Medical Humanities Program **Michigan State University** **Spring 1981**

MEDICAL HUMANITIES PROGRAM WINS NEH GRANT

The Medical Humanities Program has won a three year National Endowment for the Humanities (NEH) grant to introduce medical ethics into the curricula of the Colleges of Human Medicine, Osteopathic Medicine and Nursing. The period of the grant is from September 1981 to September 1984. Termed "Medical Ethics in the Core Curricula," the project aims to pursue a truly integrative approach.

Over the period of the grant, portions of the existing curricula in which ethical issue naturally arise will be identified. Ethics curricula which are part and parcel of the practices of medicine and nursing will then be developed and put in place. These curricula will become permanent parts of the overall curricula of the three colleges after the grant expires.

Consistent with pursuing ethics in a natural and integrated fashion, faculty from the three colleges will play a pivotal role. Slated to aid and participate in the first year are: Joy Curtis in Nursing, Sumer Verma in Human Medicine, and Gerald Osborn in Osteopathic Medicine. In the subsequent two years additional faculty will be enlisted.

Three half-time ethicists will participate, one to serve each of the colleges. Bruce Miller will fill one of these positions. A search is in progress to fill the remaining two and should be completed in the near future.

Kenneth R Howe, presently with the Medical Humanities Program, will direct the evaluation of the project. The office of Medical Education Research and Development (OMERAD) has expressed interest and a willingness to aid in evaluation, as have certain individuals in the College of Education. Graduate Assistants from each of the three colleges will also be used to aid in this effort.

Andrew Hunt, Coordinator of the Medical Humanities Program, will be directing the project. While Hunt is away next year, "retooling in pediatrics" at Stanford, Howard Brody will be assuming Hunt's duties. Brody, who has appointments in Philosophy and Family Practice in addition to Medical Humanities, will be "switch-hitting" throughout the period of the grant.

As a final note, congratulations should go to Thomas Tomlinson, Ph.D. Tom, formerly with the Medical Humanities Program, did the lion's share of work on the proposal which won the grant.

RESPONSE TO THE HEALTH POLICY CRISIS: THE HEALTH POLICY GROUP

Puzzling questions about health policy are very much on the forefront of social and political concern. The rapidly rising costs of medical care, the problems of allocation of health care resources, the continued environmental threats to health and costly advances in medical technology are all pressing toward a problem of major proportions.

The Medical Humanities Program has formed a Health Policy Group to draw together the interests of MSU faculty from many departments and colleges. On hand for an October organizational meeting were: Andrew Hunt, Bruce Miller and Linda Christensen, all in the Medical Humanities Program; Sidney Katz, Chairman, Department of Community Health Science; Jack Knott, Assistant Professor of Political Science and Jerry Hook, Director, Center for Environmental Toxicology.

It was urged that the group carefully design its programs so as not merely to have an "inquiry orientation," but specifically to have "socially useful" results. It was recommended that programs should address not only policy alternatives, but also the framework for policy implementation (eg. financial incentives, education, legal penalties).

For its first effort in the area, the Medical Humanities Program made a presentation in November at the Michigan State Medical Society Annual Scientific Meeting. The topic was cost containment in the physician/patient relationship.

A further effort was a Spring term Faculty Seminar on Health Policy sponsored by the Medical Humanities Program. MSU faculty from various departments led the sessions. Topics included: What is Health Policy; Health Policy vs. Medical Care; Justice and the Distribution of Medical Care; The Right to Health Care; Cost-effectiveness Analysis and Health Policy.

In the Spring term the Program also sponsored a series of public lectures on health policy issues. The speakers were: Ted Cooper, Vice President, Upjohn and former Secretary of Health; Norman Daniels, Professor of Philosophy at Tufts University and Dan Wikler, from the staff of the Presidents Commission on Ethics in Medicine, on leave from the University of Wisconson, Madison Medical Ethics Program.

MSU TO HOST SEMINAR IN NURSING ETHICS

"Ethics in Nursing: Issues and Inquiry" will be the topic of a prestigious five-week National Endowment for the Humanities seminar hosted by MSU this summer.

