TEACHING PROFESSIONAL ETHICS:
FOSTERING SOME OVERLOOKED SKILLS

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I: INTRODUCTION

Halfway through my dissertation, economic necessity forced me to respond to a job advertisement for an ethicist for the state child welfare system. My explicit duties would be to provide ethics consultation and education to social work, health care and administrative staff. I would also be responsible for facilitating the ethics committee and sitting on the conflict-of-interest committee. I did my best to convince the interviewers that my graduate courses in applied ethics and my experience teaching medical ethics and business ethics courses would be adequate preparation. I was wrong. One thing was for sure. I had a fairly naive understanding of what ethicists do in organizations and what professionals find most helpful in terms of ethics education. I guess I assumed that I would be consulting on ethics policies and helping professionals resolve ethical dilemmas. I did perform those functions, but, as it turned out, my function was much broader. Overall, my job was to do whatever I could to remove all the barriers to ethical conduct and promote an organizational atmosphere that encouraged ethical conduct and ethical decision-making. This meant not only helping staff to think about ethics, but also helping them to talk efficiently about ethical issues with colleagues and clients, and, perhaps most importantly, helping them to think and act in ways to avoid (rather than solve) ethical problems. I have since left my position as a child welfare ethicist for an academic job, but as I continue to find myself sitting on ethics committees and serving as an ethicist in non-academic settings, I am constantly reminded that the moral lessons that matter most in professional life are often neglected in academic professional ethics courses.

In this paper I will discuss some of the skills and strategies that I have found to be important in real-life professional circumstances, but not often addressed in college professional ethics courses. I will suggest that profes-
sional ethics courses often provide an incomplete and, therefore, somewhat misleading picture of the sort of capacities needed to become an ethical professional. Most treatments of professional ethics assume that the most helpful skills to develop are those of identifying and resolving ethical problems and appraising arguments. Certainly, these skills are crucial, and fostering them should be a central goal in any professional ethics course. However, there are a cluster of other important skills that professionals and pre-professionals should acquire if they are going to manage ethical issues successfully in real-life professional contexts. I will discuss three such skills and suggest some concrete, practical ways to foster them. The first is simply the ability to identify the causal sources of ethical problems. Ethical problems are always better avoided than solved. Being able to identify the causes of ethical misconduct and ethical dilemmas is the first important step in preventing them. The second skill will narrow our focus to one particularly common cause of ethical problems. Many ethical problems are caused by poor communication or a lack of communication. Understanding what morality requires in any given circumstance is not enough. Operationalizing moral values often requires superior communication and interpersonal skill. Without such skill, even the keenest moral intellect will be ineffective. Hence, sharpening communication is an important goal of a professional ethics education. I will discuss how role-play exercise can help improve communication skills to avoid some common ethical problems. Finally, I shall conclude with an additional reflection on the importance of effective communication. Professionals often speak to one another about ethical issues, but rarely do so with sufficient specificity. Because of this, the values that are ultimately at stake remain obscured by vague (and sometimes ambiguous) ethical language. Hence, in addition to preventing ethical problems, effective communication also allows professionals to converse efficiently about them, thereby increasing the likelihood that they will be resolved.

II: CAUSAL FACTORS & CASE DISCUSSION

Consider the following vignettes. First a social service scenario:

A social service caseworker has been harshly reprimanded for breaching confidentiality when he inadvertently confirms to a client’s employer that the client is receiving behavioral health counseling. Later, that caseworker finds himself working with a difficult client whose behavior clearly places third parties at risk of harm. The caseworker feels an obligation to take steps to protect those at risk. However, because of his recent reprimand and strained relationship with his supervisor, he is
inclined neither to warn those at risk nor to turn to his supervisor for support or advice.

Now consider this health care scenario:

Because of recent staff turnover, a visiting nurse must visit a high number of patients each day. An elderly patient is relieved when the nurse arrives because she is hoping to talk to him about adjusting the dosage of one of her medications. However, the nurse is obviously in a hurry and seems annoyed at the patient’s questions. Hence, the patient decides not to raise the issue of the dosage adjustment.

