



Presidential Commission  
*for the* Study of Bioethical Issues

## TRANSCRIPT

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Meeting 19, Session 7 and concluding remarks  
November 5, 2014  
Salt Lake City, UT

## SESSION 7: DELIBERATION AND BIOETHICS EDUCATION: OVERVIEW and CONCLUDING REMARKS

DR. WAGNER: Folks, thank you for joining us. This panel is going to be a little more theoretical, less focused on a particular incident, and a little less applied. It will give us an overview of what deliberation of bioethics education can mean generally. And folks, the way we will work this is I will introduce you each, one at a time, and ask you to speak.

Do they have a ten minute time limit, also?

DR. GUTMANN: Yes.

DR. WAGNER: For a ten-minute time window, and then we will move to the next person. And when all three of you have had a chance to speak, we will open the microphones for the conversation. So our first speaker is Dr. Daniel Levin. Dr. Levin is Associate Professor of Political Science at the University of Utah, where he teaches in the areas of - it's quite a list - constitutional law, civil rights and civil liberties, jurisprudence, administrative law, American political thought, and U.S. legal institutions. That's a large waterfall. His publications include *Representing Popular Sovereignty: The Constitution in American Political Culture*. And articles appearing in the *Kennedy Institute of Ethics Journal*, *Social Science Quarterly*, *Law and Social Inquiry*, *Polity*, *Legal Studies Forum*, and *Crime and Delinquency*. And there are other journals in which he publishes. His current research project includes *Civil Liberties and Un-American and perceived sympathizers during the Cold War*, as well as a book chapter on institutional review boards and free speech. Welcome, Dr. Levin. We are pleased to have you here. Please push the button on your microphone.

DR. LEVIN: Members of the Commission, thank you for the opportunity to speak with you today, and welcome to Utah. In 2004 Albert Dzur and I published an article entitled *The Nation's*

Conscience, Assessing Bioethics Commissions and Public Forums. In it, Professor Dzur and I argued that Bioethics Commissions have the potential to provide the larger democratic public with a method of ethical deliberation, and to set the agenda for public deliberation of essential questions affecting all persons. We were interested in bioethics as an area presenting opportunities for public deliberation because bioethics presents often concrete choices that engage larger principles in areas where citizens recognize their normative differences and regularly speak about normative commitments. We were particularly concerned that bioethics not be understood as an area dominated by professionals. We believe that bioethics is simply too important to be left to the bioethicists, but should offer opportunities for the general public to engage on a broad array of pertinent issues and to articulate their beliefs, secular or religious, and their concerns, be they related to technology or social injustices. We sought for what would enable such discussions without the drama of such events as the Terri Schiavo case or the barely controlled emotions that currently animate the American experience with Ebola.

Our proposal for understanding Bioethics Commissions as fora for public deliberation was modest. We were primarily concerned in bioethics commissions for their agenda-setting function. We reviewed the history of not only bioethics commissions, but of other federal advisory commissions as a whole, in terms of their capacity to have an impact on the larger debate in society.

We noted in particular the success of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which was active from 1980 to 1983. One researcher, Bradford Grey, found in 1993, ten years after the President's Commission had completed its proceedings, that the Commission's reports had been cited 52 times in court cases; 56 times in the Federal Register, often in conjunction with the issuance of federal

regulations; 177 times in law reviews; and 247 times in medical journals.

Elisa Eiseman, a RAND Corporation analyst, surveyed the impact of the National Bioethics Advisory Commission, active from 1996 to 2001, and found that 13 bills had been introduced in Congress based on the Commission's recommendations, although none of those had been enacted into law. That commission was also the subject of almost 1300 media reports during its tenure.

Our understanding of the role of bioethics commissions in public debate is very different from the strong version of deliberative democracy which some might advocate. And I wish to make clear that our primary goal in our article was to articulate the agenda-setting possibilities of commission deliberations. Any broader notion of encouraging wide-scale popular deliberation is unlikely.

I note this, given one of the most important recent studies in American politics. In the late 1990s John Hibbing and Elizabeth Theiss-Morse set about trying to determine the extent to which Americans are interested in politics and are willing to participate in politics; especially how willing ordinary citizens would be to deliberate over divisive issues. The answer was hardly surprising to anyone who has ever been to a large family Thanksgiving dinner. Predictively, most Americans were less than enthusiastic about politics, and in the words of Hibbing and Theiss-Morse, simply do not like the process of openly arriving at a decision in the face of diverse opinions. Americans, as a whole, are conflict avoidant, and would prefer to deny the degree to which they, their neighbors, even fellow citizens several states away, disagree about both values and interests.

Instead, Hibbing and Theiss-Morse argued most believe that Americans all have the same basic goals and that they are consequently turned off by political debate and deal making that

presuppose an absence of consensus. People believe that these activities would be unnecessary if decision-makers were in tune with the consensus-based public interest, rather than cacophonous special interests. They labeled this preference "stealth democracy."

As I have laid it out to this point, understanding public deliberation in terms of stealth democracy does not sound very encouraging, and it is not, if one conceives public deliberation as the act of participation of a large portion of the citizenry.

But Hibbing and Theiss-Morse and their work on stealth democracy found that the larger public did have one important belief that can fortify the case for bioethics commissions and other advisory committees. They discovered that Americans, while not wishing to participate in the political process themselves, were quite concerned about the process itself. Americans are especially concerned with special interests, those parties which they view as divisive and selfish, not be allowed to have undue influence on those decisions which affect the public good.

And while they may not wish to show up for all the evenings which democracy would require, they believe that political processes should be transparent. Such concerns about transparency are not only important for those who make final decisions on matters of import such as legislators and public officials, but also to those who would set the public agenda.

As any of us who have followed the political process for a substantial amount of time well know, the ability to set the agenda is almost as important as the authority to decide a policy. Public policy is made based on how problems are defined. And the definition of problems is by no means obvious.

Because many of the most important issues in bioethics are found near the cutting edge of medicine and biotech, it is especially likely that without public intervention, debate over

innovation will be set by experts. Such experts, distinguished by their extensive training and long experience in their fields, may have special insight into these concerns; but their disciplinary training and their professional commitments may also shield them from other concerns of greater interest to the general public. And given the amount of money which is at issue in American medicine, whether in the form of commercial payments or research grants, many of these experts may also have their financial interests, or the financial interests of their employers, among their considerations, consciously or unconsciously.

Bioethics commissions, intended primarily to provide advice to the administrations which establish and appoint them, may provide a substantial service to the public by acting as honest brokers capable of translating the evolving concerns found in professional, medical, and bioethical circles into clear policy recommendations presented in nontechnical language. And in doing so, commissions may further that mission by making explicit concerns that may not receive much attention in the professional and scientific communities most directly involved in that research and in those innovations.

Such concerns must include the apprehensions of the general public, addressing them in straightforward inclusive terms that demonstrate consideration of the broadest range of values and interests.

It is also essential, given many Americans' great concern about special interest influence and frequent distrust of experts who may not share common values, and given the importance of the issues addressed by bioethics commissions, that such commissions place the highest priority on transparency in deliberations. The arrangements this Commission has made to bring its deliberations into public view in a number of U.S. cities, and to webcast its meetings, as well as

post so many of its documents and conclusions on the internet, are certainly important and necessary steps to further that interest. Yet we should have no illusions that we are going to displace the Kardashians any time soon.

