

MEDICAL HUMANITIES REPORT

MEDICAL HUMANITIES PROGRAM

MICHIGAN STATE UNIVERSITY

FALL 1988

Evaluating the Ethicist

The age of the "ethics consultant" has arrived. Spurred by increasing appreciation of the complexities of the ethical dilemmas encountered in health care; the encouragement of hospital ethics committees by governmental and professional policy recommendations; new accreditation requirements concerning DNR orders, organ donation, and other ethically sensitive matters; and by risk management for malpractice liability, hospitals are increasingly turning to a specialist in medical ethics for advice on patient care and institutional policy. Advertisements are appearing seeking full-time clinical ethicists for large hospitals and research institutions, a professional society has recently been formed for bioethics consultants, and professional corporations are being created, offering ethics consultation on a fee-for-service basis.

It is an atmosphere ripe for entrepreneurial charlatanism. With no widely-accepted standards of education or training, and no authoritative credentialing body, hospitals are left to their own seat-of-the-pants judgment of the competence of the person who presents herself as an "ethicist". No doubt, some hospitals will be burned. It will likely be some time, if ever, before hospitals can look for board certification by the American Academy of Bioethics Consultants. In the meantime, however, it is possible to use more informal standards of competency which will help determine whether the ethicist is likely to provide informed and useful advice.

There are two times when this judgment needs to be made: before the ethicist is hired, and after she's begun the job.

BEFORE THE JOB

Does the ethicist show evidence of sufficient knowledge and intellectual depth?

Is she familiar with recent issues of important journals like The Hastings Center Report? Does she keep up with the mainstream medical journals for articles relating to medical ethics? Has she read any recently published books in the field?

It is essential that the consultant be abreast of current developments in law and policy, and share some common understanding of the issues with other specialists in the field. Although the average administrator will not be able to test the consultant's level of sophistication, it is possible to get some idea of the extent of the consultant's reading by asking her to describe recently read articles or books, or share her reaction to a recent article that the administrator has also read.

It is a bonus if the consultant has peer-reviewed publications, since these suggest that her work is up to the standards of other specialists in ethics.

Does the ethicist actively participate in the medical ethics community?

Does she attend professional meetings or conferences with others in medical ethics? Does she make presentations or conduct workshops at them? Is she connected to a network of other ethicists, through some organization like MERN? Can she solicit letters of recommendation from others more prominent in the field?

This is another index of the consultant's acquaintance with ongoing developments in medical ethics. The lone wolf who seldom attends professional meetings and knows virtually no one else in the field is not participating fully in the dialogue through which professional and public consensus is formed.

Does the ethicist have a history of successful collaboration with health professionals around issues of ethics or policy?

Has the ethicist made presentations or participated in grand rounds on topics in medical ethics before health professional audiences? Been an active member of a hospital ethics committee or institutional review board? Contributed to development of hospital policy? Do the health professionals she's acquainted with have a high opinion of her skills?

There are many people who are very well-read in medical ethics, and who have a great deal of experience in classroom teaching. But the consultant's job is to make practical recommendations which take account of the political and psychological realities of practice, and which in fact persuade the practitioners and administrators who will have to implement them. The would-be consultant who has no track record of success in the hospital setting is at best a pig in a poke.

Does the ethicist have first-hand experience in patient care?

This is a topic of some controversy. There are some physician ethicists, notably Mark Siegler of the University of Chicago, who believe that the clinical ethicist must first be a clinician who has been responsible for delivering direct service to patients. They argue that only the clinician has been imbued by training with the required fiduciary obligation to the patient; and only the clinician can know enough about the relevant non-ethical aspects of care.

Even if we accept these arguments as valid, their pertinence depends on the work that the ethicist will be performing. If she is going to be consulting about hospital policy, then experience in clinical care will be less important.