In both of these cases or examples, we may rightly say that the person in the case acted unethically or made a bad ethical decision. In the case of the social service caseworker, he failed to act on his obligation to warn third parties who were at risk of harm. Likewise, in neglecting to listen to and act on the wishes of his patient, the visiting nurse failed to adequately respect patient self-determination or autonomy. Both acted unethically, however their actions and decisions were a consequence of a backdrop of factors that made it very difficult to make the right decision or do the right thing. In the instance of the caseworker, the problem was not so much a conceptual inability to properly balance, say, client confidentiality and trust against the degree or likelihood of harm to a third party. Rather, it was poor communication and an overall strained relationship with his supervisor that prevented him from taking steps to protect those at risk. Similarly, the nurse may have had a solid command of the concept of patient autonomy and its ethical significance. However, his time constraints made it difficult to have a substantive conversation with the patient. Knowing more about the meaning of patient autonomy or the conditions of informed consent would not have helped him much. What would have helped is an understanding that time constraints, time mismanagement, unreasonable work loads, demeanor and disorganization are among the most common factors that silence a patient’s wishes and/or prevent important conversations from taking place.

It seems, therefore, that one very important ethical skill in professional life is simply that of being able to identify the mundane, sometimes subtle, factors that cause unethical conduct or bad ethical decisions. One effective way to help students become ethical professionals is to provide them with exercises that not only help them to resolve ethical problems, but also help them to identify the various kinds of causal factors that lead to ethical problems.¹ This can be accomplished through the use of case studies whereby students attempt to identify the causes that lie at the root of the ethical prob-
lem(s) under consideration. Take, for example, the above case of the visiting nurse. A fleshed out version of this case would reveal that the nurse has a very heavy caseload of patients, and therefore is inclined to make his visits as short as possible, answering as briefly as possible, and overall conducting himself in a way that discourages patients from asking questions or talking about how they feel. The home nursing organization may be very unorganized and therefore very inefficient in its scheduling, overstaffing certain shifts, under-staffing others. Other sources might be related to allocation. If the organization cannot afford to hire more nurses, it may need to re-examine the priority of its resource allocation. It may be spending more than it needs on relatively unimportant aspects of the operation.

Using case studies in the way I have suggested helps students begin to develop an eye for the causes of ethical problems so that they can see ethical problems as something to avoid rather than solve. If you provide a decision-making model to your students, you can easily integrate this idea by simply adding a step, as I have done, that requires students to “[I]dentify any of the likely causes of the ethical problem(s) and determine how similar ethical problems could be avoided in the future.” Skipping this step is to skip over what often turns out to be the most important type of ethical question in real professional circumstances. For ethics teachers who are trying to prepare students to successfully manage the ethical dimension of their professional lives, cultivating the skill of diagnosing the causal sources of ethical problems is as important as conceptual skills, such as balancing competing values and resolving ethical dilemmas.

III: EFFECTIVE COMMUNICATION & THE ROLE-PLAY EXERCISE

We have been considering the general importance of being able to identify the causal sources of ethical problems, but will now focus on one of the most common causes of ethical problems, specifically, poor communication or lack of communication. Understanding the nature and implications of professional values cannot, by itself, guarantee ethical conduct. Successful application of such values often requires the ability to effectively manage conversations with clients or patients. Consider the obligation to respect patient/client autonomy. Pre-professional and professional students should not be given the impression that respecting autonomy is simply a matter of complying with wishes. Rather, it requires an understanding of the vast array of factors that can potentially compromise autonomy and, as already discussed, an ability to identify them when they are present. One of the most important ways in which professionals uncover these factors is by conversing with clients in
ways that reveal them. Consider four real health care cases; the first one occurred a number of years ago, the last three are recent futility-type cases brought to the attention of a local hospital ethics committee on which I sit.

