



Medical Humanities Program

Michigan State University

Fall 1981

UPDATE ON
MEDICAL
HUMANITIES
NEH GRANT

With all staff appointments filled, the Medical Humanities Program is well into its schedule of proposed activities under the three year grant awarded by the National Endowment for the Humanities to integrate medical ethics into the core curricula of the Colleges of Human Medicine, Osteopathic Medicine, and Nursing.

As mentioned in the last newsletter, Howard Brody, M.D., is serving as acting director of the project this year while Andrew Hunt, M.D., is away at Stanford. Bruce Miller, Ph.D., Assistant Coordinator of Medical Humanities, is serving as the ethicist working with the College of Human Medicine, and Tom Tomlinson, Ph.D., has been newly appointed to serve as the ethicist working with the colleges of Osteopathic Medicine and Nursing. In charge of evaluation of the project is Ken Howe, M.A., also with the Medical Humanities Program.

This fall, as one of the first steps in the grant process, Miller and Tomlinson have been coordinating a survey of the curricula of the three colleges in order to identify those courses in the existing curricula which deal with clinical decision making and which will most readily accept inclusion of the ethical dimensions of medical and

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UPDATE, CONT.

Heavy emphasis is being placed on evaluation. In coordination with the medical ethicists, the project evaluation team is responsible for designing and producing instructional materials, researching and testing evaluation methods, and assisting in the training of faculty in the use of the new medical ethics materials.

Some phase or other of each of the grant activities described--curricula survey, course material development, evaluation design, faculty development--will be going on simultaneously. The key word for understanding the timing of grant activity is "gradual." 1981/82 will be devoted largely to surveys of the curricula and tentative development of course and evaluation materials, some of which will be tested in a very small number of selected courses in the Spring of 1982. The lessons learned this year will be applied to a somewhat larger group of courses in a "pilot implementation" to be run during 1982/83, with any remaining selected courses brought into the project in the final year of the grant, 1983/84, when an overall evaluation of the project will be made. Faculty development will proceed at the same measured pace. This gradual introduction of medical ethics into the regular curricula will give all faculty and students the time they need to become thoroughly familiar with the methods, materials, and goals of the project. Faculty and student understanding and cooperation are essential to the success of the project.

CASE
COMMENTARY:
RESOLVING
DISAGREEMENTS
AMONG MEDICAL
CAREGIVERS
IN A LIFE OR
DEATH SETTING

The patient is an 84 year old male who lived independently with his 84 year old wife in their own home and enjoyed apparent good health until about 2 weeks prior to admission when he developed malaise, fever, decreased appetite, and red urine. He had not seen a physician in years, and was reluctant to do so, except at the insistence of a visiting son who was alarmed at his appearance. On admission he was confused, lethargic, feverish, and jaundiced.

Physical exam findings included a temperature of 102.6°F, respiratory rate 24, blood pressure 100/46 lying and 70/40 sitting. Blood pressure was noted to be declining over time. Lab studies demonstrated Hgb 12.9 and Hct 37, WBC count 19,900 with 35% bands, BUN 25 with creatinine 3.1, total serum bilirubin 3.3 (2.3 direct), alkaline phosphatase 675, bacteriuria, trace hemoglobinuria, and metabolic acidosis. Ultrasound study was compatible with extrahepatic biliary obstruction and distended gallbladder.

Tentative diagnosis was septic ascending cholangitis with secondary acute renal failure, and although the patient was at that point a poor surgical risk, surgery was felt to be his only chance. After the peritoneum was entered, the patient went into cardiac arrest. Defibrillation was required 5 times, at which time the heart stabilized but the patient's pupils were noted to be fixed and dilated. The anesthesiologist argued for immediate termination of the cholecystectomy on the basis that the patient now had a zero prognosis for brain recovery. The surgeon opted to complete the procedure, arguing that fixed and dilated pupils were not that reliable a prognostic sign in a septic patient under anesthesia. From this point surgery was completed without further complication. The patient was returned to the ICU unconscious and on a respirator.

