist to resolve a problem. Conversely, if a problem is approached with dread, perseverance is less likely. Practice in resolving difficult and recurrent problems—like responding to an angry patient, or discussing a disciplinary issue with an offending peer—changes the expectations of efficacy, which in turn changes behavior. Apathy and cynicism arise when students can’t figure out how to effectively implement professional expectations. In research ethics education, such “survival skills” are deemed critical to the responsible conduct of research (Institute of Medicine [IOM], 2002b, p. 105).

**Dynamic Processes of the FCM**

Rest saw the processes encompassed by the FCM as distinctive, yet dynamic in nature. A wide range of studies (e.g., Bebeau, 2002; Thoma, 1994) show that moral judgment development predicts pro-social behavior; yet it predicts only 10–15% of the variance. Other processes, particularly component 3 (moral motivation and commitment)—what Blasi (1984) refers to as the development of the moral self and Kegan (1994) refers to the development of an identity—appear to be the primary driver of moral action (Thoma & Bebeau, 2013). For example, when dental professionals who have been disciplined by a licensing board are compared with a sample of dental professionals who consistently demonstrate exemplary moral behavior, those disciplined not only exhibit shortcomings in one or more of Rest’s Four Components, but with few exceptions illustrate only vague understanding of professional expectations. In contrast, exemplary dentists can and do spontaneously articulate professional values and expectations. In a similar vein, Walker and colleagues’ (e.g., Frimer & Walker, 2009) studies illustrate the distinctiveness of moral exemplars’ ability to integrate the personality traits of communion and agency—something that comparison group participants (ordinary citizens and the occasional moral hero) cannot do. Frimer and Walker’s (2009) reconciliation model describes development as the shift from the person’s conscious recognition of a tension between agency and communion to an active integration of the two. Taken together these two sets of findings suggest that moral motivation is furthered when individuals have a sense of connection between the self and others as well as a confidence in one’s ability to affect change. The challenge for educators and researchers who wish to further establish the role each process contributes to moral action must first attend to the validity of measurement. Without well-validated measures, it is not possible to establish the role each process contributes to moral action.

**THE NATURE OF PROFESSIONALISM**

Many people in today’s society refer to themselves as professionals, though society generally distinguishes among occupational groups based upon the presence or absence of particular attributes (Freidson, 1988; Hall, 1975). Whether a particular occupation actually qualifies as a “profession,” based upon criteria sociologists advance, makes for interesting debate. In our view (Bebeau & Monson, 2012), such a debate needs to precede ethics instruction in a profession, as characteristics of a profession and the expectations of a professional are not well understood, especially at entry to a profession. We show how to assess and educate for these understandings. The need for such education is heightened by environmental and political factors that impact individuals and the professions collectively.
Many today (e.g., Benner, Sutphen, Leonard, & Day, 2009; Cohen, 2006; Hafferty, Brennan, & Pawlinska, 2011; May, 1999; Rule & Welie, 2009) see professions in a state of crisis. In medicine, access to health care has been addressed through the Affordable Care Act (H.R. 3590–111th Congress: Patient Protection and Affordable Care Act. 2009), yet the gap in public health outcomes by level of education and race has widened in the last two decades (Olshansky et al., 2012), despite the steadily increasing amount the US spent on health care (Berwick & Hackbarth, 2012). Dentistry, having exempted itself from government programs such as Medicare, has neither addressed access to care or cost containment (Rule & Welie, 2009). In law, the failure to control costs has resulted in the outsourcing of legal services, which in turn results in a decline in available jobs for recent graduates—yet there is a paucity of affordable legal services for the nation’s most poor and vulnerable (Landsman, 2009). Mann (2006) argues for “the development of a sociological consciousness, interdisciplinary thinking, and understanding of the economic and political dimensions of health care” (p. 167). Advancing the scholarship of teaching and learning in ethics education has as its first goal to develop good professionals, and as its second goal to develop good professionals who work collectively to advance the public good.

**The Ethics Education Movement: A Brief History**

In the health professions, the push for ethics education originated with technological advances in medicine that foreshadowed new and emerging problems for health care providers. The goals of professional ethics education were first articulated by Bok (1976), and promoted by the Hastings Center (1980)—one of the first centers organized to focus on applied ethics, and ethics at bedside. In 1982, Rest was invited to introduce his Four Component Model of Morality in the Hastings Center Report (Rest, 1982). Interestingly, the first three of Rest’s components (sensitivity, reasoning, and motivation) are analogous to the goals Bok and the Hastings Center articulated—the need to develop moral perceptions and aspirations, in addition to moral reasoning. Absent from Bok’s vision is emphasis on Rest’s Fourth Component—variously described as character and competence or implementation.

In the early days of ethics education in the health professions, the predominant method for resolving ethical issues (Beauchamp & Childress, 1979—now in its sixth edition) was application of principles (autonomy, beneficence, nonmaleficence, and distributive justice) to the resolution of tough problems. If assessment of ethical decision making occurred, the methods were those typical of courses in philosophy—the analysis of written argument. Some alliances were formed between medical educators and moral psychologists in the late 1970s and a number of studies using Kohlbergian measures to assess moral judgment of medical students and physicians began to appear in the literature (e.g., Candee, Sheehan, Cook, Husted, & Bargen, 1982; Sheehan, Candee, Willms, Donnelly, & Husted, 1985). As we review the status of ethics education in the professions today, we see pockets of moral psychology’s influence, sometimes in the structure and organization of ethics educational programs (e.g., Bebeau, 1994; Dukett & Ryden, 1994; Hamilton, 2008; IOM, 2002b), more often in efforts to assess the effects of instruction (Baldwin & Self, 2006; Bebeau 2002, 2006, 2009a, 2009b; Rest & Narvaez, 1994). What is quite clear, however, is that unlike moral education in elementary and secondary education where moral psychologists have been the driving force behind the design and assessment of moral education (Lapsley
educators with grounding in moral philosophy and ethics have been the driving force behind much of professional ethics education (Doukas, McCullough, & Wear, 2010; 2012). As has been argued elsewhere (Bebeau, Rest, & Narvaez, 1999), grounding education and assessment in a view that knowledge, skills, and attitudes are the processes that give rise to morality is less helpful than a vision like the FCM that helps to define researchable variables and create authentic measures of professional ethical development and performance.

