

## Trying on the Rings of Glaucon: Conscience Centered Medical Ethics.

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Imagine now that two such rings existed and the just man put on one, the unjust the other.... To begin with the unjust man. [With his ring on,] he must operate like a skilled professional- for example, a top-class pilot or doctor, [who] must be perfect in his wickedness; he must be able to commit the greatest crimes perfectly and at the same time get himself a reputation for the highest probity, while if he makes a mistake he must be able to retrieve it, and if any of his wrongdoing comes to light, be ready with a convincing defense.... Beside our picture of the unjust man let us set one of the just man... 'Who wants to be and not seem good.' [With his ring on, the just man] is not allow[ed] to seem good.... No, [he is stripped] of everything except his justice...[is given] an undeserved and lifelong reputation for wickedness, and [made to stick to] his chosen course until death....

(rendered from passages 359a-361d in the Prelude to Plato's **Republic**: the story of Glaucon's rings)

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Appeals to personal conscience are often heard in the course of bio-ethical deliberations. An appeal made to conscience appears, at times, to be a first resort. More likely, it is only the first step to emerge in awareness, following upon the heels of many more steps that have NOT fully emerged, as occurs in commonplace *procedures* beginning with *tacit* moral assumption and *implicit* approaches to the conditions of moral engagement. When an appeal, apparently of first resort, is made to it, conscience is often referred to as 'an internalized moral compass', assisting one in getting her bearings, after she is alerted to the possibility that there is distinctively moral terrain to be traversed. At other times, an appeal to conscience appears to be made *explicitly* or *declaratively*, as a last resort or as a default position; for example, after consequentialist, deontological or casuistical arguments, among others, have failed to achieve moral suasion.<sup>1</sup> Yet from another perspective, personal consciences (in the plural) are neither alphas nor omegas in deliberative processes, but instead, determine- by their contours- the boundaries of any ethical discourse. Whether discerned as first or last resort, or as running a continuous thread through an ethical argument, the entity involved, the personal conscience of the

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<sup>1</sup> The italicized terms are used in the technical sense found in the cognitive science of memory.

professional, almost always escapes examination -even if its presence does not entirely elude detection.

The position taken by the authors is that a secular examination of the developing professional's conscience can be conducted with the help of conscience sensitive clinical educators and that such an examination will have at least *instrumental* and *contributory* value, and perhaps *intrinsic* and *original* value as well, with respect to a practical, coherent, as well as more fully self-aware approach to bio-ethical concerns.<sup>2</sup> A theory of conscience formation and functioning was initially developed to account for empirical findings from a study of the moral developmental psychology of children and adolescents begun in the early 1980's. The principal instrument used was the Stilwell Conscience Interview (SCI), a semi-structured interview that engages the child in her awareness of aspects of her moral identity. Initial investigations highlighted the normal developmental progression of conceptualization of conscience from something posited in the locus of external authority by the preschool child to something internalized, personified, and eventually integrated into the personality as a moral organizer by the older adolescent (Stilwell et al., 1985, 1991). As the study proceeded, other domains of conscience were identified and characterized developmentally. In addition to the anchor domain, **conceptualization of conscience**, the investigators found the following domains to have value in accounting for subjects' responses to the SCI:

**moralized attachment** (Stilwell et al., 1997),  
**moral emotional responsiveness** (Stilwell et al., 1994),  
**moral valuation** (Stilwell et al., 1996 ) and  
**moral volition** (Stilwell et al., 1998 ).<sup>3</sup>

The last aspect of the theory that evolved was the idea that for each domain of conscience there corresponds an intrinsic (bedrock) value that may be seen as exerting both a developmental push and an ethical pull on the person of conscience. These bedrock values are, respective to the above-mentioned domains:

**Moral meaning-making** (composing a good life),  
**Connected-ness**,  
**Balance or harmony or equanimity**

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<sup>2</sup> The italicized terms are used in the technical sense found, for example, in Nozick's theory of value.

<sup>3</sup> For the sake of coherence, the boldfaced domains are ordered differently from their historical appearance in the peer-reviewed literature.

**Worth** (attributable to authority, self and others) and  
**Freedom.**

As we presented the findings from our studies of conscience in children of advantage and, later on, in children of adversity (Galvin et al., 1997; Goenjian et al., 1999), we found dialogue was enhanced if we first invited concerned adults to respond themselves to selected questions from the SCI. Encouraged by the level at which these adults were willing to be engaged, we developed an adaptation of the SCI entitled: The IU Conscience Autobiography for (Healthcare) Professionals (IUCAP; Galvin, 1997: *see* Gaffney et al., 2002 Appendix).

