MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY WINTER 1982

UPDATE ON THE NEH GRANT

INDEXING PROJECT. Judy Leatherwood-Smith, Elliot Stern, and Sandy Schwarcz have been working on a project in which medical cases are being indexed according to various descriptors (such as medical specialty, organ system, disease process). The purpose of the indexing is to enable people to find cases that raise ethical issues and that are identifiable by various patient/case characteristics, thereby facilitating the easier integration of ethical aspects of medical cases into existing medical and nursing curricula. The project is nearly completed. About 700 cards have been written up, with plans to computerize the final list.

EVALUATION. Ken Howe and Martha Jones have continued to work on program evaluation. The primary focus of their work at this point is on developing materials, means of evaluating students, and instructional strategies, as well as continuing to tease out more precise objectives. This is being accomplished chiefly by soliciting the opinions of students and participating faculty (at this point, primarily through CHM Track I Focal Problems), observing instruction, and developing "objective" tests of improvements in students' ethical reasoning abilities. This last aspect of the evaluation program is in embryonic form, since there is little precedent for such an approach in the history of ethics curricula evaluation. Such innovative objective tests serve to judge student improvement while involving minimal time demands on participating faculty. Substantial effort has been put forth in CHM Track I Focal Problems this term (see below). What is being learned from the relatively controlled setting of the Focal Problems will be valuable in other settings into which materials will eventually be integrated. Less ambitious and detailed evaluation activities are ongoing in the Medicine clerkship, COM, and Nursing. In COM and Nursing these activities have concentrated on so-called "front-end analysis", i.e. sizing up the contexts and provisionally designing materials and means of evaluation.

CHM. Drs. Bruce Miller, Assistant Coordinator of the Medical Humanities Program and Howard Brody, Acting Director of the Program have been conducting the Winter 1982 Track I Focal Problems course. The problems have focused on non-medical issues in medical decision making in terminal care cases. Topics covered have included anoxic encephalopathy and the definition of death, law and medicine in the Quinlan case, the concept of death and the permanently comatose, withdrawing treatment from the non-competent, autonomy and the refusal of life saving treatment, euthanasia, resource implications of terminal care decisions, and ethical issues in gerontology.

Spring term, MHP staff will be working with Track II Focal Problems and Neuropathology.

COM. Dr. Tom Tomlinson of Medical Humanities will be working with Dr. John Schneider, Psychology, and the Department of Family Medicine in revising the curriculum for doctor-patient transactions sessions in OST 530.

Spring term Tomlinson will also give lectures on refusal of treatment by the mentally ill (PSC 521) and on ethical issues in the treatment of the elderly (OST 558).

NURSING. Dr. Tomlinson, Joy Curtis, Nursing, and Judy Leatherwood-Smith, graduate assistant in Medical Humanities, started a discussion group Winter term for nursing faculty on issues in nursing ethics. This term the group discussed Sally Gadow's article, "Advocacy: An Ethical Model for Assisting Patients with Treatment Decision." More meetings are planned for Spring term.

Tomlinson has also developed some materials in collaboration with nursing faculty that will appear Spring term in NE 400 and NE 405. The materials for NE 405 deal with paternalistic treatment decisions and with uses of values clarification, while the materials for NE 400 concern suicide prevention.

MEDICAL ETHICS CASE CONFERENCE
St. Lawrence Hospital, January 27, 1982
"Physician Responsibilities to the Patient opting for Home Birth A.M.A."

A 32 year old white married Gravida III Para II presented at the Family Practice Clinic for a routine prenatal visit at 23 weeks gestation. During this visit she told the Resident physician of her desire to have a home delivery under the supervision of an experienced area midwife with a nursing background. The patient's two previous children had been uncomplicated spontaneous vaginal hospital deliveries at term. Her largest baby was 8 lbs. 4 oz. Pertinent labs included blood type A pos, rubella titer greater than 1:16, gonorrhea culture neg, pap smear normal, and UA clear. The Resident discouraged this home birth plan, however, outlining potential risks such as unrecognized abnormal labor patterns, respiratory distress of the infant at birth, and excessive maternal bleeding.

The pregnancy proceeded uneventfully. At 35 weeks gestation the clinical suspicion of twins prompted an ultrasound. This revealed a single fetus in cephalic position with posterior placenta, and confirmed the gestational age. The patient decided to proceed with home delivery against medical advice.

Several weeks later the Resident received a phone call at the hospital from the patient. She had just given birth at home to a large healthy male infant, and the midwife noted a laceration of the birth canal which she felt unqualified to repair. There was no significant vaginal bleeding. Could the Resident please come over and do the repair? The Resident refused.