But while making the Commission's deliberations as public and transparent as possible is both important and necessary, it is also certainly the case that this Commission, like those which came before it, will be most successful if it can demonstrate that it has considered the many social values external to the often bounded literature of both academic medicine and bioethics as a professional discourse.

Finding creative ways of bridging the distance between the expert discourse which so often typifies debate over bioethics and the plain language used by most citizens can help to assure the public that while many of the controversies under consideration involve difficult choices and challenging conversations, decisions have been made following a broad and disinterested discussion of both those choices and those conversations. Thank you for your consideration.

DR. WAGNER: Dr. Levin, thank you. Let's move on to our next speaker. It is Dr. Diana Hess, who is Professor of Curriculum and Instruction at the University of Wisconsin in Madison. Since the fall of 2011, Dr. Hess has been on leave to act as the Senior Vice-President of the Spencer Foundation. Dr. Hess researches how teachers engage their students in discussions of highly controversial political and Constitutional issues, and what impact this approach to civic education has on what young people learn.

Her first book on this topic, *Controversy in the Classroom: Democratic Power of Discussion* has won a National Council for the Social Studies Exemplary Research Award in 2009. She also investigates the ideological messages imbedded in high school textbooks and other forms of

curriculum, and recently completed a study of what curriculums communicate about terrorism and about 911 and its aftermath. Fascinating work.

It sounds, however, like it's going to be very informative to us. So please push your button on the microphone and let us hear from you.

DR. HESS: Members of the Commission, thank you very much for inviting me to testify. I was asked to talk about the relationship between democratic deliberation and education, and how efforts to engage students in discussion of complex and controversial issues, including topics of contemporary bioethics, help to prepare them for wider public deliberation on those issues.

Let me begin by saying that I approach these questions from three very different perspectives. As a former high school teacher and current professor, I have tried to teach literally thousands of students how to deliberate highly controversial political issues, many of them with a bioethical connection.

As a staff member of a civic education organization, I spent almost a decade working to develop high quality curriculum materials on controversial issues, and trying to figure out how to teach teachers across the country and in central and eastern Europe how to do this kind of work in classrooms.

And finally, as a researcher since 1998, as Professor Wagner mentioned, I have been trying to get a better sense of what happens in classrooms when this is done well; what happens in classrooms when it is not done well; and what can we learn about the effect of engaging students in these kinds of discussions on their participation politically and civically after they finish high school?

And let me say that stealth democracy informed my research. I, too, read the research

undergirding that very interesting book. And I was nervous about it. And I think that they made the case that a lot of Americans don't like to talk about highly controversial political issues.

And in the conclusion of that book, they did what we all do when we write books, which is to say, "What should we do about this?" And one of their recommendations is we need to start in schools and we need to make a better effort in schools to teach young people how to engage productively in these discussions.

So for that reason, in my testimony today I'm going to focus on three questions. The first is why schools? Why should we be doing this in schools? The second is, what happens in schools and in classrooms specifically when this is done really well? In other words, what constitutes best practice? And finally, what are the challenges confronting us if we want more students in more schools to engage in high quality discussions of these kinds of issues?

Well, to begin with, why schools? I think this is a very, very simple question to answer. Schools are where the children are. It's kind of like the old joke, "Why do you rob banks?" And the bank robber said, "Well, that's where the money is." Well, if we want to affect all of the young people in the United States, we need to go into the schools.

It is not that there aren't other good venues. For example, a lot of science museums are doing a wonderful job with educational problems around bioethical issues. But what we know is that we have 55 million young people in schools. We have 3.7 million teachers. That's just an unbelievable reach. So if we want to do something that has the potential of influencing all young people - and we should want that if we are concerned about equity - then it just makes sense to go into the schools.

But schools have some other characteristics that make them really good venues for this kind of

work. One is that schools have courses in which bioethical issues could be inserted, or in some cases courses could be constructed so they revolve around bioethical and other controversial issues.

So every high school student in the United States takes at least one science course. Every high school student in the United States takes at least one social studies course. So those are ready-made venues for doing this kind of work. And we also know that even though we don't have as much high quality curriculum as we need, there are some organizations that are developing really good curriculum on controversial political issues, and many of those issues have a bioethical component.

So, for example, I mentioned that I spent almost a decade working for a civic education organization called the Constitutional Rights Foundation Chicago. And about ten years ago that organization, along with two other national organizations, created this unique international deliberation project called Deliberating in Democracy that's been used by thousands and thousands of teachers and young people across the United States, across the Americas, and in central and eastern Europe. And the curriculum that they created as part of that project included a unit on cloning and a unit on physician-assisted suicide.

So what was interesting about that project is even though it characterized the nature of the work as being about what we call controversial political issues, it recognized that there are many controversial political issues in the United States and in other nations that, by definition, have a bioethical component. There are other groups that are doing the same work.

So if we've got high quality curriculum materials that could be used in schools, we are going to be able to have the potential to have high quality conversations that we, frankly, are not going to

have at Thanksgiving.

One of the things that we know is that people need to be taught how to engage in high quality deliberation. So what we learn from teachers who are really good at doing this is that they maximize the ideological diversity that exists within their school and class by trying to make sure that students are participating as equally as possible, trying to make sure especially that students who have a minority point of view have the opportunity to get that minority point of view across.

But we also know that teachers recognize that to engage in controversial issues discussions, you need norms of civil discourse. And those norms of civil discourse, quite frankly, we don't have a lot of public models for. And so one of the things that teachers in the research that I'm doing continually say is, "We don't want our students to mimic political discourse in the world outside of school. We actually want to do a better job than what they see in the world outside of school."

And teachers call this teaching with informed discussion. And what that means is they teach with the deliberation of these controversial issues in order to make sure that students are learning high quality content; that they understand a lot of the factual information that we were listening to in the last panel; but that they also are improving their critical thinking skills, et cetera. But they also teach for discussion, which means that at the end of the day, they want their students to know how to engage in these conversations when they get outside of the classroom.

So what we know about best practice in schools is that teachers use high quality curriculum terms, that teachers try to engage students in discussion that uses civil norms; and in the best classrooms I'm in, those norms are really enforced. I have seen students suspended from school for violating the norms of civil discourse in classes that are designed to teach kids how to talk

about controversy.

Now that would seem, on its face, to be very strange. And it's clearly very unusual. But what the teachers will say is, "If we can't enforce norms of civil discourse, we are not going to get high quality discussion."

The other thing that we see in these best practice classrooms is that teachers understand that good discussion doesn't happen spontaneously. Just like what we have seen this morning, people come prepared; they come prepared to make statements, they come prepared to ask questions. There's a structure for how this works. Well, in classrooms, that kind of preparation is occurring, as well.

Finally, let me talk just briefly about some of the challenges that we see. One challenge is political polarization. What we know is that if we've got a society that is politically polarized, and we certainly have increasing evidence that that is the case, we are going to have schools that are politically polarized.

And one of the things that we are finding in our research now is that there are a lot of schools that look ideologically very similar to the community in which they are housed. This shouldn't be a big surprise. But it's actually a big problem, because teachers who are teaching in red schools or blue schools have distinct problems that they have got to encounter. The teachers that are teaching in purple schools, don't. The purple school teachers will say, "We want to keep a lid on." The red and blue school teachers will say, "We want to make sure that people are hearing points of view that they regularly don't hear in their community." So political polarization is a problem.

