MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY FALL 1984

We are completing work this year on an NEH supported curriculum development project entitled "Ethics in the Core Curriculum". The lead article of this issue of MHR is distilled from the final report on the project. Future issues of MHR will contain more focused discussions of the results and lessons learned.

Ethics in the Core Curriculum Project
Summary and Conclusions

The "Ethics in the Core Curriculum" (ECC) project involved pre-clinical and clinical education in Michigan State's Colleges of Human Medicine, Osteopathic Medicine, and Nursing. Its primary goals were to (1) develop ethics materials for integration into appropriate existing courses in the regular curriculum, (2) prepare clinical faculty to do the lion's share of teaching of these materials, and (3) design measures of ethics content comparable to measures of the "hard" content of courses. The beliefs underlying these goals were that in order for ethics teaching to be effective with health care professions' students, it must prompt them to recognize the pervasiveness of ethical issues in health care, provide appropriate role models, and instill an appreciation of ethics' cognitive dimensions.

Prior to the ECC project, teaching by the Medical Humanities Program (MHP) consisted mainly of hospital conferences and guest lectures confined to the College of Human Medicine. Currently, all students in each college receive some exposure to ethics instruction and several additional teaching formats have been implemented such as clerkship seminars, teaching integrated within existing courses, and separate ethics courses. An unplanned but welcomed spin-off of the ECC implementation was a marked increase in ethics teaching in the College of Veterinary Medicine.

Several kinds of data were used to evaluate the ECC project: formal and informal interviews with faculty, formal and informal observations by the MHP staff, course evaluations, conference evaluations, surveys of faculty and students, and tests of knowledge and skills. Evaluations of individual activities were by and large favorable but include too much variety and detail to be considered here. A general pattern for both students and faculty emerged which indicated increased exposure to the ECC project was associated with increased acceptance and appreciation of ethics teaching. General conclusions were also derived about the strategy of the ECC approach as embodied in its three goals.

(1) Integration. The effectiveness of reliance on integration of ethics teaching into existing courses may be questioned. Experience with separate ethics courses suggests they generate a critical mass of knowledge and skills which may then be reinforced and refined in other contexts. Students who have been required or who have elected to take such courses endorse them and appear better equipped than other students to recognize and deal with ethical issues which arise in less structured contexts. Clinical faculty with first-hand

experience believe separate courses in ethics are needed to provide students with a framework for working through ethical problems.

(2) Clinicians as Ethics Teachers. The amount of responsiblity for ethics teaching that can be turned over to clinical faculty is limited. Although some clinicians are able to teach ethics on their own, the requisite combination of interest, motivation, skill, knowledge, experience, and available time is rare. Substantial faculty development and continued monitoring can produce clinicians who can perform adequately, but a turnkey approach is infeasible. Team teaching that combines ethicists and clinical faculty is likely to be the most effective approach under most conditions. This conclusion is reinforced by the opinions of students and faculty who prefer team teaching by a wide margin.

(3) Measures of Cognitive Performance. Students are less accepting of testing in ethics than in other curricular subjects--they are unaccustomed to ethics as a cognitive pursuit with rigorous standards, and some believe it is inappropriate to test in ethics because there are "no right answers". These attitudes should not be permitted to undermine testing. Foregoing testing when it is indicated (e.g., in a course) increases the likelihood that ethics will lose out to other areas in which students are tested, eliminates a valuable source of information about the effectiveness of instruction, and imparts a hidden message that ethics cannot be evaluated because it is "soft", i.e., because it has no defensible standards. Our experience indicates that resistance to testing (in the form of objective and essay tests) diminishes as students become accustomed to the idea, and as test design and statements of objectives improve.

K. Howe, M.A.

CASE STUDY

Editor's Note: This case study was presented at the 1985 Michigan State Medical Society meeting in Dearborn, Michigan Nov. 15. Commentaries are from the panelists.