A discussion ensued between the Resident, the Emergency Room physician, and the Obstetrician on call as to how care might be provided. The E.R. physician argued that a laceration of this nature could not be adequately repaired under E.R. conditions, and that the patient should be admitted to Labor and Delivery for repair in the delivery room. The patient expressed extreme reluctance to be admitted to the hospital. The Obstetrician argued that there was no obligation to provide follow-up care for a patient who had been deliberately non-compliant, and that in fact to provide such care would only encourage future non-compliance. The patient decided to seek care for her laceration elsewhere, where she could be assured that it would be done on an out-patient basis. Repair was successfully accomplished later that evening in the E.R. of a neighboring hospital. At the follow up visit two weeks later, the patient's second degree repair was noted to be healing without complications.

Is there a place for home birth in modern obstetrics? What is the current Michigan law with respect to home delivery? What principles ought to guide the management of patients like this one? What are the responsibilities of a physician to a well-known patient when she becomes "non-compliant?" If disagreements arise between Residents and Attendings over appropriate treatment plans, how can these disagreements best be resolved? Does a physician who hopes to discourage "worrisome non-traditional" patient practices like home birth have a right/obligation to refuse to provide pre- and post-natal care for such patients as this one?

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Burnett, C.A. et al, "Home Delivery and Neonatal Mortality in North Carolina", JAMA, Dec 19, 1980, Vol 244, No 24.
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"It is easy to prove that there are deliveries at home where death of the baby or death of the mother could have been prevented if labor had taken place at a hospital. And it is easy to prove that high-risk patients are worse off at home than at the hospital."[1] This quotation was not taken from Williams Obstetrics, but from the book, Immaculate Deception, and it was not made by the president of AMA, but by the Dutch obstetrician and home birth advocate, Professor G.J. Kloosterman.

Childbirth is not a disease, yet it is associated with an increased risk to health. Once one accepts the fact that risks exist in childbirth, then attempting home births becomes an ethical question. Every child has a right to be born safely-every child. It is not justifiable to play the averages, to take chances, to play the odds with the life of a fetus.

There are articles published that would lead us to believe that home birth is as safe or safer than hospital birth. That is plainly not so. One such article is Home Birth and Neonatal Mortality in North Carolina. This article concluds that home deliveries, by lay-midwives, are as safe as hospital deliveries, that is, they have the same neonatal mortality rate.[2] This conclusion is misleading, because it does not take into account the intended place of delivery. If a labor is not going well at home and then the patient is transferred to the hospital with poor results, statistically the poor results are blamed on the hospital. With regards to transporting a labor patient, this North Carolina study did show 12 neonatal deaths in 177 deliveries occuring en route to the hospital, for a rate of 68/1000.[2]

Another often quoted study exalting the safety of home births is that by Lewis Mehl, M.D. concerning the Marin County, California home birth program. This article, by the way, appears in the NAPSAC publication, Safe Alternatives in Childbirth. In this study, 11.9% of laboring patients had to be transferred to a hospital, the nearest hospital is up to twenty miles from some patients, the transport vehicle is the private car of the attendant, lay-midwives are attending breech births at home, and previous obstetrical complications, such as previous stillbirths, are not enough to exclude one as a home birth candidate.[3]

These practices are far from safe. To quote Sheila Kitzinger, again, from Immaculate Deception, "People often write me from the States about how to have a baby at home. They know I'm very much in favor of home confinements. Because of the lack of a back-up system in America, I advise them about the tremendous risks."[1] (pp.327-328)

The back-up system Sheila Kitzinger is used to is the English Flying Squads, which are specially equipped ambulances complete with IV fluids, blood, an incubator, oxygen, anesthetics, instruments for emergency forceps or Cesarean deliveries, and an obstetrician. These units are stationed at local hospitals and, within minutes, are able to bring a mobile operating room to the birthing mother's door.[1] (pp.327-328)

In spite of such an elaborate back-up system, the neonatal mortality rate for intended home births was 12.7/1000 in National Health Service hospitals.[4] Furthermore, the overall stillbirth rate in

England and Wales, from 1965-1974 had fallen, while the stillbirth rate for homebirths had not.[4] (p.765)

Another English study brings attention to a very disturbing aspect of human nature which I call cutting corners, or taking shortcuts, or deviating from accepted practices, which is much easier to get away with in a home setting. In this study all general practitioners and midwives in the study area were informed, in advance, that a study to evaluate abnormalities in neonatal development would be in progress. They were also informed of which high-risk factors would require a hospital delivery. In spite of this, 39% of mothers with these risk factors were delivered at home. For example, a patient with hypertension was induced at home at 42 weeks, but required an emergency transfer due to a compound presentation, and another with a previous intrauterine fetal death was transferred to a hospital as an emergency in labor at 43 weeks.[5] It would be much safer having such practitioners in a hospital with their peers, other health professionals, and administrators looking over their shoulders.

