MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY SPRING 1985

GPEP Report of the AAMC

In the fall of 1984 the Association of American Medical Colleges issued its long awaited report, "The General Professional Education of the Physician" (GPEP). This article briefly describes the report, suggests several problems with its recommendations, and then relates the report to efforts at Michigan State to integrate humanities into health professions education.

The GPEP Report persuasively analyzes the conditions future physicians will face. Because ongoing advances in biomedical knowledge and technology surpass what any person can memorize, the report argues that the present approach to medical education--with its emphasis on memorization and repetition of facts --does not prepare physicians to deal with this reality. Accordingly, the report urges that students be taught skills that permit them to acquire independently new biomedical information as it becomes available and to discard information which is outdated. Furthermore, medical students must master domains of knowledge relatively new to medical education. Physicians must become effective self learners not only to update their biomedical knowledge and awareness of basic science; they also need to understand the socioeconomic and environmental factors which determine individual well-being and illness, as well as how legal and ethical considerations affect the practice of medicine.

Regarding prevailing pedagogical practices, the report decries the absence of agreement on "the common knowledge, skills, values and attitudes" that every physician should acquire to be prepared for graduate medical training. The report criticizes current pre-clinical medical education as often amounting to a collage of specialty minisessions seriously lacking in continuity and coherence. It also criticizes current clinical medical education for its emphasis on training in hospital settings and its consequent failure to prepare physicians for the real world, because relatively few contacts with patients presently result in hospitalization and the proportion of outpatient to inpatient care will increase in the future.

Finally, the report contends that miseducation begins before students enter medical schools. Evidence is provided to show that undergraduate pre-medical students are encouraged to specialize in the natural sciences and avoid instruction in humanities and social sciences; students are led to believe that this emphasis will help ensure medical school admission. GPEP places some of the blame on undergraduate college faculties, but aims the bulk of its criticism at medical school admissions committees.

The report's analyses of the problems confronting medical education are uniformly cogent. Its recommendations, however, are often silent on how to overcome well-known obstacles to effecting change in medical education. The explicit recommendations it does make imply unrealistic institutional revolution rather than reforms of the present system. Three issues are particularly troublesome.

First, the report acknowledges that much of what it recommends has been said before, particularly in the 1932 report of the AAMC Commission on Medical Education. But if nothing has changed in medical education in almost 50 years of reformist concern, what is the likelihood of change now? Furthermore, if contemporary conditions are now so unparalleled, why are the conclusions and recommendations of the GPEP Report unchanged from those of reformers half a century ago?

Second, the report contends, implausibly, that contact with the humanities and social sciences is necessary in order to produce "caring, compassionate, and dedicated" physicians. Yet at no point does the report provide supporting arguments for the inclusion of these areas, detailed recomendations about the kinds of courses premedical students ought to take, or guidance on how to integrate the humanities and social sciences into current medical education.

Third, and the most striking weakness of the GPEP recommendations, is the underestimation of institutional inertia and the radical faculty retraining necessary to rectify the identified problems. Medical schools are not unusual in their unwillingness to reward teaching on a par with research and clinical practice; many universities have similar problems in the nonmedical colleges. Moreover, few teachers in any discipline at any level are comfortable with teaching methods that view students as collaborative inquirers; and the retraining process would be long and costly before medical school faculty could begin to direct active, intellectually independent students.

Radical changes in evaluation methods would also be required to implement the GPEP recommendations. While the report recognizes the need for new evaluation techniques, it underestimates the complex and difficult problem evaluation poses. Unless considerable development efforts are undertaken, it is likely that the evaluation of such things as "attitudes" and "values" will be so "soft" and subjective that faculty will be unwilling to stand behind their evaluations or will so inflate their ratings that evaluation of these goals will be meaningless. As a result, "objective" tests, by design or by default, will probably continue to be the sole means of evaluating students' performance. Another more worrisome possibility is that faculty **will** stand behind their evaluations **without** first carefully developing defensible evaluation instruments and methods. The consequence would be personalistic, biased evaluations.