In my experience, these represent very common types of ethics cases:

(1) A middle-aged man with chronic obstructive pulmonary disease was admitted to the hospital and was breathing with the assistance of a ventilator. The patient insisted on being taken off ventilator support, stating that he “did not want to be hooked up to machines.” Since that patient was judged competent and seemed to fully understand that he would die without ventilator support, there seemed to be no legitimate reason to override his autonomy. Hence, is was agreed that he be taken off the ventilator. However, it eventually occurred to one of the nurses to pry a bit deeper into the man’s rationale for his decision. She quickly discovered that while the doctors and nurses knew that the ventilator was only temporary and fully expected this man to recover, the patient, himself, assumed he was close to death and did not want to die “hooked up to machines.”

(2) Against the advice of his physician, an elderly cancer patient opted for additional treatment. Out of respect for the patient’s autonomy, treatment was continued. It was later learned that the man chose additional treatment only because he did not want to die without paying his hospital bill, and in order to pay he would have to go back home to pick up his pension checks that arrive in the mail. Once this was learned, the man’s worries were addressed and payment arrangements were made to his satisfaction.

(3) The family of a sixty-year-old man has decided, contrary to the recommendation of the doctors, to continue ventilator support. Terminally ill, incommunicative and unresponsive to treatment, further intervention or support was judged futile. Still, the family would not allow the health care team to discontinue ventilator support. This went on for roughly two weeks before it was discovered that the family’s primary concern was that the patient not die without being baptized. However, the family practiced a particular tradition of Christianity in which baptism required emersion of the entire body in water so that the entire body is completely under water. The family assumed that their only hope to baptize the patient would be for him to recover enough so that he could be brought home where the baptism could take place. When this piece of information surfaced (and it was determined that the patient, himself, had also hoped to be baptized) the hospital simply arranged to have a
large tub brought to the patient’s room where the patient was baptized in the manner required by his religion.

(4) With multiple organ-systems failing and continual amputations due to diabetes, all agreed that any further intervention would be medically futile. However, the patient’s wife insisted on continuing life-prolonging treatments. With each new infection and amputation, the circumstance became increasingly gruesome and inhumane. When the wife was eventually confronted about why she insisted on keeping her husband alive, she confessed that she needed her husband’s social security checks, and that if he died, she would no longer receive them. With this out in the open, a hospital social worker was able to address the financial issue and resolve the matter.

A number of other similar cases come to mind, but these fairly typical cases should suggest that effective communication is fundamentally important in promoting patient (or surrogate decision-maker) autonomy. In each of the four cases, the patient or decision-maker appears, at least on the surface, to be acting autonomously. However, in reality, their decisions turn out to be driven by false beliefs and unjustified worries. As these cases clearly show, an ineffective dialogue or a missed opportunity to communicate with a patient or surrogate decision-maker can obscure important details needed to promote autonomy and other important values. In the case of the middle-aged man who did not want to die on a ventilator, the dramatic clash between respecting autonomy and promoting the patient’s best interest was exposed as a simple, though nearly fatal, misunderstanding. The same basic point applies to the man who did not want to die without paying his hospital bill. Without the insight into the man’s rationale for continuing treatment, the doctors either would have had to agree to continue burdensome and futile treatment or prepare to invoke the hospital’s futility policy. Cases 3 and 4 contained similar impasses that were escalating toward “showdowns” between the hospital futility policy and the wishes of surrogate decision-makers. These dilemmas could have been avoided altogether with more effective communication between patients, families and the health care professionals. The ethical importance of clear communication is underscored in a recent study in the *American Journal of Medicine* that compared the outcomes of dying patients with whom health care staff maintained intensive and ongoing communication against those who experienced the “normal” amount of communication with their health care providers. The study concluded that those who received intensive communication received more effective palliation and used fewer critical care resources than those in the control group. Therefore, I argue
that a sound ethics education for professionals should strive to improve communication skills with patients or clients.

