

# MEDICAL HUMANITIES REPORT

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MICHIGAN STATE UNIVERSITY

FALL 1986

## ***Michigan Establishes Nation's First State-Wide Medical Ethics Resource Network***

On October 10-11, 1986 a new organization of educators, clinicians and other professionals was formed at the MSU Kellogg Center to establish a statewide network of resources relevant to the teaching and study of medical ethics. The organization has been named the Medical Ethics Resource Network (MERN) of Michigan and plans a formal press release announcing its structure and function in the near future. Dr. Howard Brody, M.D., Ph.D., and Coordinator of the MSU Medical Humanities Program is chair of the MERN steering committee which will oversee the set up and operations of the organization until its formal establishment in the spring of 1987. All of the MHP faculty are also members of MERN.

The MERN of Michigan is believed to be the only statewide organization of its kind in the United States and, if successful, may serve as a model for similar organizations in other states. When asked why a statewide resource network and why now?, Dr. Brody noted several factors which contributed to the formation of the organization. One of the major factors includes attempting to meet an increasing demand for knowledge about medical ethics in general, as well as specific topics of high public interest and visibility in the media. Some of these topics include medical care of seriously ill newborn infants; concerns relating to the practice of euthanasia; hospital policies concerning cardiopulmonary resuscitation of terminally ill and non-terminal but seriously ill patients; allocation of medical resources including the distributing of physicians; truth telling and confidentiality; and other subjects.

Dr. Brody noted that both the American Hospital Association and the American

Medical Association have recommended utilizing local hospital ethics committees as a means to improve decision making at the institutional level. With this in mind, one of the primary functions of MERN of Michigan will be to develop and make available to local hospital ethics committee members, series of modular teaching units on decision making in medical ethics. In addition MERN will eventually be able to provide lists of speakers on various topics in medical ethics to interested academic, political and community groups and organizations to help initiate public discussions on these topics.

Establishing a centralized information resource network in medical ethics to serve the needs of Michigan makes a lot of sense at this time for a number of reasons, according to Dr. Brody. The availability of current knowledge on medical ethics is spotty, with some centers (usually hospitals and academic institutions) having well developed library and personnel resources, some with few resources and others in-between. Secondly, a duplication of effort along these lines is common in Michigan. Several hospitals or medical staffs may simultaneously be developing policies in a given area without any knowledge of what the others are doing or what problems should be avoided, based on others' experience. Third, a lack of communication among interested and active parties may lead to wasted resources and opportunities for exchange or mutual participation. Finally, local hospitals and their medical staffs concerned about quality and accountability have no way of evaluating their programs in ethics or the function of their ethics committees. They

cannot critically compare activities in their own centers with the "state of the art" as practiced in similar institutions elsewhere in Michigan.

Dr. Brody cautioned that since this sort of organization is unprecedented, its initial visibility and functions may be modest and primarily self serving to its organizers, at least until more of the "bugs" have been worked out. The initial organizers number approximately thirty persons and represent nearly twenty different hospitals, colleges and universities throughout Michigan. The MERN of Michigan, while housed in Michigan State University, has a separate identity from that of MSU or the Medical Humanities Program. Dr. Brody reported a high degree of optimism among the organizers regarding the future potential for service to Michigan communities and hospitals resulting from MERN's activities and resources currently available.

The MHR will continue to monitor and report on future developments of the new MERN of Michigan.

For information about individual or institutional membership in MERN, write: **Medical Ethics Resource Network of Michigan, C-201 East Fee Hall, Michigan State University, East Lansing, Michigan 48824.**  
P.J. Reitemeier, M.A.

## **President of Society for Health and Human Values Launches Distinguished Speakers Series**

The MHP and Ingham Medical Center kicked off the new **Distinguished Speaker Series**, on November 25 with two invited lectures by **Christine Cassel, M.D.** Dr. Cassel is President of The Society for Health and Human Values and Associate Professor of Medicine, University of Chicago Pritzker School of Medicine where she is Chief of the Section of General Internal Medicine. Dr. Cassel delivered two addresses: "Physicians' Roles in Shaping the Nuclear Arms Debate" at Grand Rounds for invited health care professionals; and a public lecture, "Justice, Cost Containment, and Health Care for the Aged," at the MSU University Club Ballroom.

Professor Cassel's clinical specialty is in the care of the elderly, and she is co-editor of a major two-volume

textbook, Geriatric Medicine, published by Praeger in 1984.

The Distinguished Speaker Series is a new approach to catalyzing public consideration and reflection of humanistic issues in health care. The Medical Humanities Program at MSU has approached the four Lansing area hospitals to co-sponsor the Distinguished Speaker Series to initiate public discussion of various topics in medical humanities and host a public reception for such discussions after each Distinguished Speaker presentation. The Distinguished Speaker Series is scheduled through 1988, and is made available to the public free of charge by the MHP and a local hospital.

P.J. Reitemeier, M.A.