In contrast to the health professions, the impetus for ethics education in law was the egregious conduct of lawyers in the Watergate scandal (Graham, 1997). The typical approach to teaching professional responsibility courses in law (note they are not referred to as ethics courses) is to read opinions from appellate cases, judgments from the deliberations by association ethics committees, and to study state rules of professional responsibility or code of conduct (usually based on the American Bar Association Model Rules of Professional Conduct) in preparation for the required professional responsibility licensing examination. Egan, Kayhan, and Ramirez (2004, p. 309) note, such “courses suffer from three main shortcomings: they are mostly rule-based, they seldom venture into actual ethical analysis, and they are often not taken seriously by students.” In addition, teaching to the profession’s code perpetuates the notion that conduct not prohibited by the rules is ethically permissible. Thus, rather than promoting professional ideals to which one aspires, the rules serve as the prevailing ethical norms, rather than the minimum standards that keep you out of trouble.

As in elementary and secondary education, educators in the professions debate whether to focus on the individual’s character or on reasoning and problem solving. This ongoing debate is evident in Volume 10 of Advances in Bioethics (Kenny & Shelton, 2006). As its title implies (Lost Virtue...), the concern is with character formation. Advantages for the character approach are presented by physician ethicist Ed Pellegrino (2006) whose work with ethicist David Thomasma (Pellegrino & Thomasma, 1993) provides rich and useful operational definitions of the virtues of medical practice. A cogent critique of virtue ethics as a guide to educational program development is presented by Robert Veatch (2006). Other chapters argue for other dimensions of development, with no real resolution to the debate. Of particular interest is the work of Beauchamp and Childress (2009; sixth edition) whose work over the decades has responded to critiques from the bioethics community on methods for moral justification—particularly the application of moral principles (referred to as principlism) to resolve moral issues. The current edition includes an expanded theory of common morality and a reworked theory of the ethic of care as a form of virtue ethics.

In the last edition of the Handbook of Moral and Character Education (Bebeau & Monson, 2008), the dominant concern for ethics educators had shifted the debate from questions of character or ethical competence to a concern for simple adherence to appropriate behaviors. Predicated on a series of studies (Papadakis, Hodgson, Tehrani, & Kohatsu, 2004; Stern, Frohna, & Gruppen, 2005; Tehrani, Hodgson, Banach, & Papadakis, 2005), educators were able to link behaviors exhibited during medical school with subsequent disciplinary action by a state licensing board. Such findings were noteworthy, as educators had been unable to link GPA and national board examinations (the available gatekeepers for incompetence) and professional behavior. The Accreditation Council for Graduate Medical Education (ACGME, 2013) defined professionalism “as
manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.”

Even before the evidence linking behaviors exhibited in medical school with subsequent disciplinary actions, Papadakis, Loeser, and Healy (2001) argued for an administrative structure to remediate students’ deficiencies in behaviors judged as unprofessional. Yet, it is simply not enough to focus only on the external manifestation of behavior. In fact, in a closing chapter in *Measuring Medical Professionalism*, Hafferty (2006) eloquently asserted our belief: that tying too much of the assessment of professionalism to observable behaviors would not address the internalization of professional expectations reflected in Rest’s third component.

[Medical care must avoid the self-serving inconsistency of claiming to establish professionalism as an internalized and deep competency while willing to settle for graduates who manifest it only as a surface phenomenon. Such fence sitting, of course, calls into question just how core professionalism is to the nature and identity of medicine. A professionalism that is deep must exist at the level of identity. Surface professionalism … is nothing more than doing one’s job in a “professional manner.” Surface professionalism sidesteps issues of identity and treats professionalism as something physicians can put on and take off like one’s stethoscope. Professionalism as a deep competency might generate the same behavior, but the behavior in question is more real/authentic because the behavior is consequentially linked to the social actor’s underlying identity (as a professional) rather than to how the job was carried out (in a professional manner).]

(p. 283)

Today, we see medical educators (e.g., Jarvis-Selinger, Pratt, & Regehr, 2012) beginning to embrace Shulman’s call to focus on the identity of the individual—a perspective that is consistent with the view of moral psychology that the moral self is the link between knowing and doing. Our work of identity formation (Bebeau & Monson, 2012) illustrates that the usual socialization process in the professions doesn’t sufficiently develop either a basic understanding or an internalization of professional expectations. This is not to suggest that the measurement of medical professionalism should not be included as a dimension of assessment of professional competence, but it should not be the only strategy that focuses students’ attention on appropriate professional behaviors.

**STATUS OF ETHICS EDUCATION**

The early work of the Hastings Center (1980) defined goals for ethics education that are in concert with Rest’s evidence-based model of morality. Yet, our reviews of the status of ethics education across professions (detailed below) reflects a surprising lack of consensus on goals and purposes—both across and within professions, significant variation in time devoted to instruction, significant variation in content and methods and limited attention to assessment. This finding was not surprising in the 1980s, but today nearly every major medical center has an affiliated bioethics center and accreditation organizations have for some time required instruction in ethics and/or professionalism. Accrediting bodies tend to refrain from prescriptive recommendations, thus few institutions included evidence of the outcomes of ethics education in their self-studies. Today, the
accountability movement in the US appears to have influenced the latest accreditation guidelines for the five professions we studied.

The situation is similar for graduate medical education. Reviews of residency programs (Downing, Way, & Caniano, 1997; Mulvey, Ogle-Jewett, Cheng, & Johnson, 2000) indicated minimal attention to clinical ethics in either surgery or pediatrics, though such education was deemed desirable. Further, except for the recent appeal to fostering professional identity formation (Jarvis-Selinger et al., 2012)—which clearly appeals to Kegan’s constructivist theory of identity formation, and occasional references to the use of the Defining Issues Test to assess moral judgment development (e.g., the work of Self and colleagues reviewed by Bebeau, 2002) and two recent studies stemming from Baldwin’s (Baldwin, Adamson, Self, Sheehan, & Oppenberg, 1996) observation of the relation between malpractice and moral judgment development for orthopedic surgeons (Bohm et al., in press; Mercuri, Karia, Egol, & Zuckerman, 2013)—there simply isn’t a consistent appeal to moral psychology for the framing of goals and purposes for ethics education. Our findings are confirmed by a team of medical ethics and humanities educators (Doukas et al., 2010, 2012) recently convened to advance education in medical ethics and humanities.

