

MSU'S MEDICAL HUMANITIES THEMATIC PROPOSAL
PART II: THE STATE OF THE CURRENT DISCUSSION

In the winter issue of MHR, I described how MSU's budgetary crisis in 1980-81 squelched a proposed undergraduate medical humanities degree program. Its demise was, in most respects, a blessing. The program had been formulated largely in isolation from, and often with antagonism toward, faculty and staff who had considerably more experience with pre-medical students than the people who had drafted the degree program. Consequently, the formulators were unaware that their elitist, track-oriented approach conflicted with contemporary opinion that mixing with a variety of majors in the arts and sciences was the most effective deterrent to the emergence of "the pre-med syndrome," characterized by grade-grubbing, cheating, anxiety, narrow-mindedness, etc. These qualities were hardly unknown among other majors, but a concentration of pre-meds seems to bring them out in spades. However, the proposed degree program didn't founder on substantive grounds; it was simply too costly to receive serious consideration during a period of retrenchment.

The budgetary crisis of the early 1980s also set the tone for subsequent attempts to devise curricular remedies for a problem long acknowledged by many educators at MSU—that many students admitted to our health professional colleges have inadequate educational backgrounds for their future experiences, particularly clinical situations. Since the degree program was too ambitious, several core faculty in the Medical Humanities Program (MHP) began to tinker with a major in medical humanities. But that also proved overly ambitious since such a major presumed the elevation of MHP to departmental status, extremely unlikely at a time when the central administration was paring old growth and discouraging expensive curricular ventures. So opinion swung behind an informal "thematic," in which undergraduate advisors throughout the campus would encourage pre-professional majors to choose electives from a list of existing courses on subjects that fit, often tightly but sometimes quite loosely, under the general rubric, medical humanities. A special issue of the MHR in 1983 disseminated this list to undergraduate advisors. But the MHP lacked the staff to make individual contacts with the advisors or to shepherd the proposed thematic through the academic governance system.

In the fall of 1984, I was added to the MHP core faculty on a part-time basis to accomplish several long-standing projects, including the undergraduate thematic in medical humanities. The process has been protracted, partly because that's the nature of such things, partly because university guidelines on thematic programs are under review. Nonetheless, we have identified enough interested faculty and staff from a variety of departments, schools, and colleges in the university to provide a tentative description of what a thematic might include when submitted to the university curriculum process.

It seems to us that any person interested in issues in health care delivery or health care policy ideally should have introductory training in (a) a comparative history of healing, (b) medical ethics, (c) multi-cultural perspectives on health and illness, (d) literature and art as media for expression by both patients and healers, (e) social and institutional organizations of health care systems, (f) religious dimensions of health and illness, and (g) economic and public policy issues in health care. The reality, however, is that few students have room in their programs to take

coursework in all these topics and that where there are courses on these issues, some are not offered with sufficient frequency to make them required for completion of a thematic.

Since it is difficult to distinguish among the above topics on substantive grounds, we envisage a distinction between required and elective courses largely determined by their projected availability over the next half decade. Courses required for the thematic would probably be: PHL 340, "Moral Problems in Medicine"; HSI/LBS 409, "History of Modern European and American Medicine"; ANP 356, "Culture, Health and Illness"; and SOC 423, "Sociology of the Health Care System." Three of the four are current offerings, the fourth is under review, and all can be offered at least once per year. Elective courses, totaling at least 14 credits, would probably be drawn from NE 511, "Women and Health in the U.S.": AL 461, "Aging and Human Values": one course from Lyman Briggs' STS offerings, 361 and 373-378; several courses already under formulation ("Literature and Medicine" by English, with cross-listing in Lyman Briggs, and "Religious Dimensions of Medicine" by Religious Studies); a projected course in public policy and allocation of economic resources through James Madison; and, it is hoped, a course on images of health and illness by Art. Eventually, we want to develop an interdisciplinary capstone seminar in medical humanities, team-taught by several instructors also involved in the required/elective courses, an experience that would help students synthesize the perspectives and interpretative skills developed serially and would bring closure to the thematic.

