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From Knowledge Transmission to Value Formation: Reform Practice of Contextualized Teaching in Medical Ethics

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Abstract

In the context of the ongoing advancement of New Medical Education, the Healthy China strategy, and initiatives to strengthen medical humanistic care, the course Medical Ethics has been entrusted with an educational mission that extends beyond the transmission of disciplinary knowledge. In conventional teaching, course objectives have often remained at the level of conveying ethical principles, norms, and institutional rules, while giving insufficient attention to students' humanistic perception, value judgment, and moral action. This has easily produced a structural dilemma in which students know ethical concepts but cannot make sound judgments, and can recite principles but struggle to enter concrete situations. With the enhancement of humanistic literacy as its core orientation, this article selects contextualized teaching as its point of entry and, on the basis of existing curriculum-reform designs, systematically discusses the theoretical rationale, implementation framework, practical pathways, and directions for improvement involved in transforming Medical Ethics from a knowledge-transmission course into a value-generating course. The article argues that contextualized teaching is not a simple supplement to traditional lecturing; rather, it is a reconstruction of the classroom centered on real problems, role experience, value conflict, and reflective expression. By bringing clinical ethical conflicts, tensions in doctor–patient relationships, life-and-death decision-making dilemmas, and ethical issues raised by emerging technologies into the classroom, the course can move students from abstract principles to situational judgment, from one-way reception of knowledge to dialogic engagement among multiple subjects, and from external understanding of norms to internal identification with values. Drawing on the project plan and preliminary pilot experience, this article further proposes a reform logic of goal reshaping, content reorganization, method

reconstruction, and evaluation redesign. It emphasizes the combination of situational introduction, role-playing, structured discussion, reflective writing, and multidimensional assessment in order to strengthen the humanistic educational effectiveness of the course. At the same time, it points out that, if the contextualized reform of Medical Ethics is to genuinely achieve value formation, further progress is still needed in case-bank development, teacher competence, clinical collaboration, and evaluation tools.

Keywords*:* Medical ethics; contextualized teaching; medical humanities; value formation; curriculum reform

1. Introduction

Medical Ethics occupies a foundational yet distinctive position within the system of medical education. On the one hand, it is responsible for providing a systematic explanation of ethical principles, professional norms, and institutional requirements in medicine. On the other hand, it bears directly on how medical students understand life, patients, professional responsibility, and the moral significance of medical practice. For this reason, the course is not merely a theoretical subject in the ordinary sense; it is an important vehicle for medical humanities education and a key link between the teaching of medical knowledge and the cultivation of professional values. At the policy level, the General Office of the State Council, in its Guiding Opinions on Accelerating the Innovative Development of Medical Education, explicitly called for the cultivation of guardians of the people's health who possess both noble medical ethics and excellent clinical skills, thereby promoting a shift in medical education from single-track professional training toward the cultivation of compound talents. In 2024, four ministries and commissions jointly issued the Action Plan for Enhancing Medical Humanistic

Care (2024-2027), further stressing that medical humanistic care should run through the entire process of training medical students, so that the humanistic spirit may genuinely enter curricula, classrooms, and clinical practice (General Office of the State Council, 2020; General Office of the National Health Commission et al., 2024). Against this background, the course Medical Ethics can no longer remain at the old position of merely "explaining the knowledge points clearly."

But in actual teaching, the course still faces a widespread structural predicament. First, the design of learning objectives remains heavily oriented toward cognitive expression, with a strong emphasis on objectives such as "understanding," "mastering," and "becoming familiar with," while giving relatively weak expression to ethical judgment, empathy, value discernment, and moral-action tendencies. Second, although the teaching content covers ethical principles, professional norms, laws and regulations, and representative institutional arrangements, it is usually organized in parallel by theoretical chapters and lacks reorganization around real problems. As a result, students may remember concepts in class but find it difficult to transfer them to concrete situations. Third, lecturing still dominates classroom practice, and cases often appear only as supplementary illustrations. Students may have "heard many moral principles," yet they have not truly entered sites of conflict, positions of role responsibility, or fields of value tension. Fourth, assessment still relies primarily on final examinations, papers, or attendance, and thus has difficulty effectively capturing changes in students' ethical sensitivity, depth of reflection, communication ability, and situational judgment.