The Need for a Systematic Approach to Ethics Education

What happens if insufficient attention is paid to the theoretical grounding for ethical decisions? As Shulman concluded, “the moral core around which habits of mind are organized” is missing. Bebeau and Faber-Langendoen (2014) summarize defenses offered by advance-level medical students caught cheating in a medical education course (Clarke, 2011). A subsequent remedial course for these students revealed that most could not articulate basic expectations of a medical professional even though they were about to graduate. Others (Editorial, 2006; Rudavsky, 2007; Sherman & Margolin, 2006, 2007), describe similar breaches of integrity and the amazing justifications offered. Less blatant, but troubling because they reflect shortcomings in ethics education, two studies reveal shortcomings in ethical competence. Using four hypothetical cases involving end-of-life decision making, Wong, Eiser, Mrtek, and Heckeryl (2004) observed that physicians were guided by (1) patient-focused beneficence; (2) a patient- and surrogate-focused perspective that included risk avoidance; and (3) best interests of the patient determined by ethical values, rather than self-interest concerns, such as (a) economic impact on the physician; (b) expediency in resolution of the situation; and (c) the expense of medical treatment. Whereas the values that appeared to be influential determinants of decisions were guided by biomedical principles, the participants’ decision methods appeared to resemble casuistry more than principle-based decision making. Testing actual performance, Gisondi, Smith-Coggins, Harter, Soltysik, and Yarnold (2004) measured the uniformity of ethical decision making for 30 emergency medicine residents using five high-fidelity simulations. In only one ethical scenario did the residents perform all the critical actions. Residents performed the fewest critical actions for a patient confidentiality case. Whereas professional behaviors appeared to be learned through some facet of residency training—senior residents had better overall performance than incoming interns—this study, together with the Wong et al. study, highlight: (1) the need for more focused ethics instruction; (2) the value of performance-based assessment for providing authentic learning and testing experience; and (3) the importance of feedback that enables
professionals to compare their performance with peers and against a standard (the criterion rating form).

**Accreditation Guidelines for Professional Ethics Education**

Accrediting bodies for the five professions we reviewed have required institutions to include education in ethics and professionalism for at least the last two accrediting cycles. For undergraduate medical schools, the accreditation standard states

A medical education program must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients’ families and to others involved in patient care.

(LCME, 2012)

What hasn’t been required is that institutions specifically demonstrate the effectiveness of ethics and professionalism education—though some outcome-minded institutions have included such data at part of their accreditation self studies.

Responding to the accountability movement in the US, two accrediting bodies are requiring that institutions engage in the specification and assessment of competencies. Both the Accreditation Council of Graduate Medical Education (ACGME, 2013) and the Commission on Dental Accreditation (ADA, 2013) are phasing in new accreditation systems requiring schools to report attainment of educational outcomes. In medicine, seven of 26 specialties (emergency medicine, internal medicine, neurologic surgery, orthopedic surgery, pediatrics, diagnostic radiology, and urology) have articulated levels of resident physician competencies based on expert panels and existing literature (Nasca, Philibert, Brigham, & Flynn, 2012). Schools will assess residents at six-month intervals. The levels, referred to as milestones, suggest their developmental nature. One of the subcompetencies of professionalism concerns the ethics of patient care.³

The challenge, of course, is to design systems to demonstrate achievement of such competencies. The systematic use of behavior checklists completed by multiple raters—the likely method of monitoring competence achievement—is certainly preferable to simply claiming learning outcomes are achieved, or relying on the fact that few students fail national and regional board exams. The concern, expressed by medical education scholars, is that “competency is not enough” (e.g., Jarvis-Selinger et al., 2012). Jarvis-Selinger and colleagues, together with Hafferty et al. (2011), recommend a focus on the individual’s inner psychosocial capacities associated with identity formation coupled with a focus on the professions’ contractual obligations to society (Cruess & Cruess, 2008a). Others, Ginsburg, Regehr and Lingard (2004) stress the underlying reasons and justification for the behaviors, and Dyche and Epstein (2011) stress cultivating an attitude of curiosity. A balance must be sought between behavioral observations and the assessment of capacities such as those suggested by Rest’s FCM.

Standards for law school accreditation state that the curriculum must include instruction in “substantive law” and “other professional skills” that are “generally regarded as necessary to effective and responsible participation in the legal profession” (ABA, 2013). Arguing that the standards generally refer only to the floor requirements needed to prepare students in legal rules and procedures, and professional skills, Hamilton (2008)
offers a definition of professionalism that integrates legal knowledge and skill with a set of aspirational values and ideals to guide a lawyer’s decisions and actions. Calling for a systematic empirical approach like the FCM for developing curriculum, assessment, and pedagogical methods to foster professionalism, Hamilton stresses professionalism’s developmental nature which requires a lifelong commitment to learning and development. Currently, he is engaged in research to define specific competencies expected of law school graduates in the first year of their employment (Hamilton, 2013a). Whereas the American Bar Association Accreditation standards do not currently incorporate Hamilton’s focus on outcome assessment, the ABA is expanding efforts to share knowledge of this, and similar approaches (Hamilton, 2013b).

The National League for Nursing Accrediting Commission, Inc. (NLNAC, 2013) Standards and Criteria state that programs being reviewed in January 2014 must have clearly articulated student learning outcomes and program outcomes consistent with contemporary practice. Student outcomes are defined as “statements of expectation written in measurable terms that express what a student will know, do, or think at the end of learning.” Beyond requiring “clearly stated learning and program outcomes” the document does not specify reporting of the assessment of outcomes.

Responding to animal welfare concerns (Tonsor & Wolf, 2011), the American Veterinary Medical Association (AVMA, 2012a) Council on Education (COE) (AVMA, 2012b) mandates that schools teach ethics within the curriculum. Recently mandated is a requirement that schools develop outcome assessment of holistic competencies necessary for the professional practice. Unlike professions that specify particular ethics competencies, veterinary medicine appears to consider ethics integral to each of its competencies. How ethics outcomes will be assessed is unclear. However, the COE policy states that in order to meet accreditation standards, veterinary schools must provide opportunities throughout the curriculum for students to gain an understanding of professional ethics, delivery of professional services to the public, personal and business finance and management skills; and gain an understanding of the breadth of veterinary medicine, career opportunities and other information about the profession.

Its stance towards animal welfare ethics is reflected in the directive that veterinary schools provide students with the “knowledge, skills, values, attitudes, aptitudes and behaviors necessary to address responsibly the health and well being of animals in the context of ever-changing societal expectations.”

**Current Practices**

Current practices in ethics education are documented to varying degrees. Methods range from surveys of school administrators or faculty to outcomes assessment with alumni.