Since pre-medical students constitute a significant portion of the anticipated audience, **the thematic's success will rest heavily on early identification and advising of interested students.** MHP will rely on the experienced advisors of pre-medical students in Lyman Briggs School and the Pre-Professional Advisement Center, both under the College of Natural Science. The Department of Natural Science also offers a number of potential "feeder" courses to the thematic, particularly NS 129, "Biotechnology and Human Values," NS 173H, "Science-Technology and Human Values," and NS 209, "Humans and Disease." We anticipate that most students will learn about the thematic from one of the instructors in these courses, either of whom could send them to the Medical Humanities Program office in East Fee to sign up for the thematic. Medical Humanities will monitor each student's progress and keep the advisors informed of that progress on a term-by-term basis. Medical Humanities would inform the Registrar when students have completed thematic requirements, and a note to that effect will be added to their transcripts.

Obviously, we are still in the formative stages in developing a viable medical humanities thematic at MSU. There is still time now for interested persons to identify themselves for possible involvement, but by the beginning of the 1986 Fall term, we need to prepare the materials, including descriptions of new course requests, for submission to the appropriate curriculum committees. The sooner you send me your ideas, the easier it will be for me to consider them for incorporation. Although now is the time to begin institutionalizing a medical humanities thematic, I ask for your assistance in keeping our fundamental purpose at the forefront, regardless of the institutional form that it is hoped will emerge from this process -- to send reflective, rather than reflex, thinkers for subsequent training in the health care professions. **Peter Vinten-Johansen Ph.D., MHP, History**

*** CASE STUDY ***

Full Code, No Code or "Limited" Code?

Mr. J. N. is a 79 y.o. married, white male with severe COPD, dependent on home oxygen who was admitted to the CCU for evaluation of acute onset of chest pain and dyspnea. He is a retired police captain and a proud man whose illness causes him great frustration and anger. He abhors the dependency and disability which it creates for him. Though MI was not apparent from laboratory and ECG analysis, his condition was quite fragile and it was clear he could decompensate at any time. During rounds on the first morning after his admission, the attending physician, resident and medical student discussed code status with the patient. He stated that he did not want to be intubated because he did not want to be maintained on a ventilator. He felt he would be contributing nothing to society, while wasting tax payers' money. He did not object to short term resuscitative measures other than intubation. When asked by the

med student about short term intubation, he stated that it was not an option because once the ventilator was started the doctor would be unable to turn it off. He believed the courts would not permit it. He did not want to put his physician in what he perceived to be a legal and ethical bind. The physician made a vague and half-hearted effort to tell the patient that this was not likely to be a problem. When the med student asked Mr. J.N. whether he would desire resuscitation including mechanical ventilation if he could be guaranteed that the ventilator would be used only for acute resuscitative measures and he would not be maintained indefinitely on the vent, he indicated that this would be the most desirable situation, but then reiterated that the courts would never countenance it, that this guarantee could not be made, and that, therefore, he would not permit himself to be intubated in the first place. After leaving the patient's room, the resident inquired as to the implications of not using ventilator support in a code. The attending stated that this amounted to de facto no code status and orders were written as such. The patient was not informed. He improved over the next few days and was moved from the ICU and later discharged.

Commentaries

Several reasonable arguments against permitting limited codes might be made. First, they may be technically difficult to perform. Codes usually follow a protocol, and limited codes may interfere with it, thus leading to confusion and poor patient performance. Second, codes also happen quickly, whether or not they are expected, which exacerbates the technical problems. Potentially, many patients in a busy ICU could have complicated and specific requests all of which would have to be instantly recalled in the event of sudden decompensation—a management nightmare. Third, patient's could carry their "right" to a limited code to bizarre extremes; e.g., you may intubate me but only with a number 6 fenestrated tube on the first full moon in February. Fourth, it would be difficult to decide which limited codes are acceptable and which are not. Finally, all of these factors could adversely affect the nursing and medical staff, impairing their performance of usual duties and normal patient code management.