The Instrument.

The IUCAP consists of 15 sets of questions beginning with a request for a general definition of conscience:

“ To begin, write about how you conceive of conscience. It’s all right to speculate, draw analogies or use metaphors. What is it? How does it work?”

The semi-structured narrative guide proceeds with inquiries relevant to how the auto-biographee experiences himself historically in each of the domains of conscience. A developmental perspective is encouraged as he is asked to retrieve moral memories from childhood, then from medical, nursing or other allied health-professional schools and finally from clinical experiences. Self-awareness with an appreciation for moralized attachment is prefigured by these inquiries and fleshed out subsequently with questions that explicitly address role-modeling and professional ideals. The rings of Glaucon are represented by invitations for the interviewee to reflect upon psychophysiologic, mood -related and other changes in inner states as well as how he believes these changes are evinced or concealed in the presence of others. Varying conditions of approval and disapproval have also been specified to enhance appreciation of shifts in moral emotions as well as vicissitudes in imagined conduct. Particular attention is given to the autobiographee’s amendatory and reparative responses to the moral emotions that accompany the assumption of agentic responsibilities. There follows a survey of moral mandates active in the autobiographee’s conscience with an invitation to link these to moral attachment figures and underlying values. The mandates and underlying values may be recognized as

intergenerationally transmitted or described as originating with himself. They may be instrumental/pragmatic rather than moral in which case the questions subsequently posed regarding one's best reasons for complying-or not-with the mandates may uncover the moral value. Questions probe discernment of, and strategies for, resolving moral dilemmas (right vs. right issues). The autobiographee proceeds in his narrative account by responding to questions pertaining to his attitudes towards his own and others' agency and concludes by envisioning future developments in his conscience.

### Format

The IUCAP may be used in a variety of educational formats. Prior to its use, particularly in group format, the ethical issues of confidentiality, informed consent, regulation of self-disclosure, the participation/observation ratio, and potential fates for the information acquired in the educational process (e.g. research) either emerge spontaneously in discussion or can be introduced by the preceptors. Without having offered a formal definition of conscience, the preceptors can nonetheless model a conscience-sensitive approach and also highlight the concept of moral dilemmas followed by recommending appropriately provisional process rules that address the ethical concerns.

Our initial format- one with which we have acquired experience in each of the last eight years- was a course in six sessions for Post Graduate Year III psychiatry residents (Galvin, et al., 1997b, reproduced in Appendix). The preceptors have been a child psychiatrist paired with a medical ethicist. A demonstration interview, consisting of the first 10 or 11 IUCAP questions, is first conducted with a practicing health-professional who has agreed to volunteer after having been informed of the nature of the interview. The role modeling involved allows for a benchmark of self-disclosure intended to serve the residents as they undertake the assignment to engage in their conscience autobiographies. An examination of the contours of the volunteer's conscience is best informally drawn from the learners' observations, using their terminology, before introducing the conscience domains. Preceptors encourage an attitude that is not morally reactive to conscience contents disclosed. It is likewise salutary to the process to discourage staging in favor of appreciating the varieties of conscience experiences. Different domains and intrinsic values may have more salience or pre-eminence in the

conscience contours of different individuals. With some groups, particularly mental health professionals, it has been helpful to redirect attention from perceived psychopathological interference in the domains of conscience functioning to normative features demonstrated by the volunteers. Once the autobiographies are assigned to the residents, remaining sessions in the course are organized around group discussions of the question sets informative about each conscience domain. A psycho-educational format is employed, each session beginning with any current ethical concerns or responses to the IUCAP that residents are comfortable disclosing. While we have not encountered any residents who have exercised remarkably poor judgement in regulating self-disclosure, preceptors should be prepared for the possibility that an individual seeking a dynamic group therapeutic experience rather than a psycho-educational one may require supportive redirection. Propaedeutic to handling this contingency, preceptors should have discussed how confidentiality (and its limits) would be observed. Didactic materials from recommended readings and audiovisual tapes are tailored to the discussions that emerge in the context of each domain. The mental health professional with knowledge of moral psychological development facilitates this group work. The process does not pretend to value neutrality. In fact, we try to make explicit how we envision bridging the gap from the enterprise of ascertaining and/or considering developmental psychological facts about our moral nature to adopting and promoting values regarding the nurturance of our moral nature. With the guidance of the medical ethicist another bridge is constructed from intrinsic values to biomedical principles. The ethicist facilitates an exercise in which residents are asked to explore the derivation of the core professional values from the intrinsic values of conscience.