**MEDICINE**

Medical education appears to distinguish ethics instruction (i.e., promoting reasoning) from promoting professionalism (i.e., behavior). In a survey of 126 US medical schools (Swick, Szenas, Danoff, & Whitcomb, 1999), 89.7% of the 116 responding schools offer formal instruction related to professionalism—teaching professionalism as a single course or incorporating it as part of multiple courses. Diverse strategies
to promote professionalism include “white-coat ceremonies” and other orientation experiences. Earlier reviews focused on ethics instruction (Eckles, Meslin, Gaffney, & Helft, 2005; Lehmann, Kasoff, Koch, & Federman, 2004; Miles, Lane, Bickel, Walker, & Cassel, 1989). DuBois and Burkemper (2002) conclude (1) ethics teaching occurs during the first two years in the preclinical setting, and just over half of the medical schools teach ethics for one year; (2) no single source, reading, or code shapes the curricula; (3) 10 teaching objectives were identified, with the majority including these: to become familiar with medical ethics topics, and to develop ethical reasoning; (4) methods include discussion/debates, readings, writing exercises, and lectures; (5) evaluation methods described did not dispel the notion that courses are not rigorous; and (6) the most common method of grading is pass/fail and the most common criterion for grading is class attendance and participation. In sum, schools rarely engaged in formal assessment of the effectiveness of their courses—even when developing ethical reasoning is the most commonly-stated purpose. Eckles and colleagues (2005) concluded: It appears that the approach taken within a particular institution reflects the educator’s preference or background, rather than a carefully crafted analysis of the educational and developmental needs of the students.

Some 40 years after programs in medical ethics and humanities were established, three medical ethics and humanities faculty (Doukas et al., 2010, 2012) confirm Eckles’ observations, reporting the lack of a comprehensive critical appraisal of medical education in ethics and humanities. Doukas and colleagues organized an expert panel as part of The Project to Rebalance and Integrate Medical Education (PRIME), which convened an expert panel to specify a need for clear direction and academic support that should be based on clear objectives that can be reliably assessed. However, the panel did not get beyond affirming the importance of “two essential skill sets”: patient-centered skills, and critical thinking skills. Their next publication promises to address learning objectives, sound assessment, critical appraisal of residency learning, and refinement of objectives and measurement based upon critical appraisal.

**Dentistry**

Lantz, Bebeau, and Zarkowski (2011) surveyed the status of ethics teaching and learning in US dental schools. All 56 schools responded. Compared with previous surveys conducted over the last 30 years, the researchers note little change in the mean number of contact hours (26.5), which represents 0.5% of the mean clock hours of instruction for dental education programs. However, positive changes are evident—from rules-based lectures merged with jurisprudence and practice management—typically presented in the fourth year until at least the mid 1980s—to a gradual introduction of case-based teaching as suggested by Bebeau (1985). Also influential in facilitating change were results of a task force of ethicists, dental educators, and practitioners commissioned to develop guidelines for the teaching of ethics. Grounded in Rest’s FCM, the resulting 1989 Curriculum Guidelines on Ethics and Professionalism in Dentistry (Commission on Dental Education, 1989) specified goals for ethics education that subsequently informed accreditation standards requiring ethics instruction in undergraduate dental education. Today, all schools require ethics instruction, but after July 2013, the Commission on Dental Accreditation (CODA, 2013)—responding to the accountability movement—will require that schools report attainment of educational outcomes.
What has changed over time is what qualifies as ethics instruction, the pedagogies used, and the development and availability of norm-referenced learning outcome assessments used by a number of schools to demonstrate program effectiveness. More impressive, however, is the percentage of schools that say they use reflective writing and other assessment procedures that require students to demonstrate their ability to apply ethical principles to complex cases. To support ethics instruction and outcome assessment, the American Society for Dental Ethics, with support from the American College of Dentists, regularly sponsors Faculty Development Workshops at the Annual Meeting of the American Dental Education Association. Outcome measures and instructional materials developed for these workshops are available through the Center for the Study of Ethical Development (www.ethicaldevelopment.ua.edu/bebeau-materials). Thus, dentistry is well positioned to respond to CODA’s (2013) requirements for outcome assessment.

**Law**

Contrasting legal education with medical education, Egan et al. (2004) noted that legal ethics did not attempt to teach foundational frameworks for making moral judgments, and did not concern itself with the development of altruism, integrity, or character. Courses focused on teaching legal rules to enable students to pass a professional responsibility examination required for licensure in all states (National Conference of Bar Examiners [NCBE], 2013). Prior to the 2007 Carnegie report (Sullivan, Colby, Wegner, Bond, & Shulman, 2007), efforts to influence moral judgment such as those reported by Hartwell (1995), or to study the relation between moral judgment and professional characteristics (Landsman & McNeel, 2004) were exceptions in legal education.

Several initiatives have broadened the perspective of legal education scholars about the primacy of moral reasoning development and professional identity formation. Following the 2007 Carnegie report’s recommendations, Neil Hamilton of the University of St. Thomas (Minnesota) School of Law, advanced a definition of professionalism in law (Hamilton, 2008) that incorporated the FCM as its core, and organized a national symposium on empirical professionalism in law inviting influential scholars affiliated with the Carnegie report to present position papers subsequently published in a special issue of the *University of St. Thomas Law Journal* (2008). The 2008 symposium inspired a subsequent series of a local and national symposia, that connected influential legal scholars with scholars outside the legal profession (e.g., Shulman, Colby, Sullivan, Bebeau) to address research and pedagogy regarding professionalism. These efforts inspired law schools to collaborate on curricular changes and pedagogic innovations to foster identity development (e.g., *Educating Tomorrow’s Lawyers* at the University of Denver, a consortium of 28 law schools nationally, and the National Institute for Teaching Ethics and Professionalism at Georgia State, a consortium of seven law schools). He also arranged funding for educational research, engaged the authors in consultation (MJB and VEM) to plan and conduct research on identity formation of lawyers (Hamilton & Monson, 2012b), to engage educators in innovation in law students’ moral reasoning development using team-based learning and academic controversy (Johnson, Johnson, & Monson, 2013), and also to analyze longitudinal and cross-sectional studies of law students’ moral reasoning development (Hamilton, Monson, & Organ, 2013; Monson, Hamilton, & Organ, 2013).
Nursing
A recent critique of nursing education (Benner et al., 2009) argues for a radical transformation of nursing education to better prepare nurses to function in a chaotic and dysfunctional US health care system. Our review of the nursing education literature suggests that the current status of nursing ethics education is consistent with Woods' (2005) review, noting that schools employ many of the possible philosophical and theoretical approaches to teach ethics. Woods lists and references 14 philosophical approaches (e.g., traditional theoretical ethics, virtue ethics, values approaches, narrative ethics, casuistry, an ethic of care approach, codes of ethics) and an array of teaching methods (e.g., lectures, tutorials, debates, model emulation, cases studies, relational narratives, reflective practice, clinical supervision, or combinations of these). Yet, based on their extensive field research, Benner and colleagues (2009) cited “a significant difference between what educators and students articulate as their understanding of ethical comportment and the actual teaching of it.” Whereas educators and students “describe ‘ethics’ in terms of learning the principles of bioethics, in everyday practice, [the focus] is with ethical comportment, on becoming good practitioners” (p. 11). Consistent with Shulman (2010), Benner and colleagues recommend that programs focus on the formation of professional identity rather than on socialization. However, the Benner critique does not suggest a theoretical model to guide the focus on identity formation. We found only a few studies (e.g., Park, Kjervik, Crandell, & Oermann, 2012; Ryden, Duckett, Crisham, Caplan, & Schmittz, 1989) that ground their educational programs in a theory of learning that is linked to an assessment of competence.