Twelve teachers of nursing from across the nation will be accepted for the program, beginning June 29. Directors are Joy Curtis, associate professor of nursing, and Martin Benjamin, professor of philosophy.

Participants will discuss actual cases that raise ethical questions for nurses--situations involving, for example, questions of paternalism, deception, confidentiality, conscientious refusal, and the problems of autonomy and conflicting personal and professional loyalties that arise in institutional hierarchiacal settings.

The seminar will examine basic ethical principles and their justifications, philosophical reasoning and analysis, and the relationships between ethics, law and religion. These elements will be refined through application to case studies involving nurses and clients, nurses and physicians, disagreements among nurses, and responsibility for institutional and public policy.

There will be a brief intensive introduction to ethical issues that raise problems for patients, nurses and physicians, and the public: questions

about the use of life-prolonging medical technology, the nature and justification of informed consent, justice and the allocation of scarce resources, and rights to health care, for example.

One of the texts will be a new book by Benjamin and Curtis, recently released by Oxford Press. Entitled "Ethics in Nursing," the book is the first of its kind; its authors believe it fulfills an increasing need in the nursing profession.

NEW COURSE: LITERATURE AND MEDICINE

A new course was offered Winter term. Open to all students, it should prove to be of particular value to premedical students: English 399--- Literature and Medicine: Disease and Health.

Taught by Donald Rosenberg, professor of English, the 4-credit course included such readings as Thomas Mann's Magic Mountain, The True History of the Elephant Man by Michael Howell and Peter Ford, Richard Selzer's Mortal Lessons, Illness as Metaphor by Susan Sontag, Jonathan Miller's The Body in Question, and a book of 12 short novels including works by Tolstov, Kafka, Porter and McCullers.

The aim of the course is to help students to develop their sensitivity to the needs of the ill, through the imaginative experience of literature. Students work to understand how writers imaginatively represent illness and handicaps, to enter the world experienced by the diseased,and to improve their ability to tolerate the ambiguities of the imaginative truths in literature which are at once literary, medical and human.

AN UNDERGRADUATE THEMATIC IN MEDICAL HUMANITIES?

The potential for developing an undergraduate "thematic"program in medical humanities is being explored. Similar in design and purpose to the already-existing thematics in women's studies and in global studies, such a program would allow premedical students and other interested undergraduates to focus on the medical humanities in addition to their declared undergraduate majors.

Numerous courses pertinent to the medical humanities are already offered by various departments and could comprise the thematic. Among the courses are: English 399: Literature and Medicine: Economics 410: Medical Economics; Philosophy 340: Moral Problems in Medicine; Family & Child Sciences 831: Death, Dying and the Family; History 409: History of Modern Medicine; Anthropology 495: Issues in Medical Anthropology; Urban & Metropolitan Studies 447: Aging in Urban America; Natural Science 325: Biological and Social Aspects of Human Reproduction; Music 471: Music Therapy Techniques.

CASE COMMENTARY:

THE TREATMENT OF CHRONIC PATIENT-INDUCED DISEASE

The patient is a 36 year old white male with advance cirrhosis X 5 years, esophageal and gastric varices, and a drinking habit of more than a fifth of whiskey per day for many years-especially in the past month as he celebrated his recent divorce and re-marriage. He presented in the emergency room in a shocky state for evaluation and treatment of hematemesis of several quarts of bright red blood and some coffee ground material. He denied any other symptoms except weakness and sore stomach from retching. The patient began drinking as a young teen. Both his father and paternal grand father died of cirrhosis. He has had several unkept appointments with the achohol detox unit at SLH. Past medical history includes spenectomy, ulcers X 2 years, hypertension X 15 years, low back pain X 5 years, and 4 previous episodes of upper GI bleeding requiring hospitalization. He has a 25 pack year history of cigarette smoking, is unemployed, and has applied for medicaid and welfare. Current medications include Tagamet, folic acid, Mylanta, Lasix, and Darvocet. He has no known allergies.