Very few women have home births; in the United States 1-2%[6], in Michigan in 1976 0.29%[7], in England 50% in the 1950's and less than 4% in 1978[4](p.763). These numbers are small, yet they are harbingers of dissatisfaction with current hospital practices. To a large extent, hospitals have ignored or downgraded the experience of birthing for the family in the name of safety, as if safety and a rewarding experience could not co-exist. Hospitals and those who practice in them can treat patients with respect, love, and care and, at the same time, provide optimal expertise. Humanizing the hospitals, not returning to homebirths, is the answer.

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3. Mehl, L.E.: Statistical Outcomes of Homebirths in the U.S.: Current Status, in Stewart D., Stewart L.(eds): Safe Alternatives in Childbirth. Chapel Hill, N.C., NAPSAC, 1976 pp.74-76.
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5. Cox, C.A., Fox, J.S., et al: Critical Appraisal of Domiciliary Obstetrics and Neonatal Practice. Br Med J 1:84, 1976.
6. Shy, K.K., Frost F., et al: Out-of-hospital Delivery in Washington State. Am. J. Obstet. Gynecol. 137:547,1980.
7. Conklin, M., Simmons, R.: Planned Home Childbirth: Parental Perspectives. Lansing, Michigan, Michigan Department of Public Health, 1979, p.65.

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Birth has polarized America. On the one hand, proponents of modern obstetrics, who view birth as a medical event, enthusiastically employ the latest technology and surgical intervention, believing that this will prevent disaster. On the other hand, advocates of childbirth reform conceive of birth as a normal physiologic and biosocial process, which can be both emotionally enriching and medically safe with minimal medical intervention.

The philosophical rift between adherents to medical orthodoxy and those who are seeking alternatives to the current standard of care has its roots in a fundamental disagreement over the concept of the proper relationship between doctors and their clients. Most physicians and patients foster the traditional doctor-patient relationship in which an active, knowledgeable physician instructs a passive, naive patient, who then either complies with or disobeys the "doctor's orders." I unequivocally reject that model as both outdated and inadequate in today's complex world. Happily, more and more people are taking personal responsibility for their health. They still value the technical expertise and medical knowledge of the medical profession, but refuse to concede to doctors ultimate responsibility for important life decisions.

Couples elect home births for many reasons.[1] Home birth nurtures intra-familial relations based on joint experience. It represents a humanization of birthing in contrast to the trend toward increased medicalization of the birth process. Parents often cite a desire to avoid hospital routines and an underlying mistrust of doctors as factors in deciding to stay home. Of course, home birth is less costly than hospital birth, whereas the emotional and spiritual rewards reaped cannot be quantitated.

But it is safety for both mother and infant that is at the crux of this debate. Dr. Brigitte Jordan, medical anthropologist at Michigan State and author of Birth in Four Cultures, points out that both American health professonals and their clients share a pervasive, unspoken assumption that the principles and practice of modern obstetrics are scientifically grounded.[2] According to her review of the literature, however, examination of the evidence undermines this belief. Statistical analysis, moreover, shows home birth to be as safe as hospital confinement. I will support this assertion by briefly reporting on a well-coordinated homebirthing service, reflecting on a community experiment in home birth, and relating high-lights of the only controlled study comparing home to hospital births ever performed in America.

A home obstetric service now serves Mill Valley, California.[3] They carefully screen and refer all high risk pregnancies. All home birth parents must participate in extensive childbirth education. All homes are specially prepared for births. Non-interventive birth attendants are present throughout labor and delivery. Obstetric devices, drugs, and resuscitation equipment are on hand if needed. Expert consultation and access to hospital facilities are readily available, if required. Analysis of 418 of their births in the mid-1970s revealed a perinatal death rate of 16.28, a neonatal mortality rate of 8.77, with no maternal deaths or preventable deaths. These mortality rates compare favorably to rates for hospital deliveeries.

The Farm is a spiritual community in Tennessee.[4] Their extraordinary record, based on 1200 births over a ten-year period, argues eloquently for conservative obstetrics. 91% of babies were born at home. 98% were delivered spontaneously without the use of drugs or obstetrical devices. 94% of babies were caught by mid-wives. And 99% of mothers breastfed their babies.

Birth outcome statistics were excellent. The perinatal death rate was 13.3 per 1000. The neonatal mortality was 5.8 per 1000, and the maternal death rate was zero.

