

In Search of an Ethical Imperative: Exploring Medicine's Standard of Care as a Concept for Higher Education

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ABSTRACT: In a time when higher education faces a growing array of delivery formats such as interactive television and on-line courses, what ethical standards do we have to guide our profession? The purpose of this paper is to suggest that we might benefit from the medical field's concept of *standard of care* and the ethical obligations it implies. We now have the research-base to establish a standard of care for undergraduate education for traditional-age students and it is the thesis of this paper that this concept should form the basis for informing our practices and policies. The paper will also include some of the sources for developing a standard of care based on this body of research. Contrasting the way the medical profession has approached *tele-medicine* to how higher education has approached distance education is offered as an example of the implications for the application of the concept of standard of care to higher education.

RÉSUMÉ: A l'heure où l'enseignement supérieur fait face à une offre toujours plus grande dans la diversité de cours; tels les cours interactifs à la télévision, nous nous demandons quels peuvent être les principes moraux qui doivent guider notre profession? L'intérêt de ce papier est de faire comprendre le bénéfice que nous pouvons tirer du concept de la réglementation des soins médicaux et des obligations éthiques qu'il en découle. A l'heure actuelle, nous avons les données de recherche pour fonder une réglementation de soins pour les étudiants d'âge normal qui préparent un diplôme. Le fond de cet article montre que ce concept devrait être la base même d'informations pour alimenter nos pratiques et nos mesures. On révèle aussi dans ce papier, des sources permettant de développer une norme de soins basée sur le corps de cette recherche. Le contraste entre l'approche de la profession médicale vers la télé-médecine et celle de l'enseignement supérieur vers l'enseignement à distance est cité en exemple dans les conséquences de la mise en pratique du concept de norme de soins à l'enseignement supérieur.

There are times when one profession might learn valuable lessons from another. This may be one of those times. Both the medical and educational professions are in a period of considerable stress. We face a period of remarkable transition in higher education when the basic assumptions about both the content and the delivery of education are being questioned. We are being told by some that residential education for undergraduate students is no longer necessary and that, therefore, *virtual universities* will soon replace physical campuses (Levine, 2000). Governing boards and legislators wonder if they would be wiser to invest in technology rather than in campus buildings and faculty salaries. Parents are being told that Suzy or Johnny will be able to stay home after breakfast and simply return to the bedroom or family den where they can gain all of the benefits of a college education on-line on a personal computer. We are being told that the role of faculty should make a radical shift from a *teacher centered* to a *learner centered* perspective (Barr & Tagg, 1995). In this environment of rapid change, what standards do we have to guide our professional practice? Upon what basis should we make decisions about the form and substance of the educational experience for undergraduate students as we enter the 21st century?

The rapid proliferation of new higher education alternatives has led at least one of the regional accrediting bodies to consider whether a single approach to accreditation is appropriate for all types of educational providers. The Higher Learning Commission (2001) has initiated a project titled "Restructuring Expectations: Accreditation 2004" in which two of the purposes of the project are to "respond to changes in the higher education landscape," and "acknowledge different delivery mechanisms" (p. 2).

The projection of enrollment trends in higher education also present us with a reason why this issue will become more compelling. The National Center for Educational Statistics (2001) has recently noted the reversal of an earlier trend by issuing the following statement: "Although part-time and 2-year enrollments in undergraduate education grew more rapidly than full-time and 4-year enrollments in the 1970's, future growth is expected to be greater in full-time and 4-year enrollments" (p. 8). Thus, the question of what ethical standards we have to guide our practices and policies is a pressing one.

Purpose

The purpose of this article is to suggest that as professional educators we might benefit by considering the ways that our colleagues in the medical profession have established standards to guide professional practice. The medical profession is undergoing its own period of transition with the advent of managed care and telemedicine, challenges that parallel some of the same that we face in higher education. What seems different, however, is that the medical profession has a long and well-established process that is used to guide and judge professional practice. While it could be useful to examine those more broadly, for the purposes of this article, the concept of *standard of care* will be offered as a starting point for consideration. It is important to note at the outset that the purpose here is to offer this concept as an ethical imperative, not a legal injunction. The issue is whether, as professional educators, we have an equivalent to a standard of care, and if so, whether it carries a similar ethical obligation as it does for medical professionals.

The Standard of Care

One of the concepts that anchors and guides consideration of medical practice and policy is the concept of "standard of due care" (Beauchamp & Childress, 1994). A standard of care is a widely accepted and agreed upon plan of care for a particular medical condition. The standard of care is, however, more than the aggregated personal preferences of physicians. A standard of care is built on a base of research and practice that leads the profession to an understanding of the expected range of care that is most likely to benefit the patient. The physician examines a patient and makes a diagnosis of the presenting symptoms but also keeps in mind the patient's medical history. The particular malady has to be understood in the context of that particular patient's age, family history, personal medical history, and other relevant considerations. The appropriate standard of care is considered after the assessment has been made.