If she will be consulting on individual cases, then some acquaintance with hospital routine, divisions of labor, and vocabulary will be necessary. Since interviewing of patients and families will often be essential for gathering the facts about a case or helping to resolve it, the ethicist should have some experience and skill in interviewing patients. This may have been gained by going on rounds, participating informally in family conferences, and the like. I don't believe that the level of skill needs to go much beyond personable ease of conversation and the ability to function well under stress.

In passing, I'll comment that there is a

disadvantage to requiring that the ethicist be a trained health professional. In the course of acquiring the professional's experience, she has probably also acquired the professional's blind spots.

ON THE JOB

Once the ethicist has been hired, the responsible administrator will want to assess her performance on the job. What are some of the characteristics of the "good ethicist"?

Does the ethicist seek to persuade by reasoned dialogue, or instead rely upon a mantle of "expertise" to lend authority to her views?

Does the ethicist provide articles, law reviews, model policy recommendations, and the like pertaining to the problem at hand? Does she respond to disagreement or objections in a respectful and constructive way that is not wishy-washy? Does she attempt to improve the staff's own skills at resolving ethical problems, rather than maintain their dependence on her?

The responsible ethicist will operate primarily as a teacher, educating staff and increasing their own skills at ethical problem-solving. This is done by inviting them into the process of deliberation about the issues that are presented to the ethicist, welcoming reasoned disagreement. The ethicist's objective should be to increase the staff's commitment to reasoned dialogue, and their tolerance of ethical uncertainty.

Is the ethicist a problem-solver before being a theorizer?

Is every ethical problem viewed as a grand struggle between competing ethical theories like utilitarianism or Kantianism, or does the ethicist usually rely upon more garden-variety moral considerations? Is she adept at devising creative strategies or compromises that avoid tragic choices by honoring all of the values at stake?

A sure sign of the unsophisticated amateur is the habit of placing all ethical choices into the framework of a rock-bottom basic principle like "Always treat a person as an end in herself, never as a means." Because they are exceedingly vague and their interpretation a matter of great controversy, such principles often do little to clarify the problem at hand. In fact, too-ready resort to them frequently does violence to the complexity of the real-life situation.

The practical ethicist will do all she can to avoid cosmic ethical dilemmas, preferring to create ways to satisfy all the values in conflict, rather than forcing

choice among them.

Is the ethicist a person of integrity and moral courage?

Is she willing and able to go toe-to-toe with the powerful surgeon or hospital legal counsel on matters of conviction, and keep their respect? Or does she too readily become an arm of risk management?

Of course, the effective ethicist should be neither a martyr nor a Don Quixote. But if the ethicist is to contribute anything unique to patient care or hospital policy, it will only be to the extent that she is willing to defend a point of view different than the prevailing wisdom. The ethicist who is too timid to do this is eminently replaceable.

Does the ethicist appreciate clinical and moral complexity?

Does every question have its answer, or does she acknowledge those times when she genuinely doesn't know what to do? Is the ethicist a Johnny-One-Note for whom a single principle, simply applied, rules all else?

The ethicist will often be approached by those who expect an authoritative and simple answer. The ethicist who always meets this expectation is misleading the staff about the nature of the problems they face, and making them dependent upon the word of the ethicist, rather than independent moral agents. Satisfying the yearning for certainty is often accomplished by making a single moral consideration the magic touchstone which dissolves all quandaries. The patient's right to autonomy is the principle most frequently abused in this fashion, blithely invoked even when there are doubts about the patient's capacity for autonomous choice, or when there are conflicting rights of other persons at stake.

Aware of her limitations, does the ethicist resist rescue fantasies?

All sorts of conflicts or difficult choices get labelled an "ethical problem", which then get taken to the ethicist, who must decide what counts as a problem of ethics within the scope of her expertise. Contrary to Dr. Waun's assumption elsewhere in this issue, (1) the ethicist cannot be a purist who insists that she will only work on those problems that boil down to stark, unavoidable choices between conflicting values. If she did, she'd be doing ethical theory most of the time, and very few felt problems would actually get resolved.

