Medical Humanities Program **Michigan State University** **Fall 1980**

A FUNDAMENTAL CHANGE NEEDED?

The following thoughts are extracted from remarks by Andrew D. Hunt, Coordinator, MSU Medical Humanities Program, during a Workshop on Religion and Health at the University of Illinois Medical Center.

There is a basic conflict between the value-free ethic of biomedical research and the value-laden ethic of medical practice. For a time, the conflict remained latent and unnoticed, but recently it has become troublesome and--at least in part--may be at the root of much of medicine's problems, including runaway costs.

Some medical educators have become aware of the need to reorganize curricula because of the knowledge explosion in the sciences. Among the educational reforms have been: to substitute problem-solving exercises for rote learning of science, to give validity to behavioral science for medicine, to offer clinical experience early, and to give special attention to interpersonal skills. Community hospitals have become more widely used for clinical clerkships, and family practice has emerged as an accepted clinical discipline. A few new medical schools have institutionalized the humanities.

"How can I be a good doctor without first becoming a good person?

Agreed, these are worthy pedagogical demonstrations. But none have sought really to change the fundamental biomedically-based educational paradigm, to acknowledge medical practice's humanistic base. Adding resistance to such a metamorphosis has been the accreditation process.

With few exceptions, medical students continue to be overloaded with facts in the pre-clinical phase. Memorizing facts tends to diminish the nurture of a more fundamental and desirable characteristic: the ability to use the scientific method in problem solving. All too often, the student's clinical years take on the quality of a rite of passage--which continues through residency--characterized in part by pressing the assault on disease through high-technology life-support systems and constantly facing desperate human suffering under near physical and mental exhaustion. Frustration, anger and cynicism all too often become predominant. After medical school, the exorbitant rate of alcoholism drug abuse and suicide among physicians suggests--at least for some--a low level of self-esteem and job satisfaction.

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While the biomedical establishment must remain strong and be jealously nurtured in essentially its present form, it should relinquish its leadership in education for medical practice. Educational experiences should be built around a recognition of the primary humanistic nature of medicine.

What is needed is a modern medical equivalent of the moral philosophy sequence of the 19th-century liberal arts college. Its conduct could be the medical dean's responsibility and could serve as the patient-oriented focus for most learning. With primary interest in the patient's concerns, fundamental cognates might well be philosophy, ethics, fine arts and religious studies. Biomedical sciences would be learned specifically as needed, recognizing that full competence is not expected with the awarding of the professional degree, but is largely acquired in residency training.

As one student said to me a few years ago, "How can I be a good doctor without first becoming a good person?"

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The content of the medical education program would focus heavily around personhood, autonomy, duties and obligations, and wellness, illness and death. Patient-oriented problem-solving exercises would be important, with basic science relevant to medicine to be learned and applied in ways having clinical significance. Development of students' ability to think logically in dealing with ethical dilemmas is essential, and some rigor in assessing this capacity might well be in order.

Without attempting further to be specific about this proposal (since obviously it could take many forms), suffice it to say that it reverses the current priorities in medical education, with the humanistic development of the medical student as the primary purpose of the educational process.

The young physician would be receptive to the notion that continuing patient care might be devoted to assisting patients successfully to live out their own life plans. Recognizing the limitations of the medical contribution to such a goal, the physician would focus on illness (defined here as the individual personalization of disease) rather than upon disease as an end in itself.

Unless extensive exploration of the disease process per se is appropriate for teaching or research purposes, and informed consent obtained and payment mechanisms worked out, diagnosis and treatment would be selected for simplicity, minimization of discomfort, lowest hospital utilization, and least cost. When death begins to loom as an unavoidable part of the life plan, this approaching event would be incorporated into the patient/physician dialogue, and plans for caring developed accordingly.

COMING UP

"Ethical Issues in Medicine" Brown-Bag Lunch Hour Series
Thursdays Noon - 1 PM A-133 Life Sciences

NOVEMBER 13 Is There a Right to Health Care?
Jay Rosen - Office of Health & Medical Affairs
Howard Brody - Family Practice

NOVEMBER 20 Ethical Theory in the Medical Context:
Social Welfare vs. Individual Rights
Martin Benjamin - Philosophy

CASE COMMENTARY:

PLAYING ROULETTE WITH MENINGITIS

A 32-year-old woman was brought to the emergency room by her husband, with suspected meningitis. She was seen first by her obstetrician--who had attended delivery of her child nine days earlier--and then by a physician from the medical practice where the woman worked.