The essence of this predicament is that Medical Ethics has long been treated as a body of knowledge that ought to be taught to students, rather than as a set of capacities and dispositions that ought to be formed in them. In medical practice, ethical problems are difficult not because

students do not know principles such as respect, autonomy, nonmaleficence, and beneficence, but because real situations often involve overlapping value conflicts, role conflicts, institutional conflicts, and emotional conflicts. Examples include how to respond when family members' wishes diverge from those of the patient in informed consent, how to weigh life-sustaining treatment against dignity-oriented care in palliative settings, how to balance fairness with clinical effectiveness when resources are scarce, and how to define efficiency gains and responsibility attribution in AI-assisted diagnosis and treatment. All of these issues show that, if ethics education cannot guide students into situations, role experience, and reflection, its teaching effect will be very difficult to translate into a genuine enhancement of medical humanistic literacy.

For this reason, this article does not attempt to treat all dimensions of reform in Medical Ethics in an evenly distributed manner. Instead, it selects contextualized teaching as its central point of entry. On the one hand, contextualized teaching most directly responds to the practical, conflictual, and generative character of ethics education. On the other hand, it can effectively absorb the existing reform designs of "immersive, interactive, and inquiry-based" teaching embedded in the project plan, thereby enabling the course to move naturally from knowledge transmission to value formation. The core concern here is not whether the classroom becomes more lively, but how contextualized teaching can help medical students, while learning ethical knowledge, gradually develop an understanding of patients' situations, a sense of professional responsibility, and prudent judgment in the face of value conflict, so that Medical Ethics may truly become a key course in medical humanities education.

2. **Why Contextualized Teaching Can Promote Value Formation**

The reason contextualized teaching is particularly suitable for Medical Ethics lies first in the fact that ethical knowledge is not an abstract proposition existing independently of concrete

circumstances. Ethical principles certainly possess normative universality, but their educational significance is fully activated only when one confronts concrete persons, concrete relationships, and concrete consequences. This is especially true in medicine, where ethical issues are always intertwined with patient suffering, family pressure, institutional constraints, professional roles, technological conditions, and socio-cultural contexts. If medical ethics education is to avoid remaining at the level of principle inculcation, students must be enabled to understand, in concrete and complex scenes, why norms matter, why norms may conflict, and why individual judgment must constantly coordinate between normative requirements and practical realities.

From the general logic of medical humanities education, values cannot be stably formed through simple instruction alone. Value education differs from factual knowledge education: it requires not only rational analysis, but also emotional entry and practical experience. Existing studies have shown that empathy, reflection, and professional identity in medical education are closely related to experiential, narrative, and participatory forms of teaching. In a systematic review of interventions aimed at improving empathy among undergraduate medical students, some scholars found that narrative, writing, drama, patient interviews, and experiential learning can all help strengthen empathy (Batt-Rawden et al., 2013). Other scholars demonstrated that when patients participate in teaching through storytelling, accompaniment experiences, or video narratives, students are often better able to understand the personal situations and emotional worlds behind the experience of illness (Boshra et al., 2022). Other scholars have noted, in an integrative review, that higher levels of empathy are positively associated with better communication skills, clinical competence, and professional orientation (Chen et al., 2024). This means that medical humanities teaching is not merely an “emotional supplement,” but is internally connected with the development of professional competence.

Contextualized teaching is also highly compatible with theories of reflective learning. The key task of an ethics course is not simply to help students produce the "correct answer," but to help them understand why they make a certain judgment, what they may have overlooked, and what consequences they may bear. In this sense, a situation is not created for performance, but to trigger judgment; discussion is not organized for liveliness, but to expose disagreement; and reflection is not an accessory after class, but a key mechanism for value internalization. Reflective writing helps learners revisit their own emotions, positions, and actions, thereby promoting the construction of professional identity and deeper moral learning (Lim et al., 2023). Sustained meta-reflective practice can enhance medical students' reflective capacities and better connect personal experience, course knowledge, and future professional roles (Heydari & Beigzadeh, 2024). In Medical Ethics, reflective writing after situational discussion is precisely what can transform external case-based stimulation into internal value clarification.