The problem is a commonplace one in your general internal medicine practice--a 42 year-old district sales manager wants a brief physical in order to start an exercise program. He is about 10-15 pounds overweight, feels out of shape, and wants to resume jogging and running for moderate distances, an activity he had engaged in a number of years ago until his job schedule began to interfere. Careful history, followed by a focused physical exam, fails to turn up any specific risk factors for cardiac disease. The patient now mentions that some of his acquaintances, prior to starting an exercise program, had been given exercise stress tests; he wonders if you recommend this for him.

Looking solely at medical considerations, you are inclined to advise against the test. You know that for asymptomatic patients in this age group, exercise ECG's have very high false-positive and false-negative rates. A recent editorial has suggested that physicians would do better to warn runners to quickly report any possibly cardiac-related symptoms, than to do stress tests on people with no symptoms and no known risk factors. You personally know of some cases where a false-positive or equivocal exercise test has caused great anxiety for the patient and has unduly interfered with a beneficial exercise program.

On the other hand, you are aware of recent press reports regarding the sudden deaths of famous athletes while running and the amount of public scrutiny that this issue has received. You fear that if you do not order the stress test, and this man subsequently dies of or suffers a myocardial

infarction during exercise, the chances of a lawsuit might be significant. The patient or the family will surely remember that he raised the question of this test and that you refused to order it.

What should you do?

References:

Council on Scientific Affairs. Indications and contraindications for exercise testing. JAMA 246:1015-18, 1981.

Siscovik DS et al. The incidence of primary cardiac arrest during vigorous exercise. N Engl J Med 311:874-77, 1984.

Thompson PD, Mitchell JH. Editorial: Exercise and sudden cardiac death: Protection or provocation? N Engl J Med 311:914-15, 1984.

Commentary #1

This is a good case to discuss the issues around "medical ethics and malpractice" because it is commonplace. It's instructive to investigate the role that "defensive medicine" and fear of legal repercussions may play in the unusual life-or-death case in which life-sustaining treatment is being debated in an intensive care setting; but failure to examine the day-to-day role of defensive thinking in ambulatory practice, as well, would lead to a distorted picture of the overall issue.

In this case, I would argue, the fact that the idea of "lawsuit" flashed through the physician's mind **is** a fact, an understandable one in our current climate; and as such has little ethical significance. What the physician does with that fact is of ethical significance. I think there is at least one negative and one positive scenario.

The negative scenario would be to order the test simply to be "covered just in case." Part of the reason that this is negative is that it is self-exacerbating over time. My understanding, as a non-lawyer, is that all negligence cases hinge at some point on the issue of "standard of care." The medical considerations raised by this internist are good reasons to argue that an exercise ECG in this low-risk individual ought **not** be viewed as within the "standard of care." But if this physician and others like him routinely think defensively, their behavior **will** establish this as the standard of care. Physicians, as a group, would then have only themselves to blame for giving non-optimal care to patients **and** for getting sued when they act sensibly.

The positive scenario would be to use the thought "lawsuit" as a trigger to indicate a need to take extra time with the patient, to explain the pros and cons of the exercise ECG, and to involve the patient more actively in the decision. Most legal advice I've received would hold that the physician who seeks this sort of relationship with the patient is less likely, over time, to be sued. Also, we think the current rash of lawsuits has something to do with a public perception that medicine should be more of an exact science than it is, and that bad outcomes always mean that somebody is to blame. If more of these educational sessions took place routinely, physicians might start to chip away at these unrealistic public expectations (if they indeed exist).

H. Brody, M.D., Ph.D.

Commentary #2

The obvious answer to this case is clearly the correct one. The physician should discuss the matter with the patient and explain that:

(1) A stress test for persons his age is not necessarily an accurate indicator of ability to engage in physical activity;

(2) It is better, in the physician's opinion, for the patient to monitor himself carefully during his exercise and be alert for the known warning signs;

(3) No matter what the results of a stress test might be, it would still be important for the patient to (a) monitor himself, (b) not try to do too much too quickly, and (c) avoid overexertion.