On physical exam the patient is a slim pale male, somewhat impatient and agitated. Blood pressure is 120/60, up from 96/48 in the emergency room. Pulse is 128, respiratory rate 22, and temperature 99°F orally. He is slightly diaphoretic, with multiple tattoos on arms and chest, and small spider angiomas on chest and face. No palmar erythema or gynecomastia were noted. Multiple upper body abrasions and scratches were reportedly from riding his motorcycle through the brush. Lung and heart exam were within normal limits, there was no HJR. The liver was palpable and firm, extending 8cm below the RCM in the MCL. No fluid wave was noted in the abdomen. Lab studies revealed HGB 7.1, Hct 23.7, WBC 12,200 with 71% segs, anisocytosis, polychromasia, and target cells. Alkaline phosphatase, SGPT and SGOT were all elevated, and total protein was low. Coagulation studies and electrolytes were within normal limits, except for slightly decreased potassium.

Acute treatment included transfusion with packed red blood cells, IV with $D^5/\#NS$, and nasogastric tube to suction with iced saline irrigation. The patient checked himself out against medical advice on the morning following admission.

1) Do self-destructive patients have a "right"to health care?
2) What principles ought to guide the management of this patient?
3) What are the obligations of physicians, if any, to treatment of patients who will assume no responsibility for self care? What are the obligations of society, if any, to pay for that treatment?
4) What physician attitudes toward life and health tend to sabotage the effective treatment of patients like this one?
5) How can health caregivers minimize their frustrations in dealing with patients of this type?

James Blake Thomas, M.D.
Psychiatrist

This case of a 36 year old white male with chronic alcohol abuse and major medical illness presents a number of complex medical-ethical issues.

The central issue in this case, in my opinion, is the patient's inalienable right to choice and to human dignity. Most of us would see this man as being unreasonable and not acting in his best interest. However, there is nothing in the record to indicate that he has been deprived of his legal adult status; there is no evidence that he has a court-appointed guardian; and, in fact, since there is no psychiatric evaluation, there is no documented evidence that this patient is incapable of acting in his own behalf. Therefore, despite the patient's present decision to sign himself out of the hospital, even in view of life-threatening conditions, and even in the view that this patient has done the same thing in the past, we must understand that he has every right to choose to be discharged. The fact that this is a costly and inefficient use of health care facilities is, and must be, secondary to the patient's right to maintain his own human dignity. Society dictates that each of us must be responsible for our own behavior, but nowhere does it say that it is expected that everybody will behave as I do.

The second issue in this case is, what recourse does the physician have to attempt to provide adequate treatment to such a patient. The physician's training is focused on maintaining life and well-being, and this man's removing himself from the hospital flies in the face of the physician's

committment to providing adequate health care. The distinction between maintaining life versus maintaining human dignity is a major ethical concern to medicine; a concern which has become more apparent in the last two decades and will undoubtedly continue to be a significant issue in our field. In this particular case, the only recourse that the physician has to provide necessary life-saving treatment to the patient would be to either personally file formal committment procedures or to encourage a family member to do so. Under the present Michigan Mental Health Code, persons may be committed to psychiatric care if they are potentially dangerous to themselves or others, or if they are unable to care for themselves. However, in this case, it is highly questionable whether or not the patient would meet the criteria for formal committment, and in my experience, it would be unlikely that he would be committed even if a formal committment were filed. Another alternative which is used in psychiatry is a formal voluntary admission, in which the patient signs a form indicating that he will stay in the hospital until such a time that he formally declares his intent to leave the hospital, and that once he has so declared, he must remain in the hospital for an additional 72 hours. Whether or not this same procedure is feasible in a medical unit, I do not know.

Another issue in this case is the patient signing out AMA, against medical advice. This is a procedure that is often used, but very rarely is it used appropriately. In a legal sense, in order for a physician to discharge a patient against medical advice, a number of things must occur. The physician must explain to the patient, either in person or by telephone with a witness or another line, the medical condition which requires continued hospitalization, and must explain this condition in a manner that is intelligible to the patient. As part of the description, it must also be explained what the appropriate treatment is, and what the potential outcomes are with treatment and without treatment. Once this explanation has been given and the patient has indicated that he or she understands it, the patient still has the right to request discharge. At this time, the physician then may discharge the patient formally with the notation "against medical advice." However, in most cases, and very probably in the case presented at the conference today, the patient demanded to leave the hospital and an order was apparently written "discharge the patient AMA." In fact, the patient was probably not discharged AMA.