Contextualized teaching also has an additional significance for medical ethics education: it can bridge the long-standing gap between medical humanities and clinical practice. Research conducted in Taiwan on scenario- and discussion-based teaching showed that when multidisciplinary instructors guide students in discussing psychiatric cases, students' understanding of social and philosophical issues can be effectively broadened, allowing them to engage with complex problems even before they have accumulated abundant clinical experience (Lin et al., 2023). Scenario-based role-playing and reflection are especially effective in teaching abstract professional ethics and professionalism because they transform "what theory ought to be" into a perceptible process of "how one should act in practice" (Mianehsaz et al., 2023). Thus, contextualized teaching does not lower theoretical difficulty; rather, it returns theory to practical

problems and enables students, through role experience and value debate, to understand the real difficulty and weight of medical ethics.

Based on the above analysis, it becomes clear that if Medical Ethics is to complete the transition from knowledge transmission to value formation, it must abandon the traditional logic of "teach principles first, then attach cases," and instead establish a teaching chain of problem entry, situational experience, value discernment, and reflective consolidation. Within this chain, knowledge is no longer the endpoint but a tool for judgment; the classroom is no longer merely a space for information delivery but a space for the generation of ethical experience; and students are no longer passive recipients of knowledge but participants in the construction of value.

3. Reconstructing the Course Logic of Medical Ethics Through Contextualized Teaching

Given the existing design of the reform project, changes in Medical Ethics should not be understood simply as the replacement of one teaching method with another. Rather, contextualized teaching should be embedded within the overall reconstruction of the course so as to form a systematic logic of goal reshaping, content reorganization, method reconstruction, and evaluation redesign. Goal reshaping provides direction, content reorganization offers the carrier, method reconstruction constitutes the key, and evaluation redesign serves as the safeguard. Only when these four dimensions are aligned can the course truly move from "having taught ethics" to "having generated value."

First, with regard to course objectives, the former system focused mainly on cognitive memory should be adjusted into a layered structure centered on ethical cognition, humanistic perception, value judgment, and moral agency. Ethical cognition refers primarily to students' understanding of medical ethical principles, normative requirements, and institutional frameworks. Humanistic perception emphasizes students' capacity to sense patient suffering,

family situations, vulnerability, and the subtlety of doctor–patient relations. Value judgment stresses the ability to analyze, explain, and weigh competing principles and conflicts of interest. Moral agency, finally, points toward future professional practice and requires students to translate ethical judgment into responsible communication and action tendencies. This objective structure is not merely a matter of adding several elevated terms; it demands that subsequent content, activities, and assessment all be organized around these capacities.

Second, in teaching content, the traditional structure of parallel progression by theoretical chapter should be broken up and replaced by modular organization around problems, situations, and themes. The project proposal's composite content system of "ethics + technology + culture" is highly instructive in this respect. Concretely, course content may be organized into three blocks: a foundational ethics module focusing on core norms such as basic principles of medical ethics, doctor–patient relations, informed consent, confidentiality, and privacy; a conflict-analysis module dealing with typical conflicts involving end-of-life decision making, organ allocation, justice and fairness, failures in doctor–patient communication, and public health emergencies; and a frontier-expansion module introducing contemporary issues such as AI in medicine, digital health, emerging technologies, and palliative care, while also appropriately incorporating traditional Chinese medical ethics and current institutional contexts. After such reorganization, students no longer face scattered knowledge points, but clusters of problems that can genuinely trigger judgment.

Third, in terms of teaching method, contextualized teaching can be designed as a relatively stable classroom chain. The first step is situational introduction: teachers introduce problems through real or adapted cases, short videos, doctor–patient dialogue texts, or news events so that students rapidly enter the scene of conflict. The second step is role experience:

through role-playing, positional grouping, or assigned standpoint tasks, students come to understand the issue from the positions of patients, family members, physicians, nurses, hospital administrators, and even technology developers. The third step is discussion and analysis: structured group discussion, debate, or value-ranking activities are organized around the central points of disagreement, guiding students to explain reasons rather than merely state attitudes. The fourth step is reflective elevation: reflective journals, short analytical writing, case review, or teacher synthesis help students consolidate the outcomes of discussion into relatively stable understanding. This model preserves the necessary role of teachers in theoretical guidance while significantly enhancing students' subjectivity.