The only matched population study comparing home to hospital birth was published by Lewis Mehl in 1977.[5] He matched 1046 home to 1046 hospital birth mothers by maternal age, gravity, socioeconomic status, years of education, and risk factors including presentation, multiparity, previous Cesarean section, pre-existing hypertension, and pre-eclampsia.

Mehl found no significant differences in terms of maternal or infant mortality. However, in comparing complications of labor, he saw significantly higher rates of elevated blood pressure and pre-eclampsia during labor in the hospital group, while noting that the home birth group had a higher rate of second stage dystocia. Three times as many of the hospital patients underwent Cesarean section and nine times as many episiotomies were performed in the hospital. The rate of post-partum hemmorage was 300% higher in the hospital group.

The home birth infants fared better than their hospital counterparts. They required less resuscitation and had a far lower incidence of respiratory distress and neonatal infection. Apgars at one and five minutes were higher at home. And whereas the hospital infants suffered from 30 birth injuries, there were no birth injuries sustained at home.

Mehl's study not only underscores the safety of home birth, but points to a need to re-evaluate in-hospital routines which may be contributing to increased maternal and infant morbidity.

To summarize: First, the debate between believers in modern obstetrics and the advocates of home birth can be understood in terms of the philosophical schism which separates them. Secondly, familial, emotional, economic, and medical benefits may be gleaned from childbirth at home. Thirdly, a planned, attended home birth is an alternative that cannot be dismissed because of unacceptable risk to maternal or infant health, at least not on the grounds of current medical evidence. Finally, controlled, prospective studies comparing planned home births to hospital deliveries are urgently needed.

1. Mary Conklin and Ruth Simmons, Planned Home Births: Parental Perspectives (Lansing: Michigan Department of Public Health Monograph Series No.2, 1979)
2. Brigitte Jordan, Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States. (Montreal and St. Albans, VT: Eden Press Women's Publications, 1978), p.68.
3. Milton N. Estes, M.D., "A Home Obstetric Service with Expert Consultation and Back-Up," Birth and the Family Journal 5:3 (Fall 1978), pp. 151-157.
4. Ina May Gaskin, Spiritual Midwifery (Summertown, TN: The Book Publishing Co., 1978)
5. Lewis Mehl, M.D., et al., "Outcome of Elective Home Births: A Series of 1146 Cases," J Reprod Med 19 (1977, 281-90.

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I should like to preface my remarks by noting that while the following remarks state my understanding of the current status of Michigan law, they do not necessarily comport with emergent views of medical practice or with what is good and moral for society or for individual patients. I leave those questions to the doctors and philosophers to decide.

From the stated facts of this case it appears that the duty of the resident physician not to abandon his/her patient was not violated by the conduct of the resident physician. The use by the patient of the services of a midwife constituted a breach of the physician-patient relationship, which was sufficient to immunize the resident physician and the hospital from any liability for refusing to render services to the patient outside the hospital setting.

If the physician had gone to the residence of the patient to deliver the patient's child and/or to assist the midwife in such delivery or in suturing the patient's laceration, there would not have been a violation of the criminal law because the Michigan recognizes the utilization by patients of a midwife's services. It would be a criminal conspiracy for a physician to aid and abet the rendering of health care services by someone not authorized by law to do so; but Michigan law recognizes the services of midwives, and accordingly, physicians can jointly with midwives attend patients. Nevertheless, it is doubtful that the majority of physician witnesses who would be called to give testimony in any case brought by the patient against the resident physician or hospital, would testify that it is part of the doctor's standard of care (either of the locality, if the physician is a general practitioner, or of the medical specialty, if the physician is a specialist) to attend patients in home birthing situations. The medical community sets its own standard of care and the courts will apply that standard of care in jury cases in instructing the jury whether there are sufficient facts to find that a doctor has violated the standard of care in doing or not doing something in attendance of a patient. In this case, it is highly doubtful that probative evidence could be obtained to show that the doctor violated the standard of care in refusing to attend the home birth.

As to the refusal to guarantee the patient that services would only be rendered in the emergency room if the patient came to the hospital, rather than rendering services somewhere else if the patient were admitted as an inpatient at the hospital, the patient has no power under the Michigan law to tell the doctor how to practice medicine or the hospital how to carry out its responsibilities as a community institution. Again, the standard of care for the doctor and the standard of care for

hospital practice in the area would dictate the parameters that can be drawn by the patient in requesting emergency room services. Clearly it is within the standard of care for the doctor and the hospital to reserve the right to admit the patient if the clinical facts are such that a workup needs to be done on the patient in the hospital as an inpatient, other than as an emergency room patient. Indeed, a resident physician may be violating hospital rules and regulations if he/she were to guarantee in a telephone conversation that no inpatient admission would be required and that services would be rendered only on an outpatient basis in the emergency room--such a guarantee cannot be made and if made, could contravene the standard of care for the doctor and the hospital.