Post-op peritoneal dialysis was ordered to correct the patient's acidosis, but the intensive care unit nurse refused to do it on the basis that the patient was already effectively dead and should be allowed to die with dignity; "I wouldn't want that done to my grandfather."

CASE
COMMENTARY
CONT.

- 1) What principals ought to guide the management of this patient?
- 2) How can this disagreement among medical caregivers best be resolved?
- 3) Are there circumstances under which an anesthesiologist or nurse has a right or obligation to refuse to continue a procedure or treatment?
- 4) Is the diagnosis of brain death an urgent one, and if so, why?
- 5) How reliable a prognostic sign is fixed and dilated pupils under various clinical conditions?
- 6) What does the law say about a commitment to continued treatment for a patient once treatment has been begun?

References: Freeman, J.M. & Rogers, M.C., "On Death, Dying, & Decisions," Pediatrics, Vol 66 #4, Oct. 1980.
Sweet, W.H., "Brain Death," NEJM, Vol 299 #7, Aug. 17, 1978.

Howard Brody, M.D.

Family Practice Department and Medical Humanities Program

When a dispute occurred in the operating room over the decision to complete this patient's surgery after he had been resuscitated, one of the residents involved was reported to have said, "What we need is a stat ethics consult." Intrusion of a consultant into the case at that time would hardly have been appropriate, but I can envision a useful role of an "ethics consultant" later the same day when the ICU nurses were balking over the orders to start peritoneal dialysis. I will try to respond to the case in the way such a consultant might have done at the time.

The basic ethical issue is clear if one assumes that indeed this unfortunate man has the very grim prognosis suggested by the very bad neurological symptoms coming in the wake of the renal failure, septic shock, and cardiac arrest. Aggressive medical therapy would be advocated by very few among those now engaged in teaching and writing about medical ethics, unless the family positively demanded a heroic course of action. In Roman Catholic teaching aggressive life support given the almost zero prognosis and the high likelihood of irreversible brain damage would be "extraordinary" or "disproportionate" care and hence not morally obligatory. All of this is true, but the "ethics consultant" would not be appreciated if this was his response to the consult request--any more than the gastroenterologist would have been thanked had his advice consisted of a masterly physiological description of gall bladder contractility. The consultant's job is to find out exactly where the disagreement is and to suggest a manner of resolving it.

There is no evidence that the residents and nursing staff had any disagreement over the basic ethical issues as just described. Instead the dispute seemed to be as follows: The residents were perfectly willing to avoid heroics given the very grim prognosis but were not satisfied among themselves that they had adequately proven that the prognosis was that bad. They felt the need at least to buy some time so they could re-evaluate the patient's condition. The nurses may have been saying something like, "Oh no, here we go again. How many times have we seen this before--the physicians start out saying this is just temporary support until we can make a fully informed decision. Then more data accumulates, the physicians continue to evade the decision, and the nurses are stuck taking care of a moribund body and juggling the communications with the distraught family"

By digging in and registering their dismay at the point when peritoneal dialysis was first ordered, the nurses may have been fighting the right war but the wrong battle. Their problem is to distinguish between two superficially similar but really very different patterns of behavior among the

physicians--first, waiting and collecting more data SO THAT ONE CAN MAKE A BETTER INFORMED ETHICAL DECISION, and second, using the absence of a "totally complete data base" as a rationalization SO THAT ONE CAN EVADE MAKING THE ETHICAL DECISION. What distinguishes #1 from #2 in operational terms is a specific plan to gather the missing data and a specific time at which the patient's condition will be re-evaluated in light of that data so the decision can be made regarding further aggressive support. The nurses could have begun the dialysis but then confronted the residents as to whether they had such a plan to re-evaluate, and the ethics consultant could have supported them in this approach to the case.