In summary, this case appears quite straightforward. The medical facts are obvious. It would seem also quite obvious that the patient is an unreasonable man who is acting in a self-destructive way. It is equally apparent that this person presently, in the past, and probably in the future, will present a burden to the health care system directly, and to society in that he is being supported with Medicaid and Welfare. But finally, it is equally obvious that this man has every right to make choices for himself, even though they are choices that we would not make for ourselves, and which we might see as being unreasonable choices for anybody. However, as long as our society supports the ethos of every man being equal, then physicians and the health care system will continue to be faced with these difficult and demanding cases, which run counter to our own professional and human instincts.

Bruce M. Reinoehl, M.D.
E.R. Physician
St. Lawrence Hospital Emergency

Patients with chronic self-induced disease and those who are unwilling to accept responsibility for their own well being are fairly common visitors to the Emergency Department. These people are entitled to the same standards of care that apply to any other patient entering our department. All patients are presented with an assessment of their problem(s) and a reasonable and appropriate mode of treatment. It is entirely the patient's choice whether or not he or she will accept this plan, or continue to the conclusion of treatment via the pathways outlined. If the patient chooses not to follow instructions, that is his or her decision and it should be respected. At this point, the physician has concluded his obligation to the patient. The physician in private practice has the option of terminating his relationship with a patient and can request that they find another doctor. In the Emergency Department, we are obligated to evaluate anyone who requests care.

One major problem faced in dealing with the patient with chronic self-induced disease is the tendency on the part of the physician to attribute symptoms to the patient's chronic condition without an adequate evaluation of the patient. In the patient described in the case above, his condition can be easily diagnosed without complicated means. Let us assume that this patient has a less serious and less easily diagnosed condition such as chronic esophageal reflux. Let us also assume that this patient frequently presents to the Emergency Department complaining of chest pain secondary to his chronic problem. Under these circumstances it would be easy to overlook such serious conditions as Myocardial Infarction, or Pulmonary Embolus by blaming his symptoms on his chronic disease process.

Willing or not, Society will continue to provide health care for this type of patient. This can be in the form of tax supported payments such as the Medicaid program or by having our own hospital bills increased to cover hospital bad debts. Our Western Culture is not able to deny a certain segment of the population access to our health care delivery system.

HUNT"S CALL FOR FUNDAMENTAL CHANGE DRAWS RESPONSE

The following is a response by Arnold Werner, M.D., Professor, Department of Psychiatry, to comments by Andrew Hunt which appeared in the Fall 1980 eddition of this Newsletter.

Change is inherent in medical education, an institution that reflects society's knowledge and values. Whereas change is necessary for continued growth, it should be forward looking and evolutionary, not a wistful recreation of a flawed past disguised as fundamental change. Dr. Hunt's basic concern is that physicians should care for their patients as fellow humans who have needs and values that are not addressed soley by the biotechnical dimension of medical practice. All of us--we are after all, patients at times--would agree with this. I part company with Hunt when he outlines his suggestions for accomplishing this goal.

The educated 19th century gentlemen (they were nearly all men) were not so charming. Under their often religiously motivated inspiration there was a growth in bioscientific reductionism, moral selfrighteousness, and imperialism as well as the oppression and conversion of "heathens", and nasty authoritarianism. In other words, some of the worst aspects of 20th century medicine were begun by those educated in the 19th century, suggesting that there are important variables other than what people are taught.

The distrust of the "biomedical establishment" in Hunt's suggestions misses the point. Science and technology are not the problem alone and stereotyping scientists, subtley or otherwise, creates an antiscience attitude that magnifies the problem. Nor is the problem the control of education. The problem is biomedical science's failure to broaden its interests to include heretofore unexamined aspects of human behavior, which is nowhere more apparent than in clinical medicine.