## **Case Study: Medical Lies or Justifiable Deception?**

A junior resident in Internal Medicine has completed the physical examination on a 45-year-old woman, without noting any abnormalities. Following current guidelines on screening for breast cancer, he orders a screening mammogram. The senior resident with whom he confers notes, "This patient is on Medicaid. They won't pay for a screening mammogram." The junior resident asks "Then what do you usually do? Do you refuse to order mammograms on your patients who fit the screening criteria? They can hardly afford the \$100 fee themselves." "Oh, I order them alright; only I don't write down 'screening'. I write something like "questionable mass" or "outer quadrant thickening." Then Medicaid will cover it." "But isn't that intentionally falsifying medical records?" "You could call it that. It still sounds better to me than letting patients go without the medical care I think they need, or worse, battling with an entrenched bureaucracy when I'm sure to lose, and with me, the patient's only real chance for good care."

**Question: Are treatment refusals for economic reasons morally obligatory, given current restrictive payment coverage plans? OR do physicians have an ethical obligation to "beat the system" in order to secure payment for indicated medical care?**

**Commentary:** One's response to this case will depend heavily on whether or not one thinks that the restriction on Medicaid reimbursement is reasonable and just. If it is reasonable and just, then there is little question that the deception is wrong; if it is not reasonable and just, then the deception is morally justifiable.

The Medicaid restriction is a reasonable one if screening mammograms offer no improvement in early diagnosis over other methods which are reimbursed; or the benefits of early diagnosis are counterbalanced by the risks of harm that result from any false positives and the additional procedures which they precipitate; or if early diagnosis adds nothing to subsequent survival and quality of life. If any of these conditions is true, then the deception cannot be justified by appealing to the patient's presumed right to effective health care. Therefore, the first step in justifying the deception must be to establish that none of these conditions is met. One might wonder whether a junior resident is in a position to carry this burden of proof, without additional special knowledge or consultation.

But let's assume that the screening mammogram is a reasonable procedure, and that therefore, the Medicaid restriction denies poor patients some demonstrable medical benefit. Still the deception might not be justified, because deceptions are not in general justified simply in the name of benefiting someone. I would not be justified in fraudulently filling out a loan application in order to buy my mother a new Mercedes. **What must be shown in addition is that the benefit is something to which the person has a right, and that the deception is the only way to secure that right.** Given a world of limited resources, we can all grant in principle that there are benefits, even life-preserving benefits, to which people don't have a right. The hard question is whether a screening mammogram is one of those benefits not secured by a right. Our answer depends only in part on whether distribution of limited health care resources is perceived to be "fair" in the formal sense: everyone is in the same boat. It also depends on whether we think it is morally defensible to spend less on health care in order to spend more on defense, or education, or entertainment. Our conception

of justice in health care cannot be determined apart from our vision of what the good society should value.

But let's suppose finally that not only does the screening mammogram offer a benefit, but it is a benefit to which the patient has a right, and that the Medicaid denial is therefore unjust. If we add the additional assumption that the deception is the **only way** to secure that benefit for this patient, then the deception is morally justifiable. This all adds up to a very heavy burden of proof for the resident who proposes to do this, and requires a great deal of investigation and deliberation. But it is a burden that can be met.

It might be objected that by doing this, the resident is using money that would have gone to another Medicaid patient who was in greater need. But given the way the Medicaid budget is administered, this possibility (and this greater need) is purely hypothetical; the patient before her now is as real as can be. It might also be said that the deception meets only the needs of this individual patient, and does not secure the rights of other patients unknown to the resident who are denied screening mammograms. It is true that the doctor should also take political action to correct what she sees as injustices in Medicaid reimbursement. But in the meantime, this patient should not be made hostage to a more just policy that may never come. **Tom Tomlinson, Ph.D.**

**COMMENTARY:** The easy response to this case is that the medical record ought not to be falsified, the mammogram should be done, and the cost of the mammogram should be absorbed as bad debt/charity care by the hospital. And if this were an isolated and infrequent case, this would be the correct response as well. However, in an era marked by increasing cost containment efforts from both the public and private sectors this answer is not adequate. After all, there are dozens of procedures like this that Medicaid does not fund, and there are large numbers of Medicaid patients in any given hospital for whom such procedures may be medically appropriate. The costs to any given hospital could become rather substantial. Additionally, there are the "working poor" who might have health insurance but with high deductibles or many exclusions. They too could not afford the out-of-pocket costs of the

mammogram, and they might tell you that. Fairness would require providing the mammogram to them as well and writing it off as a bad debt, which would surely add to the fiscal problems of the hospital.

Another perspective which needs to be considered is that the mammogram is not therapeutic, but diagnostic. It is strongly recommended because it reduces the risk of undetected breast cancer by some degree. Again, there is a large number of other medical procedures that can also reduce the risks associated with undetected diseases. Should all such procedures be made routinely available to members of the two population groups mentioned above, with all the costs written off to charity care? Consider the larger consequences. There are 35 million Americans without any health insurance at all. Every hospital charity dollar spent on risk reduction is a dollar not available for underwriting the costs of effective **therapeutic** interventions that ought to be available to the uninsured and underinsured.