*John Strandmark M.D.
Resident in Internal Medicine*

This case presentation affords the opportunity to explore an important problem in intensive care medicine--consensual decision making in the face of rapidly evolving, life-threatening disease. When staff and family are confronted with a patient/loved one who is unstable and close to death, the potential for conflict is ever present. Intense emotional strain and uncertainty pervade. A sense of helplessness is a frequent accompaniment. All set the stage for conflict and create barriers to decision making.

The conflict between physician and nurse detailed in the case presentation indicates a profound problem. Events moved so rapidly with this patient that a consensus, which delineated parameters of care, was never formulated. Decisions were made in an incremental fashion, reflecting the patient's rapidly deteriorating status, rather than as part of an agreed upon plan.

The family's role in arriving at such a consensus is central. While physicians and nurses have legal responsibilities to individual comatose patients, it is the family that must agree to therapeutic interventions. Once a family has set forth their wishes in a consensual fashion, there is rarely disagreement between medical and nursing staff. The challenge then is to facilitate a consensus among family members. The consensus should: 1) provide optimal care for the patient; 2) support the family through and following the time of crisis.

The following model is designed to accomplish these purposes. It contains three discrete elements: 1) a first phase, in which information, including therapeutic options, is gathered and presented to the family; 2) a second phase, in which each family member assesses and expresses his/her preferential course of action; and 3) a third phase, where through communication with each other and the physician, familial consensus is reached.¹

Both physician and nurse function as collectors and assimilators of information, the first step in reaching consensus. In addition to gathering clinical data, staff should query family members to determine a clear picture of the patient's life prior to hospitalization as well as the patient's feelings concerning the application of heroic measures. An important part of this first phase of decision making is the presentation of information in a manner fully understood by the family. Therapeutic options are then presented with the benefit of a context for understanding their implications.

Following this initial phase, primary family members must each evaluate the information and therapeutic alternatives to arrive at a preferential course of action. Little in life prepares family members to assume such awesome responsibility. Physicians can and should ease this burden by sharing their own feelings and recommendations.

Frequently agreement among family members is unanimous and consensus is realized. When disagreement arises, the responsibility for facilitating consensus, the third phase of the process, rests with the physician. With sensitivity and compassion, the physician must explore the roots of individual disagreement. Once the source(s) of disagreement are understood, the physician works to clarify and if necessary to negotiate in an effort to reach consensus.

Three disparate points need mention: 1) Family members should all be aware that the consensus achieved is dynamic and that re-evaluation with the family will be an ongoing process pending changes in the patient's clinical status. 2) Efforts should be made to meet with all primary family members at the same time and at the earliest point possible in the patient's hospitalization and 3) Regarding physicians, one member of the medical staff should assume responsibility for managing interactions with the family.

The sudden intrusion of rapidly evolving critical illness presents a family with profound problems and responsibilities. Physicians, well-versed in treating the patient's disease, frequently are ill-prepared to provide the supportive and facilitative roles the patient's family requires in making decisions. An understanding of the elements of decision making and a willingness to apply them actively with the family may help physicians fulfill these vital roles.

¹Radford KJ. Complex Decision Problems, an Integrated Strategy for Resolution. Reston, Va.: Prentice Hall, 1977.

*Becky S. Mason, RN
Head Nurse, Critical Care Unit
St. Lawrence Hospital*

We in the nursing profession see death as being in direct opposition to our commitment to life and health. We ask many questions, such as, "How far do we go?" or "What does this family want?" or "Was the patient able to express any wants and/or desires prior to surgery?"

The time nurses spend with patients differs greatly from that spent with them by doctors. This difference is the result of a difference in the roles of doctors and nurses. Nurses are often in the position of having to explain doctors' medical care plans to patients and their families. When explanations are given to patients and their families, nurses are aware that these explanations must be in terminology that they can understand. Nurses recognize that under stress--especially when dealing with life and death situations regarding loved ones--people have difficulty making decisions.

Families under stress may hear only part of the medical care plan. This may be due to denial, or it may be due to the families' being unclear as to what is happening. When this happens, the nurse may be able to provide a fuller explanation in terminology more understandable to the family. For example, the physician may say to the son of the patient, "Your father is stable." To the patient's family, this may be interpreted as "Your father is okay and will recover," and both patient and family can wind up assuming that everything is okay. In this situation, the nurse, who probably has spent more time with the patient and family, can explain to them that the doctor's statement only applies to the present time, and is not intended to predict full recovery.