Another problem is that the public often doesn't want students to hear points of views that are

different than their own. Parents, in particular, sometimes believe that it's important that schools mirror, that schools kind of perfectly reflect the values in the home. And I think what we need to do, more than anything, is communicate to the parents in a very kind and pedagogical way, that that is not something that they should want in schools. That what parents should want from schools, what we should all want from schools, is for schools to help young people deliberate about these important issues with people who are different from they are, and hearing views that are different from what they hear at home. Because if we don't do that, we are never going to get beyond what we see right now, which is, unfortunately, people kind of marinating in their own ideological stew. Thank you very much.

DR. WAGNER: That's wonderful. Thank you. We're going to have quite a set of questions with this group. The last speaker today is Lisa Lehmann, who is a primary care physician and Director of Bioethics in the Department of Medicine at Brigham and Women's Hospital, Associate Professor of Medicine and Medical Ethics at Harvard Medical School, and Associate Professor of Health Policy and Management at Harvard School of Public Health. There she teaches a required medical ethics and professionalism course to students at Harvard Medical School, and an ethics and public health practice course to students at Harvard School of Public Health. Dr. Lehmann is also a teacher of medical ethics and professionalism to residents and fellows in clinical departments at Brigham and Women's Hospital.

Welcome to the table. We appreciate you having been with us throughout our deliberations the past couple of days.

DR. LEHMANN: Thank you. I want to thank the Commission for inviting me to address the critically important topic and also the under-valued area of bioethics education. My charge

today is to discuss the value of ethics education in healthcare professionals, the skills and competencies necessary to achieve the goals of ethics education, and to explore the challenges of integrating ethics into medical training.

I will also share some thoughts on what I think is necessary to achieve a vision of bioethics education that is inspiring and holistic, and will lead to better outcomes for patients.

So what are the goals of bioethics education? From my perspective the ultimate goal of bioethics education is the cultivation of competent and compassionate physicians who can improve the care of patients. I think there are three ways in which bioethics can help us achieve this goal.

Firstly, bioethics education, when done well, can develop critical thinking in the skill of ethical deliberation. This process can improve students' moral reasoning abilities, increase their ability to identify ethical issues that arise in clinical care, provides an opportunity for students to develop their own values, and helps facilitate decision-making on complex ethical issues that arise in the context of patient care.

Secondly, bioethics can play a central role in cultivating professionalism with the goal of improving physicians' behavior, and I'll speak more about this in a moment.

And lastly, I think bioethics plays a role in developing practical skills that are central to becoming an effective physician. This includes communication skills, shared decision making, how to engage patients in the process of informed consent and advanced care planning, how to deliver bad news, and how to disclose a medical error.

I therefore see bioethics education as attending to the cognitive, the affective, and the practical dimensions of students' development.

I'd like to say a little bit more about professionalism as it is one of the core competencies and is seen by many as the ultimate unifying goal of medical education. While it can be challenging to succinctly define professionalism, I find it helpful to understand it as the personal qualities beyond the knowledge and skills necessary to deliver high quality care to patients. It's the internalization of professional values such as altruism, accountability, integrity, a commitment to excellent and lifelong learning. It is something that is dynamic and evolves as the practice of medicine changes, and it can be instilled through the process of active learning, role modeling, reflection, self-assessment in our institutional cultures.

So why should we care about cultivating professionalism? Why is this a core competency and ultimate goal of our educational process? Well, it turns out that most complaints against physicians relate to unprofessional behavior. Physicians are quite competent when it comes to knowledge and technical skill. But knowledge and technical skill are not sufficient for producing ethical physicians. A focus on professionalism allows us to shape students' moral development. We have good evidence of the erosion of students' professionalism when they enter the clinical wards, and the hope is that bioethics education can prevent this regression.

Lastly, professionalism forms the basis of a social contract between physicians and society. Physicians are granted a privileged status by society, and the continuation of that status depends on the public's belief that physicians are trustworthy and will put patients' best interests above their own self-interest.

So bioethics education, I think, through its focus on critical thinking and professionalism, can generate moral courage. And it is this moral courage that is necessary for physicians to put their ethical principles into action. By "moral courage," I mean the courage to do what is right for

patients, despite potential risks.

In the clinical setting, speaking up about what is best for patients, or the ethical thing to do, may risk alienating one's self from a team, a negative evaluation or recommendation by someone higher in the medical hierarchy, or doing what is right even if it may conflict with the law. And I'm happy to provide some examples of these in our discussion period.

Students who have carefully considered ethical questions and the goals of medicine will be better prepared to make good, ethical decisions, and will be able to justify their reasons for acting. I think that this capacity to justify their reasons for acting empowers students and physicians to have the moral courage to do the right thing, despite the risks.

I realize that the Commission is focused on bioethics education, but I would be remiss if I did not mention the role of other humanities such as literature, art, and history in achieving our ultimate goal of better patient outcomes. The humanities can help students achieve a deeper understanding of illness and suffering that can influence their attitudes and behaviors. Students may become more self-aware and provide better care to a patient if they are able to see them as individuals with a shared humanity, as opposed to objects of physical diagnosis.

Art is inherently ambiguous and may cultivate greater tolerance for ambiguity. There is also some data to support the idea that exposure to art can improve observational and descriptive abilities of physicians. So the humanities may be a source of personal rejuvenation, and redirect our focus to the ultimate ends of medicine.

So what should be the reach of bioethics education? While most medical schools have embraced the idea of some ethics education during medical school, there is significant variability in content, quality, and placement within the curriculum. Bioethics is important not only for

physicians, but for all healthcare professionals including nurses, nurse practitioners, and physicians' assistants.

Although bioethics is central to the education of health care professionals, its reach should be much broader. Health care is important to all members of society, and therefore bioethics should be a concern of every citizen. Every citizen should give thought to whether they want to be an organ donor, and to what kind of care they want to receive at the end of life. It is, therefore, our responsibility to ensure that all members of society understand the importance of bioethics and that we provide opportunities for reflection on these issues.

Our discussion this morning was an excellent example of the significance of bioethics for public health professionals. There are important public policy questions that intersect with ethics, and public health professionals also need the ability to reason through these complex ethical questions.

Lastly, bioethics should also be part of the education for scientists so that they consider the ethical and social implications of their research and understand the gravity of scientific misconduct.

In its prior work, the Commission has affirmed its commitment to the principle and practice of deliberation. In the area of bioethics education, I believe deliberation can play an important role in achieving a consensus on public policy questions. There's no reason to think that physicians or bioethicists should be the ultimate decision-makers about what is ethical at the intersection of medicine and public policy.

For example, is it okay for physicians to restrict access to IVF based on a patient's age or an assessment about what kind of parent an individual is likely to be? Should patients have easy

and unrestrained access to their in-patient and out-patient physician notes? Should parents have access to their childrens' adult-onset genetic predispositions? These are questions for our society to decide, not ones that should be decided solely by physicians or bioethicists. Public deliberation on bioethical questions will encourage all individuals to justify their perspective and provide reasons for their position. These group deliberations will help clarify our values and inform our choices.

