

MEDICAL HUMANITIES REPORT

MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY

Spring 1983

DECISION -MAKING IN THE MEDICAL CONTEXT

This issue of the Medical Humanities Report does not have a case conference write-up. What we do have, rather, is three articles touching on the question of decision-making in a medical context. Dr. Martin Benjamin, Professor of Philosophy and Associate Faculty/MHP, has written a review of a book dealing with the general notion of negotiation and, in his review, he applies this specifically to the medical context. This issue of the Report also describes work that Dr. Benjamin will be doing over the course of his Hastings Center Fellowship next year on the problem of conflict, compromise, and integrity in biomedical ethics. Finally, Dr. James Waun has written a commentary on a medical ethics case that appeared in the Winter 1982 Report which involved a patient's opting for home birth against medical advice. Dr. Waun argues that patients will always make their own decisions, and that these decisions will usually be such as to choose safe and self-responsible courses of action. He sees the physician as not only providing technically proficient services, but also as acting as an agent of the patient/family, which, in his words, "involves teaching, problem solving with them, counseling, and, when appropriate, confronting them." We hope that these articles will contribute to an ongoing discussion of this important issue.

Review: *Getting to Yes* by Roger Fisher and William Ury (Penguin, 1983) Martin Benjamin, Ph.D., Department of Philosophy, MSU

Doctors and nurses frequently find themselves embroiled in conflicts with each other as well as with patients, administrators, and others with whom they work. Yet little in their education has prepared them to arrive at negotiated settlements to such conflicts. The authoritarian nature of medical and nursing education and practice is in many ways incompatible with the temperament and skills of the negotiator. As a result mutually acceptable agreements in cases of conflict are less common in the medical context than they could and should be.

Getting to Yes, a short, very readable paperback by Roger Fisher and William Ury, provides a useful introduction to negotiation. The authors are associated with the Harvard Negotiation Project and the tips and methods that they present are based on years of study. Drawing on numerous real-life examples of successful and unsuccessful negotiation, they have identified what they call the method of principled negotiation, which is designed to resolve conflicts on grounds that are fair and independent of the will of each side. As the authors put it: "Principled negotiation shows you how to obtain what you are entitled to and still be decent. It enables you to be fair while protecting you against those who would take advantage of your fairness."

After showing the limitations of the standard strategies of positional bargaining--a form of bargaining wherein each side takes a position, argues for it, and makes concessions to reach a compromise--they offer their method as an alternative. Principled negotiation is characterized by four principles: (1) separating the people from the problem; (2) focusing on interests, not positions; (3) inventing options for mutual gain; and (4) insisting on using objective criteria. The major part of the book consists of explaining and illustrating these principles and their interrelatedness. The examples are practical ones and although few concern the medical context, it will not be difficult for nurses and physicians to apply these principles to their own situations.

Although the methods set out in this book will not resolve most of the deeper problems in biomedical ethics, the majority of disagreements that arise in the medical context do not, I believe, turn on deep conflicts of moral principle. Many of them turn on practical or political considerations, on disputes over "professional turf," on questions of status, or on differing perspectives on a particular decision or outcome. For such problems as these, the method of negotiation set out in this book may lead to well-grounded, occasionally creative resolutions that will respect the personhood and integrity of all concerned. Moreover, even where problems turn on what appear to be irreconcilable conflicts of ethical principle, the method of principled negotiation may be useful in arriving at the best interim position; viz., that tentative and uneasy middle ground which, given irreconcilable moral conflict, assures that each of the opposing parties is accorded equal concern and respect as persons.

Getting to Yes is presently being used as a required text in one introductory ethics course at MSU. It could as well be used in nursing and medical education at all levels--undergraduate, graduate, and continuing education. Individuals will also benefit from reading it on their own. For anyone who is committed to the ethical principle of "respect for persons" will find the method of principled negotiation valuable in her personal as well as her professional life.

Commentary: Physician Responsibilities to the Patient Opting for Home Birth A.M.A.
James E. Waun, M.D., Ludington, MI

Editor's note: In the Winter 1982 Medical Humanities Report, we presented a medical ethics case conference report on a patient opting for home birth against her physician's advice. As background for Dr. Waun's commentary on this case, we are repeating the details of the case.

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?