The nurse often finds herself in the middle, between patients (and their families) and the physician. She may be praised or blamed, depending more on how the case evolves than on her actions at the time. For example, she may be seen as (unjustifiably) interjecting her own philosophy of life if she explains to the patient's family that "he may not have the same personality if he recovers," whereas the family may only want the patient to be kept as comfortable as possible in order to give the body a chance to recover on its own. Or she may explain that certain procedures will be done without detailing what this will involve. For example, if a patient's heart stops, the nurse may explain to the family that the medical team will try to get the heart started without explaining how that will be done.

Families and patients are entitled to receive information relevant to making decisions. They are entitled to the truth, no matter how painful it might be for those involved--whether it be the patient, the family, or the staff. Patients and families have values of their own that should be respected.

Medical and nursing staff should collectively review goals and treatment of the patient. The nurse can share input on the goals of the patient and family; patients may not rank their best chance for effective medical treatment above all else.

MEDICAL
HUMANITIES
PROGRAM
DIRECTORS
MEET IN
WASHINGTON

The first meeting of directors of medical humanities programs in U.S. and Canadian medical schools was held in Washington, DC on November 2, 1981 under the auspices of the Society for Health and Human Values. Howard Brody represented the MSU program and Andrew Hunt was present in his capacity as the new president of the SHHV.

The number in attendance was impressive. Some 67 medical humanities programs have been identified, many emphasizing medical ethics only but also with many involving humanities disciplines besides ethics and philosophy.

The formal program emphasized the development of new evaluation methods in medical humanities teaching. Presentations were made of projects under way at Southern Illinois University, University of California-San Francisco, and the National Board of Medical Examiners in evaluating teaching of medical ethics. It seems that significant developments will take place in this arena in the next couple of years, and MSU should be heavily involved, given the strong role of evaluation in our current NEH grant for ethics curriculum development.

There was also an important unofficial agenda, as the meeting was used by a group of faculty as a forum to present their proposal for a new association of medical humanities faculty, to be organized under the umbrella of but distinct from the SHHV. It was argued that the SHHV is currently unable to meet the needs of this group of faculty to develop their own special interests and to meet regularly to "talk shop." Considerable discussion on the pros and cons of this proposal followed. Dr. Hunt appointed a committee, headed by SHHV council member Glen Davidson and including the head of the organizing committee of the new group, Warren T. Reich of Georgetown, to explore the matter further. New developments should be forthcoming in the next few months.

STAFF NEWS
AND
ACTIVITIES

Medical Humanities Program Coordinator Andrew D. Hunt, MD, was installed as President of the Society for Health and Human Values at the Society's November 1 convention in Washington. Howard Brody, MD, Acting Coordinator of Medical Humanities was present for the occasion.

On November 6, Dr. Brody also moderated a panel at a session of the Family Practice Research Day V, held at MSU's University Club. The panel members discussed presentations given at the Friday morning session entitled "Research into Ethics in Family Medicine: The State of the Art."

Dr. Brody also was one of two speakers introducing the session on "Deception in the Teaching Hospital," of the Eighth Conference on Ethics, Humanism and Medicine held in Ann Arbor on November 14.

Bruce Miller, PhD, Assistant Coordinator of the Medical Humanities Program, testified in Los Angeles on September 12 before the President's Commission on Ethics in Medicine. Dr. Miller was invited to testify regarding the Michigan Medical Treatment Decision Act

Dr. Miller also presented a paper on proxy consent at a conference sponsored by the National Institutes of Health in Washington on November 23-24. The conference was titled "Senile Dementia of the Alzheimer's Type and Related Diseases: Ethical and Legal Issues Related to Informed Consent."