Despite the significant difficulties just outlined, the GPEP Report recommendations should be taken seriously. The fall 1984 edition of this newsletter reported the successes and limitations of the MHP three-year project, "Ethics in the Core Curriculum," to integrate ethics into health professions education at MSU. This NEH sponsored project's rationale and goals are consistent with the GPEP Report's recommendations.

Ongoing efforts to revise the curriculum at MSU are also consistent with the GPEP recommendations. The College of Human Medicine is currently engaged in the preliminary stages of revamping its curriculum, based on recommendations including but not limited to the GPEP Report. Having just completed the three year NEH Grant, the Medical Humanities Program is in a good position to influence and assist this curriculum revision. A new curriculum that emphasizes active learning and problem solving skills instead of lectures and multiple choice exams should be more congenial to the exploration of humanities topics. Since teaching techniques previously used by the MHP include small-group discussion, case presentation, and short essays for evaluation, we are well prepared for a new curriculum based on the GPEP outline. In the long term, humanities disciplines in addition to medical ethics, particularly the history of medicine, will help provide students with a needed perspective on the evolving conditions of medical practice. Finally, collaboration with the premedical colleges and departments in an effort to offer a humanities course concentration for pre-med students has been undertaken to help avoid the dangers of the "pre-med syndrome." Our 1983 report to pre-med advisors showed not only that such courses already exist, but that the admissions committees of the Colleges of Human Medicine and Osteopathic Medicine are prepared to give serious consideration to any student prepared in the humanities. Further formalization of a humanities oriented pre-med curriculum, together with innovations in medical school admission processes, including early admission, promise further advances in this important area.

Peter Vinten-Johansen, Ph.D., Howard Brody, M.D., Ph.D., Ken Howe, Ph.D.

**** CASE CONFERENCE ****

What Exactly Does "NO CODE" Mean?

Problems for nurses and house staff in interpreting and applying "No Code" and "No Extraordinary Care" orders were the focus of Medicine Grand Rounds at **Ingham Medical Center** on **January 29** and again at a medical ethics conference at **Lansing General Hospital** on **March 27**. Speaking at Ingham Medical Center, **Howard Brody, M.D.** noted that some physicians fear writing "No Code" orders because nursing staff will overgeneralize and withhold other useful care, or effectively "abandon the patient". Responding to those concerns, **Lori Weber, R.N.**, SICU-Ingham and **Sue Burgener, BSN**, CCU-St. Lawrence described problems in physician-nurse communication involving "No Code" decisions and called for both a clear rationale for the decision in the progress notes and clear orders indicating which interventions are to be withdrawn and which continued. Brody commented on the gap between theory and practice in "No Code" situations with very clear guidelines having been published in the literature[1], but a good deal of evidence that they are poorly followed in many hospital settings[2].

At Lansing General Hospital interns **Mary Closser, D.O.** and **Rita Seck, D.O.** pointed out that they were often required to explain the details of a patient's code status to families when they had been given no clear rationale by the attending physician. Staff nurse **Jane Brownfield, R.N.** echoed the concerns expressed by the nurses at Ingham regarding ambiguities in interpreting physician orders relating to a given patient's "No Code" status. All three panelists at LGH agreed that the largest problem was in caring for patients in the end stage of terminal illness when the attending physician refused to discuss the possibility of a "No Code" order with the patient, family or other staff.

At IMC audience discussion highlighted two other areas of concern: 1) the uncertainty of a terminal prognosis; and 2) uncertainty that a patient might change his/her mind later in the course of an illness. One question raised but not fully dealt with is whether any potential legal liability attaches to written "No Code" rationales, and whether a signed consent from a patient or family is desirable or necessary.

LGH Moderator **Tom Tomlinson, Ph.D.**, noted that since "No Code" had become almost a synonym for "No Extraordinary Care", with all the uncertain vagueness which plagues that expression, without some explicit **hospital policies** governing "No Code" decisions, misunderstandings were likely to continue.