The work is concluded with a consideration of *prima facie* duties that are sometimes competitive with one another in making moral claims and how moral dilemma resolution may be affected by the diverse contours of conscience among those engaged.

### Case Illustrations

#### Case #1: Demonstration Interview Version

Dr. A: Do you have a general definition of conscience?

Dr. B: The part of the personality that motivates, evaluates and teaches conduct-with respect to my interactions inside and with other people.

Dr. A: I want to go to more of a personal definition.

Dr. B: Well, the part of me that at the end of the day can feel success [and] what I want to do better the next day.

Dr. A: Do you become concerned about matters of conscience in the form of right vs. right dilemmas, decisions? Can you give an example?

Dr. B: I just came from a feeding conference, at the hospital, and it's the whole feeding team –the dietician, psychiatry was represented and pediatrics was represented-

Dr. A: I think you might explain what a 'feeding conference' is.

Dr. B.: It's a young child who is 17 months but below the fifth percentile and was also small at birth-uterine growth retardation-and still size –wise and nutritionally not taking enough calories.

Dr. A: Not enough calories to sustain himself?

Dr. B (nods affirmatively): And right versus right?

Some members of the team were really struck that this mother wanted to infantilize this 17-month-old child and maybe were having problems with him growing up and complained and were critical.

They were being critical and the baby needed to eat and there were some thing the mother needed to change in the way she was feeding.

So, some staff were right but then other staff pointed out a greater right in that the mother knew her child and that she was the primary person: Was there a bigger picture? Was there a greater right? In other words, how were we going to work with *that* mom? And so in a way I look at that as right vs. right. The baby needs to eat and that's right -- those people were right-- but there's a bigger picture.

Dr. A: Was this a kind of thinking that you had to learn to do-the right vs. right in opposition to right vs. wrong?

Dr. B: Absolutely.

Dr. A: Where is your conscience located?

Dr. B.: Throughout me.

Dr. A: Is there anything more you could say about its processes, how it works?

Dr. B: When my conscience is pleased I feel contentment, a sense of accomplishment, a peace. When my conscience is displeased, there is

just general anguish and probably tension--muscle tension--and emotional distress or stirring.

Dr. A: Is there a psychophysiologic component to this-- a bodily response?

Dr. B: Yes. And a mood response. It's like euphoria when I please my conscience and peace and a relaxation and a joy.

Dr. A: Do you have an example of that?

Dr. B: I committed myself in my general residency to seeing a fairly low income-not indigent-but uninsured woman who could not pay for services. Borderline. And I committed myself to this one person saying 'regardless of circumstances, if I think that our work is of benefit to her, I would continue.' And sometimes it's difficult and sometimes it's frustrating but the fact that I have followed through and that she's making progress is probably as rewarding to me as anything I have done professionally.

Dr. A: Have you ever done something good and no one knew about it?

Dr. B (nods affirmatively): Do you want me to describe it?

Dr. A: Yes, you can, unless you still don't want anyone to know about it.

Dr. B: Professionally it's something I judged as good and maybe some people know about it but it was never discussed. It was when I was an intern, a man was very sick, I mean as a matter of fact we were coding him and we had stabilized him to the point that we were moving him to the ICU. I bucked the rest of the code team a little bit in letting his wife touch him and see him-that he was stable. I assessed that as 'good'. I guess other people knew I did it but no one in authority over me or any other family members knew I did it and I didn't have any more contact with them. I still feel good about that.

Dr. A: If someone had been observing you, would they have sensed what you were doing?

Dr. B: Maybe. In the midst of that stressful situation, I probably lightened up a little bit and started feeling better about what I was doing.

Dr. A: Tell me about a time perhaps you have gone against your conscience.

Dr. B: There are a lot of those times. Which one can I talk about is the question....

Leaving work early.

Dr. A: What happens on the inside when you leave work early?

Dr. B: I feel overwhelmed. Hurt. Tense.

Dr. A: How does it show?

Dr. B: My stomach acid starts pumping. Muscle tension. Scowling. Irritability.

Dr. A: Have you displeased your conscience and no one knew about it?

Dr. B: Yes. Many times.

Dr. A: And what happens then?

Dr. B: Same thing.

Dr. A: What relieves it?

Dr. B: Thinking what my motivations were and my particular priorities. Even though it might be labeled as the wrong thing to do. And I look over at my children and I think about them.... Over-compensating the next day.

Dr. A: In general, if you have gone against your conscience, what do you do to make things right?