The effective ethicist must be willing to get involved in creating and implementing practical strategies which tread a path between the horns of apparent dilemmas.

These strategies may require a great variety of skills in counseling, interviewing, and social work, as well as substantial background knowledge of medical diagnosis and treatment. It can be a great temptation for the ethicist to think that she is the last resort, the only one left who can make everything right again. But of course, there is no one who embodies all the virtues that may need to be called upon to negotiate the obstacles to a solution. The ethicist who hasn't succumbed to delusions of sainthood is well aware of her limitations. Just as importantly, she has developed effective relationships with nursing, medical, social work, and consultation liaison psychiatry staffs so that she can call upon their special expertise and talents as needed.

The standards described above are those which are probably most important for an ethicist to meet, but are not intended as a comprehensive list of all the desirable virtues. Neither is anything said about the relative importance of each of these standards. No doubt, some persons who are deficient in some respect might compensate in other ways which produce good results. The final judgment which must be made is the holistic one: is the administration and the staff pleased with the ethicist's contribution to the work of the hospital?

Tom Tomlinson

1. See commentary #1 following the case study in this issue, p. 3-- Editor

Case Study

K.W., a 77 year old black woman with congestive heart failure and a pacemaker, was brought to hospital after a cardiac arrest. Her heart function was restored by paramedics and she was placed in Intensive Care upon arrival. Her neurologic evaluation revealed severe anoxic encephalopathy, with complete inability to respond to family or staff. The family agreed to a Do Not Resuscitate (DNR) order and discussion centered around long term care options. The recent development of a major bedsore has presented a focal problem. The nursing staff believes that parenteral feeding may help restore her nutritional status and help reduce the diarrhea which is exacerbating the bedsore problem. On the other hand there is some question whether any further treatment would be of any benefit to this patient in the relevant sense, given her poor neurologic prognosis.

The major complicating factor is the presence of a granddaughter whose role has been that of principal voice in the decision making, but with whom the medical staff has had trouble communicating effectively. In the opinion of the social work team the granddaughter shows some characteristics consistent with personality disorders. She is likely to misinterpret medical terms and gets confused when different things are said by different people. The patient's daughter has resigned herself to the poor prognosis and accepted the DNR order, but has avoided any decision making. It is noteworthy that the family is a maternally strong black family with a significant distrust of males, especially white males. The granddaughter does seem to respond best to other forceful women.

The following is excerpted from the Ethical Case Consult requested by the medical staff.

We believe the resolution to this case will require a two step process. First, it is essential for the medical, nursing and social work teams to get together within itself on a specific plan of treatment. Second, it is then necessary to communicate this to the family so they can handle this information productively, given the above mentioned psychological and family issues.

Given the prognosis and the very, very low likelihood of significant neurologic improvement, ongoing medical treatment of virtually any sort is of no real benefit to this patient. Nonetheless, there is a need to maintain the patient's dignity and to allow the psychological impression for the family that the patient is not being abandoned. This may be best accomplished with a trial period of parenteral feedings to attempt to restore the patient to a more dignified state, relative to her bed sore and incontinence. However the feeding trial should be strictly limited in time, so that if it is not achieving these nursing care goals, the feeding can be stopped.

Once the medical/nursing team has arrived on an approved course of action which meets the above objectives, there is a need for clear and consistent communication with the family. We think a strategy aimed at the following objectives may very well solve most, but not all, of the problems in communicating to the family and getting their agreement with what appears to be a rational plan of treatment:

a) A single main communicator, ideally a strong female figure, on behalf of the hospital staff should be designated to insure

that the family hears the same message repeatedly and from the same person.

b) The primary communicator should insist that both the daughter and granddaughter be present for discussions of the patient's management and in person, to minimize any communication difficulties. It should be pointed out that the granddaughter should not have to assume all decision making responsibility, that the daughter has a natural role in this function as well.

c) Specific care recommendations should be presented in a fairly structured way as the recommendations of the whole medical team. Limits need to be set and the granddaughter especially needs not to feel that she is being put in control with a lot of medical decisions. She seems to respond much better and more productively when clear limits are set for her.