One way for students to improve their communication skills is to engage in role-play exercises, i.e., exercises in which students act out scenarios, some students playing the role of professionals, others acting as clients or patients. As the scenario is acted out, the class observes and later critiques the dialogue, suggesting ways in which the conversation could have been better managed and/or ways in which it was managed well.

A particular kind of role-play to practice having such conversations involves one student playing the role of the professional who must converse with a patient in a way that brings to the surface factors that may be compromising that patient’s autonomy. The other student, playing the role of the patient, is given information about her background, values, fears, hopes and motives. She participates in the dialogue according to the other’s questions and remarks. Here is one role-play that I use.

Mary is a nurse at an assisted-living facility in the community. One of her clients, Mrs. Black, is a paraplegic who needs help getting in and out of bed. Mary visits her each morning to help her out of her bed and into her wheelchair. In the evening, Mary returns to settle her in for the night. Recently, Mrs. Black has developed pressure sores on her buttck. Mary advises her to stay off it in order to promote healing, but Mrs. Black adamantly refuses. Meanwhile the sore gets larger. Mary once again warns Mrs. Black of the seriousness of the condition, but to no avail. Frustrated, Mary is now considering refusing to get Mrs. Black out of bed in the morning, thereby forcing her to stay off the area.8

To set this up as a role-play exercise, a student playing the role of Mary must converse with the student playing the role of Mrs. Black about her refusal to remain in bed. The class (audience) and the student playing Mrs. Black are to be given the following pieces of additional information:

- Mrs. Black had a close friend who recently passed away after she broke her hip and was bedridden for months.
- She, herself, suffered a near-fatal bout of pneumonia two years ago after a prolonged hospital stay. Because of this, Mrs. Black worries that if she allows herself to be committed to prolonged bed rest, she may never recover and may die.
- With the assistance of a volunteer, she regularly meets a group of friends to play cribbage. These get-togethers have come to mean a great deal to Mrs. Black, especially since her deteriorating health has made it more and more difficult to remain social.
Unlike the student playing the role of Mrs. Black, the student playing Mary only knows what is given in the case. Mary must manage the conversation in a way that reveals Mrs. Black’s worries, assumptions, expectations and values. If the conversation goes well, Mary will uncover Mrs. Black’s worries. Mary might point out to Mrs. Black that she could continue to play cribbage with her friends. Perhaps they could meet at Mrs. Black’s house so that she could remain in bed, but still participate in the game. Or, perhaps Mary and Mrs. Black could reach a compromise. Mrs. Black could spend a limited time in her wheelchair, say an hour and a half a day. Mary should also talk to Mrs. Black about her belief that she might die if she is temporarily confined to bed-rest. Mary might admit that prolonged bed-rest increases the likelihood of pneumonia, but that there are ways to minimize the chances. She might also clarify to Mrs. Black that her pressure sores will likely heal very quickly and, contrary to what she might have assumed, that there is no reason to anticipate a prolonged period of bed-rest. Hence, respecting Mrs. Black’s autonomy turns out to require the ability to converse with her in ways that uncover the challenges to her autonomy.

It is important for the student assuming the role of the client/patient to respond appropriately and realistically when answering questions. This means staying in character, taking seriously the background information that is driving the patient’s decision and behavior. It sometimes happens when setting up the above role-play that the student playing Mrs. Black is overly bent on being uncooperative and keeping hidden any information that would shed light on her decisions. Although this may, in many cases, be realistic, it can interfere with the point of the exercise and consume too much class time as the student playing the role of the professional tries in vain to have a productive conversation with Mrs. Black. For instance, last semester the student playing Mrs. Black was unrealistically reluctant to reveal anything about her rationale for refusing to stay in bed. When she finally disclosed her worries about not being able to play cribbage with her friends, she rejected every compromise Mary offered, refusing, for example, to grant Mary permission to contact Mrs. Black’s friends to see if they might be willing to move the cribbage game temporarily to her room.