Dr. B: It depends. If I've hurt someone, I will try to verbally apologize and come as close as I can to correcting my mistake. My husband is an example. When I am arguing or short with him, I try to do better next time.

Dr. A: Now I'm going to go back in time as far as you can. What's the first thing that you can remember doing that was considered to be good?

Dr. B: This would have been when I was about four. My great-grandmother was ill and in the hospital and we lived about 2 hours away. We had a rose bush. I cut roses and wrapped them in damp paper towels and carried them to her.

Dr. A: And then what happened?

Dr. B: They were all wilty but everyone said 'how sweet' and patted me on the back. My great-grandmother smiled and touched me and that was all there was.

Dr. A: Did that experience have a lasting effect on you?

Dr. B: I hadn't thought about it. When you asked about it, that's what popped into my mind.... From very early on, I wanted to be a doctor. I wanted to make sick people feel better in some way.

Dr. A: I also notice it's the second time you mentioned touching. It's important?

Dr. B: Oh yeah.



Dr. A: Since beginning residency, what is the first thing you can remember doing that was affirmed by someone as right?

Dr. B: Wow. My child residency or even further back?

Dr. A: I suppose you could even go back to the beginning of medical school if there's a memory.

Dr. B: The first thing that comes to mind--I don't know if it's good or not. I was a junior student on Medicine and ... on an admission, I did what I thought was a pretty good job. My resident, who I admired very much, said, "You did a really good job and that's good to see." That felt morally good and my conscience was pleased.

Dr. A: What has been the effect of that experience?

Dr. B: Good and bad. I always--I mean it's very pleasing when I feel like I've done a good job. But I can also get pretty punitive when I don't have time--which seems more often than not-- to do what I feel is my best job.

Dr. A: Let's look at the flip side of this. Going back very early in life, what's the first thing you can remember doing that you can identify as bad.

Dr. B: I stole my sister's dimes. I was five. There are probably other things but this is the first I can remember. My sister had dimes she rolled. This is an older sister. My dad was a basketball coach so we spent a lot of time at the high school. In the women's rest room there was this machine that took dimes. I didn't know what it was and it just struck me that my sister had this whole roll of dimes in her top drawer. I didn't take them all but I did take half a roll. I slipped in and tried to use the machine and it got jammed and I never got to use it and I wound up never finding out what was in that machine.

Dr. A: What happened?

Dr. B: I felt very bad. I was very embarrassed and I waited thinking someone was going to find out and I was going to get into trouble. It seemed like a long time. I finally went to my dad and said, "I took these dimes." I was somewhat disappointed that my sister hadn't found them missing.

Dr. A: What did your dad do?

Dr. B: He called my sister. He was gentle. He said it was a good thing that I talked to him and he called my sister and he asked me to tell her what I told him. He asked the two of us. She would have been about seven--she's a couple years older. I think we wound up--she didn't get mad-- and dad didn't get mad which surprised me. If I'm

remembering right, I had some dimes left over that I'd taken, one or two were missing, so we worked out how I would pay her back.

Dr. A: And what's the long lasting effect of that experience?

Dr. B: That people can make mistakes. I very much admired my dad and how it was handled but the situation was corrected. I like to be that way with my dealings either if someone has wronged me.... Or with my children.

Dr. A: Have you had to deal with that situation with your children?

Dr. B: Yes. Yes--not a whole lot. I think they probably take things from each other but their stuff is sort of mused in the house. Nothing major but one of my sons took a glass from a hotel that we stayed at. This part I don't know. I think I did OK in that situation. We took it back and he apologized and replaced it.

Dr. A: Did you tell him the story of the dimes?

Dr. B: No.

Dr. A: Now in terms of professional school--medical school: what is the first thing you remember doing that was identified as wrong?

Dr. B: That's easy. It was in my junior year. I had come off two months of surgery. So it had been awhile since I had seen my bed.... University Orthopedics.... It was 11 at night and we had call, and I remember how I had to excuse myself from my own service to go over to another hospital to take call. At that point their staff sent their student home -- which I thought was really unfair because I was tired and worn out and I really didn't want to be there. And we didn't have pagers. After we finished the surgery we were doing, which I probably did with a really bad attitude, I went to the call room and took the phone off the hook and figured if they wanted me they could come get me. I locked the door.

Dr. A: What happened?

Dr. B: Nothing.

Dr. A: Any lasting effect from that experience?

Dr. B: I still feel bad about it. I had really mixed feelings about it.

Dr. A: Do you feel like a good person most of the time?

Dr. B: Most of the time.

Dr. A: Do you feel like you were born good or bad?