Veterinary Medicine
An increasing focus on animal welfare ethics in veterinary education (Tonsor & Wolf, 2011) parallels changing consumer attitudes regarding farm animal production as well as the laws and regulations defining humane treatment of companion and sport animals. In the past, ethics instruction typically focused on legal and practice management issues. To meet emerging concerns for animal welfare, farm animal veterinarians must be able to respond to advocacy groups who challenge animal production methods as well as regulations within companion or sport animal industries. Similarly, both large and small animal veterinarians must be able to competently assist law enforcement when called upon to provide expert consulting on cases of possible abuse or neglect.

Although some model courses (e.g., Michigan State University’s long-standing required two-credit animal welfare course [Abood & Siegford, 2010]); and the UK’s animal welfare ethics curriculum developed for veterinary schools through a partnership between the University of Bristol and the World Society for the Protection of Animals (WSPA) (Main, 2010) have been developed, we did not find current information on the status of ethics teaching, and only an announcement in 2011 that an AVMA committee has been organized to develop a model curriculum in veterinary ethics and animal welfare. Further, aside from Self’s work on moral reasoning development of veterinarians (see Bebeau, 2002 for a review), studies do not provide outcome data on the effectiveness of instruction. Although Abood and Siegford (2012) provide student opinion data on their introductory course, they do not include an analysis of the effectiveness of student writing assignments, though a scoring rubric for analyzing student assignments is presented.
Reflections on Current Practices

Our review of reports on the status of ethics education across professions suggests that most articles in the literature are “much ado about what to do” with little evidence as to what works. When evidence is presented (e.g., Abood & Siegford, 2012; Jensen, 2003), it is student course evaluation data indicating whether students “like” the instructional strategies or “like” the professor. Like Jensen, in our experience, students “like” instruction when it is highly engaging, uses real cases with outstanding speakers/or commentators, but find fault with the professor and the instructional strategies when they are judged on the basis of the adequacy of their ethical arguments or on the adequacy of action plans and dialogs they design to demonstrate ethical competency (e.g., “respect for persons” or “informed consent”) in real or simulated situations. Relying on student course evaluations as an indicator of the success or value of ethics instruction assumes that if students enjoy instruction, they will learn. This assumption is not supported by empirical evidence (Clayson, Frost, & Sheffet, 2006). For an extensive discussion of the relation between ratings and learning, see Bebeau and Monson (2008).

CAPACITIES AS THE FOCUS OF ETHICS EDUCATION: A REVIEW OF THE EVIDENCE

Ethical Sensitivity

Studies using well-validated measures of ethical sensitivity—as Rest defined it—demonstrate that sensitivity is a construct that is distinct from moral judgment (Bebeau, 2006). Similar to studies of moral reasoning (see next section), both professionals and professional school students vary greatly in their ability to interpret the characteristics of patients/clients and responsibilities of the professional embedded in tests of ethical sensitivity. Further, some studies (Bebeau, 2006, 2009b) show that sensitivity can be influenced by educational interventions, and in some settings (You, Maeda, & Bebeau, 2011) small but significant gender differences, favoring women, are evident.

In a meta-analysis of ethical sensitivity research, You et al. (2011) identified 37 studies in which 23 measures were described to assess ethical sensitivity in dentistry, medicine, nursing, counseling, business, science, and school settings. After classifying the measures along several dimensions, including the extent to which the construct was elicited by the stimulus materials, they concluded that only seven of the measures met criteria, and most have not been extensively validated. Examples of validated measures that elicit the process include the Dental Ethical Sensitivity Test (DEST; Bebeau & Rest, 1982; Bebeau, Rest, & Yamoor, 1985) designed for dentistry and the Racial Ethical Sensitivity Test (REST; Brabeck & Sirin, 2001; Sirin, Brabeck, Satiani, & Rogers-Serin, 2003) designed for counseling psychology.

What distinguished measures like the REST and DEST is the extent to which the stimulus presents clues to a moral problem without ever signaling what moral issue is at stake or what professional responsibility is called for. In contrast, some test designers seemed to conceptualize “ethical sensitivity” as the ability to name the moral issue when a condensed synopsis of a moral problem is presented. For example, in a case like Heinz and the Drug dilemma, one could argue that naming the moral conflict as a tension between the rights of the druggist to his property and the rights of Heinz’s
wife to her life is a matter of moral awareness or ethical sensitivity. In fact, Hebert, Meslin, and Dunn (1992) designed such a measure for assessing ethical sensitivity in medical education and observed wide variation in students’ abilities, finding it a useful assessment tool.

Such findings no doubt are of interest. However, when ethical sensitivity is simply defined as the ability to name the moral issue (e.g., patient autonomy, informed consent, distributive justice, or practitioner autonomy), important dimensions of ethical sensitivity may be overlooked. In fact, Rest (1983) thought that naming the moral issue was part of the reasoning and judgment process, and that the ability to diagnose what was happening from ambiguous clues and putting these together with sometimes vaguely understood professional and societal expectations was an unmeasured capacity that provided insight into moral failings (Bebeau, 2009b).

**Moral Reasoning and Judgment**

Several approaches are used to assess moral reasoning and judgment, and each has its place in the design of ethics education. Following is a brief overview of the various techniques, their usefulness and appropriateness for assessing student learning, providing feedback, and assessing curricular effectiveness.

