

PEER-REVIEWED CME ARTICLE: MEDICAL EDUCATION

Teaching Clinical Ethics at the Bedside: William Osler and the Essential Role of the Hospitalist

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Abstract

As the field of hospital medicine celebrates its twenty-first anniversary, we believe it is time to expand its mission to play an even greater role in medical education. Given hospitalists' proximity to students and clinical material, members of this growing cohort of physicians are uniquely positioned to teach normative reasoning, professionalism, communication, and medical ethics in real time to trainees on the wards. But, to do so, we must reimagine the role of the hospitalist in graduate and postgraduate medical education.

Introduction

William Osler's vision in 1903 of the hospital as a college revolutionized medical education by bringing clinical teaching from the lecture hall to the bedside [1]. By transforming the clinic into a classroom, Osler's Johns Hopkins experiment altered the course of American medicine [2]. But in the intervening century, we have seen an erosion in the scope of bedside teaching as the professoriate has gradually retreated from hospital wards to research laboratories and administrative positions [3]. In place of professors, we increasingly find hospitalists—specialists in inpatient medicine—who now provide the bulk of inpatient care for hospitalized patients and often serve as clinician-educators for medical trainees [4].

The field of [hospital medicine](#) dates to 1996, when Wachter and Goldman introduced this new model of care into American medicine [5]. As the field celebrates its twenty-first anniversary, we believe it is time to expand its mission to play an even greater role in medical education. Given their proximity to students and clinical material (in the form of hospitalized patients), members of this growing cohort of doctors are uniquely positioned to teach normative reasoning, professionalism, communication, and medical ethics in real time to trainees on the wards.

The mere presence of attending hospitalists discussing these issues with medical students and house staff would help overcome the “hidden curriculum” of medical training [6] and serve as a normative corrective to the ascendant primacy of evidence-based medicine. In short, the hospitalist can bring humanism to the bedside and validate topics such as professionalism and communication that are sometimes perceived as soft or marginal. But, to do so, we must reimagine the role of the hospitalist in graduate and postgraduate medical education.

Exploring Ethics in Real Time

In 2002, the American College of Graduate Medical Education (now the Accreditation Council for Graduate Medical Education) identified six core competencies for the practicing physician: (1) patient care, (2) medical knowledge, (3) practice-based learning and improvement, (4) systems-based practice, (5) interpersonal skills, and (6) professionalism [7]. Expanding on this list, the American Board of Internal Medicine enumerated three core principles related to professionalism: (1) the primacy of patient welfare, (2) patient autonomy, and (3) social justice [8]. But, based on our experiences, disagreement exists over how these principles can be measured, assessed, and taught to students.

As the senior educator on inpatient wards, the hospitalist has the potential to redefine medical education by exploring the ethical implications of medical decision making in real time. While some may argue that it is too time intensive to teach bioethics on rounds—Aristotle argued that only leisure makes philosophy possible [9]—there is reason to believe the process will actually save time and improve patient care.

The Hospitalist as Ethicist

From diagnostic decisions to discharge planning, the practice of hospital medicine is laden with ethical quandaries. On a daily basis, the hospitalist is confronted with issues of information disclosure, autonomy, and truth-telling, to name but a few. In our experience, few hospitalists have received formal training in clinical ethics; even fewer, we suspect, feel comfortable teaching trainees about their approach to these complex situations. A tremendous educational opportunity exists, and it should become a priority of hospital medicine to incorporate normative reasoning into the array of patient-centered clinical skills that are taught at the bedside [10]. While the details still need to be worked out, it's time to begin to reconceptualize the role of the hospitalist in medical ethics education in the twenty-first century.

Trainees should be taught to think beyond evidence-based treatments. By examining the legal, historical, and ethical precedents regarding seemingly mundane interactions with patients, they will be prepared to have more thoughtful interactions with their patients amidst the flurry of activity on the hospital wards. To do so, however, we should

establish a training mechanism. Hospitalists should have a grounding in bioethics and an educational ethos that fosters deliberation over [efficiency on rounds](#). We believe this novel approach to medical education will also improve communication, patient satisfaction, and, most importantly, outcomes.

The implications of ethical decisions should be discussed and dissected on ward rounds with the same rigor, enthusiasm, and attention to detail with which differential diagnoses are generated and treatments are rendered. We believe these impromptu didactic sessions will create more astute physicians who are better communicators. It is our hope that this novel educational ethos will lead to more satisfied patients and more thoughtful clinicians who are able to fully engage in shared medical decision making. But this will only work if we strengthen the ties between ethics and medicine; medical ethicists can (and should) be brought to the wards to broaden teaching opportunities during ward rounds. Conversely, hospitalists should have exposure to medical ethics, either formally or informally.

As clinicians, we have become quite good at making decisions and teaching others how to make them. But often we do not have a coherent moral framework that respects the goals and values of our diverse patients. Inconsistency in the approach to ethical decision making can lead to confusion among health care workers, patients, and students and may ultimately compromise the doctor-patient relationship [11]. Moreover, an important learning opportunity could be missed. A structured approach to these situations is an unmet normative need and, if taught properly, will provide a remarkable opportunity to enhance the quality of graduate medical education.

Conclusion

In his address to the New York Academy of Medicine in 1903, entitled “The Hospital as a College” [1], William Osler laid out a blueprint for graduate medical education and put forth a provocative claim: “Ask any physician of twenty years’ standing how he has become proficient in his art, and he will reply, by constant contact with disease; and he will add that the medicine he learned in the schools was totally different from the medicine he learned at the bedside” [12]. As the field of hospital medicine celebrates its twenty-first anniversary, it seems fitting to ask what we have learned at the bedside of the patient and to examine how well hospital medicine has fulfilled Osler’s vision of the hospital as college [4]. For as many changes as medicine has witnessed since Osler’s day—including the rise of managed health care, subspecialists, evidence-based medicine, and electronic medical records—one constant remains: the ethical imperative to teach while providing humane care. It is this obligation on which all others are based and can be measured.

The properly trained hospitalist could be poised to make important contributions to the teaching of medical ethics and doctor-patient communication and thereby serve as an

antidote to the hidden curriculum. If these goals could be realized, we might be able to return to William Osler's original vision of the hospital as a college [1].

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