Some or perhaps all of those involved in the case have reason to believe they were right in what they did. I doubt any have genuine good feelings about their common experience. I believe an appropriate agenda for the physician would be to have there be some shared positives in every physician-patient interaction so that the lingering memory will be at least somewhat pleasant. This agenda can become a goal of the transaction

To begin, I think the physician first and foremost has an obligation to him/herself to practice what he/she knows to be good medicine. A physician who wishes to be more than a doctor has an obligation to the patient/family to be a technically proficient practitioner and to act as an agent of the patient/family. Being an agent involves teaching, problem solving with them, counseling, and, when appropriate, confronting them. In short, a good physician is also a good psychologist.

A physician like I have described might approach the patient desiring a home delivery as follows: He/she could say, "I can see some advantages for you in doing that. I think that there is a very good chance that it can be done safely, and I will do my best to help you figure it out in advance so that if you decide to do it that way it will be more comfortable for you and have less chance of unpleasant problems." At the same time, the physician could emphasize that "It might be better to delay the final decision for a while, however."

Then the following steps could be taken, with, optimally, a week or two interval between each step, if there is the luxury of time:

1. "Homework" for the patient for arranging resources for home delivery:
 - 1) Selection of midwife: Interview for skills, attitude, training, experience, "satisfied customer" references to be contacted.
 - 2) Prepare for possible infant problems:
 - (1) Equipment midwife has to assist baby if problems arise;
 - (2) Interview ambulance/rescue unit for training, equipment, experience in caring for newborn SHOULD problems arise;
 - (3) Ambulance/rescue unit response time? What kind of guarantee in case of coincident call for their services?
 - (4) Interview backup hospital and physician for care, selection of one IF needed for backup, arrangement of those resources.
 - 3) Prepare for possible maternal problems:
 - (1) Evaluate midwife's ability to cope with retained placenta, bleeding, lacerations, etc.
 - (2) Interview ambulance/rescue unit's ability to respond--time, capability of instituting IV infusions, etc.
 - (3) Hospital and physician backup for management of unusual situations. Be sure you have interviewed for satisfactoriness of care and arranged for smooth transfer of care if it is needed.
2. Physician and patient discuss progress in above "homework".
3. Physician could state, "I know you strongly prefer to not have your baby in the hospital--but before you decide for sure, would you like me to go with you to see how and if the hospital system can be modified to make the experience more humane for you and baby?" Then, either the patient alone, or the patient accompanied by the physician, could interview appropriate hospital departments and personnel.
4. The Plan: The physician could have the patient formulate, preferably write out, a plan for her delivery and necessary care.

5. Negotiation: Finally, the physician can inform the patient clearly what part of the program he/she will and will not associate him/herself with. The patient can alter the plan as desired.
6. Patient makes final decision and acts accordingly.

In summary: it is better for the physician to be more than a doctor; patients will always make their own decisions; when encouraged and assisted, patients will usually make their decision to do safe and self-responsible things. Patients often need more information than they have at their finger tips to make rational decisions. It is better for the physician to not inflict his/her own anxiety on the patient who already has a good deal of anxiety of their own clouding their rational decision making system.

(Dr. Waun practices anesthesiology in Ludington, Michigan. His other medical interests include counseling and psychotherapy, hospice and terminal illness care, communications and the art of medicine, and hypnosis. Among his interests outside of medicine are parenting, running, music, hiking, and camping.)

Research at the Hastings Center on Conflict, Compromise, and Integrity in Biomedical Ethics.

We are pleased to announce that Martin Benjamin, Ph.D., Professor of Philosophy and MHP Associate Faculty member, has been awarded a Hastings Center Fellowship for 1983-1984. With the support of the National Endowment for the Humanities, the Hastings Center offers several fellowships each year for scholars in the field of ethics and the life sciences. The fellowships provide stipends for research and study in residence at the Center, and are intended to provide a year of advanced study and research for those who have already made a contribution to the analysis of ethical issues in biology, medicine and the behavioral or social sciences. The fellowship year, at least nine months of which must be spent in residence at the Center, may be spent either on research on a specific project or in the study of an area considered central to the enhancement of the fellow's ability to continue work in ethical issues in biomedicine, or in the behavioral and social sciences.