**Classroom Assessment**

In ethics and philosophy courses, the essay is the preferred method for assessing and providing feedback to students on their developing reasoning ability. Whereas it is possible to achieve agreement on criteria and standards for assessment of essays (e.g., Bebeau, Pimple, Muskavitch, Borden, & Smith, 1995), most ethics educators in professions find such assessments time-consuming or find themselves insufficiently equipped to develop criteria and standards to achieve sufficient interjudge agreement to use essays to assess learning outcomes across educational and institutional settings. What experience and evidence show (Bebeau, 1994, 2006) is that students in professional education are intellectually mature and though they may come to professional education with low P scores on measures such as the DIT, they often learn quickly to construct well-reasoned arguments and to apply criteria for judging the adequacy of an argument. For sample cases and criteria for judgment, see www.ethicaldevelopment.ua.edu/bebeau-materials/.

**Standardized Measures of Life-Span Development**

Standardized tests like the DIT (Rest, 1979; Thoma, 2006) are frequently used to test the effects of professional education on moral judgment development. The interest is in establishing whether professional education adds value beyond the well-established finding—that moral judgment shows dramatic growth during college unless programs are narrowly focused on the technical aspects of career development or are dogmatic in their approach (McNeel, 1994; Pascarella & Terenzini, 2005). Findings from studies of moral judgment development in the professions typically do not show change in moral judgment development in the absence of a well-validated ethics intervention. For an extensive summary of studies describing education effects, intervention effects, subgroup differences, regression effects, and climate effects across professions, see Bebeau (2002) and Bebeau and Monson (2008) for an update of findings.
Profession-Specific Measures of Reasoning and Judgment

The question for educators in areas like “integrity in scientific research,” is whether to teach to the codes and policy manuals or to teach concepts particular to the discipline: intellectual honesty, humane care of animals, intellectual property, collegiality in scientific investigations, and so on (IOM, 2002a, pp. 36–40). Following Strike’s (1982) suggestion that measures of life-span development may not be sensitive to learning of profession-specific concepts taught in an ethics curriculum, Bebeau and Thoma (1999) devised the Dental Ethical Reasoning and Judgment Test (DERJT) as a prototype measure of intermediate concepts. Such concepts are thought to reside between the more prescriptive directives of codes of professional conduct and the more abstract principles (e.g., autonomy, beneficence, and justice) described by ethicists (e.g., Beauchamp & Childress, 1994). The DERJT is sensitive to dental ethics education interventions, is a useful measure for diagnosing deficiencies in reasoning and judgment as displayed by dentists disciplined by a licensing board (Bebeau, 2009b), and is moderately correlated with DIT scores (Thoma et al., 2008).

In the past, ethics educators were typically limited to measures of life-span development (e.g., the DIT or the MJI) to demonstrate the effects of ethics education. Two recent studies support the added benefit of an intermediate concept measure (ICM) as an outcome measure for ethics education programs. Initially, the ICM was thought to be most applicable to professions education, where the acquisition of particular and often unique concepts is required. In concert with this expectation, Turner (2008) designed and validated an Army Leader Ethical Reasoning Test (ALERT) that provides information on ethical competence over and above what is provided by DIT scores. Whereas Thoma, Derryberry, and Crowson (2013) demonstrated that an ICM designed for adolescents can capture the transition from personal interest to conventional reasoning, Bebeau (2009b) demonstrated the dental ICM was particularly useful in helping disciplined dentists see how often they were unable to distinguish bad choices from better choices.

MORAL MOTIVATION AND IDENTITY FORMATION

Development of a professional identity is an important outcome of the professional education and socialization process. One approach is to use essays or interviews to elicit a sense of professional identity as it unfolds during the course of professional education. A second is to design sets of items to measure a professional’s role concept (Bebeau et al., 1993).

Professional Identity Formation

Kegan (1982) proposed that one’s identity is first embedded with close others (i.e., family, friends, and co-workers), and through life experiences (including education) can become more inclusive, with an increasing sense of self-authorship (Baxter Magolda & King, 2004) and moral responsibility to society. The developmental challenge of forging one’s identity involves becoming authentic and shedding others’ definitions of us that are self-limiting or leave us vulnerable to succumbing to pressures of self-interest or loss of autonomy. Forging a professional identity requires integration and meshing of professional values and expectations with personal ones. Validation
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studies of Kegan’s model (Forsythe, Snook, Lewis, & Bartone, 2002) conducted within the military profession support the constructivist’s view that individuals move from self-centered conceptions of identity through a number of transitions, to a moral identity characterized by the expectations of a profession—to put the interests of others before the self, or to subvert one’s own ambitions to the service of society or to the nation. The fully integrated moral self (i.e., personal and professional values are fully integrated and consistently applied) tends not to develop until midlife—if it develops at all (Forsythe et al., 2002).

Explorations into the development of a professional moral identity (recently summarized by Bebeau & Monson, 2012; Hamilton & Monson, 2012a) ask students to compose essays on questions derived from Kegan’s interviews. Essays reflect a wide range of commitment to and understanding of professional values and expectations, the extent to which societal obligation to underserved populations is expressed, and whether such expectations are a core part of the entering student’s personal value system. As with Forsythe and colleagues’ studies of entering professionals, the predominant mode of identity was a Stage 2/3 transition, meaning a focus on self-interest with professional expectations seen as external to the self, rather than a constituent of the moral self. Monson and Bebeau (2006) found that dental students at higher stages (about 37% of entering students) were more likely to incorporate issues of access to care, serving medical assistance patients, and volunteering to help those in need, as key expectations of the self.

Role Concept

The Professional Role Orientation Inventory (PROI; Bebeau et al., 1993) is designed to elicit a professional’s conception of their professional role. Four 10-item scales assess dimensions of professionalism that are described in models of professionalism cited in the professional ethics literature. The PROI scales have been shown to consistently differentiate beginning and advanced student groups and practitioner groups expected to differ in role concept. The measure is sensitive to the effects of instruction and has performed well in construct validation studies. See Thoma and Bebeau (2013) for a recent summary of validation studies. Further, the measure has been adapted for other settings (e.g., physical therapy by Swisher, Beckstead, & Bebeau, 2004 and to Korean dentists by Choi & Kim, 2007).