1. Miles, et al, "The DNR Order in a Teaching Hospital" Ann Intern Med 96:660, 1982.
2. Younger, et al, "The Do Not Resusciate Orders: JAMA 253:54, 1985.

**** Heart Implants and Human Guinea Pigs ****

The February, 1985 issue of the Hastings Center Report contains many commentaries on the Baby Fae baboon-to-human heart transplant and on the artificial heart program of the Humana Heart Institute. While these commentaries predate the more recent case in Arizona of the temporary use of a non-FDA-licensed artificial heart, many of the conclusions could apply to that case as well.

In general, the commentators (with the exception of a couple who are actually involved in one of these programs) take a very dim view of this "cutting edge" of medical technology, its largely unknown risks and benefits, and the atmosphere of media exposure in which it has been pursued. A typical, if harshly worded, conclusion is that of Richard McCormick, S.J., regarding Baby Fae: "This inadequately reviewed, inappropriately consented to, premature experiment on an impoverished, terminally ill newborn was unjustified."

One frequently heard defense of these procedures is that the patient, in each case, would have died soon without these extraordinary attempts; therefore, the experiment was clearly in the patient-subject's best interests. Unfortunately, this defense is not usually investigated from the opposite point of view--that there is a serious danger that the terminal status of the subject will be used to justify an otherwise unjustifiable experiment. To take the argument to a cynical extreme, one could carry out almost any poorly conceived, risky experiment with inadequate informed consent; the

experimenter simply has to be diligent in seeking out a subject who is already dying.

The ethical problems are further obscured by the media atmosphere created by daily or hourly "progress reports," in sharp contrast to the usual media coverage of medical research when only carefully digested and reviewed findings are released. In sum, the subjects of these experiments are treated more like astronauts on a lunar mission than like the subjects of medical research; and the "hero" role we generally accord to the astronauts is automatically conferred upon these patients because of the risky nature of their experiences. The reluctance to criticize a "hero" thus extends into a reluctance to take a hard, ethical look at the experiment itself.
H. Brody, M.D., Ph.D.

(**Do you disagree?** Medical Humanities Report will publish edited versions of opposing viewpoints in subsequent issues.)

**** LITERATURE REVIEW ****

The Evaluation of Curricula in Medical Ethics in Schools of Medicine, Report to the National Endowment for the Humanities and Josiah Macy Jr. Foundation, 1984, by A. Jameton and A. Jonsen.

The expressed purpose of Jameton's and Jonsen's The Evaluation of Curricula in Medical Ethics in Schools of Medicine is to answer the question: "How should one evaluate a medical ethics program?" (p. 3) The study's method was to develop critical conclusions based on (1) a literature review and (2) interviews of medical school faculty, students, and administrators. The interviewees were from eight medical schools and consisted of 9 medical school deans, 45 interested faculty, 17 faculty engaged in medical ethics teaching who had a background in the humanities, and 7 medical students who had some experience with medical ethics teaching.

The study reaches three general conclusions: that medical ethics teaching in medical schools should promote the "significant aims" of medical education, that it should be integrated with the particular aim of improving clinical judgment, and that examinations are an appropriate means of evaluating student performance. More specific questions that are addressed include: indoctrination, grading, role modelling as a teaching method, the relevance of the general goals of the humanities, attitudinal versus cognitive objectives, and desirable backgrounds for medical ethics teachers.

The authors provide a comprehensive and thoughtful review of the literature, and combine this with enagaging interview data. Numerous verbatim excerpts from the interviews are illuminating by themselves and are used to illustrate various beliefs about medical ethics teaching. The literature review and interviews are effectively combined in a way that should make the study of interest to anyone engaged in medical ethics teaching in medical schools.