What is important about the concept of standard of care is that there is a presumption that the physician should follow the standard of care that applies in the presenting situation. To do anything less or different should be based on some exceptional necessity. If a physician does not follow the standard of care, or in other words, does not give the patient the care to which she or he is entitled, the physician is not fulfilling the professional obligation that exists between physician and patient. If the failure to provide the proper and adequate standard of care is so serious

that it causes harm to the patient, the physician could be vulnerable to a claim of malpractice. "Professional malpractice is an instance of negligence in which professional standards of care have not been followed" (Beauchamp & Childress, 1994, p. 195).

This concept of standard of care is very much at the heart of the current controversy over the respective roles of managed health care organizations and individual physicians (American Medical Association, 1998). Whether the standard of care will be determined by the managed health care organization or by the attending physician utilizing the standard of care described by the specialty in the medical literature, is the question. While this concept is actually quite complicated in practice and includes difficult cost/benefit considerations, it does provide a foundational basis upon which these matters may be considered.

Do we have a standard of care in higher education? To be more specific, do we have any sense of what constitutes appropriate educational experiences for certain types of students? When a particular student approaches a college or university, do we have a body of research and professional practice that can help us determine what the standard of educational care ought to be for that particular student?

A Case in Point: Traditional Undergraduate Students

The case in point that seems most clear is that of the traditional-age undergraduate student. Can we say, as professional educators, that we know what the standard of educational care ought to be for most traditional undergraduate students? Do we have a body of research and professional practice that can lead us with reasonable assurance to a responsible answer to that question? The answer, I believe, is yes.

In actuality the educational profession has followed the practice of the medical profession in some important respects. One of the ways to establish a standard of care is to conduct a meta-analysis of the research about a given issue. The medical profession periodically conducts these sorts of meta-analyses of the growing body of research about particular conditions and treatments. These findings are reported in the medical journals so that practitioners can keep up to date with the evolution of the standards of care.

The most impressive and comprehensive meta-analysis of the research on undergraduate education is found in the work of Pascarella and Terenzini (1991). There are other important studies such as the work of Astin (1993), Kuh, Schuh, Whitt, and Associates (1991), and Pace (1980). The findings from these studies provide the basis for a

standard of educational care that should guide our practice. Based on these findings, we know what works best for most students. We know what kinds of outcomes to expect when we provide the proper combination of educational programs and experiences within a particular context.

George Kuh (2001a) has concluded that "the voluminous research on college student development shows that the time and energy students devote to educationally purposeful activities is the single best predictor of their learning and personal development" (p. 1). He goes on to argue,

The implication for estimating collegiate quality is clear. Those institutions that more fully engage their students in the variety of activities that contribute to valued outcomes of college can claim to be of higher quality in comparison with similar types of colleges and universities." (p. 1)

With the support of the Pew Charitable Trusts and the Pew Forum on Undergraduate Learning, along with the Carnegie Foundation for the Advancement of Teaching, Kuh and his colleagues have developed a survey instrument called the National Survey of Student Engagement that attracted the participation of 276 colleges and universities in the first administration of the instrument to about 63,000 students. The project is building a database that will become a benchmark for comparisons within and across categories of institutions of higher education. For a description of this project and a discussion of its implications, see Kuh (2001b).

It seems clear from these developments that we are rapidly moving toward what could easily be considered the development of a standard of care for undergraduate education. Just as physicians use the standard of care to guide the treatment of patients, in higher education we may now have the equivalent of a standard of care to guide the education of traditional undergraduate students.

A Standard of Care for Traditional Undergraduates

Space will allow only the outlines of a standard of care but there is enough agreement within the literature (Astin, 1993; Pascarella & Terenzini, 1991), to suggest that most traditional undergraduates would benefit from the following educational practices and experiences:

- living on campus;
- attending college full-time;
- being actively involved in campus life and activities;
- having frequent interactions with certain types of peer groups;

- having frequent interactions with faculty;
- participating in certain curricular experiences such as interdisciplinary courses, scientific inquiry, extensive writing, and core general education programs;
- working at outside jobs fewer than ten hours per week;
- beginning the college experience at a four-year institution if the goal is to acquire a four-year degree.

These are only some of the findings that should guide our professional practice and policies. But they are based on a solid body of research over an extended period of time. They do not apply to every student and are limited to traditional undergraduates but they are reliable and significant enough for the development of an educational standard of care. If we wish to behave as professionals who embrace the concept of a standard of care, we have the basis to do so. While there are many students for whom the ideal educational experience is not practical, just as in medicine not all patients may take advantage of the optimal treatment, it is a goal that we should strive to achieve for as many students as possible.