Several new faculty members have joined the Medical Humanities staff this year. Tom Tomlinson, PhD, returned to the staff this fall as Assistant Professor. Dr. Tomlinson did much of the work on the successful NEH grant proposal while an instructor with the program in 1979/80. He is an ethicist who will be working mainly with the Colleges of Osteopathic Medicine and Nursing. Also on staff, with 1/6 release time from their own departments, are faculty from each of the colleges of medicine and from nursing. Dr. Sumer Verma, Dept. of Psychiatry, CHM, will be working primarily with Bruce Miller, while Dr. Gerald Osborne, Psychiatry, COM, and Professor Joy Curtis, College of Nursing, will be working with Dr. Tomlinson.

Several new graduate assistants have also joined the Medical Humanities staff. Four will be working on the NEH grant proposal, while two will be working on other areas of the program. Judy Leatherwood-Smith, a student in the College of Nursing, and Elliot Stern, a student in the College of Osteopathic Medicine, are working with Dr. Tomlinson, while Sandra Schwarcz, a student in the College of Human Medicine, is working with Dr. Miller. A fourth graduate assistant, Martha Jones, a student in the College of Education is working with Ken Howe on evaluation of the project. Also new with the program this year is Susan Cope Ekstrom, Philosophy, who is assisting Dr. Miller on a survey of library holdings in medical ethics as well as editing the Medical Humanities Report. Cheryl Farmer, a year 4 student in CHM, continues this year to work with the acting director of the program to set up the medical ethics case conferences.

Dr. Lewis Zerby, Professor of Philosophy, will complete his consultantship with the Medical Humanities Program on December 31. Professor Zerby has been at MSU for thirty-five years. A reception was held on December 3 so Lew's many friends could honor his contributions to MSU.

NEH
ETHICS IN
NURSING
UPDATE

From June 29—July 31, 1981 MSU hosted a 5-week Summer Seminar for Nursing Faculty on the topic of Ethics in Nursing: Issues and Inquiry. The Seminar was funded by the National Endowment for the Humanities and coordinated by Martin Benjamin (Philosophy) and Joy Curtis (Nursing) both of whom are associated with the Medical Humanities Program.

The twelve seminar participants were selected from a total of 43 applicants. They came from as far west as the University of Hawaii and as far east as St. Anselm's College in New Hampshire. Participants stayed in University housing and availed themselves of the many natural and cultural resources of MSU during their free time.

After a brief review of the elements of ethical reasoning, analysis, and theory, the seminar focused on a number of troubling ethical issues in nursing: parentalism; confidentiality; deception; orders not to resuscitate; conflicts between doctors and nurses; and questions of personal responsibility for institutional and public policy— including the ethical justification of strikes by nurses. Examination of these and other issues was lively and illuminating.

Overall, both coordinators and participants regarded the seminar as extremely valuable and productive. Informal reports from a number of participants reveal that at least three papers that had their beginnings in the Seminar are currently being reviewed by professional journals and that some participants are presently teaching and lecturing on ethical issues in nursing.

PUBLICA-
TIONS

Bruce Miller, Ph.D., and Howard Brody, M.D., are the authors of "Informed Consent in Critical and Emergency Care Research," published in the July 1981 issue of Topics in Emergency Medicine.

Miller also is the author of "Autonomy and the Refusal of Life-Saving Treatment," Published in the Hastings Center Report, August 1981, pp. 22-29.

Brody, along with James R. Thompson, M.D., has published an article, "The Maximin Strategy in Modern Obstetrics," in the Journal of Family Practice, 12:6 (1981), pp. 977-986.

Brody has also had an article accepted for publication in The Journal of Medicine and Philosophy. The article is titled, "Brain Death and Personal Identity: A Reply to Green and Wikler."

Brody's brief commentary, entitled "Hope," appeared in the Journal of the A.M.A., Sept. 25, 1981.

COMMENTS?

Send letters in response to the case commentary and other comments to: Medical Humanities Program, A-106 East Fee Hall, Michigan State University, East Lansing, MI 48823. Ph. (517) 355-7550