Commentary #1

I want to make three points from this case and then describe what I think is a better approach to case management. First, the case seems not to be primarily a medical ethics problem but a case management problem. If the team had mentioned that in their report it might help the medical team to distinguish ethics issues from other issues.

My next point is that the case itself is basically simple. Simple and easy, like complex and difficult, are not synonymous. I think that it is simply a matter of developing a therapy plan and then obtaining approval on behalf of the patient for carrying it out: which may be difficult to do. So while difficult, the case is simple.

Next I want to raise a rhetorical question: Who should benefit from the consultation? It appears that the report primarily supported the medical team in their management of a difficult case. I think that a medical ethics consultation should primarily benefit the patient/family, or at least it should benefit them as much as it does the medical team.

In light of the acknowledged problems between the medical team and family, if the medical team were to "place limits" on the family and attempt to "maintain (what I take to be the appearance of) the patient's dignity" and give "the impression of not abandoning the patient" they may well produce even more suspicion, miscommunication and problems for everyone.

In case management I take the first order of business to be organizing support for the family and establishing a spokesper-

son for the family. The family may well feel overwhelmed by the immensity of the illness and possible impending death of their loved one and the confusion resulting from many different care providers involved in the patient's care. The family needs help that can not come from hospital people, including the hospital social worker. The help must come from people whom the family trusts, who are not already members of the hospital medical team.

Now the medical team and family can sit down and develop a plan for the patient's care together. Even though the family has an identified spokesperson, all interested family members should be encouraged to participate in developing the care plan. Many of the decisions that need to be made have moral implications. The family can and should be involved in making those decisions.

This is the point where medical ethics consultation may be helpful. For instance, there is the moral dimension to the question of prolonging the patient's life by parenteral feeding in order to make nursing care easier and more convenient.

The process that I am describing is negotiated consensus development rather than either a cafeteria of medical therapy where the medical team 'cooks' and the family chooses, or the standard process described in the report where the medical team decides what is best for the patient and family and then finds a way to implement it. The care plan is a joint venture of the family and medical team. They jointly establish it, approve it, sign it, own it, are responsible for it, and have a copy of it. Provision is made for reasonable changes of mind or for unforeseen changes in the patient's condition.

The medical team must assert leadership in developing the care plan. They should outline care options and their expected consequences and provide the family with their expert opinions on import issues, but they should also demonstrate flexibility and accommodate judgments made on behalf of the patient.

With this approach the medical team does not need to maintain certain appearances in their care or do an "end run" around certain family members as the report seems to suggest. Issues of communication and negotiation are taken care of up front and early. I have used this approach many times and found that it develops healthy and useful lines of communication and mutual trust between family and health team. It also

avoids misunderstanding and crisis decision making. Now both family and medical team are able to devote their time and energy to providing compassionate care for the patient.

James Waun, M.D.

Commentary #2

At first glance, this case report looks like a clear-cut instance of siding with the health care team, against the rights and the wishes of vulnerable family. On further investigation, I believe this view is false, and the advice given can be fully justified. Seeing why this is so helps to illuminate some of the critical components of ethics consultation.

An essential but little studied feature of ethics consultation is what one might call "getting a handle on the case." One may need to do this either for intellectual or for practical and clinical reasons. Intellectually, one gets a handle on the case when one identifies the key fact(s) that allows one to apply a particularly abstract principle, or allows one to identify a closely analogous case for which a resolution has already been carefully worked out. Clinically, one gets a handle on the case when one identifies the key factor(s) in the drama, where relatively small interventions will have the largest impact in moving toward a positive resolution.