These advantages notwithstanding, the study has several shortcomings that compromise its ability to determine evaluation's feasibility and inform expectations about how it will be received. Three problems regarding the collection and use of the interview data are significant. First, the sample is drawn from eight medical schools that are described as follows: "Two of these schools have extensive medical ethics programs, three have some instruction in medical ethics, and two have no curriculum in this subject" (p. 3). The information about the schools is too sketchy to allow the reader to make a reasonable judgment about the prevalence in medical schools generally of the beliefs about medical ethics teaching exhibited in the interview data. Second, when excerpts from the interviews are used to illustrate and support various points, the authors fail to report the prevalence of the views expressed in the excerpts within the data set. This failure precludes judgments about the representativeness of views within the sample itself. Related to this, the data is not linked to the level of medical ethics teaching--extensive, some, or none--at the institutions from which the exemplary excerpts are drawn, and thus it is not possible to determine how (or whether) exposure to medical ethics teaching influences beliefs about it. Third, no experts in the field of educational evaluation are included in the sample. Given the task the authors set for themselves, the input of educational evaluators is indispensable (even if evaluator's views are uninformed and misguided) because educational evaluators will be called upon to work out the nuts and bolts of

evaluation.

In addition to these methodological problems with the interviews, Jameton and Jonsen too heavily emphasize **what** the legitimate aims of medical ethics teaching are at the expense of suggesting **how** one ought to go about operationalizing legitimate aims and determining whether they are achieved. Given this emphasis, individuals seeking guidance in the practical task of evaluating medical ethics teaching in medical schools are unlikely to find Jameton's and Jonsen's study helpful. **Ken Howe, Ph.D.**

The Social Transformation of American Medicine by Paul Starr. (New York: Basic Books, 1982).

Although Paul Starr's book is now several years old and has been widely reviewed, few have discussed the book's suitability for the broad audience encompassed by medical humanities. As an interpretative study of the emergence of professional authority by allopathic physicians, Starr's act will be tough to follow. One can still find minor points on which to quibble, but Starr's major thesis is persuasive: Allopathy was able to extract itself from sectarian competition during the Progressive Era at the turn of the century because it offered specialized, scientific medical care to an urbanized population increasingly willing to trust scientific experts. Once this cultural authority was established, various institutional factors preserved this new-found dominance; the growth of a health-care industry under the profession's auspices consolidated it; and claims to authoritative judgment in medical matters gave the profession unparalleled economic and political influence as well.

Starr's book reflects a sociologist's interest in aggregate institutional change over time. He says little that is new about colonial and nineteenth-century medicine, but he makes available a unified, systematic interpretation of the material. He is at his best in detailing how the profession avoided incorporation at the beginning of the present century; and his mastery of the complexities of the growing health care industry since the mid-1960s is impressive.

But the book has a number of drawbacks for medical humanities. First, there is very little of the human in Starr's account. The profession dominates the book; while more than an abstraction, it is a peculiar experience to read about major transformations in medical authority with few references to concrete historical figures. Certainly, it is refreshing to downplay the heroes. But isn't there a middle way that brings to light the everyday activities of the "typical" physician wrestling with the growing complexity of providing effective medical care in changing circumstances? This omission raises a second set of problems. Starr's book is only a history of the institutional voice of medical doctors; allopaths in the trenches who didn't have the time or the inclination to labor in professional organizations receive no consideration. Nor does osteopathy receive its due in a book that purports to cover American medicine in toto. Nursing is also given little more than an obligatory nod--a mystifying omission, given Starr's interest in pursuing professional autonomy into the twentieth-century hospital.

In short, Starr's book interprets the socio-political perspective of the dominant professional group in American medicine. What he does, he does well. But Starr's story is not the whole story, despite it's comprehensive title.
Peter Vinten-Johansen, Ph.D.