Dr. B: I think I was born bad. But that's my religious upbringing but I've thought a lot about that especially since. My worldview: we're all born bad.

Dr. A: Can you get into that a little more?

Dr. B: I think, uncultivated and unrestrained, human beings are animals without boundaries and consideration for others and that it is through a lot of effort and energy that we approach something higher, something more civilized.

Dr. A: Have people tried to argue with you?

Dr. B: Actually, although that's consistent with the religious philosophy that I was brought up with, I never really embraced it until my residency when I was faced with being the therapist for a pedophile. And that was really hard for me and I remember my staff sitting back and saying to me: "That's just human nature, why does it bother you?" And you know, I think that seeing the trauma that kids I work with go through at the hands of other people, it's just--you know-- that I think my professional development had as much, maybe, with me going back to what I was taught but never really believed to really believing. It takes a lot of effort and strain and training and the rule is unruly behavior.

Dr. A: And so, overcoming is done how?

Dr. B: Through relationships with each other, through a relationship with God, through prayer. Listening to conscience, nurturing conscience. Trying to make a better world.

Dr. A: And how does that dovetail with patient care?

Dr. B: Actually, it makes it easier for me. Rather than be appalled at an abusive situation, I find myself more easily ready to empathize with a mom who may be a perpetrator of the abuse but on the other hand may or may not have done a lot of generational clean-up from what she received--in other words, making progress, moving towards improvement, starting out with dark and moving towards the light.

Dr. A: In moving from a position of being born bad to being a helping person, what are the steps?

Dr. B: It's baby-step by baby-step every day of your life.

Dr. A: And-and-overcoming or --professional self esteem-- I guess I should put it to you this way: do you feel like a good child fellow?

Dr. B: Most of the time.... I have an honest compassion for each child and family. I strive always to treat them exactly like I would want to be treated if I were the mother or this were my child. I'm constantly hypervigilant making sure they get the best care.

Dr. A: have you gone through any transitions in who you identify with in a family?

Dr. B: Yes. Yes very much so, very much so. That conference I mentioned-- I found myself thinking about the team members who were especially critical of this mom: those persons don't have kids.

Dr. A: What are some of the bad things about you in your role as a child fellow?

Dr. B: I never have the energy and time to do things I want to do.

Dr. A: What do you think makes a good resident?

Dr. B: Honesty, compassion and empathy for the patient that is strongly coupled with a state of the art, academic-driven obsessive-compulsive medical background.

Dr. A: Other than yourself, who in your life has been most pleased when you have done something good?

Dr. B: I think I should say my parents but the person who comes to mind is my maternal grandmother.

Dr. A: Is that the one you took roses to?

Dr. B: That was a great-grandmother. The maternal grandmother actually lived through my internships. So I actually knew her through my lifespan.

Dr. A: How did she show that she cared?

Dr. B: She showed unconditional acceptance, touch, [sic] feeding....

Dr. A: And since medical school and so forth, what people have cared the most about your professional goodness?

Dr. B: Myself.

Dr. A: Other than yourself.

Dr. B: Other than myself? Who has cared the most? I would say it's not the patients I work with but the team I was on at the community mental health center that has cared most.

Dr. A: And, other than yourself, who in your life is most displeased when you have done something wrong?

Dr. B: I don't know. Usually, I have a much lower threshold when I am doing something wrong and that's why I'm hesitant.

Dr. A: You're the first to critique yourself?

Dr. B: Yes, usually.

Dr. A: And that's in general life and then professional life also?

Dr. B: Yes.

## Case #2: Conscience Autobiography Written Version

### ***Question 1. General Definition:***

I think that consciousness is the awareness of self that stems from a soul. That consciousness is different than just the biologic products of reproduction, growth, maturation, movement – since examples can be found in nature that do each one separately (or in some pattern), but likely do not have consciousness. In human terms, I think that consciousness, starting with the experience and awareness of self, then burgeons into experience of others, and the interaction of self with others. When someone in medical terms is called “impaired consciousness” they may be aware of themselves, and their needs, but they are unable to interact with the real world in ways that show the ability to understand the nature of their responses.

### ***Question 2: Personal definitions***

Conscience is located in my head, stomach and hand. Head for the synthetic, integrative functioning of the senses and moral sense/higher order awareness (the nexus of input, process and output). Stomach for my “gut reaction” that I sometimes experience – either as a sickening sense of wrong, or an intuition of an answer. Hand, which is often used in carrying out the resolution that I have come to in a particular situation.