So what are some of the challenges of achieving this vision for bioethics education? On the societal level, we don't have a clear forum for public deliberation on controversial ethical questions. And as was already discussed, there may be resistant within our society to this kind of engagement. I am, however, optimistic about it despite the fact that it can be difficult to engage citizens in the process of public deliberation.

Within the context of education for healthcare professionals, there is often little time in the curriculum for bioethics and humanities education. Furthermore, the development of communication skills is time-consuming and intensive for faculty.

There is also a need for faculty development as it is clinicians who understand the clinical context of ethical issues and are respected by students who are likely to be the most effective educators for medical students and residents.

An additional challenge is how we can overcome the negative effects of the hidden curriculum and the medical hierarchy on the moral development of medical students.

Lastly, the dearth of research connecting ethics education to patient outcomes has led many educational leaders in healthcare to question the value and necessity of bioethics education. So how can we overcome these challenges and enhance bioethics education?

Firstly, we should encourage ethics education in high school and in college, and Diana has already addressed the reasons for this, so I won't go into that.

There's also a need for model curricula that transcends the entire continuum of medical education from medical school through residency and into practice, through continuing medical education. We need to find ways to integrate bioethics into the curriculum, both vertically and horizontally. One bioethics course during the first year of medical school is unlikely to be effective at achieving our goal of improved patient care. Bioethics needs to be integrated into clinical settings and relevant to learners. It should be interprofessional, iterative, and dynamic.

As discussed earlier, critical thinking is only one component of bioethics education. We also need to cultivate the internalization of professional values and develop core skills such as communication. Ideally we should use creative educational methods that include active learning and simulation, and there is a need for increased funding for ethics education research that can longitudinally assess the relationship between curricula and patient outcomes.

Lastly, we should consider how best to engage society in public deliberation of bioethics issues.

I have tried to elucidate the critical role of bioethics and humanities education for the ethical practice of medicine and improving patient care. To achieve this vision, we need model curricula at all levels of education that focus on cognitive, affective, and practical skill development. There is a need for educational leaders to support this effort and to cultivate faculty who can be inspiring educators and role models. We need more funding for research on bioethics education and patient outcomes, and we need to develop an infrastructure for public engagement and bioethics deliberation.

Thank you for the opportunity to share my thoughts on this very important topic, and I welcome

your questions and comments.

DR. WAGNER: Dr. Lehmann, thank you. And John is ready, right out of the box.

DR. ARRAS: Great panel. Thanks so much to all of you.

So I want to address a question to Dr. Lehmann. I agree with everything you said. I think it is just terrific. I have been teaching for a long time, both in high school and university and medical school. And I agree with a lot of what was said here, especially with the limited success of large courses in the first year of medical school. I once sat in the back of a class like that at Einstein and I was horrified at what I saw.

But granting that -- and granting that, you know, the best forum for really instilling the ideals of bioethics education in young physicians is going to be in the clinic. In the clinical years, I have seen wonderful models. But it is all very much retail, you know? It is all very small scale, right? Very intense, a very committed faculty can really do a good job of this. Their students come out of this thinking, "Well, this is how a good doctor behaves. These are the questions that a good doctor will ask."

So the question for you is what sort of progress are we making on that front and what sort of new and interesting ideas are there to really make this very small-scale process available for every medical student? Because from my experience, very few medical students or house staff really are exposed to that kind of fantastic mentoring. So what do we do there?

DR. LEHMANN: Thank you for your question. I agree with you. I think that it is small scale and not nearly as effective as we could be. And perhaps that's a role that the Commission could play in really motivating the leadership within our educational institutions to prioritize this. And

that's not just the medical schools, but it's also the hospitals. And there's a real need, I think, for more faculty development, and a greater integration of ethics education into the clinical setting that's not happening. It happens in a very idiosyncratic way right now, which is very problematic.

So I think the solution is that there needs to be more leadership that recognizes the value of this, and where institutions are willing to fund this, too. That's another big problem, that there isn't funding for people to do this kind of work.

DR. SULMASY: I'll join in thanking the panel for great presentations. One comment to start with is I think you see great evidence of stealth democracy behind you with the throngs of people who come here. This is not atypical for our meetings.

But more seriously, if we are going to talk about - and this is for Dr. Levin - if we are going to talk about the sort of function of presidential commissions or national commissions in agenda-setting, I wonder if you have any thoughts on the structure of how commissions are set up, and the best way to keep the sort of goals you have of transparency and achieving the sort of freedom from external influences that you say the public wants vis-à-vis two models; one of which is one the United States has adopted of, "the Commission is dead. Long live the Commission," right? One goes out, we give it another name that sounds very similar to the previous one so people get confused, and a new one is created. Versus what's been adopted in other nations of having a standing commission that survives across administrations and is more like a court.

The advantages one might see of the current model is better influence, because you've got or you

have been appointed by a particular person. But the disadvantage may be not sufficient freedom from the political process. So I wondered if you had some thoughts about that in terms of deliberative democracy, public participation, transparency, freedom from influence, and which model might be better or some mixture of both. What your thoughts might be.

DR. LEVIN: Thank you for the question. I think that much of the rationale behind the U.S. model is, of course, that you have a presidential system here in which the president's authority, of course, is very much separate from Congress's. And when you look at many of the European nations that have such standing committees, this has to do with the parliamentary model in which, while you have partisan connections and you have -- where the executive is much more closely tied to the legislature.

And I think what has happened here is that - and this does limit commissions' influence in the United States - is that commissions become very much tied to presidential administrations. The capacity to translate policy recommendations from commissions into statutes is very much dependent upon control of Congress. And this is somewhat simply the nature of the American political system, one which is loaded with veto points in which various actors can decide whether or not to cooperate, and often do not.

That commissions have become limited by presidential terms has meant that they at least have a fair variance in terms of membership and mission. That has given us some really very different looks. It is, however - and I think the literature on this is fairly clear - it is when commissions have been willing to engage more publicly and advocate in a more political fashion that they have been heard the most. And that goes with the president's commission in the early '80s. That, however, was one where the initial membership was set by the Carter administration and was

replaced largely starting in 1981 by the Reagan administration. So it was connected to a popular president and to the goals of that administration.

DR. GUTMANN: Sure. Your answer about the Commission's limits in the American system is independent of how the Commission is structured. It is dependent on how difficult it is to get laws through Congress. But it is also, from what all of you said, not the primary goal of a Bioethics Commission to enact laws in Congress.

So one of the differences between the time of the old commissions and now is our ability to communicate through the web and the media has exponentially increased our audience in that way. But I do worry a little bit thinking about how much attention a commission gets, because we are – talk about marinating in your own ideological juices, we are awash with communications that get millions of hits but do nothing to educate and certainly don't deliberate about anything in a way that's fact and ethics based. So we really have to be careful about measuring the influence on attention.

Can I ask a question, Mr. Chair?

DR. WAGNER: Yes.

DR. GUTMANN: Thank you. And this is any of you can answer, but I'll direct it first to Diana. All of you do research that I greatly admire, and Diana's research, which is sorely needed on what works in schools, is the foundation of our effectiveness because it's only getting children with those capacities and willingness that will enable us to build. It is never too late. I don't believe it is too late even in medical school, even in residencies. It's not too late, but it is better if you go early.