Several studies confirm the need for professional socialization. Anderson (2001) concluded that graduate students do not intuit the values of the research discipline either from the curriculum or from their research mentors. Similarly, entering dental students (Bebeau, 1994) couldn’t articulate professional expectation, sometimes even after explicit instruction. Further, whereas medical students (Feudtner, Christakis, & Christakis, 1994; Rennie & Crosby, 2002) believe they should report professional misconduct, most are unwilling or uncomfortable doing so. Both researchers cite situational factors that seem to work against professional self-regulation and point to the need for explicit professional socialization together with appropriate practice in confronting real or perceived misconduct. Based on the recent Carnegie reports, noting a deficiency in this area of professional socialization, and a recent report by Jarvis-Selinger and colleagues (2012), suggesting this is an area requiring attention, perhaps medical education will catch up with other professions (e.g., dentistry and the military) which are addressing this important aspect of professional development.
Character and Competence: Implementation of the Decision

The importance of practitioner attributes and practical skills is particularly evident when comparing physicians who have been sued for malpractice versus those who have not. Studies indicate that even a small increase in the amount of time spent in patient communication can reduce the likelihood of malpractice complaints (Ambady & Rosenthal, 1992; Levinson, 1994). As with the other capacities, both students and professionals vary considerably in the courage and capacity to address the tough problems they will likely encounter in practice. But sometimes what appears to be lack of courage is actually a manifestation of practical wisdom (Schwartz & Sharpe, 2005). Wading into a problem when you lack practical know-how may create a bigger mess than the failure to act.

Assessing fourth component capacities is commonly done through performance assessments or case simulations, and is routinely part of admissions processes where the individual’s undergraduate co-curricular activities are used as a proxy for character. In medical education, Objective Structured Clinical Examinations (OSCEs) present the medical student with a “standardized patient” with whom they interact. Feedback on their effectiveness is provided.

In dental ethics education (Bebeau, 1994), students are presented with realistic case scenarios with patients that examine a number of challenging ethical dilemmas.7 Taking the role of a professional, students analyze their responsibilities in complex clinical situations and develop action plans and dialogs that are critiqued for their potential effectiveness. This practice builds confidence and provides a template for situations in practice that the student will encounter. A recent analysis of the ability of 120 dental graduates to implement effective actions (You & Bebeau, 2012) indicated that women graduates developed substantially more effective dialogs and action plans than their male colleagues (effect size of 0.51). Consistent with the hypothesis that moral motivation would influence ethical implementation, the researchers noted that whereas male and female students had similar scores on the responsibility dimension of a measure of moral motivation (PROI scores) at entry to professional school, and both demonstrated growth in their commitment to professional responsibilities, women demonstrated significantly greater change, an effect size of 0.75 for women versus 0.5 for men.

APPLYING THE FOUR COMPONENT MODEL TO REMEDIATE LAPSES IN PROFESSIONALISM

Whether habits/behaviors apparent during professional school are (1) reflective of character traits that are resistant to change, (2) are indicative of an underdeveloped professional identity, or (3) are associated with underdeveloped capacities in ethical sensitivity, reasoning, or implementation of defensible moral actions are questions of considerable interest to professions education. A retrospective analysis of performance data for 41 dentists referred for ethics instruction by a state dental board provides insight into actions judged by others to be unprofessional (Bebeau, 2009a, 2009b).

Of the 41 dentists referred for ethics assessment, two were exempt from instruction based on pretest performance on five well-validated measures of the FCM, and 38 completed an individualized course designed to remediate deficiencies in ethical abilities identified at the pretest. Statistically significant change (effect sizes ranging from 0.55 to
5.0) was observed for ethical sensitivity (DEST scores), moral reasoning (DIT scores), and role concept (essays and PROI scores). Analysis of the relations between ability deficiencies and disciplinary actions supports the explanatory power of Rest’s FCM. Of particular interest is the way the model helped professionals deconstruct the usual summary judgments about character (unethical or unprofessional are some of the milder descriptors often used) and see themselves as lacking capacities that could be further developed. For example, in cases where disciplinary action was taken for insurance or Medicaid fraud, analysis of role concept and moral reasoning helped reinterpret what appeared to be acts to promote self-interest as an unbounded sense of responsibility toward others. The performance-based assessments (especially the DEST) were useful in identifying shortcomings in either ethical sensitivity or ethical implementation that accounted for the moral failing. Rather than trying to line his or her pocket—the usual attribution of such acts—the individual paternalistically manipulated the system in order to help the patient achieve much needed care.

In eight cases where disciplinary action was taken for providing specialty care below the standard of a specialist, each dentist had acceptable ethical sensitivity scores, but seven of the eight had moral reasoning scores below the mean for dental graduates, and five of the eight had very low reasoning scores (DIT P scores in the low 30s). This finding is reminiscent of Baldwin and Self’s (2006) observation showing a relation between low DIT scores and frequency of malpractice claims. Of all the examples of shortcomings in capacities observed, the most compelling was the inability of 39 of the 41 referrals to articulate key professional expectations (e.g., the responsibility for lifelong learning, for self-monitoring, and regulation of the profession), expectations that come tripping off the tongues of the 10 moral exemplars studied by Rule and Bebeau (2005). This finding argues for the importance of an explicit focus on professional identity formation—something the disciplined dentists said they had not received and something they said they highly valued about the remedial ethics program. In fact, three insights about the design of ethics curricula emerged from a qualitative analysis of the referrals’ self-assessments of learning. First, beginning the instructional process with a discussion of the distinguishing features of a profession and the expectations that follow is uplifting and renewing. Second, practitioners highly valued the insight gained from the diagnostic assessment of their strengths and weaknesses across the four capacities that give rise to decision making. Third, practitioners highly valued the emphasis the course put on ethical implementation. Instead of stopping with “What is happening?” and “What ought to be done?” as is typical of much ethics instruction, the courses spent time focusing on how to implement an action plan, including what to say and how to say it.

**Building an Environment to Support Ethical Development and Professionalism**

Two general conclusions guide our recommendations. First, there is ample evidence that our capacities to recognize, reason about, commit to, and implement actions judged by others to be moral, continue to develop across the life span. Second, there is also ample evidence that professional growth and personal development is best accomplished in a cooperative and collegial learning environment—one that uses multiple educational paradigms and multiple methods of assessment. Given such evidence, professional schools must reflect carefully on their responsibility for promoting developmental growth and should be held accountable by accrediting bodies for the evidence of their program’s
educational effectiveness. Following are general recommendations for enhancing ethics education.