I think that my consciousness works when I become aware of the situation in which I am reacting/participating. It is a reflective function – the difference between participating and observing. For instance, I was attending for the first time on the wards several months ago, and a pulmonary fellow was helping my team insert a Swan-Ganz catheter into a critically ill patient in the ICU. The pulmonary attending came into the room, and started yelling at the resident for [delaying] rounds, and essentially telling him that he, the fellow, was wasting the valuable time of the more important attending. The attending saw no one in the room that made him check his own behavior. I look fairly young, and was usually mistaken for a resident, and was gowned at the bedside.

That moment, I stopped participating in the line placement, became acutely aware of the surroundings (the number of people in the room, the position and expression of the students/nurses/residents/fellows/patient), and stood shocked, with a sinking feeling in my stomach – embarrassment for the fellow, outrage that the attending could behave so poorly/unprofessionally, and unsure in my current gowned/blooded/face –covered/outraged state that

I could effectively intervene. I spoke to the attending several days later (with the fellow present), and gently intervened to help the attending self-reflect without putting the fellow's position at risk.

To me, consciousness is not only an awareness of yourself, but also an interaction of that self with others.

### ***3A. Pleasing the consciousness***

When I do good, I become calmer and feel satisfied. My heart rate slows down, my mind functions faster, in a more organized fashion. I don't know if this is discernable to others. In fact, except under duress, I think that I am able to maintain a reasonably even demeanor.

### ***3B. Pleasing the consciousness – if no one knows.***

Another medical example. A woman in the ER was admitted to our service with chest pain that responded to nitroglycerin. Presumably cardiac. We had many admissions already that day, but she appeared to want to talk. We spend 45 minutes together with the curtain drawn, as she told me about her life – including many social and fiscal dilemmas. At the end of her narrative, she told me that a weight had been lifted off her shoulders, and she felt dramatically better. This is not really an example where “no one knows” (since the patient was present). It was however, an emotionally therapeutic encounter, but it was a moment in which, during a very busy time, I was able to take time to be human with someone in distress. I felt as if, just by listening, and sharing her burden for a short time, I had done something that was very worthwhile. None of the difficult experiences that day were in any way taxing. I felt renewed. I don't know if anyone could have told that something good had occurred in that interaction, but I smiled a lot more. I felt more calm, and was able to lend more insight into other interactions and decisions.

### ***4.A Displeasing the conscious***

When I do something I feel has violated my sense of value/morality, then I become nervous, and take action to try to correct the situation. But in the interim, my head feels sluggish, and I feel as if I need to “shut down.” This shutting down takes the form of a heaviness in my head, an inability to interact with any sophistication, loss of sense of humor, and a general tiredness. I think that it is very apparent to others. I need to sleep.

***4B. Displeasing the consciousness – if no one knows***

Usually, I don't do things against the individual that violates my sense of values or morality. However, I have been negligent in following protocol of institutions to which I have belonged – in circumventing regulations that were burdensome or unnecessary to accomplish my purpose. Taking extra supplies for one patient from a charge-out stock, etc. Usually, it does not bother me at all, and I would stand ready to face the consequences of my actions.

***5. Reparation and healing***

Usually, when I have done something against my consciousness, it involves an unpleasant interaction with someone else. I usually make sure that I am in a balanced state of mind, that I have thought through the issues involved, and can facilitate a discussion – focusing on the issues (but not necessarily the instances) involved. For instance, I was extremely rude to my parents several weekends ago at a wedding in which I was stressed (for multiple reasons), and my parents were “crowding my space,” and being somewhat intrusive. I waited for several days until I had some perspective, and spent an hour discussing our reactions and emotions – trying to keep the conversation on track.

***6A. First memories of goodness***

I was 3 or 4 years old, living in Madison WI (where my parents were doing their post-docs). I remember asking a lot of questions about rainbows and water prism, and how happy my father was as he was explaining the answers. I think that he was happy that I was curious about the world, and wanted to explore it. I don't know if it has any special significance.

***6B. First memories of goodness in professional school.***

I was in a summer program sponsored by the state medical society that was designed to give 1<sup>st</sup> year medical students clinical experience in a community hospital. I was helping to deliver several babies with an Ob-Gyn husband and wife team, when they complimented me for my interactions with their patients and diligence in getting their histories, and invited me to join their practice if I went into OB. That summer experience was the last of positive reinforcement for a while, (except for once during physical diagnosis) until I started the wards.