The doctor learned that the couple's two-year-old son had recently had viral meningitis (a mild disease for which there is little treatment and which usually heals through conservative treatment at home). Several other children and adults in their neighborhood had also had viral meningitis recently.

During the interview, the husband expressed anger over the impersonal and unpleasant way his wife had been treated by hospital personnel in labor and delivery the previous week. Especially bitter, he was certain she would have better care at home.

The lab results showed that the woman probably had an incipient viral meningitis, but may have had a bacterial meningitis (a much more serious disease, which must be treated with intravenous antibiotics).

The doctor explained his findings and advised the couple that--even though chances were high that it was viral meningitis--if he or his wife were the patient, he himself would spend two days in the hospital with intravenous antibiotics until a culture could verify the problem.

Feeling "too ill to think clearly," the woman deferred to her husband. He pointed out that the couple had no insurance. Because his wife's recent hospitalization had left a bad impression and since the probability of viral meningitis was very high, he decided to take his wife home, aware of the risks and the doctor's discomfort with the decision.

Who ought to have made the treatment decision?
Was the husband's decision justified?
If the woman herself had made the same decision, would you feel the same way?
What is the hospital's legal responsibility in this case?

Marsha M. Rohrer, MD
Assistant Director - Family Practice Residency Program
E.W. Sparrow Hospital, Lansing

Here, the medical issue needs first to be clarified: it is indeed possible to have inconclusive spinal tap results which could be consistent with either an early *viral* meningitis or an early *bacterial* meningitis. The prognosis for most *viral* meningitides is complete recovery with no treatment other than supportive measures, such as rest and hydration. In contrast, untreated *bacterial* meningitis has a 75-100 percent fatality rate; patients can become critically ill in as little as six to eight hours after the onset of symptoms.

There is, therefore, a critical medical issue in this case, in that the stakes are very high, even though the probability of bacterial meningitis is low. As a physician, I believe that the patient

should be hospitalized for the two-day period until the cultures would be ready. At the very minimum, she should be observed in hospital while preliminary bacteriology studies could be done; a repeat spinal tap in 6 to 8 hours might lead to more definitive information.

The risk of severe illness or death is not to be treated lightly--no matter how slight.

It seems to me that in a case where a decision has the potential (however slight) of causing the death of the patient, the patient herself should make the decision--or at least share in it. I think that if the woman was well enough to clearly defer to her husband, then she was well enough for the physician to include her in the decision-making process. I would not have felt comfortable as the physician with this decision being reached without the patient's understanding of the risks involved and without her consent.

It's difficult really to say if the husband's decision was justified. It's clear that having no insurance, in addition to perceived impersonal and unpleasant treatment in the hospital previously, influenced his decision, which seems reasonable. But I wonder if the possible consequences of his decision were adequately explained to him. The risk of severe illness or death is something not to be treated lightly no matter how slight.

This decision deserves careful consideration and perhaps a search for alternative methods for dealing with the problem (such as use of a different hospital or short-term continued emergency room observation before making a final decision). If the patient herself had made the decision, I would feel better about it; if I believed she was fully informed of the risks, I would be more comfortable about her assuming those risks for herself.

The physician is obligated to inform the patient of the situation, explain the risks involved, recommend a course of action, and then allow the patient to make the decision herself.

George V. Warren
Attorney at Law, Lansing

Unfortunately for the doctors and hospital in this case, the decision whether to sue anyone, to settle out of court, or to litigate any cases through to conclusion, and whether to respect the doctors' and hospital's wishes to settle or not, will be based not on ethics, but on dollars-and-cents reasoning:

Is there a case? Against whom? Can a recovery be obtained? If so, for how much? Can the hospital be sued successfully, although the doctors involved were not members of the house staff (but were--as we call in the law--*independent contractors*)?

There appear to be several causes of action which can be brought against doctors and hospitals:

Battery is the name given to a lawsuit which seeks to recover money (called in the law *damages*) for an unconsented touching of the patient by a doctor. At first glance, it appears that none of the doctors or the hospital could be sued successfully for battery. But recent court cases have expanded the notion of consent--requiring that a patient's consent to accept or not to accept treatment must be freely, knowingly and voluntarily given--with a full explanation by the doctor of all the risks involved if the patient does or does not accept treatment.