My reply to these concerns is that: (1) not all limited codes would be allowable; one can justifiably limit requests to those which are technically feasible, such as performing CPR but not intubation; most real life cases are likely to involve doing less rather than more; (2) deciding which patient requests are reasonable in a limited code is no more difficult than weighing patient requests in other areas; physicians have no obligation to provide treatment which is out of the scope of their ability, countertherapeutic, technically impossible, or of no benefit; (3) anytime a partial code is considered, it should be discussed with the medical and (especially) nursing staff so that everyone involved with the patient's care agrees on its feasibility and knows what procedure is expected; (4) most patients will be either full code or DNR; limited codes are likely to be rare and thus not unduly burdensome for the staff. On balance then I believe limited codes to be acceptable in limited situations, and, in particular, this patient's request to be acceptable. Joe Alfano, 3rd year CHM Student

First, and most importantly, this patient is flat wrong about both the law and current medical ethics, which pose no obstacle to the decision to withdraw a respirator, especially when done at the patient's explicit direction. Someone should have told the patient about Quinlan and the many decisions that followed which affirm this principle. Perhaps the word of the hospital attorney or a consulting ethics scholar would have carried enough authority for the patient. In addition, the physician might have offered to help the patient draft a Living Will, as a token of the physician's sincerity in promising the patient that his wishes would be followed.

If no such steps had worked, and the patient continued to selectively refuse intubation because of his false beliefs about the law, then the refusal should not have been honored. If a patient is incapable of understanding the facts most pertinent to his decision, then he does not have the capacities necessary for competently exercising a right to refuse treatment. On the case as described, this patient's refusal of intubation was incompetent. Therefore, the physician in this case should not have ordered a no code (behind the patient's back yet!). The patient had said he would want resuscitation if it weren't for his (false) beliefs about the law. Assuming that resuscitation had a decent chance of success for this patient, he should have

been kept on full code status, and informed that he would remain on full code status until such time as he discharged the attending physician and found another who would write the orders the patient's way.

Speaking of partial codes in general, I am skeptical that they can ever be ethically justified. What informed, rational patient would request one? As the attending remarks in this case, a partial code usually amounts to a no code in its outcome, except perhaps in increasing the likelihood that the patient will be severely impaired if he survives the arrest. For the patient who does not want to maximize his chances of survival, what coherent, informed set of values would select a partial code over a no code? I can think of none.

Even if there may be some rare exceptions to this claim, one should be wary about endorsing the moral acceptability of partial codes. The President's Commission and others have generally condemned partial codes because in practice they are not done in honor of patient's rights, but as a dodge to avoid the moral and legal responsibility of making and recording a no code decision. Discussions of hypothetical moral possibilities should be careful to lend no encouragement to this practice.

Tom Tomlinson, Ph.D., MHP

***** A MEDICAL ETHICS RESOURCE NETWORK (MERN) IN MICHIGAN? *****

On April 12, 1986 fourteen people involved in medical ethics in Michigan met at MSU's Kellogg Center to discuss the need for and feasibility of establishing a state-wide network of resources to facilitate the teaching of medical ethics and to provide resource support to hospital ethics committees who desire it. The feasibility discussion group felt that by collating an inventory of the existing resources into an organized, usable master resource and then conducting a two day working conference to explain and establish the structure and function of the network, the Michigan MERN could become a valuable asset to its two primary target groups, teachers of medical ethics (including teachers of medical students and residents) and hospital ethics committees.