Professor Benjamin will spend the year on a research project focused on conflict, compromise, and integrity in biomedical ethics. His project is to develop an account of the notion of "integrity-preserving compromise", a notion which he and Professor Joy Curtis discuss in their contribution to a forthcoming anthology edited by Tom Regan and Donald Van De Veer titled Bordercrossing: New Introductory Essays in Biomedical Ethics (Random House, 1984). Benjamin says,

Using a case study as an illustration, we point out that given the complexity of many issues in biomedical ethics and our limited knowledge and understanding, disagreements are often such that each party, if thoughtful, will recognize that the opposing view has something to be said for it. Thus, it is possible that one's own view may be mistaken and that of one's opponent (who is in no way a "moral defective") may be correct. In such circumstances, mutual respect may lead to mutual accommodation and a compromise solution which compromises the integrity of neither party.

In addition to developing this account of integrity-preserving compromise in greater detail, Professor Benjamin intends to explore the value and range of this notion by applying it to other ethical disagreements involving medicine and the life sciences. Thus, in addition to applying this notion to conflicts among individual health care providers and patients, he is interested in the actions of health care teams and of committees such as IRB's and the President's Commission on Ethical Problems in Medicine and Biomedical and Behavioral Research. He is also interested in the possibility of integrity-preserving compromise in such wider arenas as controversies over public policy with regard to the development and implementation of new biomedical technology. Professor Benjamin hopes that his work will thus be able to illuminate various conflicts and, in some cases, to help lead to practical resolutions which respect and preserve the moral integrity of the opposing parties. Finally, on the assumption that integrity-preserving compromise cannot always (or perhaps even often) be reached, he will also analyze and examine the notions of conscientious refusal and resignation in protest as integrity-preserving actions when compromise is unattainable.

Dr. Benjamin plans to publish the results of his work in a series of articles on particular issues and in a book which provides both a general account of this notion of integrity-preserving compromise and a number of fully detailed illustrations, as well as an account of conscientious refusal and the advisability of resignation in protest.

We in the Medical Humanities Program are sure that Martin's year at the Hastings Center will prove fruitful not only for him, but for all of his colleagues as well. We look forward both to the results of his research and to his return next year to Michigan State University.

SURROGATE MOTHER CONTRACTS

By Tom Tomlinson, Medical Humanities Program, MSU

Surrogate mother contracts--in which a woman agrees to be artificially inseminated and surrender custody of the child to its biological father, often for a high fee--is not an altogether new phenomenon. Michigan attorney Noel Keane has been arranging such contracts for over five years, usually quietly and uneventfully. But the recent, now notorious, case which was played out in Lansing and on national television illustrated what can happen when surrogate contracts go bad, and put into sharper focus some of the ethical questions that are present in all such arrangements.

Probably the principle objection of those who want to outlaw surrogate mother contracts has to do with the idea that these contracts involve the "selling" of children, which can only threaten harm to the children who are sold, and create a climate in which human life is cheapened. The most common response to this worry tries to make an analogy between surrogate fathers--those who supply their sperm for artificial insemination by donor (AID) -- and surrogate mothers. As Matt Seiden of the Baltimore Sun asked in an editorial supporting surrogate mother contracts, "Would it be constitutional to allow a man to sell his sperm, but not allow a woman to rent out her womb?"

In other words, since we don't have any serious policy objections against surrogate fathers selling their services, we shouldn't have any qualms about surrogate mothers selling theirs. Outlawing the one but not the other would be inconsistent and unfair.

This analogy is obviously flawed. To put it a bit crudely, what changes hands in surrogate fathering is money and sperm; what changes hands in surrogate mother contracts is money and a baby. This puts the child right in the middle of the transaction, vastly increasing the potential that it may be affected by the disputes and conflicts that can arise in any contractual agreement.

Even if this analogy is rejected, however, those who object to surrogate mother contracts have not made a compelling case if they rely exclusively on the brute fact that money is paid. Presumably, the objection to "selling children" is that this would imply that they were mere property--i.e., not human beings with vital interests that are of moral concern. So if it could be the case that the payment of money would not compromise the concern of the parents and others with the child's welfare, then the payment would not imply that the child is mere property, and payment would be much less morally objectionable. "Selling children" is thus a weak protest against a system of regulated surrogate contracts that does a good job of protecting the interests of the children who are conceived.