If, after this explaination, the patient decides that he wants to have a stress test, I believe the physician should arrange for it. In either case, the patient should be presented with a list of the warning signs that can appear upon exercise. In the matter of malpractice protection, the best thing that the physician can do is document the conversation in the patient's chart, including the fact that the "warning signs list" was given to the patient. (The truly defensive physician would ask the patient to sign a note indicating that the discussion had been held and the list given to the patient.)

Notice that this solution provides protection against potential malpractice claims and still complies with the ethical mandate of respect for the patient's autonomy and freedom of choice, as well as providing the patient with what the physician believes to be the best medical advice under the circumstances.

D. Bronstein, J.D

Commentary # 3

There are three ways to approach the decision in this case; each one fastens on a particular value, and narrowly follows it to a decision. The three values are: Avoiding a lawsuit, Respecting patient autonomy, and Using available procedures. When any one of these serves as the sole or dominant consideration in medical decision making we have what can be called, respectively, **legalism, moralism,** and **medicalism.**

Legalism is the view that above all else, a physician should do whatever will avoid a lawsuit. The obvious problem is that this ignores, or severely diminishes the importance of, good medical judgment and respecting the patient's values. Further, a physician cannot know enough about the outcome of a procedure and the patient's reaction to it to predict which alternative is least likely to generate a suit.

Moralism is the view that the physician ought to do whatever the patieent wishes because the patient has the right to autonomy. The problem with this approach is that it fails to appreciate the role of knowledge in autonomous decision making. A decision uninformed by relevant information is autonomous in only a minimal sense, i.e. a decision that is freely given - uncoerced. Respecting patient autonomy requires more; it obligates a physician to explain alternatives to the patient, so the patient's decision is the result of deliberation on the alternatives and their (probable) consequences.

Medicalism is a view which follows the technological imperative - if it can be done it ought to be done. The problem with this is that it ignores the question of whether what can be done will be beneficial to the patient and/or will advance the objectives of the patient. In stress ECG tests for asymptomatic patients, a positive result may needlessly worry the patient while a negative result cannot be used to confidently reassure the patient.

What then should be the approach to the decision in this case? The decision should be based on informed participation by the patient. Specifically, he should be made to understand the limits of predicting cardiac arrest and the difficulties associated with false positive and false negative results. Following this the patient should be told how to start his exercise program and report any symptoms. The physician should recommend against the stress test, but if the patient persists, the physician may order the test or refer the patient to another physician.

B. Miller, Ph.D.

David E. Ost, 1984, "The 'Right' Not to Know" Journal of Medicine and Philosophy 9(October 1984): 301-312.

In discussions of the right to informed consent, physicians will often bring up cases of patients who refuse information, offering them as counterexamples to the doctrine of informed consent, which is presumed to mandate maximum decision-making by patients.

The standard view holds refusals of information to be just as much an exercise of the patient's basic right of autonomy as a refusal of treatment might be. Ost argues against this view claiming the right to autonomy doesn't imply any right to refuse relevant information because irrational acts undermine autonomy instead of promoting it. Ost further claims the refusal of relevant information is always irrational, citing two defenses for such a refusal, and arguing both are evidence of irrationality. The patient who would assert that no information could possibly change his goals, values, or intentions is suffering from an obsessive illness. Alternatively, the patient who claims to **know** that the information to be imparted is irrelevant to his choice is asserting a logical impossibility -- that he already knows what he doesn't yet know.

Ost argues that since autonomy is not something that a person can (autonomously) surrender, patients have a duty, not just a right, to receive relevant information. The physician's imposition of this obligation, Ost concludes, should be tempered by humane considerations.