I should also point out that in addition to helping students converse with clients in ways that reveal ethically important information, role-play provides students the opportunity to practice maintaining the tone and direction of conversations. Effective conversations with clients and patients must be truthful but sensitive, focused but flexible, serious but caring. Often times, especially with difficult clients or patients, this is easier said than done. For example, I use role-play when discussing possible justifications for breaching confidenti-
Having to breach confidentiality because a client poses a risk of harm to outside parties is a delicate matter. Being able to dialogue with the client in a way that minimizes the damage to the therapeutic relationship requires practice. Becoming an ethical professional requires becoming a skilled communicator with clients/patients. Role-play exercises provide opportunities to begin to acquire such skill.

IV: PROMOTING GREATER SPECIFICITY

I have argued that the ability to put professional values into practice requires communicating effectively with clients and patients and that this is one important way to avoid ethical problems. However, just as poor communication may cause ethical problems, it may also interfere with the resolution of ethical problems once they have occurred. Hence, for those who aspire to be ethical professionals, it is necessary to acquire the ability to speak with clarity and specificity about their ethical concerns. Unfortunately, many intelligent professionals use vague, descriptive language when attempting to make an ethical point, assuming that if they repeat the description of a circumstance enough, the listeners will eventually intuit the value conflict. Even when appealing to a specific ethical concept, such as confidentiality, their conversations about ethical problems are often ineffective because the level of communication lacks sufficient specificity. Ethical concepts that are featured in codes of professional ethics, such as confidentiality, conflict of interest, honesty and integrity are often either too vague or too ambiguous to be helpful. Such vagueness and ambiguity are often impediments to clear ethical reflection and communication precisely because they create the false impression that one is stating something more meaningful than one actually is. The antidote to this kind of problem is greater clarity through greater specificity.

A few examples come to mind. The term “conflict of interest” is a common concept in codes of professional ethics. Unfortunately, in any given situation, “conflict of interest,” at least as it is articulated in professional codes of conduct, could mean any one of a number of things, from unreliable judgment to abuses of power to misuses of information, and more. For instance, I recall a case in which a child welfare caseworker made use of inside information to adopt a child that otherwise would have gone to a family who had followed the usual protocol for adopting a state ward. The ethical problem in this case was more along the lines of a misuse of information, rather than being in a position in which his judgment could not be trusted. When he was told that he had a conflict of interest, he objected on the grounds that he had no professional decision-making authority over the
child’s case. Although he was correct, “conflict of interest” in this particular situation did not refer to the unreliability of judgment, but rather to a misuse of information. What appeared to be a genuine dispute dissipated when it became clear that the caseworker was referring to one thing (namely, the reliability of his judgment) while the conflict of interest committee was referring to something else (in particular, the misuse of information). Because the term “conflict of interest” seems to refer to one kind of thing, professionals mistakenly think that calling something a conflict of interest clearly identifies a specific ethical problem, when, in fact, it is often far too ambiguous to be helpful.

If being able to think and communicate with greater specificity is the desired skill, how does an ethics teacher foster such a skill? One way with which I have had success involves selecting cases that clearly feature certain ethical problems, let us say confidentiality or conflicts of interest. Students should be asked to discuss such cases so that each time they would use the term “confidentiality” or “conflict of interest” they must replace that term with the values that underlie it, those specific values that are ultimately at stake. Hence, the most important rule in this exercise is that students are prohibited from using the ethical term (e.g., confidentiality) that most characterizes the case. For instance, the statement “sharing this client’s information would breach confidentiality” would be converted into something like “sharing this client’s information without her consent would make it difficult to help her because she is less likely to speak openly.” It might also be restated as “sharing this client’s information without her consent disrespects her self-determination by not allowing her to control the amount and type of information available about herself.” The point of this exercise is not to get students to abandon all use of common general terms in professional ethics, but rather to get them to understand that such terms are rarely specific enough in important conversations and that they must be prepared to provide or request more specific explanations.