What should such regulations require? Here another analogy may be made in support of minimal intervention in surrogate contracts: When a child is conceived within a marriage, we presume that the biological parents are able and willing to look after its welfare, and we grant them the right to do so. The burden of proof is not on them to prove that they are good parents; it's on us to prove that they are not. In surrogate mother contracts, the same presumption should operate--that the biological parents have the natural right to care for their child. All we have to straighten out in regulation is which biological parent shall be granted that right. Any further protection that might be needed for individual children can be handled through the existing child abuse statutes. This is the approach suggested by Noel Keane and adopted by Michigan State Representative Richard Fitzpatrick in the legislation he originally proposed (which is now under revision).

Does this analogy work? It depends on whether the same factors which justify our granting parental rights to married biological parents are also present in surrogate mother arrangements. I think there may be ethically relevant differences.

Parents are normally allowed to make important--even life-or-death--decisions for their children. This is not because of the mere fact of the biological connection, which (I will assume) is morally irrelevant, but because we have good reason to assume that parents feel a degree of love and affection for their child that others do not. We grant parents legal responsibility because we assume that they will be the ones most powerfully motivated to act in the best interests of the child.

But in surrogate mother arrangements, there are good reasons for wondering whether the biological parents will have developed the necessary emotional commitment to the welfare of their child by the time of its birth. For example, there are psychological studies of the development of maternal affection which show that that affection normally begins to develop before the child is born, often from the time the child begins to move. But the surrogate mother will have a powerful reason to try to block this natural development of affection, since she will be anticipating that she will have to give the child up once it is born. This was illustrated by the case in Lansing, where the mother made numerous statements about how she had not allowed herself to develop any "maternal instincts" for the child.

There are also reasons to question whether the biological father will have developed the necessary emotional commitment to the child's welfare by the time it is born. For one thing, he will not usually be intimately present during the pregnancy. He will not be the one laying in bed in the morning, feeling the child kick and move; he will not be the one who takes care during intercourse in the final months; in short, he will not be the one who has experiences and makes decisions that encourage and imply a love for the child that will be born.

Secondly, the biological father's acceptance of the child is conditional, conditional on the terms of the contract being fulfilled. Just like the mother, the father too will have a reason to suppress the development of any strong affection for the child because that is the safest course of action emotionally. Why get himself emotionally entangled with a baby that may not even be his?

I think these are plausible arguments for questioning whether the parents in a surrogate mother arrangement should be assumed to have the psychological capacity for fully exercising any legal responsibility for their child's welfare. None of this implies that they can't have that capacity, only that society has a reason to make sure that they have it.

How much regulation this would require is still an open question for me. If the points just made are on the mark, then at the very least we should require psychological screenings for the father and his wife, and at the most we should stipulate that custody of the child is provisional, and will not be final until follow-up visits by social workers or others have determined that the child is indeed being nurtured by loving and stable parents.

The only way we can know how much screening is required, or even if any screening is required, is by making a patient and sophisticated effort to understand the development of parental love, and by understanding how parental responsibility is more than a technical legal matter.

MEDICAL HISTORY BROWN-BAG SEMINARS

April marked the last Medical History Brown-Bag Seminar program to be led by Professor Peter Vinten-Johansen of the Department of History for the near future. Dr. Vinten-Johansen will be on sabbatical next year; his plans include a one-month trip to Norway to do research on the artist Edvard Munch. The Medical Humanities Program will attempt to carry on the noon seminar program, perhaps expanding its scope beyond history of medicine; but meanwhile we are very grateful for Peter's efforts over the past several years in organizing these seminars and leading the discussions despite his heavy press of duties in the History Department.

ETHICAL ISSUES IN VETERINARY MEDICINE

Interest in animal welfare and ethical issues is growing rapidly in the College of Veterinary Medicine. Since the highly successful revision last fall of the introductory veterinary medicine course to focus on ethical concerns in the profession, many students and faculty have become actively involved in efforts to promote a greater awareness and

understanding of these issues within the College. Faculty from the Medical Humanities Program have been instrumental in these efforts. Drs. Bruce Miller and Tom Tomlinson presented two seminars during winter term on animal rights, once for faculty and graduate students in the Department of Physiology and once for clinical faculty and students in the Veterinary Clinical Center. They also conducted a seminar on animal welfare legislation in Michigan for clinical faculty and students. During spring term, they participated with Dr. Judy Marteniuk of the Department of Large Animal Clinical Sciences in a seminar on animal welfare issues in intensive animal agriculture, and with Drs. Richard Walshaw and Steve Crow of the Department of Small Animal Clinical Sciences in a seminar on live-animal surgery in the professional program.