Ost's arguments offer a vigorous challenge to the standard position, which should always be wary of superficial interpretations of the patient's right to autonomy. But troubling questions remain for Ost's view that information refusals are always irrational. Ost doesn't consider, for example, whether it might be rational for a patient to refuse information as part of a larger decision to let the doctor decide what should be done. This might be autonomy **preserving** if the patient knows that the doctor shares the same goals and values, and the patient believes that his own powers of concentration, understanding, and decision-making are handicapped because of his illness.

T. Tomlinson

American College of Physicians Ethics Manual. Annals of Internal Medicine **101:129-37, 263-74, July and August, 1984.**

This two-part position paper outlines the views of an ad hoc committee on a multitude of ethical issues facing the internal medicine specialist. In general, the discussions of each issue are too brief to be very useful for anything other than a summation of the current "majority" view in the ethics literature. However, of great utility is the "suggested reading" section following Part II which includes a very-well-annotated bibliography of 86 articles, three fourths of which have appeared since 1980 in JAMA, New England Journal of Medicine, or Annals of Internal Medicine. Booklet versions of the "manual" are available for $3.25 each from Annals of Internal Medicine, Subscriber Service Division, American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104.

H. Brody

Robert Weir. Selective Nontreatment of Handicapped Newborns. **Oxford University Press, 1984.**

Weir, a professor of religious studies at Oklahoma State University, contributes the first book-length treatment of the "Baby Doe" constellation of issues. The book is a thorough review of the applicable ethical, legal, and pediatric views on the subject but breaks little, if any, new ground. It falls into the "old" school in the sense that the notion of the best interests of the infant remains largely unquestioned as the key moral principle in

deciding nontreatment cases. The "newer" school, just beginning to appear in the literature, challenges either the primacy of "infant's best interests" or, at a more basic level, the very coherence of the notion.
H. Brody

Ralph L. Kenny, "Ethics, Decision Analysis and Public Risk, "Risk Analysis 4 (2): 117-129 (1984).

This article attempts to demonstrate that the concepts of Decision Analysis (DA) are sufficiently broad and value-free to accomodate many different ethical viewpoints. Among the alternatives discussed are utitilarianism, some deontological theories, and Rawlsian, libertarian and egalitarian approaches to ethical decisionmaking.

The article is clear and relatively well-written; however it does not, in our opinion, manage to prove its premise. What it does prove is that the **results** of a DA can be consistenst with any of these ethical systems, not that DA as a **process** is so consistent. The fact still remains that since DA is directed to determining outcomes, not rightness, it is inherently in conflict with a deontological approach to decisionmaking. After all, the fact that all ethical theories might agree that murder is wrong does not demonstrate that the theories are consistent.

Despite this, however, the article can be recommended as a good brief summary of some of the problems encountered in applying ethical theory to public decisionmaking.
H. Brody & D. Bronstein

NOTABLE NOTES

The **Medical Humanities Program** at Michigan State University began quietly in the fall of 1977 with two "team taught" courses involving faculty members from seven departments in the humanities and sciences. Today it has its own bank of offices, a full-time secretary, a modest but growing library and a very temperamental computer. The staff is composed of a coordinator, a half-time assistant, two full-time and two part-time instructors, and three graduate assistants. In addition, it benefits from the work of twenty-six associate faculty members from sixteen departments. The Medical Humanities Program is growing and becoming recognized as a valuable and increasingly appreciated part of the University's commitment to the people of Michigan. It is also a fun place in which to work.

This year we are very pleased to benefit from two new additions to the staff who will be participating in the investigation of the role of the humanities in medical education. **Peter Vinten-Johansen, Ph.D.,** is an assistant professor in the History department at MSU and has a quarter-time appointment to the MHP. Professor Vinten-Johansen will be involved in reexamining the humanities program within the pre-med curriculum, especially the history courses. He is investigating ways to increase the visibility of the History 409 course, (The History of Modern Medicine) within the medical school curriculum. He will also be investigating further the possibilities of adopting at MSU the system whereby the medical school can assure placement to as many students as possible early in their undergraduate careers and then advise and encourage then to incorporate more humanities-oriented courses in their pre-medical curriculum.