I would argue that getting a handle on the case at hand involved the identification by the social worker that the patient's granddaughter exhibited many of the behavioral traits of an individual with borderline personality disorder. This fact appeared to explain two things; first it suggested why the medical team had had so much difficulty dealing with the granddaughter, even in the face of what appeared to be some significant agreements about overall management (most notably, the agreement of the family to a DNR order). Second, the fact indicated a clinically useful strategy for resolving communication difficulties in the future.

The process of family education and negotiation described very well by Dr. Waun in his commentary is, of course, the ideal way to work with families; and the important thing to note about patients with borderline personality disorder is that this is a highly dysfunctional, rather than functional, way to approach their particular needs and difficulties. Prior to the ethical consultant's involvement in the case, the more open information and negotiation

strategy had been tried by the staff and attending physician, but without good results. It was precisely for this reason that consultation was requested.

The phrase "getting a handle on the case", along with the recommendations for limiting options and setting clear boundaries around allowable behavior, sounds exactly like a violation of the rights of the granddaughter (and indirectly the patient) and a manipulative rather than an ethical strategy. I believe this is not what actually happened, for two reasons.

First, it is important to note that there was significant evidence to show that there was no fundamental value conflict between the medical staff and the patient's granddaughter. Admittedly, when issues were raised in a very abstract way - such as how the medical care should be approached, or who should make the decisions, or by implication how much the family loved their grandmother - the granddaughter responded in a hostile and adversarial fashion. But it was equally noted that whenever concrete evidence was pointed out to the granddaughter, she immediately came to the same conclusions as the staff, regarding her grandmother's quality of life, the uselessness of certain continued therapy, and the fact that her grandmother would probably not wish to be kept alive in that state. We therefore have strong evidence that it was the level of abstraction vs. concreteness, rather than a fundamental value conflict, which led to the difficulties in communication.

Second, it is arguably the case that presenting lots of choices and many sources of information to an individual with a borderline personality disorder, or with that pattern of behavior, leads to less autonomy, not more. These individuals will typically react to flexibility and choice situations with anxiety, self-doubt, and hostility or manipulateness. If instead, they are given very specific choices within a very concrete set of expectations, and if communications are channeled through a single individual, they will respond with much better coping skills and will be able to handle things at a much higher level of integration.

I would, therefore, want to argue that the advice given in the consultation presented both a clinically useful way to handle a patient care dilemma, as well as a way to actually enhance the limited autonomy of the patient's granddaughter, who was by later consent designated the family decision-maker. The point raised by Dr. Waun,

that this was a problem in case management rather than medical ethics is a legitimate point, and of course cases do not come labeled so that attending physicians and nurses always know the difference. I do not believe that an ethics consultant who wishes to be genuinely helpful should refuse to consult on a case because it is not sufficiently "ethical" in its content. It is, however, a crucial part of the consultation process to help to educate hospital staff on crucial differences. If the written consultation note did not adequately reflect the difference between an ethical analysis of the rights of an incompetent and the terminal patient, as contrasted with the clinical technique for managing borderline personality disorder, then the consultation is at fault in that regard. **Howard Brody**

Position Available

Assistant/Associate Professor, Medical Humanities Program, Michigan State University. Begins Sept. 1, 1989.

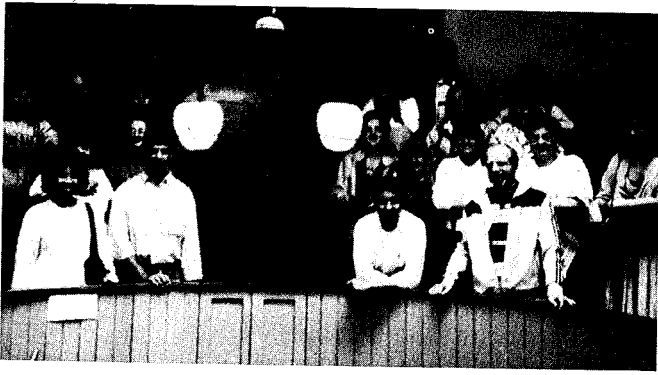
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SEASONS GREETINGS!