**6C. *First memories of goodness in residency.***

I had a patient who spoke only Spanish, who had seen several other physicians for abdominal pain. This kind, vivacious 75 year old man, who worked as a cleaning man in a retirement home, had not been taken seriously by others. However, after we diagnosed his ulcer, and treated his H. pylori, he returned to better health, and was quite happy. I felt great. I think that it showed my strength as a good communicator, and reinforced my value of treating all patients with kindness and respect.

**7A. *First memories of badness.***

I was 3-4 years old in Madison, WI and was in pre-school. Several mimes had come to the school to entertain us. Myself and a few of the boys had snuck into their dressing room, and smeared their red, blue and white face paints all over ourselves and clothes. Without the primer coat, the face paint was really difficult to remove. My mother was called, she came and very sternly took me home. I was grounded, and couldn't see my friends. My mother was mad at me for a week. The pattern of unspeaking disapproval continued for many years. Whenever I did something to violate my parents values, my mother would sternly disapprove, scowl at me, make a few disparaging comments about the behavior (“only bad girls do things like that”, “I don't want you doing that”) and then let me know that I had fallen out of favor.

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**7C. *First memories of badness in residency***

I had taken time in medical school to do research, and had had outpatient clinical rotations at the end of medical school. I was rusty by inpatient standards. However, during my first inpatient month, it took me about a week to figure out the computer system and the level of expectations. My professional abilities were disparaged by my resident, who felt that I was a “bad intern” because I was not organized. However, rather than help me, she made me feel incompetent. Generally, one was sized up within an hour or two of interaction, and a snap decision made on ability that had more to do with presentation and style. I make an effort to be more open with people, and facilitate growth of the individual – recognizing that learning curve of each person varies dramatically, but that more people who put in an effort can make the mark.



***Question 8A. Self-esteem in the eyes of consciousness***

1. I generally feel like a good person, but feel like Salieri from the play Amadeus. Good, but often not good enough. I was born with the potential for goodness.
2. I am kind, honest, fun, adventurous, open to challenges, love my family, have a terrific set of friends, work very hard professionally, like leadership opportunities, am reasonably self-aware and generally follow through with my commitments. I think that I have the potential to be a very good person. I try to spend time self-assessing and acting on those reflections (with varying success).
3. I need a lot positive reinforcement, over commit my time, accept too many responsibilities (in which case I have hard time honoring commitments on time), and feel that I often don't do well enough at what I do, or explore topics with enough depth. I have a great fear of failure. I also don't think that I have enough focus in my professional or personal life. I can become very upset when people do not show me respect (which manifests by me reacting with hostility). I've also picked relationships with men who don't have the ability/need to be emotionally open – they are fun, intelligent, interesting, ambitious people, who don't want to commit themselves. Lastly, I am slowly getting over my urge to run (figuratively) when threatened or overwhelmed.

***Question 8B. Professional ideal***

1. I think that an ideal internist is one who is trustworthy, knowledgeable, kind, competent, responsible, ethical, humorous, open, keeps up with medical knowledge, and tries to make all persons he/she interacts with feel comfortable. The internist is also aware of the surrounding issues in medicine, and has acted to try to be an advocate for his patients as a public servant. This might take the form of community, professional or governmental activism – but is geared toward improving medicine and the state of health care for patients. The ideal internist is also a phenomenal teacher who inspires his colleagues, students, and patients to learn. The internist-practitioner may peripherally participate in clinical or health services trials.
2. There are people who embody different dimensions of the essential qualities of the practitioner, the public/professional servant, the educator, and researcher. The ideal practitioner might be G., a kind, somewhat

hypomanic neonatologist. He is kind and enthusiastic, and very knowledgeable. The ideal professional servant is D., who is an amazingly inspiring character – with vision, idealism, practicality, and political savvy. I understand that he was also a phenomenal educator when he was at F.

3. I have a long way to go in all dimensions. I think that I have the dedication, openness and fairness one would expect of the ideal internist. I hope to improve my clinical abilities with time. I have put a lot of time into developing connections in community service, and have focused on physician leadership development. I think that as an educator, I do reasonably well, and my students have maintained their connections with me long after our clinical/teaching encounters have ended.

4. I fall short in consistency – I do not always bring the same energy to all encounters. Further, I often make snap decisions about patients, of which I am increasingly aware, and which I try not to let influence my professional demeanor. I also become frustrated and unhappy with non-compliant or belligerent patients. Lastly, it is difficult to keep up with the changing face of medicine, and I need to come up with better ways of doing so.

### ***8C. Developing professional self-esteem***

1. When I am doing my clinical work, I feel exceedingly satisfied. It is a wonderful experience to interact with most of the patients.

2 and 3 as above.