There have been attempts to describe a standard of care for undergraduate education in recent years, including the work of Chickering and Gamson (1987), the Educational Commission of the States (1995), and Ewell and Jones (1996). There is a great deal of congruence across these proposals and they were based on an analysis of research.

Implications

What are the implications of the concept of a standard of educational care for higher education in our present context? As with the medical profession, we have an obligation to know what the standard of care is and to apply it in appropriate ways to specific types of students. The failure to know what the standard of educational care is should be considered a breach of professional practice. The failure to apply the standard of educational care when we know what it is could be considered educational malpractice. Why should we expect anything less of ourselves? While it is true that our students will not die or suffer irreparable physical harm as a result of our failure to apply a standard of care, there are serious consequences to them when we fail to do so.

We know, for example, that a person who graduates with a four-year degree is still more likely to earn substantially more over a lifetime than a person who does not (Goodman, 1979; Knox, Lindsay, & Kolb, 1988,

National Center for Educational Statistics, 1999). This important fact has remained true for the past 40 years or so and it remains true today, despite public perceptions to the contrary. Does not this fact suggest that professional educators have an obligation to inform parents and students about practices that we know will likely increase student retention and the prospects for graduation? The financial consequences are only one and perhaps not the most important outcome of a college education. A number of important and lasting benefits flow to those who graduate from college, but also result in important benefits to our society. College graduates are more likely than high school graduates to be engaged in political activity, to espouse humanitarian values, and to be healthier and live longer (Pascarella & Terenzini, 1991). The National Center for Educational Statistics (2001), reports that college graduates are "three times more likely than adults with less than a high school diploma to report reading newspapers, magazines, and books regularly" (p. 12). It is important to emphasize that many of these outcomes are associated with the college experience, not with course taking, or isolated cognitive learning.

Over the past several decades our educational policy has drifted or been pushed in directions that are contrary to what we know is the best standard of care. We have adopted financial aid policies that make it increasingly difficult for more and more students to attend college full time and limit outside work to fewer than ten hours per week. We have encouraged more and more traditional students to attend two-year institutions rather than aspire to four-year degrees. We have failed to advise policy makers and parents, as well as students, about what we know about the best standard of educational care. The fifth principle of Medical Ethics for members of the American Medical Association is, "A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public" (American Medical Association, 1996). In a statement titled, "Fundamental Elements of the Patient-Physician Relationship," item number 1 includes the following: "Patients should receive guidance from their physicians as to the optimal course of action" (American Medical Association, 1994a). As professional educators, do we not share a similar ethical obligation to our students, parents, and the public?

The Standard of Care Compared to the Concept of "Good Practices"

The most widely accepted concept of professional practice in higher education is *good practices* or *best practices*, examples of which include Chickering and Gamson's *Seven Principles of Good Practice in Undergraduate Education* (1987), and Ewell and Jones's *Indicators of "Good Practice" in Undergraduate Education: A Handbook for Development and Implementation* (1996). It is clear that the good practices approach has increasingly become a way of attempting to address questions of accountability and quality that were initially to be addressed by the outcomes assessment approach that was widely adopted by regional accrediting bodies in the early 1990s, as required by the United States Department of Education. As progress on the assessment front has progressed with some difficulty and thus at a slower pace than many had hoped (Ewell & Jones, 1996, pp. 6-7), the good practices approach has gained more favor as both a supplement to and a proxy for outcomes assessment. The focus of the good practices approach, however, is on the educational unit if not the college or university as a whole. The more serious deficiency of this approach, in my view, is that it lacks any ethical force, at worst, and only the mildest admonition, at best. Ewell and Jones, for example, argue that this approach is "centered prominently on the need to allocate scarce public resources and to inform individual 'consumer choices' about which college or university to attend" (1996, p. 2). One could translate this statement to mean accountability and marketing are the two primary reasons for adopting the good practices approach. While both of these are important, for obviously different reasons, they hardly rise to the level of the kind of ethical obligation implicit in the standard of care in medical practice. The focus of the standard of care approach is the ethical obligation the professional has to the individual person being served. Put differently, it individualizes and puts a human face on the professional duty. Rather than emphasize the institution's need to be accountable, it places a heavy burden on the practitioner to act responsibly and, even further, to insure that students receive guidance "as to the optimal course of action," to use the language of the American Medical Association (1994a).