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A 1972 U.S. Court of Appeals case* set out the standards for an informed consent case. It states that informed consent should include whatever information an objective reasonable person would expect, rather than the more established subjective notion that the doctor can give whatever information he or she feels the patient needs.

An expert witness could fly in from New York and say, "It's not done that way in our town," then fly away...creating a question for the jury.

It appears, then, that in this particular case, there may not have been full disclosure. Or, if there was full disclosure of all risks that the woman was running by going home, those risks were not fully and clearly explained, thereby obtaining her full consent.

A more common type of lawsuit is *negligence*, which most physicians call medical malpractice. To establish negligence, there must be testimony that the physician failed to follow the standard of care of physicians, and since the doctors involved were specialists, the standard of care applied is that of an internist. The standard applied to the obstetrician would be the standard of obstetrics nationally. Thus, applying a national standard of care, a hired-gun expert witness could fly in from New York or Los Angeles, give testimony that "it's not done that way in our town," fly away and create a question for the jury to resolve--perhaps against the doctors in the suit.

As for the hospital, most courts have been reluctant to affix liability when the actions or omissions are made by non-staff doctors. The notion is that the hospital cannot "control" the physician's conduct, since the doctor is not its employee.

That general rule, however, has begun to break down, with a ruling a number of years ago by the Illinois Supreme Court,** which found a general duty of care owed to a patient being treated in the hospital's emergency room by a "moonlighting independent contractor," by virtue of the state's hospital licensing laws and standards and private standards adopted by the hospital, such as The Standards for Hospital Accreditation.

Michigan has not gone as far as Illinois in finding liability just from the state's licensing laws and standards and private evaluation standards. But when a patient goes to a hospital (without being directed there by a physician), the Michigan contractor's acts and omissions under an "apparent agency" theory. In this particular case, the patient was already in the hospital; so, it appears that the apparent agency theory may prevent the case from being dismissed as soon as it is filed.

Any questions of fact would have to be determined by a jury, and juries don't always act on cold logic (particularly when hearing a case for wrongful death of a young housewife and mother; rest assured, if this turned into a death case, the minor children would be brought to the courtroom and seated in view of the jury during the trial, in order to dramatize the point!).

To summarize: it would be my opinion that colorable*** cases could be made out against the doctors and hospital for battery and/or negligence. Whether there would be a verdict is anybody's guess. But with the costs of litigation so high today ($30,000 is a reasonably likely fee for representing the hospital and the doctors

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as defense counsel), an out-of-court settlement may be made, just to be rid of the litigation. Under many insurance policies, that settlement can be made regardless of the wishes of the client/insured--the doctor or hospital.

If physicians, however, practice medicine with a constant look over their shoulders to see if a process-server is coming from a court, the practice of medicine could come to a screeching halt. I don't advocate that. Instead, doctors should practice good medicine, following their standards of care and in accordance with medical ethics. If mistakes are to be paid--and they are legitimate mistakes--then let insurance take care of paying for them!

(Note: at the time of this writing, the Michigan Supreme Court has under consideration a case as to whether a lawyer who sues a doctor has a duty of care to the doctor/defendant not to file a non-meritorious cause of action. If the court rules for the doctor, it will create a new concept of duty in malpractice litigation which might stop some frivolous cases.)

* *U.S. Court of Appeals for the District of Columbia Circuit, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.1972)*

** *Darling v. Charleston Community Memorial Hospital 33 Ill.2d 326 (1965)*

*** *Colorable: seemingly valid*

Sumer Verma, MD
Professor - MSU Department of Psychiatry

Because we respect individuals, we feel they are entitled to do as they see fit, so long as they do not violate the comparable rights of others. This is the principle of autonomy and--roughly speaking--we believe it is obligatory to leave other people alone unless we have compelling reasons to the contrary.

A related issue, often involved when we override autonomy, is the principle of beneficence. Beneficence holds that we should do good, and part of doing good is limiting other people's freedom in order to achieve what we see as being their own good. The Kantian view would hold that rational human beings are able to consider the consequences of their actions and direct those actions by self-imposed rules. A patient, then, when rational (and this becomes an important exception) is an autonomous being and as such is entitled to control over his or her own body.