Finally, the assessment mechanism should remain consistent with contextualized teaching so as to avoid a rupture in which the learning process emphasizes value generation while the final result still tests memory alone. The project's proposed logic of process-based, performance-based, and reflection-based assessment is therefore highly relevant. In practice, the overall grade may be divided into four dimensions: mastery of theory, classroom participation, performance in situational tasks, and reflective expression. Mastery of theory examines students' basic understanding of principles and norms. Classroom participation attends to engagement in discussion, listening, and response. Performance in situational tasks assesses students' judgment and expression in case analysis, role-playing, and group tasks. Reflective expression evaluates whether students can connect the case, their emotions, their standpoint, and ethical principles. The focus of assessment should not be on reaching a single correct answer, but on whether students can provide a clear, reasonable, and responsible explanation.

4. Implementation Pathways for Contextualized Teaching in Medical Ethics

At the implementation level, contextualized teaching should not be understood as the occasional insertion of several cases; rather, it should run through different stages of the course. From the perspective of the project's preliminary design, reform may be divided into four links: situational preparation, classroom implementation, post-class reflection, and continuous improvement. The key tasks in the early stage are to redesign the syllabus, reorganize case resources, and identify pilot classes. During implementation, emphasis is placed on organizing contextualized classes around specific topics. After class, experience is accumulated through student reflection and teacher review. Ultimately, a relatively stable course mechanism can be formed through continuous teaching. Because this study is based on the preliminary practice of a curriculum reform project, the focus here is on summarizing operational pathways rather than presenting exaggerated quantitative data.

First, situation design should adhere to three principles: authenticity, typicality, and openness. Authenticity does not mean that all cases must come from the teacher's own experience or from the university's affiliated hospitals; it means that cases should conform to the logic of medical practice so that students perceive them not as fictional games, but as conflicts that may occur in real professional settings. Typicality means that a case should focus on one or several core ethical issues rather than stacking too many details at once, otherwise students may become trapped in factual minutiae and neglect ethical analysis. Openness means that a case should not presuppose a single standard answer, but should instead allow students to make divergent judgments based on different ethical principles and role positions. For example, in a case where family members request that a terminally ill cancer patient be kept uninformed of the diagnosis, the classroom emphasis is not on forcing students to choose rapidly between disclosure and nondisclosure, but on guiding them to analyze the complex relationship among

patient autonomy, familial protection, cultural background, timing of communication, and physicians' duties.

Second, classroom organization should move from 'teachers explaining cases' to 'students entering cases.' In pilot design, each topic may include one primary case and one extension case. The primary case is used to complete the full chain of contextualized teaching, whereas the extension case is used for comparative discussion or transfer training. In a unit on informed consent and family surrogate decision-making, for instance, class may begin with a dialogue text among patient, family members, and physician, through which students initially identify the conflict; groups then assume different roles and discuss whether the patient should be informed directly, how protective requests from family members should be handled, and whether the physician should postpone disclosure; the teacher then introduces the tension among the principle of autonomy, the principle of beneficence, and local family ethics, synthesizing the students' views; finally, students may be asked to write a short response to the question: 'What ethical bottom line should a physician most firmly uphold while safeguarding the patient's interests?' This process combines experience with theoretical return.