So my question is do you think the example of quarantine during the Ebola crisis is the kind of case study that could help us get more deliberation and education from a certain point in, you know, K through 12, it may be high school on up, because -- I'm building on what our last presenter said. Because it involves bringing science, law, and ethics together. So it's very alive. It's not segmented. It raises all those questions. And because it's a topic that, if not palatably discussed at Thanksgiving, it is discussed. It is not discussed in a deliberative way, maybe, but it is on people's minds. I have had so many people outside of professionals, people I come in contact with every day, ask me how much should they really be worried about this.

So Diana, could you say something about how case studies and deliberation and education can come together if we could make a contribution in highlighting the question of the Ebola quarantine, or anything you might think we could contribute as a commission?

DR. HESS: Well, when I was listening to the testimony this morning, I actually yearned to be back in my high school classroom in Downers Grove, Illinois because this is a close to perfect case study for a variety of reasons. One is that it's highly authentic. We don't have to make up the fact that people should be concerned about this. People are concerned about it.

Two, there are a lot of conflicts or tensions between core values. That's what we heard this morning. And the best case studies for young people are those that bring to the fore tensions between goods; not between a good and bad, but between goods. On the one hand we've got public safety, and we have health on the other hand. And you have autonomy and privacy and liberty, as you heard about this morning. We should want people to see all of those as good things. The tension is in specific situations do we think one should be given precedence over the other and how do we help young people make decisions about those? Those are what we call in

the business perennial issues. Even if Ebola might not be something that's with us for a long time, that tension is going to be with us forever. And so teachers who are good at this recognize those issues that bring to the fore those tensions.

I think the other thing is, quite frankly, there's a lot of misinformation that's circulating about what's happening. And schools have a responsibility to help clear up circumstances in which there's a tremendous amount of misinformation. So, for example, Action 8 in the U.K. has provided curriculum materials on Ebola to every school in the U.K. And that's happened within the last two weeks. Nothing like that has happened in the United States. Although I will say that the News Hour has a very good lesson plan that uses a lot of technology that I am pretty impressed by.

But I think this is quite a good case study. But it is also going to be very, very difficult because we know, based on the public opinion polls that we heard this morning, that there are a lot of people who believe things that are different than what people who have expertise believe. And this is a real problem in how to educate people about bioethical issues or about any kind of controversial issue.

One of my students did his doctoral dissertation on how science and social studies teachers teach about climate change. And the problem that many, many teachers recounted to him was that even though they believed, many of them, that there was a scientific agreement on whether or not climate change was actually occurring and the extent to which it was caused by human behavior, there wasn't, at that time, widespread agreement among the American public. And so teachers were really in the middle of this dilemma. And some teachers very sadly reported that they turned those questions into controversial issues, even though they thought they weren't, because

they didn't want to get pushback from parents.

So I don't want to say that just because this is a good case study, it's an easy one.

DR. GUTMANN: It is not clearly divided as the facts of this, on how virulent and when Ebola is contagious, is not a red/blue issue. It is just not understood. So if you can get there early enough, you might at least clear up or give some sense of what the science is here. Thank you.

DR. GRADY: Thank you all very much. Very interesting stuff. I have sort of a multi-tier question. I want to echo, I think Lisa said that there's a need for research into what works, what kind of education works. And I suspect that's true at the earlier levels, too.

But I wanted to ask both of you, actually, whether or not there are other -- well, I guess two.

Whether or not there are other strategies to counter the resistance to this type of education besides research, and how well research works to counter the resistance. Because I know there's resistance you said from parents and different viewpoints about what we are teaching children.

But also I think at the medical school level, you know, curricular constraints. Math is more important, hematology is more important than some of these issues.

So, you know, what's the relationship, I guess, between research and resistance? And what other strategies do we have to reduce resistance to the value of bioethics education?

And then maybe just a question for Lisa about, you know, I love this description of teaching the norms of civil discourse. How well do we do that in the medical school setting? And our cases, do they have to be controversial cases to get a good discourse going? There are some really day-to-day cases that are hard enough in the world that I think do lend themselves to some of this same kind of deliberation and discussion. But I don't think, at least my own sense is that most of

the professional school education, although some of it is case based, is much more didactic than deliberative, or something like that. So questions for both of you. And you are welcome to jump in on this, too.

DR. LEHMANN: Christine, thank you for that question. In terms of relationship between research and our ultimate goals, I don't think we really know -- I don't think we have enough research to really be able to answer that question. There is some interesting research in this area that has connected educational interventions as well as ethical concepts to patient outcomes.

So I will mention, for example, one study that was done by Hojat at Jefferson, who developed the Jefferson Empathy Scale. And there was a study that was done that looked at relationship between empathy and outcomes for patients with diabetes. And what they found was that physicians who had high empathy actually had better outcomes in terms of the care of patients with diabetes in terms of control of blood sugar as well as cholesterol. And the reasons -- the study didn't explore the causal mechanisms for that, but we can hypothesize that maybe physicians who are more empathic are better communicators, have more trust with patients, and are therefore able to inspire greater adherence to recommendations to achieve better outcomes. That's one concrete example of some research into the intersection between ethics and patient outcomes that I think can be helpful in getting educators to realize that there's a value to ethics education in terms of creating effective physicians.

So whether people are aware of that, and do we have enough of that I think is really an open question. I don't think we have enough of it, and that's part of the challenge.

In terms of other strategies to achieve that, I mean I think that that's something that we really need to give more thought to. Ultimately I think that we need leaders who value this and who

recognize the importance of it, that we are going to put an emphasis on this type of education, who believe in it and are willing to integrate it.

Let me give you an example. I'm privileged to work in an institution where we have wonderful leadership that has recognized the value of integrating ethics into the clinical setting. So our Chair of Surgery at Brigham and Women's Hospital, Mike Zinner, has really supported the integration of ethics into surgical teams and discussions. So I participate in high risk case conferences with our cardiac surgery group and our thoracic surgery group and our general surgery group where we discuss questions about should we be operating on this 92-year-old who needs an aortic valve replacement that has multiple co-morbidities and actually is DNR and is already on dialysis. And so really getting ethicists integrated into those clinical discussions I think has the potential to have an impact on the practice of medicine.

In terms of the other question that you asked about how well do we teach the norms of civil discourse, I can't speak for how the rest of the United States or the world does bioethics. I was involved in a study that looked at ethics education, but from my perspective that is already ten years old and there's probably a need for some new data in that area in which we found that there was a lot of variability in the way that ethics was actually being taught in medical schools.

At my own institution, it is actually usually done in small groups and very case based. And we do try to model those norms of civil discourse, and I do think that it works best with controversial issues where -- in environments where we have a diversity of perspectives.

Because part of what we are really trying to do is model that ethical deliberation and to engage students in the complexity of these issues and to get them to think through and generate alternatives, to consider the options, and to help them make a decision.

DR. WAGNER: Diana, did you want to comment on this?

DR. HESS: Sure. Just on the research question. I mean, right now I work for a research foundation, so you know I'm going to say good things about research. But the main thing I want to say is that in this area, where research can be most helpful, it is helping us understand what constitutes high quality practice. So research on what's actually happening in the classrooms where this is going well is extremely helpful, because that can help us put together professional development programs to teach people how to do this. So I think that's the kind of research we need.