****** SHORTCUTS TO EVALUATING THE EFFECTIVENESS OF ETHICS TEACHING ******

A good deal of effort in our program has been devoted to evaluating the effectiveness of medical ethics teaching. A novel approach has recently been suggested by Betty H. Mawardi, Ph.D., of Case Western, at the Midwest Regional Meeting of the Society for Health and Human Values. She happened to note during evaluation of a medical ethics course that more books and articles on medical ethics disappeared from the library during the course, as compared to books and articles related to other courses that were being taught at the same time. However, after the ethics course was completed, the ethics books and articles reappeared in the library at a higher rate than other missing materials. We leave to our readers a detailed interpretation of the significance of these observations.

**** COMPUTERIZED MEDICAL ETHICS CASE INDEX READY ****

The **Medical Humanities Program at MSU,** with the help of an NEH grant has completed a computerized index of over **800 cases** in medical ethics. Each case is referenced by up to 9 descriptors, and includes original source references.

Virtually any combination of descriptors can be used to locate a case study. Individual searches are available for $2.00 each, and the database itself for $10.00. Call (517) 355-7550 for further information.

**** NOTABLE NOTES ****

The **Medical Humanities Program at MSU** has recently received permission to begin seeking funds for a **one million dollar endowed chair** for the Program. Once this goal is reached we hope the appointee will bring both scholarly and administrative leadership to our staff and associated faculty. Until then, **Howard Brody** will continue as acting coordinator and **Tom Tomlinson** will assume new duties as **MHP assistant acting coordinator** with the primary responsibility of managing the ever increasing administrative tasks.

Ken Howe was named the **Outstanding Doctoral Student for 1985** by the MSU College of Education. His dissertation "Evaluating Medical Ethics Teaching" reflects the multi-discipline nature of his work, one of very few joint degrees in Philosophy and Education. Dr. Howe's publications include "3 Years Experience in a Required Pre-Clinical Ethics Course" in Teaching Philosophy (forthcoming) and "Two Dogmas of Educational Research" in Educational Researcher (forthcoming).

Tom Tomlinson was at **Union College** in Schnectedy, New York in April to deliver a talk on **Defining Death** to the Philosophy Colloquium and also studied their computer-assisted instruction in the humanities program which is currently under development.

Howard Brody delivered the **Keynote address** at the **Society for Health and Human Values** meeting in Cleveland, OH. entitled "Requiring Humanistic Qualities in Health Professionals." Copies of his address are available through the MHP office.

Bruce Miller was a recent commentator on **Advance Directives in Health Care** at the regional meeting of the Society for Health and Human Values in Little Rock, Arkansas.

Martin Benjamin has had two articles published recently: "Lay Obligations and Professional Relations" in the February, 1985 Journal of Medicine & Philosophy and, with **Joy Curtis,** "Virtue and the Practice of Nursing" in Virtue and Medicine edited by Earl E. Shelp, part of The Philosophy and Medicine Series, published by Riedel Publishing, 1985.

Paul J. Reitemeier, MHP Graduate Assistant and editor of MHR, will teach **Moral Problems in Medicine** (Philosophy 340) to nursing students in **Battle Creek, Michigan** fall term, 1985 on a special grant from the **Kellogg Foundation.** This course is part of the Battle Creek Project conducted by the MSU College of Nursing, aimed at providing area nurses the required upper division courses necessary to complete their BSN degrees.

Howard Brody and **Peter Vinten-Johansen** have begun development of a proposed **MSU Summer Session in England** for 1986. Curriculum focus will be the investigation of how the United States and Great Britain construe the **allocation of medical resources** and will include courses in Philosophy and History. Dr. Vinten-Johansen will continue with the MHP staff for 1985-86, and will be assisted in England next summer by **Louise Blackledge,** MHP Graduate Assistant, doing research for the 1986 summer session there.

Martin Benjamin, Peter Vinten-Johansen and **Tom Tomlinson** have been serving as consultants on an NEH Planning Grant for Lansing's **Impression 5 Museum.** They are helping design exhibits designed to portray the social, ethical and historical effects of advances in science and technology.