Third, the course should deliberately incorporate frontier issues into contextualized teaching in order to strengthen the contemporaneity and relevance of Medical Ethics. The project proposal's suggestion to introduce AI medicine, digital health, palliative care, organ donation, and similar themes is therefore highly necessary. The reason is that the medical environment faced by contemporary students is no longer confined to the traditional doctor–patient relationship; increasingly, they are placed within structures shaped by algorithm-assisted decision making, data governance, platform management, and institutional allocation. If Medical Ethics continues to rely only on classic cases, both its attractiveness and its explanatory power in

relation to reality will be weakened. Taking the case of delayed treatment caused by a misjudgment in AI-assisted diagnosis as an example, a teacher may design a composite scenario involving a clinician relying on AI recommendations, a patient questioning machine judgment, and a hospital emphasizing efficiency indicators. Students can then discuss technological trust, responsibility attribution, informed explanation, and the boundary of professional judgment, thereby turning an abstract issue in technology ethics into a classroom situation open to analysis. Related research suggests that integrating medical humanities education into scenario simulation may produce more positive improvements in practical performance, overall achievement, and student satisfaction (Guo et al., 2025), which indirectly supports the necessity of integrating frontier scenarios with humanistic education.

Fourth, reflective writing and post-class follow-up are indispensable to contextualized teaching. One reason many curriculum reforms fail to produce stable effects is that classroom discussion ends as soon as class is over, while students' emotional fluctuations and value collisions in the situation are never systematically processed. On this basis, a brief reflective task may be set after each topic, such as: 'What was the most difficult point for me to decide?' 'Did I overlook the situation of a certain kind of subject?' 'If I enter clinical work in the future, how would I handle a similar conflict?' Such writing should not privilege literary style, but rather authenticity, specificity, and reasoned analysis. Teachers can then, through sampled feedback, peer sharing, or stage-based synthesis, help students identify blind spots in their judgments and trace their own developmental trajectory. In the long run, reflective texts themselves become important materials for improving the course.

5. From Classroom Participation to the Enhancement of Humanistic Competence

If knowledge transmission emphasizes what students have learned, value formation is more concerned with the ways in which students begin to understand others, their profession, and themselves. In the contextualized teaching of Medical Ethics, this change first becomes visible at the level of classroom behavior. Compared with traditional lecturing, students are more readily drawn into discussion once they enter concrete situations, because what they face is no longer an abstract concept but a practical problem with roles, language, and consequences. A common classroom phenomenon is that students who speak little during purely theoretical lectures become willing to articulate positions once role tasks are assigned. Differences among students no longer lie simply in whether they remember certain knowledge points, but in how they understand the priority of values, the boundary of action, and the mode of assuming responsibility. This indicates that contextualized teaching activates students' ethical subjectivity.

More importantly, the change appears in the way students understand patients and relationships. Traditional teaching often reduces ethical principles to a checklist of rules. Students may know that they ought to respect patients, support autonomous decision making, and protect privacy, yet they may not truly recognize the life experiences behind these principles. Patient narratives, role-playing, and scene-based discussion can reveal that a patient is not an abstract 'recipient of treatment,' but a person with fear, family, economic pressure, and cultural background; that family members are not merely those who 'obstruct disclosure,' but often persons under tremendous emotional strain; and that physicians' ethical dilemmas are not simply matters of what one ought or ought not to do, but are intertwined with time, institutions, resources, responsibility, and professional risk. Once students genuinely enter these situations in class, they are more likely to move from accepting principles to understanding relationships. This is one of the core aims of medical humanities education.

In addition, value formation is manifested in students' development of a more prudent mode of judgment. Contextualized teaching does not naturally lead students to unanimous answers; on the contrary, it often allows them to see ethical complexity more clearly. Precisely through this process, students gradually learn that judgment requires not only stating a position, but also explaining reasons; not only considering individual interests, but also taking institutions and consequences into account; not only adhering to bottom lines, but also understanding strategies of communication in actual practice. Such training helps cultivate a form of well-grounded prudence rather than simplistic, intuition-driven moral expression. Scenario-based role-playing and reflection can significantly promote students' deep understanding of professionalism because they shorten the distance between theory and practice and re-embed abstract ethics into contexts of action (Mianehsaz et al., 2023).

In the longer term, this kind of value formation in the classroom may also influence students' construction of professional identity. Medicine is not a purely technical profession; it requires practitioners to confront vulnerable life, limited resources, complex institutions, and high-pressure decision making on a continuing basis. If medical students come too early to understand their future profession as merely 'delivering the most effective treatment,' its humanistic dimension is easily compressed. Contextualized teaching in Medical Ethics can instead help students, even in the preclinical stage, recognize that becoming a physician means not only mastering knowledge and technique, but also learning how to respect persons, communicate with persons, understand persons, and take responsibility for judgment. In other words, contextualized teaching improves not merely classroom performance, but students' early understanding of what it means to be a trustworthy physician.