At this time a Michigan MERN is still only a paper project, but preliminary plans have been made and partial funding secured from the Michigan Council for the Humanities for a two day working conference in the fall to establish such a network in Michigan. The Medical Humanities Report will monitor and report on these developments as they occur. **PJ Reitemeier, M.A., MHP, Philosophy**

***** THE MICHIGAN LEGISLATURE'S "AIDS PREVENTION PACKAGE" *****

A collection of legislative bills, the "AIDS Prevention Package," has been proposed in the Michigan House of Representatives to curb the spread of AIDS. Although perhaps well-intentioned, the bills appear to be based more on panic and the misguided notion that a "solution" to the AIDS problem can be legislated than on a careful analysis of the issues and the available evidence. Interestingly, the recommendations of Governor Blanchard's "Expert Committee on AIDS," whose report embodies just the kind of careful analysis that is needed, were ignored by supporters of the bills in a May first public hearing on the bills. There are seven bills in all, falling into three general groups.

I. Screening Prostitutes (HB 5279, Engler) and Prisoners (HB 5247, Bender)

Neither of these bills will effectively contain the spread of AIDS because both rest on a poor understanding of the relationship between infectiousness and symptoms. The bills provide for the isolation or detention of individuals with diagnosed AIDS, whereas the majority of infectious individuals are asymptomatic. It is by no means that the Department of Corrections has the capacity to effectively isolate the individual prisoners who might be identified. Moreover, the prostitution bill in particular appears to conflict with fundamental legal and ethical principles. Individuals are not ordinarily detained or punished on the basis of predictions about what they may do, and it is by no means irrelevant that prostitutes only put individuals at risk who voluntarily make use of prostitutes' services. Unlike other infectious diseases, where quarantine may be justified, prostitutes do not put individuals at risk merely by being out and about.

II. Screening for Insurance (HB 5272, Nash) and Marriage Licenses (HB 5276, O'Connor)

Given current estimates of the accuracy of AIDS antibody tests and the estimated prevalence of the AIDS virus in the low risk population, approximately 700 of the 140,000 marriage license applicants in Michigan would test positive on the initial (ELISA) AIDS antibody test. Using a second, "confirmatory test" (the Western-blot) approximately 699 of the 700 would be eliminated as false positive. Thus after screening 140,000 persons, 1 true positive individual would be identified, with a 5-40% chance of eventually developing symptoms and some unknown chance of infecting his or her spouse to be.

Because so many false positives result from using the ELISA alone, insurance companies screening for AIDS would have to employ confirmatory testing. But insofar as the insurance industry apparently aims to exclude individuals at risk of developing AIDS, the net results, (even with relatively accurate screening) would be (1) higher overall AIDS related costs (the cost of screening would merely be added to the cost of treating AIDS patients, their lost wages, and so forth) and (2) shifting the costs to the public sector (someone would have to pay for the care of AIDS patients excluded from insurance coverage through the screening process).

III. Reporting Requirements (HB 5300, Honigman, HB 5281 Power, and HB 5318 Bandastra)

HB 5300, requiring notification to funeral directors when the deceased had AIDS, is unwarranted; all that funeral directors need to know is that the deceased has an infectious disease. Presumably, they would want to avoid contracting other serious infections such as Hepatitis B, and precautions appropriate for such infections would be completely adequate to protect against AIDS.

HB 5281 requires tracing and contacting sexual partners on the model of other venereal diseases. The usual justification for contact tracing is that it allows Public Health Department officials to treat an infected individual's contacts, cure them, and thus limit the spread of disease. But because persons infected with the AIDS virus cannot be rendered non-infectious, this justification does not apply; contacts could merely be informed they had been exposed. Persons who already know they are at high risk of contracting AIDS would not likely find this information very useful. Furthermore, the exceedingly long incubation period for AIDS (up to 6 years) would render the data of questionable accuracy.

HB 5318 requires all hospitals and laboratories to report identity-specific positive antibody testing results to the Michigan Department of Public Health. However, fear of information leaks or coercive measures would likely deter individuals from permitting themselves to be tested for the AIDS antibody, compromising the Public Health Department's ability to monitor different populations. And unless contact tracing is to be employed (HB 5281), there is no reason to identify individuals who test positive anyway. Epidemiological monitoring only requires demographic information, not information that identifies particular individuals, and better information is likely to result from studies that employ careful sampling techniques and data control than from reliance on the reporting practices of hospitals and laboratories.