And I think that we also need to reframe what constitutes high quality education to begin with. I mean, irrespective of whether the topic is bioethical issues or some other kind of issues, to the extent that we continue to think that the best kind of teaching is lecturing, we are not going to get very far. And we've got, you know, just about as much research as you can possibly need to show that that's not the way people learn. So I think part of it is to frame this in that larger hopefully shift that we are going to see being made.

And finally in terms of other strategies, professional development for teachers and professional development for administrators is really key, because for teachers to do this well, they really have to learn how to do it. And it can be taught. I mean, I'm pretty convinced that teachers can learn how to do this.

But they also need to be working in schools with administrators who are supportive of this, so when the parent calls and says, "I can't believe that my child participated in a discussion about abortion," you want the principal to understand what that discussion was about and why that discussion was part of the curriculum, and not to cave immediately. And what I know is that in

the schools where this is being done well, it is not all about teachers. It is a lot about teachers, but it is also about administrators who have undergone good professional development on how to support teachers.

DR. GUTMANN: I just want to say that because Diana is here and can't really say it herself, but Diana's research is really important research. And not just for secondary schools. It's important research, we in higher education should pay attention to it, because there's no reason to believe it would have different results at the college and medical school levels of what works and what doesn't. It is really excellent empirical research.

And secondly the Spencer Foundation is one of the few foundations, certainly the largest that funds research, really high quality research on education. So no conflict of interest on my part to say how important that is.

DR. WAGNER: Raju, I want to hear what you've got, but I'm holding my question until Amy just said what she said. And it is about wondering what the barriers might be in higher -- in post-secondary education and then with the public. Daniel told us that getting rid of disciplinary expertise jargon is going to be necessary for the general public. Lisa was telling us that it is important that this conversation be valued, how is it going to be linked, bioethics to patient outcomes.

But this business of just -- this important critical thing of norms of civil discourse on our college campuses get challenged as speech codes that are contradictory to freedom of speech. How is it that you build -- I can see in K through 6 where it is probably possible to say, "These will be the norms with which we will engage." And maybe you can stretch that up to 12. I don't know. But when we have a campus full of faculty who actually resist such norms, how do we - and that's

not true with all faculty - but how is it that we give value to the kind of norms that invite many perspectives when we realize that it's horribly inconvenient to adhere to such norms if I really only want my view to be heard.

DR. LEVIN: So let me talk about a few things, then, with that. The first I will simply mention is that while the MCAT is now going to be broadening out some of its coverage -- and this goes to the question of higher education in the sense of the university level, but also professional education and especially the way in which students who are anticipating going into professional schools are preparing themselves. The MCAT is going to be expanded to include a social science section. That's coming up in the next, I think, two years.

And with that, however, they have focused on especially psychology, which they have said will basically take up two-thirds of the section, and sociology, basically questions about diversity taking up one-third. There is a place, I think, as well, for some degree of requirement around ethics, something else within the humanities, perhaps, as well as political science. There was an economics aspect that has been discussed. And I know at my university, we have been asked to come up with essentially a minor to help students prepare for that part of the MCAT. So that's something which is happening.

I think in terms of modeling ethical deliberation in higher education, and I can speak to one of my practices, there is an opportunity which has been created by technology. And some of you may be familiar with the use of clickers in classes. And I use this in several of my classes. For those who aren't as familiar, these are remote devices where students can reply to polls. And what I have discovered, and this is a way of helping students engage, is that the key to the clickers is not the result of the polls. The key is that most of us, when it comes to our moral

concerns, when it comes to our ethical deliberations, start out trying to avoid the question. And you can see this in a college class. You ask a question and they all sort of lean back and look to see which way the room is going.

The beauty of the clickers is that it requires students to commit to a position. And this is what social psychologists tell us, cognitive psychologists will tell us: What we do more than anything is we have to -- we find where we are, and then we find the reasons for where we are; that we work intuitively first and with a little more conscious deliberation second. I think there is an important role in teaching more broadly through these kinds of methods, and then teaching teachers to work toward these kinds of methods. And I think that is where many of the opportunities lie.

DR. HESS: So, I think there are different challenges in higher education and I think in some ways one difference is that many people who are teaching in higher education were never actually trained to be teachers, right? And that's a challenge.

DR. GUTMANN: A big challenge.

DR. HESS: So there's a lot of catching up that has to be done. One of the things that I noticed is that if you involve people in ethical deliberations about how to teach about ethical issues, those ethical deliberations are really about pedagogical issues. In my own work, I'm working with philosopher Paula McAvoy that we are trying to design deliberations with people where they talk about questions like, "What role should my own opinion have? Should I share my own opinion? And if so, under what circumstances? What criteria should I use to decide what constitutes a controversial issue, and what's an issue that I would consider settled?" These are controversial pedagogical issues that are important in high schools and also important in higher ed.

So one of the things that I have seen, as a way to work on this in higher education, is to engage people in some of those questions. Because I think it's very hard to, at the practice level, become good at doing this kind of teaching unless you really think carefully about these ethical challenges. And very often, professors in higher education are not asked to think about those. And I think my experience has been that people aren't resistant to thinking about those. They just need to be given an opportunity to do so. And they are very shocked to find out that their colleagues often disagree with them. Which is a good thing, too.

DR. WAGNER: It's a very good thing. Raju, do you remember your question?

DR. KUCHERLAPATI: I do remember the question. Let me be slightly provocative about this discussion.

DR. WAGNER: That's so out of character for you.

DR. KUCHERLAPATI: Yeah. And ask you this question. I think for some people the discussion that we were having and saying that education is an important -- bioethics education is very important might look self-serving. This is a Bioethics Commission and all of you are trained in bioethics and so on. So one has to make a case about the importance of this.

So I wanted to ask you, in high school, for example, probably the nation as a whole is struggling with issues about whether or not we are educating them adequately in terms of reading and writing. Or people may argue that you need to have more math education or physical science education. Or in medical school I have argued, for example, that there should be more genetics education than there is today. And somebody else may say, whatever. Right? There are different types of things. So for all of these different competing types of, you know, constraints and the time that is available and so on and so forth, how could you make a case that this is more

important than X, Y, or Z? Or if you have to give up something, what is it that we would give up to be able to provide bioethics education?

DR. LEHMANN: I did try and make a case in my remarks, I hope, maybe not as persuasively as I would have liked, for why we need bioethics education and why it's important. And you are absolutely right, Raju, that there are so many competing demands and that we, as individuals who are committed to the value of bioethics education, need to have a stronger voice and be more persuasive with regard to this issue.

I think that part of the way in which we can do that is by going back to our core values about what medicine is trying to do and what are our ultimate goals, right? As I tried to say, we are really, at the end of the day, we are interested in being or in producing competent and compassionate physicians who are focused on improving patient outcomes. Professionalism, the cultivation of professionalism, and communication, communication skills are central to everything we do in medicine.

Now, communication skills are not the only -- certainly not the area for only bioethicists. But I would say that bioeth-- the areas that really, where communication becomes particularly challenging, are areas that intersect with ethics like thinking about end-of-life care, like thinking about how do we disclose an error to patients and families, right? That involves fundamental communication skills. Thinking about the process of informed consent. Not just getting a patient to sign a piece of paper prior to a procedure. Those things all rely on communication skills and intersect with ethics education, I think. So I think that there's a tremendous role that we can play as bioethics, people who are committed to the value of bioethics education in trying to persuade our educational leaders of the value of this.