Etta Abrahams is concluding her year as a member of the MHP staff but will continue working on her two main projects; an accumulation and evaluation of humanities courses at MSU into a **pre-med core curriculum,** and development of **video "trigger-tapes"** of case study presentations focusing on ethical problems in medical care. Dr. Abrahams has provided a valuable dimension to the Medical Humanities Program and her presence will be sorely missed. Thank you Dr. Abrahams! **Paul J. Reitemeier, M.A.**

**** MHP CALENDAR ****

May	23	American Psychiatric Assn. Dallas, Texas	Reproductive Technologies: The Psychiatrist's Role T. Tomlinson
	24	Office of Health and Medical Affairs Law Auditorium Lansing, Michigan	Ethical Issues in Organ Transplants M. Benjamin, B. Miller
	29	St. Lawrence Hospital Lansing, Michigan	Ethical Issues in Primary Care H. Brody, T. Tomlinson
June	3	Medical Ethics Conference Lansing General Hospital	Hospital Policy on Care of the Critically Ill: Needs and Problems T. Tomlinson
	7	Michigan Kidney Foundation Hyatt Regency Dearborn, Michigan	Ethical Issues in the Treatment of Kidney Disease M. Benjamin
	11	Dept. of Pediatrics & Human Development Blodgett Hospital Grand Rapids, Michigan	Joint Decision Making in Pediatric Oncology K. Howe, R. Noll
	11	Medicine Grand Rounds St. Lawrence Hospital Lansing, Michigan	Legal Issues and No Code Orders Dan Bronstein, M. L. Buss
	12	OB-GYN Residency Conference Pontiac, Michigan	Ethical Problems in Decision Making H. Brody
	14	Family Practice Gerontology Workshop Lansing Hilton	The Law and Ethics of Decision Making With the Elderly H. Brody, B. Miller, T. Tomlinson
July	18	New Intern Orientation Lansing General Hospital	Ethical Issues in Medicine T. Tomlinson
August	3	Burns Clinic Petoskey, Michigan	Ethical Issues in Health Care H. Brody
Sept.	11or18	V. A. Hospital Saginaw, Michigan	Ethics and Cost Containment H. Brody
	28or29	Loyola University Chicago, Illinois	Ethics and Cost Containment H. Brody, D. Thomasma

**** CALL FOR PAPERS ****

A special issue of Theoretical Medicine edited by **Tom Tomlinson** will be published in **June, 1986** devoted to the topic of the physician's influence on patient decision making. How should the physician's treatment values fit in with a properly understood notion of the patient's right to autonomy? Should the doctor's role be a laissez-faire one--spreading an "array of vendibles" before patients, as Franz Ingelfinger sarcastically puts it, and then leaving them to their own devices? Or should it be more dialectical, as Jay Katz has argued? For additional information write or call Dr. Tomlinson at the Medical Humanities Program, C-201 East Fee Hall, MSU, East Lansing, Michigan 48824, (517) 355-7550. Deadline for final drafts is **November 1, 1985.**

A second special issue of Theoretical Medicine will be edited by **Howard Brody,** focusing on "The Role of the Family in Medical Decisions". Deadline for final drafts is **November 1, 1986,** for publication in June 1987. For a list of topics and further information contact Dr. Brody at the above address.

MEDICAL HUMANITIES PROGRAM MICHIGAN STATE UNIVERSITY SPRING 1985

VOL 7 NO 3

MEDICAL HUMANITIES STAFF

H. Brody M.D., Ph.D. .....Acting Coordinator
M. Benjamin Ph.D. .....Asst. Coordinator
T. Tomlinson Ph.D. .....Asst. Professor
K. Howe Ph.D. .....Instructor/Evaluator
E. Abrahams Ph.D. .....Professor
P. Vinten-Johansen Ph.D. ...Asst. Professor
P. Reitemeier M.A. .....Editor
R. Goldner .....Secretary
E. Lounds .....Secretary

Published by:
Medical Humanities Program
C-201 East Fee Hall
Michigan State University
East Lansing, MI 48824

Nonprofit Org.
U.S. Postage
Paid
East Lansing
Mich.
Permit No. 21