In conclusion, a general observation applies to the legislative AIDS Prevention Package as a whole. Ethical dilemmas in public health often require a trade-off between individual liberty and the health of the larger society--where one of these concerns must be compromised to some extent in order to promote the other. But no such dilemma is engendered by the AIDS Prevention Package because none of these bills propose an effective means of safeguarding the public health when compared to the alternatives of public education and voluntary participation in research.

Ken Howe, Ph.D., MHP (Member of the Governor's Expert Committee on AIDS)

*** LITERATURE REVIEW ***

"The Humanities in Medical Education" Annals of Internal Medicine Nov. 1984; 101:697-701

Although individual medical educators have acknowledged the importance of the humanities, the efforts of medical schools to do something about it are hampered by a number of widespread misconceptions. The first, shared by pre-medical students and their advisors, is that entry into medical school is so intensely competitive that it is essential for applicants to have majored in the sciences. The second, a consequence

of the first, is that the humanities must be included in the curriculum of medical schools. The third is that condensing premedical and medical education from 8 to 6 years, with beginning undergraduates more or less assured of admission to medical school, will make a difference by freeing these undergraduates to take courses in the humanities.

Citing the results of various studies and surveys, Ryan exposes the first misconception. The acceptance rate to medical schools in 1979-80 was 47% for natural science majors, 43.8% for social science majors, and 51.2% for applicants majoring in one of the humanities; and there is no significant difference between the medical school grade-point averages of science and humanities majors. He then maintains that both the inclusion of the humanities in the medical curriculum and the comparatively few 6 year premedical-medical programs are a poor substitute for a major in a humanities discipline which includes enough science to do well in medical school (a little more than a year). If premedical students were to major in the humanities, humanities offerings in the crowded medical school curriculum could, with the possible exception of ethics, be largely extracurricular. **Martin Benjamin, Ph.D., Philosophy, MHP**

"Ethical Dilemmas in Caring for Patients with the Acquired Immunodeficiency Syndrome" Annals of Internal Medicine. 1985; 103:787-790

Steinbrook et al. identify three ethical problems frequently encountered in providing care to AIDS patients: deciding when treatment should be withdrawn, determining who should make decisions on behalf of AIDS patients who become incompetent, and coping with the professional stresses associated with caring for AIDS patients. The authors contend that careful communication between patients and health care providers should be used to ensure that withdrawals of treatment accord with patients' wishes. In addition, they praise the use of durable power of attorney, in which a decision-maker is designated to handle the frequent problem of AIDS associated incompetence. They argue that the stress associated with caring for AIDS patients — resulting from homophobia, fear of contacting AIDS, and the nature of terminal care in general — can be most effectively handled by making fears and biases explicit and by removing misconceptions about AIDS. **Ken Howe, Ph.D., MHP**

"Counseling Patients to Counsel Physicians on Future Care in the Event of Patient Incompetence" Annals of Internal Medicine May 1985; 102:693-698

To help resolve the complex dilemmas in treatment decisions for incompetent patients, a variety of policies and procedures have evolved. Schneiderman and Arras point out that natural death statutes and durable power of attorney statutes have not had great effect on medical care. This is due in part to physician unfamiliarity. The authors urge that **physicians should advise their patients that there is no sure way for them to achieve control over future care in the event of incompetence**, but that to better realize this patients should reflect on their wishes and express them in an advanced directive. Five "ideal criteria" for advanced directives are presented: unambiguous; flexible; documented; available; enforceable. The authors argue that proxy directives (durable power of attorney) better realize the ideal criteria than instruction directives (living will). **B. Miller, Ph.D., Philosophy, MHP**

***** THREE NEW "LIVING WILL" BILLS INTRODUCED IN MICHIGAN *****

Rep. Perry Bullard has introduced House Bill 5286, to be called the "Michigan Medical Self-Determination Act" in the state legislature. The bill would allow anyone over 18 and of sound mind to execute a "declaration" requesting or refusing various sorts of medical care in the event that the person later becomes terminally ill or permanently comatose and is unable to participate in decision-making. A physician who honors such a declaration would not be liable for following such directives.