In submitting voluntarily to the care of a physician, a patient explicitly or implicitly relinquishes some autonomy. How much autonomy is given up and to what a patient submits is a decision that must be left to the patient. It may be argued it is morally unjustifiable to refuse to accept treatment--that this violates the rights of the physician. But even in this particular situation, it is not legitimate for others (physicians) to force patients to "do their duty."

Forcing any treatment on a patient is a form of assault, and assault is never justified--even if the motive is good. To my mind, there is no convincing argument that allows beneficence to override autonomy when dealing with rational individuals.

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Could or should the physician have overridden this couple? In allowing beneficence to override autonomy, the physician would have behaved in a paternalistic (or parentalistic!) way. Dworkin defines paternalism as "the interference with a person's liberty of action justified by reasons referred exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced." One could justify personal paternalism on the principle of utility, by arguing that the physician can protect the patient from unnecessary suffering. Mill, however, argued that freedom of choice is so important that it can justifiably restricted only when it can be shown that its unregulated choice would cause harm to others. The Kantian view is even more clear-cut--every person is a rational autonomous agent and is entitled to receive information relevant to making decisions--no matter how painful the information is--but ultimately must make the decision.

The woman in this case is said to feel "too ill to think clearly." This does not imply that she was irrational; therefore, she was in a position to accept or refuse treatment. This seems even more justified when one takes into account the medical findings--that she "probably" had an "incipient viral meningitis." The physician had "carefully explained" the findings to the couple and in a sense had stated that he was unsure but would rather play it safe.

Medical knowledge is imperfect at best; under the circumstances, the woman's decision was justified. The physician would not in this case (or for that matter, in others like this) be justified in making a paternalistic intervention.

The problem with these situations is the inevitable "slippery slope:" At what point does an individual lose autonomy? At what point does he or she cease to be rational? We have clearer legal definitions that medical ones. Clearly, a person who is floridly psychotic is not rational; but this is an extreme. What about a person "too ill to think clearly?" The whole issue centers on the doctor/patient relationship. We need to ask not merely "when does a patient give up autonomy," but rather, "how much autonomy must a patient give up and what are the limits of paternalism that legitimately can be exercised by a physician?"

WHEN RESPECT FOR TECHNOLOGY AND RESPECT FOR PATIENT CONFLICT

In medical decision making, a conflict often exists between the scientifically-driven disease-oriented imperative and an orientation toward the best interests of the individual patient.

When these two approaches conflict, what are the ethical and moral issues, implications for resource allocation and cost containment, and legal implications?

During the November 20 annual meeting of the Michigan State Medical Society in Dearborn, the MSU Medical Humanities Program will present a session addressing that issue, with illustrative work-ups comparing the two paradigms.

A plenary session describing the cases and implications will be followed by small group discussions and a concluding session focusing on practical implications for physicians and the significance for policy making.

Staff Changes and Honors

Medical Humanities Program Coordinator Andrew D. Hunt has been elected president-elect of the Society for Health and Human Values, the national organization encompassing humanities in medical education and practice.

Howard Brody and Bruce Miller have been appointed assistant coordinators of the Medical Humanities Program. Martin Benjamin has returned full time to the Department of Philosophy, although--like others on the MSU faculty--he continues to contribute time and expertise.

Miller is appointed half time each in philosophy and medical humanities. Brody joined the faculty this summer, with appointments as assistant coordinator of the Medical Humanities Program and assistant professor in the departments of Family Practice and Philosophy.

Brody opened this year's series of Medical Humanities evening seminars in mid-October with "Placebo: The Lie That Cures," a session during which he described the history and changing views about the ethics of placebo use. He discussed arguments that have been put forth about when it may be ethically proper for a physician to give a patient a placebo as part of medical therapy. He also described situations in which a physician might elicit the placebo effect and its benefits without actually using a placebo, thereby avoiding morally-questionable deception.

Also new on the staff are Graduate Assistants Martha Salyers and Cheryl Farmer, two College of Human Medicine students who share the duties of coordinating off-campus case conferences. Secretary JoAnn Wittick has recently taken a position with the College of Education.

COMMENTS?

This newsletter is published Fall, Winter and Spring terms by the MSU Medical Humanities Program. Coordinator is Andrew D. Hunt, MD. Editor is Linda Christensen. Send letters in response to the case commentary and other comments to: Medical Humanities Program, A-110 East Fee Hall, Michigan State University, East Lansing, MI 48824.

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