At the same time, contextualized teaching does not automatically produce value formation once adopted; in practice it still faces several challenges. Case use may easily become lively in form but weak in analysis. If teachers emphasize only classroom atmosphere without attending to problem-chain design and theoretical return, students may gain a sense of participation while remaining at the level of attitude expression and experiential judgment, rather than entering genuine ethical analysis. Accordingly, cases should not function merely as opening devices, but should be clearly linked to course concepts, normative frameworks, and assessment criteria. Teachers need to design analytical dimensions in advance for each case, including the principles involved, relevant stakeholders, focal controversies, and the relative persuasiveness of different lines of argument. Contextualized teaching also places higher demands on teachers. Compared with straightforward lecturing, teachers must be familiar not only with ethical theory, but also with case adaptation, classroom facilitation, disagreement management, and reflective assessment. Especially when student opinions differ sharply and discussion becomes emotional, teachers must preserve openness while preventing the class from losing focus. For younger instructors, such capacities are not naturally given; they need to be developed gradually through collective lesson planning, demonstration classes, variation in teaching the same course, and interdisciplinary collaboration. The project proposal's suggestion of relying on a mentor system and teaching-research salons to enhance implementation capacity is therefore highly necessary. Assessment tools and evidence accumulation also remain relatively weak. Many teaching-reform studies are quick to claim that students' humanistic competence has been significantly improved, yet without stable process records and valid evaluation tools such claims easily remain impressionistic. Subsequent reform should therefore further explore an evaluation-index system suited to Medical Ethics—for example, by establishing rubrics or scales around ethical

sensitivity, role understanding, argument quality, depth of reflection, and communicative performance, and by combining classroom observation, student assignments, and learning interviews into a more reliable chain of evidence. Only in this way can the achievements of curriculum reform rise from teaching experience to transferable educational research. Finally, contextualized teaching needs to be linked more closely with clinical settings. The value of an ethics course does not end in the classroom; it must ultimately return to clinical observation, clerkship experience, and professional practice. If classroom cases remain detached from real clinical life, students may come to regard ethical discussion as merely ‘moral exercise in class’ rather than rehearsal for future professional judgment. Where conditions allow, theoretical teaching should therefore be progressively connected with observational placements, hospital ethics rounds, narratives shared by clinical mentors, and patient-story activities so as to form a continuous experience from classroom to clinic.

Overall, the real difficulty in reforming contextualized teaching in Medical Ethics does not lie in whether one adopts a certain new method, but in whether one can establish a continuously operating course mechanism in which goals, content, methods, and assessment remain internally consistent. Only when classroom cases are constantly updated, teacher competence is continuously supported, evaluative evidence is gradually accumulated, and genuine connections with clinical practice are established will value formation cease to be a phrase in reform documents and become a stable fact in the cultivation of medical students.

6. Conclusion

The key to reforming the course Medical Ethics lies neither in adding more knowledge points nor in making the classroom appear more active on the surface, but in whether the course can genuinely change the way students understand medicine, patients, and professional

responsibility. Centered on the problem consciousness of moving from knowledge transmission to value formation, and drawing on the overall design and preliminary practice of the curriculum reform project, this article has argued for the appropriateness and necessity of contextualized teaching in Medical Ethics. Its fundamental value lies in returning ethical knowledge to real problems and enabling students, through role experience, value conflict, and reflective expression, gradually to form an internal understanding of medical humanities. In this way, Medical Ethics is no longer merely a theoretical course within the system of medical education, but can become an important educational link connecting knowledge, emotion, judgment, and action. In the future, as case resources, teacher support, and evaluation systems continue to improve, this reform pathway is expected to further expand both the depth and breadth of medical humanities education and to provide practical experience that may inform innovation in curriculum-based education under the background of New Medical Education.

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