Etta Abrahams, Ph.D., is a professor in the American Thought and Language Department and Assistant Director of the Undergraduate University Division which serves as the Dean's office for all entering freshmen and sophomores at MSU. Professor Abrahams will be examining the collection of humanities courses that are designed to augment the required courses of specific majors. She will be looking at the appropriateness of these collections and investigating ways of disseminating the information to the appropriate departments and colleges. In addition, Ms. Abrahams will also explore the

feasibility of developing video "trigger tapes" for discussions with medical students which focus on ethical issues and dilemmas both in medical education and the practice of medicine.

We are pleased and proud that **Dr. Brody,** our acting Coordinator, has been invited to London, England as a Visiting Professor in the section of General Practice as a guest of the Royal Society of Medicine (11/25-12/21). Dr. Brody will present a lecture to the Royal Society regarding patient autonomy and a second lecture on the study of medical ethics. The Royal Society of Medicine publishes the Journal of Medical Ethics. Dr. Brody has also recently completed a manuscript entitled Sickness and Self-Respect.

Other notable notes include the invitation from the **Encyclopedia Britannica** to Professors **Martin Benjamin** (Philosophy and MHP) and **Joy Curtis**(Nursing) to author a new section on Nursing Ethics. Their book Ethics in Nursing has sold over 5,000 copies to date and received very favorable comments in the literature reviews. It is being prepared for its 2nd edition.

The staff of the MHP recently attended the 1984 annual meeting of the **Society For Health and Human Values** in Chicago and was easily the largest contingent from any medical humanities program in attendance. Dr. Brody participated in two presentations at the annual meeting. **Dr. Andrew Hunt** , former Coordinator of the MHP at MSU and currently Assistant Dean for Southeast Georgia and Professor of Pediatrics at Mercer Medical College, received the SHHV annual award for Distinguished Service to the Society in Medical Humanities. Dr. Hunt was the first Coordinator of the Medical Humanities Program at MSU, serving from 1976 to June of this year.

This issue of the **Medical Humanities Report** reflects a new format and, hopefully, improved service to our readers. We publish the Report three times a year during the fall, winter, and spring terms at MSU. Our circulation has recently increased to 2,500 and is sent at no charge to the reader. Each issue will follow the same general guideline, featuring a lead article on the front page, followed by a case study and commentaries. The second half will include a Literature Review section, Notable Notes, Special Announcements, Calendar, and what we hope will be a beneficial section, Questions From Readers. If you have further suggestions or comments to share we encourage your participation in this section and will do our best to continue to improve our effectiveness.

P.J. Reitemeier

*****CALENDAR*****

Nov.	15	Hyatt Regency..... Dearborn, MI	Medical Ethics and Malprictice: Is it Better To be Safe or Right? Dr. Brody, Professors Benjamin, Bronstein, Miller, Verma.
Nov.	24	Sparrow Hospital..... Lansing, MI	Case Conference on Ethical Issues in Cancer Care. Family Practice Rounds. Dr. Brody.
Nov.	28	Pontiac General..... Hospital, Pontiac MI	Workshop on Ethical Issues in Family Practice. Mr. Howe.
Nov.	30	Mich. Catholic Conf..... Ann Arbor, MI	Ethical Reasoning and Ethics Committees. Conference. Prof. Benjamin.
Dec.	18	Butterworth Hospital..... Grand Rapids, Mich.	Workshop-Seminar; Parents' Religious Based Treatment Refusal for Children. Prof. Tomlinson, Benjamin.
Feb.	26	Blodgett Hospital..... Grand Rapids, Mich.	The Rise and Fall of The Baby Doe Regulation. Pediatrics Dept. Professor Miller, Mr. Howe.

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