In terms of, you know, what does it replace? I don't -- that's a bigger question that we need to really take a step back and look at the entire curriculum. I'm not sure if the issue is whether it should replace something per se, but thinking about how we can really integrate it into our existing curriculum at different levels of education.

DR. WAGNER: Diana.

DR. HESS: With respect to high school, let me say quickly we need to be aware of the fact that the majority of young people in the United States do not ever go into higher education. And that's a problem, for sure. But the reality of it means that what we do in high school, for many students, is going to be really, really important because that's going to be their last chance.

And the way that I think about high school is that we should be preparing people for college and for careers. But we are also preparing people for citizenship and to live in communities. And we are preparing people to hopefully have better personal lives than they would have otherwise. So I don't think it's an either/or, or that we replace something. I think it's a both/and. I think we can do this. I know a lot of schools that are doing this. That we can prepare people to be participants in civil and political life at the same time we are teaching people how to read and how to do math and how to do other things that we want them to do.

But the other thing that I think is hardly ever talked about is that in our personal lives, we are going to be making bioethical decisions. In my own life, three times I have had to engage with end-of-life decisions for both of my parents and for one of my grandparents that were very, very challenging, with a family that had to deliberate a question about what do we do in this situation? And I know I'm not unique.

And so I think we've got a responsibility not just to prepare people to participate in public policy

discussions about what should we do about laws related to cloning, for example. I think we need to prepare people to participate in decisions about their personal lives. And I can tell you that if people have had experience listening to different points of view and respecting evidence and knowing what questions to ask, and knowing to demand professional expertise and the kind of treatment that Lisa was talking about, that's going to make for a better life. And at the end of the day, when people say what is education for? I mean, education, we want to create a better society, but we want people to have better lives. And I think we've got a real responsibility there that often gets ignored when we think of schooling as just being about preparing people for what's next in a very instrumental way.

DR. WAGNER: Very good. Thank you. I have Anita, Dan, and Steve I think will wrap this up.

DR. ALLEN: That was so powerful what you just said. I really think that's absolutely right. We all have to make these very important decisions in our own lives, and we need some help in how to think through those important choices.

A couple of points I wanted to make. One is that there is a very strong attraction to teaching bioethics and using case studies that involve, I think one of you said, competing goods.

Competing goods and tension. I want to make a pitch, though, for including in our bioethics teaching at all levels cases of clear bad. Cases where the doctor, the scientist, the public just make a bad choice, because those kinds of things happen as well. I recently wrote a paper about a doctor in Baltimore who was videotaping his OB/GYN patients. Just bad.

But a thoughtful, ethical discussion of what makes that bad? Why shouldn't you do that? And what should be the response of the patients, the hospital, and the doctor to the discovery that that kind of evil has taken place. So I just want to make a pitch for that additional kind of instruction.

Then I just wanted to raise a point of the sites of bio education, like where do you do it. In the cities, half of the boys drop out of school, public school. They are not there. But they also need bioethics education. And what are going to be the sites of education, where can we find them? Is it going to be in the community center, the library, on twitter, Facebook, churches? Where do we find people in order to engage them in this kind of civic discourse around bioethics that everybody is advocating and thinks is so important. And I just wondered how do we do that? The schools can't be the only focus of our conversation.

Then just a point about bioethics teaching in higher education. I have done it for decades, as others around this table have done it. And a couple of things I've noticed. One is that the textbooks are terrible. I mean, there just aren't really good bioethics textbooks. The ones that we use in my philosophy class, I have 14 different books that all have the same 25 articles in them arranged in different ways. That is beyond, you know, the one article on abortion, the one article on the right to die. So how can we enliven and make more contemporary and relevant and rich our bioethics education to include problems that are more common and even more difficult, like what do you do with a 90-year-old cardiac patient? Problems of just real, you know, difficult problems.

And then finally, one of the things that we have done at Penn just in a class that I teach with my husband, but we have discovered the value of having two people in the classroom. One teacher teaching bioethics is one thing. But two teachers, male, female, black, white, different perspectives on contemporary issues, is a very powerful way to model civic engagement around difficult ethical issues for students. I think the students are more willing to disagree with one another if they see these two people who are team teaching who disagree about a lot of different things. It's a very interesting way to teach ethics and bioethics.

Thanks for your great, great presentation.

DR. WAGNER: Did somebody want to comment on those points?

DR. LEHMANN: Sure. I'll take a stab at commenting on some of those. First of all, I completely agree with you that we do need to talk about clear cases of bad. I'm thinking, for example, of the whole fiasco in the V.A. system and using that as a teaching moment and an opportunity for reflecting on what is ethical practice in medicine. And there's certainly many other cases, as well.

DR. GUTMANN: Lisa, could I just interrupt for one second? Could I add something to what you and Anita said, because I think it's an important point. When we teach clear cases of bad, it's really important, and this gets to what Christine said, not to just say, "Here is a clear case of bad," but, "Why is it bad?"

So I did this years ago in my ethics and public policy class. I decided to just ask my class what is wrong with slavery? And this was a very highly educated, smart group of Princeton undergraduates. And what it exposed was how many students couldn't say what is wrong. And then it also brought up a variant of, "Who's to say?" There are people who said, "Well, I think slavery is wrong, but other people may think it's right. And who's to say?" So it actually gets you at the issue, the same kinds of issues that come up when people deny certain, you know, things that are commonly accepted. And it's really a teaching moment.

And I dare say putting out just the facts, there's good evidence that if you just give people facts in teaching, they won't remember it. If they have an experience of being challenged in something that they believed deeply or hear a challenge, they will remember that experience. So I think that's something with our Guatemala case --

DR. ALLEN: Yes. I was thinking about it. I think we handled that very, very well. It was a case where most people would say clearly bad. But I think we handled it the way we got all perspectives.

DR. GUTMANN: I just wanted to pull it for the record.

DR. LEHMANN: Absolutely. I think that is a foundation of the way in which we work, the way in which we teach, the way in which we engage students in our ethics courses. Or at least the way I personally do. Being -- again, going back to what I said earlier, being able to justify your reasons for something and articulate that in a clear and convincing manner is part of the skill that we are trying to develop. And I think actually part of the effectiveness of that kind of teaching works best when students hear those different perspectives and reasons articulated by other students; when it's not just coming from faculty, but it's their peers that are articulating different perspectives and providing reasons for those different perspectives. So that's one thing.

In terms of the sites of bioethics education, Anita, that you mentioned, I think we should really be thinking very creatively and broadly about that issue. I was privileged just this past Sunday to do a program through the Cornerstone Forum in Boston and in Sherborn, Massachusetts which is put on through a church, and it was at the Sherborn Community Center, engaging the public, about a hundred people there to talk about end-of-life care, and really trying to educate people about this particular issue.

And in addition to getting people to be aware of these issues and what the options are and what to think about, got into conversations about Brittany Maynard and physician-assisted suicide. And those are issues that the public cares about and that they are concerned about. And we should be, I think, leveraging and building alliances with churches and synagogues and other

community centers to develop these kinds of public forums and engagement.

In terms of your concern about there being bad textbooks and how we can really enrich our educational process with real problems, I think that the reality is that the world of academic medicine doesn't really rely on textbooks, for the most part. It's journal articles. And in our course we don't have any textbooks we use. It's all case studies.