A suggested form for the declaration is:

"If I become permanently unconscious or terminally ill and if I am unable to participate in decisions concerning my medical treatment, I direct all medical intervention be withheld or withdrawn, except that medical intervention necessary for my comfort. If I

am unable to take food and water by mouth, and if food and water are not necessary for my comfort, I do/do not (circle one) wish food and water provided intravenously, by neo-gastric (sic) tube, or by gastronomy (sic). I understand I may revoke this declaration at any time."

The patient may alter this language in any way desired. The patient also may name a representative to assist in assuring that these wishes are carried out.

If a physician objects to carrying out the patient's directive, he may arrange to transfer the patient to another facility or attending physician; no penalty for failure to comply is indicated in the bill. (Insurance companies may not use a declaration to change a patient's coverage nor may they require signing one as a condition for insurance.)

Bullard's bill differs from Rep. David Hollister's "Medical Treatment Decision Act," voted down in the last session, by proposing a document or "living will" as the primary approach and allowing a representative as a back-up means. The Hollister bill promotes the representative (via "durable power of attorney") as the primary mechanism and would use a document as advisory only.

Senate Bill No. 638, introduced in January 1986 by Senators Faxon and others, is modified from the first "natural death act" which recognized a patient's right to issue an advance directive refusing future life-prolonging medical care-- the California Natural Death Act of 1976. The bill provided a model declaration in which a patient, judged by two physicians to have a "terminal condition," may refuse life-sustaining procedures. Restrictions include: death must be judged to be imminent "whether or not life-sustaining procedures are utilized"; pregnant patients are excluded; a patient may not refuse food, water, or "any medical procedure that is necessary to provide comfort or alleviate pain." Physicians and health professionals who follow this directive in good faith are protected from legal liability. Insurance companies may not modify coverage based on the fact that the insured party has signed this declaration; however, an insurance company is not prohibited from making the signing of a declaration a condition for getting insurance.

Comment: As the first bill passed in the country, the 1976 California Natural Death Act received a lot of scrutiny in the medical-ethics community; and some of the concerns voiced seem to apply equally to SB 638. **By restricting qualified patients only to those who would die soon with or without life-prolonging therapy, the directive effectively limits the "right to refuse treatment" to a right to refuse totally futile and ineffective treatment.** For instance, it is frequently noted that Karen Ann Quinlan's respirator could not have been turned off under the provisions of such an act. This bill, therefore, is much narrower in the choices it allows the individual patient than either of the two bills now before the Michigan House (Hollister and Bullard bills). **Howard Brody, M.D., Ph.D., MHP, Family Practice**

**** NOTABLE NOTES ****

Tom Tomlinson and Howard Brody authored an article entitled "**Ethics in Primary Care: Setting Aside Common Misunderstandings**" in an issue of Primary Care Clinics of North America, Michael S. Victoroff, editor, (forthcoming 1986).

Sheila Horn, a fourth year MSU COM student and former research assistant in the MHP is the author of "**What's in a Name?**" published in the Journal of Medical Humanities and Bioethics. Her essay discusses ethical implications of students posing as physicians during clinical training.

Louise Blackledge, MHP research assistant, completed an M.A. in philosophy at MSU in June. Her major paper was entitled "**Pediatric Oncology: Who Should Decide?**"

Len Fleck's article "**Confidentiality: Moral Obligation or Outmoded Concept?**" appeared in the May 1986 issue of Health Progress, The Journal of the Catholic Health Assn.

Tom Tomlinson is editor of a special issue of Theoretical Medicine: The Physician's Influence on Patient Decision-Making: Persuasion, Manipulation, or Coercion?