*from the Medical Humanities
Program Faculty and Staff*



Surgical theatre at St. Thomas Hospital



Pathology museum at Guy's hospital

London '88 The Best Ever!

For the third consecutive year, Michigan State University has offered a Summer Program entitled "Medical Ethics and the History of Health Care" in London, England. Nineteen undergraduate, professional, and graduate students participated in the 1988 course, along with Professors Peter Vinten-Johansen (History) and Martin Benjamin (Philosophy). In addition, two "graduates" from the 1986 Program returned for clerkships in General Practice, supervised by physicians affiliated with St. Bartholomew's Medical College (Bart's).

The goal of the Summer Program is to examine complex issues in health care from both a historical and comparative perspective. Throughout the five-week course of study, students develop a better sense of how political, ideological, and organizational factors shape differences between British and American "medicine." To accomplish this, the course focuses on two major themes: the changing status of patient/practitioner relationship, especially as it evolves during the 19th and 20th centuries; and the development of strategies for allocating limited resources with the aim of providing equitable medical care. Team-taught seminar sessions form the anchor of the Program; they consist of whole-group discussions of an intensive series of readings drawn from literature in bioethics and the history of medicine. In conjunction, videotape presentations relating to bioethics accent the practical importance of issues raised in the seminar.

However, the course is more than an American interdisciplinary venture transplanted onto British soil, as the Program draws generously on educational resources available in the London metropolitan area. Class sessions are held at Bart's Charterhouse Square facility, allowing periodic participation by British practitioners and

medical students. Visits to several museums--the Museum of London, Science Museum, and Gordon Museum in Guy's Hospital, in particular--provide students an overview of the historical context in which the British National Health Service developed. Travel to health care facilities offers a view of the British National Health Service (NHS) in action; students see first-hand the results of health care policies and organizational structure that might have remained abstract and alien if solely discussed in the classroom. Specifically, each student spends one morning in the course of the summer sitting in on a general practitioner's "surgery" to get a taste of how primary care is managed in urban London. The experience is usually enlightening, and many return for a second visit on one of their free days. In addition, students individually take a half day to accompany home health visitors on their rounds, to see how health care is provided outside the clinical context. Students' experiences--both with GPs and health visitors--form the basis for informed discussion about the practical benefits and shortcomings of the NHS.

The program's schedule consists of three-day "work weeks", with extended weekends to allow students time to visit Scotland, Wales, Ireland, or other parts of England, if they desire. Many choose to remain in the greater London area for most of their free time, taking advantage of the opportunity to immerse themselves in the day-to-day life of another culture. During their stay, students are housed at College Hall (University of London) in the Bloomsbury district, just north of the British Museum and only a few steps from the renowned Dillon's bookstore. This central location means easy access to the places and events travellers come to London for, yet the academic environment of Malet Street is

a reminder that London is not just for tourists. Indeed, the fact that participants have the opportunity to interact with Londoners as part of their studies provides an added dimension to their Program; it is an explicit goal that students not be allowed to remain isolated from the people they are studying.

The Summer London Program has much to offer its participants, perhaps best conceptualized as a series of bridges between the familiar and unfamiliar. A sociocultural bridge forms in students' attempts to make sense of the different assumptions Americans

and Britons have about the meanings of health and quality of life. An intellectual bridge develops between the educational background students have before coming to London and its practical application in the complex arena of health and medicine. And interpersonal bridges result from being a member of a relatively small but disparate group of scholars--both British and American--grappling with issues as future practitioners, policy-makers, or consumers of health care.

Brian Brown and Peter Vinten-Johansen

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