Distance Education as an Example

A brief discussion of how the medical profession has approached what is called *telemedicine* might also provide valuable lessons for higher

education. In a joint report of the Council on Medical Service and Council on Medical Education, telemedicine is defined as "medical practice across distance via telecommunications and interactive video technology" (American Medical Association, 1994b, p.2). In the section of the report on "Impact on Quality of Care," the report indicates that while the initial outlook for telemedicine is good, the Health Care Financing Administration (HCFA) "has reported that the technology for telemedicine has developed rapidly, expanding more quickly than have evaluations of the appropriate medical use and cost effectiveness of the technology" (p. 5). In the 'Discussion' section of the report the Councils state:

The quality of care delivered by telemedicine has not yet undergone rigorous clinical or peer review. This lack of research has been proffered by HCFA as a reason why telemedicine remains classified as "experimental" for purposes of Medicare coverage. The Councils believe that quality of care provided by telemedicine should be documented and evaluated by relevant clinical peer groups to determine its effectiveness and quality based on comparisons to nontelematical medical care On balance, the potential benefits of telemedicine warrant further development of this modality. At the same time, the Councils are concerned that resources are finite. Public resources allocated for telemedicine may limit funds for other valuable and competing medical and health care needs. (American Medical Association, 1994b, pp.12-13)

This measured statement stands in sharp contrast to the uncritical embrace of "tele-education" by many educational leaders and policy makers. While studies are emerging, they often deal only with cognitive knowledge acquisition (i.e., content) rather than the full range of learning domains including attitudes, beliefs, skills, and behaviors. For an interesting exception, see a cautionary perspective by Frances, Pumerantz, and Caplan (1999). The study they conducted was of two similar groups of students, one taking a campus program and the other a videoconferencing program. While the GPA of the two groups reflected "no significant difference," as has often been the case with such studies, they discovered that there were statistically significant differences between the two groups on a series of measures such as "rate the environment in being conducive to learning," and "compare the overall quality of the program," with the students in the videoconferencing program rating it much lower (pp. 32-33). The authors concluded, "The flaw in the conventional wisdom with respect to 'no significant difference' is, we believe, that it equates education with a mere 'information transfer' and ignores the 'Human Factor' essential to true

education" (p. 33). In a recent study for the Institute for Higher Education Policy, the authors conducted an extensive review of the research on distance education. The authors (Phipps & Merisotis, 1999) found that most of the studies focused on individual classes rather than on complete programs and that the quality of much of the research was questionable, thus rendering many of the findings inconclusive, at best. In spite of this lack of evidence, many policy makers and educational leaders are pouring millions of dollars of public funds into the new educational technologies including those that could be described as "tele-education." One searches in vain for warnings or acknowledgement that much of this is really experimental. The jury is still out on whether it is either cost effective or even close to as beneficial to students and the general society as traditional undergraduate education. We lack comprehensive studies of how the outcomes of a tele-education degree for traditional undergraduates would compare to what we know are the benefits of the residential college experience.

Higher education seems to be moving or being pushed forward without a serious and responsible standard of educational care. The use of the new technologies to enrich and enhance the college educational experience is a more responsible approach than the urge to abandon residential undergraduate education. As Carol Geary Schneider, the President of the American Association of Colleges and Universities recently wrote,

The kinds of learning that matter, both to individuals and to a complex society, cannot be "delivered," no matter how intriguing the package. They have to be acquired through repeated effort and practice And, as even my 16-year old knows, it all works better when there's a teacher on hand who knows the student as well as the subject, reads the paper, and gives advice. (Schneider, 2000, p. 43)

While the technology may be a valuable tool for specific tasks, such as enabling students to send papers to the professor electronically, it is the professor "knowing the student as well as the subject" that is essential to the college experience.

Conclusion

In conclusion, higher education stands in need of a conceptual framework that can assist faculty, administrators, and policy makers to make sound and responsible judgments about the kinds of educational programs and delivery methods we offer to students and the likely costs and benefits to both the students and the larger society. It may be that

the medical profession, which is in the midst of a struggle with its own issues, offers a valuable approach in the concept of the standard of care. The concept is consistent with the values of both professions, medical and educational, in that both serve individuals in an effort to make their lives more enjoyable, productive, and whole, while carrying out that work within complex organizations that are increasingly concerned about costs and benefits, not only to the individuals who benefit from the care, but the larger society.

What has been missing from our educational discourse has been the sense of ethical obligation to inform our clientele and the general public about what constitutes the educational standard of care. When we lacked a sound research-base about the undergraduate experience, that stance was understandable. We now have that research-base but we continue to behave as if there is no ethical obligation to either inform our clientele about what we know or to use that research base to shape practice and policy.

There are real consequences to our failure, as educational professionals, to embrace the standard of care, or some similar ethical concept. Without such a standard and its attendant ethical obligation, we may look back in a few years and discover that we failed an entire generation of traditional undergraduates and we will all have to live with the consequences for them and for our larger society.

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