Veterinary students have formed an ethics interest group, which has sponsored several faculty presentations on ethical case studies. At the suggestion of several faculty members, the College is considering the formation of a committee on the thoughtful use of animals in teaching and research. In the clinical program, Dr. Tomlinson has participated in oncology rounds to comment on ethical issues.

Susan Reardon, administrative assistant and editor for the College of Veterinary Medicine and the College's liaison to the Medical Humanities Program, will present the results of her survey of veterinarians' attitudes on animal welfare and ethical issues at the companion Conferences on the Human-Animal Bond at the Universities of Minnesota and California-Irvine in June. She also is organizing a half-day session on ethical issues in veterinary medicine for the College's Postgraduate Conference for Veterinarians next January.

STAFF NEWS AND ACTIVITIES

Dr. Andrew Hunt was the speaker for an ethical grand rounds at the Mott Children's Hospital at the University of Michigan and participated in an all day seminar in medical ethics at the Newman Center which is affiliated with Schoolcraft College in Livonia. He was also a member of the consultant team to review the National Endowment for the Humanities Medical Ethics Program at the University of Tennessee. Dr. Hunt finished his term as President of the Society for Health and Human Values and is continuing as a member of the Council as Immediate Past President until November 1983. In June, Dr. Hunt will be a co-leader of the American Pediatric Society Tour of China.

Dr. Howard Brody addressed the Maternal-Perinatal Health Conference of the Michigan State Medical Society on "Ethical Issues in the Treatment of Very Low Birth Weight Babies," April 7, 1983. He spoke on moral aspects of the nuclear arms race at a conference on the impact of nuclear war on children and youth, Wayne State University, May 14, 1983; and participated (with Associate Faculty member Dan Bronstein) in a panel discussion of "Occupational Toxicology and Safety in the Research Laboratory," national meeting of the AAS, Detroit, May 27, 1983. He also participated as a discussant in a group exploration of humanities in the medical school curriculum for the Midwest regional meeting of the Society for Health and Human Values in Chicago, May 7, 1983. Dr. Brody was recently named to participate in a task force to study bioethics of the Michigan State Medical Society, and to the editorial board of the new journal, "Bioethics Reporter."

Dr. Bruce Miller presented a lecture, "Medical Decision-Making in a Pluralistic Society: Values in Conflict," on April 22, before the Michigan Hospital Association, in Lansing. He attended a workshop on "Philosophers in the Legislative Process", at the University of Florida, Gainesville, Florida on April 4-6 and presented "Ethical Issues in Aging," at the Consortium of Washington, D.C. Medical Schools on April 14. On February 4, he gave a Presentation on a Panel: "The Patient with Severe Neurologic Insult: Issues Surrounding Decisions to Treat" at the Conference on Advances in Neuro Critical Care Nursing. University of Michigan Hospitals, Ann Arbor, and on February 22, he spoke on "Euthanasia and the Prolongation of Life" at Lawrence University, Appleton, Wisconsin. Dr. Miller published "Autonomy and Proxy Consent" in IRB: A Journal of Human Subjects Research, December 1982. Drs. Miller and Brody published "Contracting the Principles of Medical Ethics: A Critical Review of Robert Veatch's A Theory of Medical Ethics", in the Westminster Review, February 1983.

Dr. Tom Tomlinson was the featured speaker at Lawrence University's Humanities Institute on Biomedical Ethics, held February 15 at Lawrence University, Appleton, Wisconsin. His topic, "Defining the Moment of Death--The Biological Facts and the Moral Dilemmas," was based on his forthcoming paper in the Journal of Medicine and Philosophy -- "The Conservative Use of Brain-Death Criteria: A Critique."

Dr. Martin Benjamin and Joy Curtis have been invited to teach at an NEH funded Summer Institute on Moral Philosophy and Nursing at Tufts University.

COMMENTS?

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