An emphasis on specificity and clarity in communicating ethical views should inform our views about the purpose of ethical theory in ethics courses. Teachers of professional ethics often disagree on the proper amount of ethical theory in professional ethics courses. I argue that there needs to be more careful consideration, not about the amount of ethical theory, but about its purpose in such courses. The purpose of covering ethical theory in an ethical theory course is to acquaint students with the various traditions of moral philosophy so that they can appreciate what underlies moral claims and begin to formulate their own views on normative and meta-ethical issues. This goal is not entirely out of place in a professional ethics course, but it
should not detract from another important purpose of ethical theory, namely, to provide greater specificity and organization to ethical reflection and, in particular, to provide greater specificity and organization in the communication of ethical views. Covering ethical theories helps professionals and students “look behind” terms such as “conflict of interest” and “confidentiality” and reflect on why we really care about such concepts. Having a sense for why we really care about, for example, confidentiality, encourages students to think and communicate more specifically, and therefore more effectively, about their real ethical concerns. If, for example, in a clinical circumstance, our concern for confidentiality is ultimately one about maintaining a client’s trust (and not so much about, say, protecting privacy), we can address this issue more effectively if we speak and think specifically about client trust, rather than obscure our real concern by referring to a general value of confidentiality. Exploring consequentialist, deontological, rights-based or other kinds of justifications pushes students to look beyond general ethical rules or values in order to identify precisely what makes, for example, breaching confidentiality or creating a conflict of interest wrong.

V: CONCLUSION

My purpose in this paper was not to criticize the more usual goals and strategies in the teaching of professional ethics, but to point out a few that often get overlooked.

I have suggested three skills that pre-professional and professional students should acquire in the course of their ethics education. First, they should learn to identify the causes of poor ethical decisions and misconduct. I suggested that using case studies to practice identifying the causal sources of ethical problems is an effective way to begin to develop such a skill. Second, since poor communication prevents the effective application of professional values and is, itself, a very common cause of ethical problems, I have suggested that students should improve their communication skills with clients or patients. Here I recommended role-play exercises as a way to practice having conversations with patients and clients in ways that reveal ethically relevant information. Finally, I have proposed that students should learn to speak about their ethical concerns with specificity, making as transparent as possible the values that may be at issue. To encourage this, I suggested case study exercises that require students to replace the general ethical values expressed in professional codes of ethics, such as confidentiality and conflict of interest, with the values that underlie them. My general point is that there are many elements to being an ethical professional. To the extent possible,
professional ethics courses should strive to include them all. This means looking beyond what philosophy and theology have to offer to include any skill that may help a student become an ethical professional.\textsuperscript{13}

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NOTES

1By “ethical problem,” I mean both ethical dilemmas and unethical conduct.

2For the purpose of this paper I have shortened the case, but when asking students to identify the causes of an ethical problem, it is important to use factually dense cases that depict the events that led up to the misconduct or dilemma at issue.


4For example, see Howard Brody’s conversational model of informed consent. *The Healer’s Power* (Yale University Press, 1992), 90-102.

5The patients and families have given permission for these cases to be used for teaching purposes.


7Ibid., 474-475.

8This case is adapted from one presented in Michael Yeo’s *Nursing Ethics: Concepts and Cases* (Broadview Press, 1996), 72-73.

9However, even this turned out to be quite valuable because Mary was forced to think on her feet to try to find out why Mrs. Black would object to her proposed compromise. This led Mary (and the classroom spectators) to speculate about Mrs. Black’s overall loss of independence and other possible threats to her autonomy.

10I recommend an excellent nursing ethics video on confidentiality, *Confidentiality: Legal and Ethical Concerns in Health Care* (Medcom, Inc., 1996). It ends with a cluster of four role-play primers that work quite well.


13“I would like to thank Michael Davis, Gail Daly, my liberal arts colleagues at UDM and many of the attendees at last year’s SEAC conference for their helpful comments on earlier drafts of this paper.”