### ***9. Who care about your goodness?***

My parents have been concerned about my goodness, as well as my first serious boyfriend, whom I dated for 3 years. My parents reward me with expressions of happiness, and with food. My boyfriend would just tell me when he thought that I was doing something really worthwhile. We are still good friends.

The additional people who have been professionally concerned about me have been my mentors in fellowship as well as a few good friends. I think that I value my fellowship director's opinion most of all. He is a warm, smart, insightful man – whose trust is important to me.

### ***10. Who cares when you are bad?***

Same as number 9.

### **11. Conscience drawing.**

If I had moderate artistic abilities, I would draw a veiled sun, with a bright gold sheen. The veil would be moderately opaque, but translucent in areas, giving glimpses of the light below.

### **12. and 13.**

#### **Mandate list**

#### **Mandate Values**

#### **Mandate authors**

Honesty, openness,  
etc., as described above.

D----, R----,

In addition...

Try to be self-aware      Self-awareness is key to growth

Father, Mother, Self (in no particular order)

Try to be self-accepting      To grow one must know and accept where one is

Mother, D----,  
S----, Self,

Try to be consistent      Demonstration of responsibility, trustworthiness

S----, Mother

Try to be self-improving      Learning, exploration, not compromising for less, wanting to achieve excellence

Self

Contribute to societal good      Improve society in which we live

Self, C----

Try to be adventurous      Learning, exploration, expanding experiences

Self,  
C----,J----,  
S----,M---- (friends)

Try to be less outside the norm      Effectiveness, social desirability

Failures when I am not so (speak too fast, don't care about common things)

Be more aware of political interactions      Effectiveness

Again, failures when I have not done so

Try to be non-violent      *Ahimsa*

Father, all family members

**14A. Valuation and Defenses**

Self-awareness:

Best reason: It is a very powerful method of self-improvement, and improving the level of consciousness. It allows one to improve the quality of interactions with others.

Reasons not to do so: Very difficult and takes time. More importantly, when one is reacting, it is often difficult to reflect. Perspective of the observer is difficult when one is the participant.

Strongest motives for doing so: same as best reason. I think that a motive is also a reason.

**Question 14B: Moral dilemma**

Whether to stop treatment of a particularly difficult non-compliant substance-abusing patient. This patient with severe alcoholism appeared repeatedly in the ER intoxicated, consistently with recurrent abdominal pain. This pain was difficult to assess, and was sometimes pancreatitis, other times factitious. We tried everything that we could do to help this patient – appropriate referrals to psychiatry, substance abuse clinics, etc, but nothing worked. When the patient would come into the ER, he would verbally abuse the staff. What was our duty to this some-times malingering patient who could not and would not help himself? Who had had no social coping skills? Who used scarce resources in a economically stressed system? Who was frustrating to interact with? Who would not show up for his appointments, and would not honor his commitments as a patient? We continued treatment. But it really made us wonder what the responsibility of the patient should be in their own health care.

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**Question 15A: Sense of Change and Volition**

I was 10 years old when I entered into a discussion with my father about eating meat. I told him that I thought it was O.K. because of a Darwinian hierarchy, our nutritional needs, and it was socially acceptable with a longstanding tradition. He countered with the principle of *ahimsa* – which is a principle of non-violence that stressing a more harmonious interaction with all life. I stopped eating meat.

## Discussion

Caring for persons made vulnerable by illness or loss requires wisdom and fortitude, as well as practical knowledge and skills. Young persons enter the profession with personal moral codes they've developed which guide and frame their conduct and character, and the process of medical education profoundly affects this moral self, and shapes it according to the principles and practice of the profession. The modern practice of medicine emphasizes evidence, facts, reproducibility, and this is to be respected, but even seasoned professionals may wonder how their own values and principles 'fit' with those of their new profession, and more poignantly, what to do if they do *not* fit or frankly conflict with professional norms or patient's wishes.

As demonstrated by the two conscience case illustrations, an examination of one's own moral beliefs, values, and motivations may facilitate understanding of another's values and choices, especially by illuminating two areas rarely addressed by traditional bioethical principles or theories: moral attachment and moral emotional responsiveness. Understanding the important role that connectedness and equanimity play, along with freedom (autonomy) and worth (valuation), both in the patient's life and in the healthcare provider's experience, promotes better medical care, and often provides the 'missing link' in ethical dilemma resolution. The IUCAP is a useful and provocative tool for engaging healthcare professionals in this important self-awareness activity, thus promoting an opportunity for persons of conscience to enter into mutually respectful dialogue and relationship with each other.

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