This leads to the role of the dean. Today, the dean is the most compromised person in the medical education system save for his internuncial assistant deans and his department chairmen. Torn by financial worries, answering to community, university, and legislative demands, particularly at public institutions, the dean is no longer the inspirational teacher of times past. That past era may have been better in many ways but it is no longer reality. Separation of the dean from the admissions process has even been necessary to maintain some purity in this age of the perpetual conflict of interest. What then should the role of the dean be? The contemporary dean should be a masterful facilitator, realizing that one cannot accomplish ambitious goals by oneself. The dean must be a positive force, not one who is constantly critical. Faculty cooperation is the only means to produce a curriculum that reflects our professed values. Therefore, the dean must create an atmosphere in which faculty find rewards in working together and reducing conflict. The dean should identify important goals to be achieved by faculty and students and help insure that the qualities students bring to medical school are not diminished by the educational process. The dean must not adopt the role of Czar of Righteousness, Values and the True Word.

In my years on medical school committees I have been struck by how often basic scientists raise concerns about the values, ethics, responsibilities and actions of clinical year medical students. As well, clinicians often raise concerns about matters assumed to be in the province of the scientist. Both express humanistic concerns.

My final point of disagreement concerns becoming a "good person." If only it was as easy as taking courses in ethics and the humanities! My career has been concerned with behavior and changing behavior; it is not as easy as Hunt suggested. If we select students for something other than smartness--and we should--it must be for goodness, a quality that is independent of sex, religion, color or college major and formed long before medical school. Yet, goodness alone will not suffice. In our desire to bring attention to missing elements in the development of the medical student we risk shifting the emphasis toward understanding personal dimensions of oneself and one's patient at the expense of a scientific knowledge base.

The shift away from broad liberal arts requirements for all undergraduate students is deplorable but cannot be remedied by medical schools (except by admissions requirements and other pressures on undergraduate schools). In this regard, medical school is structured by society's desires. Alteration of society using the medical school as the main instrument is doomed to failure. Worse yet, the medical school will lose direction, diminish its quality, and confuse its purpose.

The fundamental changes advocated by Hunt would produce a new elite quite willing to impose its values on others, for if you know you are a "good person" you can do anything.

MEDICAL HUMANITIES PROGRAM REFLECTS ON PAST AND CONSIDERS FUTURE

On May 13 the Medical Humanities Program sponsored a retreat. All members of the Program staff were present. The staff presently includes: Andrew Hunt, Bruce Miller, Howard Brody, Kenneth Howe, Cheryl Farmer, Martha Saylers and Rose Goldner. Associates of the Program from around the University who attended were: Etta Abrahams, American Thought and Language, Undergraduate University Student Affairs: Daniel Bronstein, Resource Development, Psychiatry; Joy Curtis, Nursing; Bishop Pipes, Humanities; Donald Rosenburg, English; Teresa Tavormina, English; Peter Vinten-Yohansen, History; and Lewis Zerby, Philosophy. Ronald Means, Executive Director, Michigan Council for the Humanities, and Jack Paget, Chairman, Department of Philosophy, Albion College were also in attendance.

Coordinator Hunt and Assistant coordinators Miller and Brody reviewed past and present activities of the Program. Topics included in their review were: Medical ethics activities such as hospital case conferences; the relationship of the Medical Humanities Program to undergraduate education; the Medical Humanities directed Health Policies Seminars and Lecture Series; community outreach activities; and a progress report and overview of the NEH grant combined with a review of the NEH pilot grant project which preceded.

The subsequent discussion indicated that all is well with ongoing activities, and they should be continued. This includes continuing to explore the possibility of a thematic or some other formalized approach to undergraduate education. New activities which were suggested and approved were increased efforts to obtain research grants and expanded outreach efforts. It was suggested the latter might be accomplished by soliciting interested agencies to fund a conference directed by the Medical Humanities Program. Such a conference would include physicians and persons in the humanities to be invited in pairs from outlying communities.

COMMENTS?

This newsletter is published Fall, Winter and Spring terms by the MSU Medical Humanities Program. Coordinator is Andrew D. Hunt, M.D. assistant coordinators are Howard Brody, Ph.D.,M.D. and Bruce Miller, Ph.D. Editor is Kenneth R. Howe. 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 48823. Ph. (517) 355-7550

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