First, ground the goals and purposes of ethics education in the FCM and begin the socialization process by focusing on the identity of the individual and its congruence with both societal and professional expectations. Ethics education often begins with a focus on moral quandaries, sometimes preceded by a brief review of moral theories. Such an approach is sure to engage students—maybe not the theory part—but it also can do them a disservice. Asked to take a position on an ethical dilemma when the student has had little opportunity to become acquainted with professional and societal expectations may encourage a defensive stance on personal moral values, rather than open reflection upon what it means to become a professional and, in effect, exploring whether the profession’s value system and one’s own are congruent. No one has to become a dentist or physician or lawyer, but if one decides to do so, doesn’t the profession have a right to expect that when the individual takes the oath of office that he or she not only means it, but knows what it means? Students rarely come to professional school with a clear vision of societal and professional expectations, and do not intuit them from the general educational process. Professional education must be conveyed as an opportunity to reflect on this important commitment. It should not be assumed that if one is in professional school that one has resolved personal and professional expectations and integrated these into one’s identity as a dentist, lawyer, or physician. In fact, our research (Bebeau & Monson, 2012) illustrates the developmental nature of professional identity formation, and our experience (Bebeau & Faber-Langendon, 2014) with students who have violated professional norms indicates how challenging it can be to address unprofessional behavior in practice.

Second, design ethics curricula appropriate to the students’ level of professional development. Genetic engineering and cloning may be intriguing value problems for medical ethicists, but seldom are such problems of central concern to the novice. Rather, students worry about problems that are more mundane (e.g., performing a physical examination on a very ill patent, speaking up when noticing a questionable practice performed by a superior, managing conflicting directives given by a resident and an attending physician, responding to an angry patient, deciding whether the physician has the right to assert his or her values with respect to filling prescriptions for “the morning after pill”). As we have argued, students need not only decide on an ethically defensible response, but need to work out how to effectively implement their good intentions.

Third, professional education is expected to define professional expectations and develop reflective self-directed learners (Knowles, Holton, & Swanson, 2005). Professional schools need to collaborate in order to design or utilize measures of ethical sensitivity, moral reasoning, and role concept, to provide students with insight about their own personal and professional development, thus enabling them to become reflective and self-directed. Tests of life-span development (e.g., DIT) can be used to provide students with personal insight as to how their skills at reasoning and judgment compare with those of their peers and with expert judgment. Likewise, profession-specific measures like the DERJT or the PROI can be used to counsel students about the development of their abilities so each can engage in more reflective practice. A part of reflective practice is to set personal learning goals.
Fourth, behavioral indicators of professionalism have been defined and validated (Papadakis et al., 2001; Platfoot Lacey, 2012). These may include such things as meeting commitments, treating others (including faculty) respectfully, or self-monitoring the use of mood-altering drugs. By defining professional expectations, we include bottom-up processes of empowering students to articulate their understanding of professional expectations. By this, we mean that program evaluation and student development efforts designed to glean the opinions of students and empower them are successful to the extent the students who are given leadership and power have the vision and values to advance professional expectations. Coaching student leaders to raise the bar for their peers on community service may be necessary, as opposed to allowing a *laissez-faire* approach to shape student culture and values.

Fifth, the institution must attend to the moral milieu. Because students learn from observing peers and faculty, requiring the assessment of professional behaviors within an environment where those behaviors are not the norms would present a considerable challenge and risk being perceived as organizational hypocrisy. There must be a whole school commitment that includes modeling the professional behavior we wish to promote. Modeling will also extend, from time to time, to confronting issues of intolerance, arrogance, entitlement, or paternalism. When brought to professional settings, such behaviors can be devastating—to clients, patients, and to careers. This dimension of personal development cannot be relegated to a single ethics course, but rather must be woven into the fabric of school culture. The ultimate respect we can accord students is to act as swiftly in confronting these issues as would a human resources officer with an employee.

Last, a professional ethics curriculum needs to promote a sense of the profession’s collective responsibility for the welfare of society. Only when professionals exercise their collective responsibility to promote the public good will the trust society has carefully given be maintained. The role of the educator is to raise such consciousness.

**NOTES**

1. Ethical sensitivity embraces what is currently referred to as “cultural competency”—i.e., the knowledge and understanding of difference that enables a provider to deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of a particular patient.

2. Our approach is consistent with Cruess and Cruess (2008b) who recommend the integration of sociological and virtue-based approaches to defining professional expectations. A virtue-based approach is certainly acceptable, but unless the approach also reflects what medical sociologists have observed, the profession runs the risk of failing to meet legitimate societal expectations.

3. Five milestones of ethical competence are:

   1. Is aware of basic bioethical principles and is able to identify ethical issues in clinical situation.
   2. Consistently recognizes ethical issues in practice and is able to discuss, analyze, and manage such issues in common and frequent clinical situations.
   3. Is able to effectively analyze and manage ethical issues in complicated and challenging clinical situations.
   4. Consistently considers and manages ethical issues in practice and develops and applies a systematic and appropriate approach to analyzing and managing ethical issues when providing medical care.
   5. Demonstrates leadership and mentorship on understanding and applying bioethical principles clinically, particularly responsiveness to patients above self-interest and self-monitoring, and develops institutional and organizational strategies to protect and maintain these principles.

4. The Multistate Professional Responsibility Examination (MPRE) is a standardized exam of the National Conference of Bar Examiners (NCBE) and is required for admission to the bar in all but three US
jurisdictions. The MPRE assesses mastery of the rules, principles, and codes contained within the American Bar Association’s (ABA) Model Rules of Professional Conduct (MRPC) and Model Codes of Judicial Conduct (MCJC).

5. Dental students in the Minnesota curriculum demonstrate significant growth in the ability to develop a well-reasoned moral argument following 10 hours of small group dilemma discussions. In addition to the discussions, students receive written feedback during the course on five written essays.

6. Whereas it is hard to imagine actual erosion in the ability to reason in the sense that individuals who are able to comprehend more advanced moral arguments and therefore prefer them (which is what selection of postconventional moral arguments on the DIT amounts to), suddenly lose the ability to comprehend such arguments. However, when students encounter the complexities of professional practice, some become disillusioned and cynical about the possibility of applying such ideals in real-life situations. Selecting more self-interest or maintaining norms arguments at post-test may simply reflect students’ concerns about the practice environment.

7. Cases include how to manage a case of suspected child abuse, substandard work by a previous dentist, drug-seeking behavior of a patient, and patient requests for treatment that does not align with the dentist’s values or judgment.

8. The Dental Practice Act does not prohibit the generalist from providing specialty care (e.g., endodontic or orthodontic care), but does hold the generalist to the standards of the specialist.

9. See Bebeau and Monson (2012) for an extensive discussion and list of citations.

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