Some of the cases come from our clinical-- our teaching hospitals, clinical ethics consultation services that faculty have been involved with. Cases come from students when we deal with ethical issues that come up for students. We actually have cases the students have brought in terms of their own experience from being on the wards that can be very, very powerful teaching experiences. So I think that the -- and it's constantly updated with new cases and new articles that are being published in the literature. So that's just one example of a strategy to combat that problem.

In terms of the value of two people teaching, I think you are absolutely right that the more interdisciplinary that we get of both interprofessional, multi-cultural, and have different views that are articulated in the classroom, the more effective that we are going to be. The challenge is that there aren't enough faculty to both teach in small groups so that we can really have active learning going on, as well as to have that kind of diversity and resources in the classroom.

DR. SULMASY: Very much following on this, Lisa your method of teaching cases is exemplary, I think, but probably not typical of the way it's done in most medical schools. And I don't think your survey went into that depth, but I think that in most places in the country, at least anecdotally, and I have been to a lot of them, the case is a clinical one and the most you can get out of it is every student sort of being asked, "How do you feel? How do you feel? How do you

feel?" And at the end of it, no feeling can be challenged, right? And that's the end of it. That's the extent of the education.

So my question is how do we get, if we are to make a case base, how do we get beyond that? Do we wait for the primary and secondary education and university education to catch up? Do we sort of go to AAMC and LCGME and notice that they set better standards? Should this be something within the profession itself, trying to get better methods of instruction?

DR. LEHMANN: Thank you for your question, Dan. I think it is a really important issue, because it's certainly, at the end of the day, it's not just about how people feel. I think that when we teach in that manner, we leave people coming away from our ethics courses with a feeling that this is all relative and doesn't really matter. And that's very, very problematic and not the message that we want to communicate.

I think the way in which we can really get beyond that is by developing clearer course objectives, clear objectives for each class, and approaches to the conversation with questions and ways of thinking about it, and in giving students an approach to the analysis of ethical issues. So that's part of our educational process is to teach them how to think critically about these issues, how to develop and consider different alternatives and weigh them, and how to justify their different positions and how to make an argument. I mean, that's part of what I'm trying to do with my students, as well as also inspire them and empower them to have the moral courage to act ethically.

But I think that there's a role here at the national level for bringing together individuals who really care about this issue to develop that kind of model curricula. We don't have that, and I think that that's something maybe that the Commission can contribute to this area.

DR. HESS: I just want to say one brief thing about the high school dropout problem. I think we need to worry a lot more than we do about that problem. And I think in many ways, the best kind of education for civic and political participation is keeping people in school. I mean, we just need to keep students in school, and there are a lot of school districts that are doing a much better job with this. What's happening in Chicago is close to a miracle, the lowering of the dropout rate.

But I just want to say something about who gets this kind of education. So I think we need to be concerned about high quality education that looks like this, but also about equality. And what we know is that students who are in well-financed school districts, who are more likely to be middle or upper SES and white, are much more likely to get this kind of education. And what we need to be worried about is how do we make sure that teachers in schools especially in urban areas, but also in rural school districts, are getting support to do this.

And thankfully there's some really big, good new projects. There's one in Oakland, one in L.A. County, one in Sacramento, and one in Chicago going on right now where hundreds of teachers are being taught how to teach this way. And it's really quite remarkable, but it's still not going to do what we need to do unless we are really concerned about what every young person gets. And I think sometimes we just are way too willing to accept the fact that some students in some schools get this robust, amazing opportunity to build these kinds of skills, and in other schools, well, they just don't. And we just can't tolerate that. It's terrible for the students, but it's also horrible for society as a whole.

DR. WAGNER: Steve.

DR. HAUSER: Thank you. I have a question to Lisa, but also to the others. We start where

John began a half hour or so ago, and going back to the clinic and really to the bedside and the clinic. We know how complicated life is there with all of the difficult nuanced decision-making that has to happen, the compliance issues, the workflow requirements. And my question with Lisa is how do we think about prioritizing better models to promote dialogue and to mentor clinicians in their roles as educators to their patients, including seasoned clinicians?

DR. LEHMANN: That's an excellent question. There's no doubt that the structure in organization of a healthcare, especially in the clinical settings, may impede careful ethical practice or, you know, thoughtful ethical practice. And that's a real problem that I think that we need to confront in terms of how we deal with that reality that, in the clinical setting, there are so many stresses and such little time to devote to thinking about these issues, that decisions need to be made immediately and in the moment. And oftentimes when that's the case, the decisions may not be as good as we might like.

And I think that part of the goal of the educational process that precedes that point of being in that clinical environment is to really anticipate that reality, and prepare students in advance by hopefully if they have thought through the situation of, "Well, do I have an obligation to disclose a medical error once it happens? And how do I go about doing that in an ethically sensitive way and a responsible way?" If they have thought through that issue in advance and they had had an opportunity to actually role play how they would do that, then when it comes the time to do that clinically, despite all the pressures of the clinical environment they are going to be much better able to rise to that occasion. What do I do when I see someone -- let's say I'm a student and I'm observing my residents do a procedure at the bedside, thinking that they have a sterile field but they forgot and they broke their sterile field. Do I say anything about that? Do I speak up, knowing that speaking up is actually in the patient's best interest, but if I speak up, I may create a

problem in terms of how I'm perceived as a member of the team, because not everybody necessarily values, in the same way, what's in the best interest of a patient.

So the hope is that if we can really anticipate these kinds of challenges that students are going to confront in advance, and get students to think through them and guide them for what's the ethically appropriate response in those situations, that they are going to be empowered and have that moral courage to act in a responsible fashion.

DR. WAGNER: Other thoughts or comments on that? I know some schools, and I assume you are familiar with these, as well, are now instituting pledges along those lines, which seems to have worked to some good effect.

Bigger thing to do right now, though, is to thank you. The depth and breadth of this particular panel is probably one we could have spread over a longer period. Thank you all for your presentations and your answers to our questions today. Wonderful to have you.

DR. GUTMANN: I have the pleasure of thanking you again. I know each of your work and it's really quite basic to what we are doing on this current topic.

And we are going to conclude this meeting. But before we do, I want to encourage anybody who is listening by web or listens down the road on the web to give us comments on [bioethics.gov](http://bioethics.gov), on our website, or e-mail us, as well.

So thank you all. I would just conclude by saying that we look forward, as a Commission, to a report on bioethics deliberation and education. We will use the Ebola public health crisis as a point of focus for our deliberations about education and deliberation. And it is our view, as a Commission which is set up as an independent body, that we, without all professions -- we talked

about this. But all professions, medical profession, science and stuff, has, as its undergirding, a commitment to doing what's good for individuals and the public. And without that undergirding, there is no basis for professional life.

And so I go back to what Larry Gostin said earlier. Not that ethics, science, and law are the same, but that they must come together if we are going to serve the good of individuals and the good of the public. And you really, the three of you, spoke both eloquently but also with great evidence to that. So thank you all again.

Thank the Commission members, thank the Commission staff for doing terrific work. And last and certainly not least, thanks to our vice-chair, Jim Wagner, who gets the last word.

DR. WAGNER: And actually I don't think there needs to be many more words. The only person you left out with thanks was you. So thank you for your leadership. Commission members, thanks for all the energy that you give to us.

DR. GUTMANN: And safe travels.

(End of proceeding.)