Again, in reviewing the problem presented at the case conference, I find no cause for liability of the doctor or of the hospital in what was done, or what was not done, on the facts presented in the case.

STAFF NEWS AND ACTIVITIES

As Acting Project Director for the National Endowment for the Humanities grant to MSU, "Medical Ethics and the Core Curriculum," Howard Brody attended a conference for NEH project directors in Washington, DC on February 11-13. MSU's Medical Humanities Program was one of three medical school programs represented at the meeting. Also present was one nursing educator who has a grant to teach nursing ethics; and humanities programs aimed at professional and technical students in law, business, and engineering schools have also been funded.

Two aspects of the meeting were of particular interest to our program and its activities. First, the degree of interest in medical humanities and medical ethics teaching shown by other project directors engaged in more traditional humanities teaching was very high. It was clear that these humanists regarded activities such as ours as a challenging and intellectually stimulating expansion of the academic role of the humanities. We received several requests to share some of our materials with other humanities teachers.

Second, on comparing the content of our grant proposal with those of other professional schools, it became clear that MSU is breaking important new ground in our plans for including medical ethics into the required curriculum of the Colleges of Human Medicine, Osteopathic Medicine, and Nursing. It is fairly commonplace for humanities professors to teach courses in humanities for professional students, and it is considered rather more innovative and daring for humanities teachers to enter into team teaching arrangements with teachers in the professions. We seem to be the only NEH-funded project, however, to be so bold as to think that we can train professional (clinical) faculty to actually do the lion's share of the humanities teaching, with the humanities teachers participating primarily by doing the curriculum design and the faculty development part of the task. We also seem to be much more advanced in our ideas for course evaluation than almost any other proposal. Hence, even if our grant project succeeds only partially over the next three years, major ground in applied humanities teaching will have been broken.

The major purpose of the meeting was to acquaint project directors with the finer points of accounting and reporting, and to encourage us to make good use of NEH staff as consultants and problem-solvers as we encounter difficulties in our project.

Howard Brody led a panel discussion on "Deception and Integrity in Medicine" at Albion College on February 18, 1982. This was part of a larger conference on integrity and deception sponsored by Albion's Gerald R. Ford Institute of Public Policy. Lead-off speaker was former Congressman and presidential candidate John Anderson, and final speaker of the day was philosopher Hugo Adam Bedau.

Bruce Miller, Ph.D., Assistant Coordinator of the Medical Humanities Program, gave a presentation in Kalamazoo on March 2 to the Bronson Clinical Investigation Unit on "Equitable Selection of Research Volunteers."

Miller also gave a presentation in Grand Rapids on March 11 to the Grand Rapids Women's City Club on "The Ethics of Medical Decisions." The presentation dealt with State Representative David Hollister's proposed legislation regarding medical treatment decision-making for the non-competent.

Miller, Brody, and Martin Benjamin, Ph.D., Philosophy, gave a series of three presentations in Kalamazoo during February and March on medical ethics. The series was sponsored by the Kalamazoo Area Council for Humanities.

Brown Bag Seminars in the History of Medicine, led by Dr. Peter Vinten-Johansen, History, recommenced winter term. The topic was a continuation of the discussion on medical reformism in 19th century America.

LETTER TO INTERESTED PARTIES FROM B. MILLER
SUBJECT: DON'T BELIEVE EVERYTHING YOU READ IN THE PAPERS

Recently the Lansing State Journal ran a story about a father who demanded that physicians continue efforts to resuscitate his son who was unconscious after falling into a swimming pool. The paper said that the boy had "drowned", was "dead", "clinically dead" and "technically dead." The fathers determination brought the boy back to life, so the newspaper indicated. This kind of headline journalism creates wrongheaded views and ignorant expectations in the public.

At a local OB/GYN conference, it was confidently asserted (based on newspaper accounts), that a court gave a $13 million judgment against a physician and/or hospital in a case where a physician did not resuscitate a premature newborn. Yesterday I met a lawyer who represented the hospital. The facts are: the case against the physician was settled out of court for $200,000; the case against the hospital was settled out of court (albeit one day before trial) for $800,000. That was $400,000 to the parents and $400,000 in an annuity for the child. If the child lives to 87 years, the $400,000 will yield $13 million.

Just another reminder that the media does as well for law as it does for medicine. The public may believe everything it reads about either; we professionals should believe neither.

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