We can argue that more money needs to be made available to meet more adequately the basic health needs of the poor, the uninsured, and the underinsured. I would certainly agree with the desirability of that goal. But that fails to address the large social question of **how much risk reduction might be prudently purchased with our limited health care dollars, especially if fewer dollars are then available to purchase reasonably effective therapies.** It also fails to address the immediate practical problem, that at any point in time only limited funds are available for charity care in any hospital. These funds need to be distributed fairly. **If we have no reason to believe that the woman in this case is in a very high risk group so far as breast cancer is concerned, then the mammogram should not be done.** If this results in such individuals being exposed to more risk than is morally justifiable, then health care professionals will have to work very hard to change the Medicaid legislation, and, more generally, to work for a fairer and more adequate system of charity care for the poor, uninsured and underinsured.

**Len Fleck, Ph.D.**

## **Pricing Human Life: A Public Conversation**

There is a growing recognition that the moral problems generated by increased efforts for health care cost containment need to be the object of broad and sustained public conversation. The undisputed forerunner in this effort is the "Oregon Health Decisions" project, reported on in March, 1985 in JAMA.<sup>(1)</sup> That project involved 300 town meetings around the state over a three-year period aimed at discussing some of the more pressing moral issues connected with health care policy. The project concluded with a Health Parliament that met for two days to hammer out a half dozen legislative recommendations.

There is much that is commendable about the Oregon project. But our judgment is that several important features of that public conversation were sacrificed for grass-roots coverage over 300 separate sites. Specifically, depth, coherence, comprehensiveness and connectedness were all sacrificed.

The MSU Medical Humanities Program tested an alternate model of what that conversation should be like on a smaller scale last spring in Flint, Michigan. The Flint project involved six seminars over a six-week period. Seminar topics included: Justice, rationing health care resources, and the good doctor; Justice and the allocation of scarce life-prolonging resources; Justice, health care cost containment and the elderly; Justice and health care for the poor; Justice and the critically ill newborn; and Setting an issue agenda for the '90s. We invited about 40 people to be members of a "core seminar group". Half of these were health care professionals, the other half were community and professional leaders. This group was broadly representative of the community, but it was not a grass-roots group. All seminars were open to the public.

Core group members were given several articles to read prior to each seminar so that they were better prepared to participate in the conversation. Speakers were used to initiate each session by identifying some key issues, but were then encouraged to recede into the conversation as a whole. Much of the

conversation proceeded by fits and starts. It was more difficult for people to articulate their sense of what was just in specific circumstances than we initially imagined. But participants did make connections from one week to the next. They saw, for example, that we could not treat as wholly separate issues the health care entitlements of the poor and the elderly, at least if what we wanted at the end was a just health care system and just health care policies. Making those connections, recognizing the need to make difficult trade-offs and to do that fairly, were major objectives of this project.

We are now planning a statewide version of this project that will probably span a three-year period. There may be as many as ten major project sites, and there may be as many as 25 seminars at each site for a core seminar group. Without that kind of sustained public conversation we do not believe we are faithful to the complexity of the moral and policy issues that need to be addressed. We expect that focused, problem-oriented task forces will be spun out of each core group, and these will produce policy papers and recommendations for a statewide conference at the conclusion of the project. A formal project report and issue agenda for the '90s may be obtained from Len Fleck, Ph.D., c/o Medical Humanities Program, C-201 East Fee Hall, MSU, E. Lansing, MI 48824.

(1) Journal of American Medical Association, March, 1985, Vol. 254: 3213-16.  
Len Fleck, Ph.D.

## **MHP Welcomes New Faculty and Staff**

Joy Curtis, R.N., M.A. from the MSU College of Nursing and Melanie McLeod, R.N., BSN, from Seattle, Washington have joined the ranks of the MHP as quarter time faculty and quarter time graduate assistant, respectively. Ms. Curtis and Ms. McLeod will be investigating problem solving approaches to ethical issues in hospital nursing practice in the greater Lansing area and hope to develop a model for establishing ongoing dialogues with hospital based nurses elsewhere.

Ms. Curtis has been a registered nurse for 30 years and is currently Associate Professor and Director of Student Affairs at the MSU College of Nursing, where she has been a faculty

member since 1965. Her book, Ethics in Nursing, co-authored with Martin Benjamin, Ph.D. is in its second printing by Oxford University Press. Professors Curtis and Benjamin have been members of the MHP Associate faculty since its inception in 1981.

Ms. McLeod has begun graduate studies in philosophy with a focus on medical ethics at MSU and was awarded a graduate assistantship at MHP for 1986-87. Ms. McLeod, (BSN Calif. State University-Sacramento, 1981) has worked as a staff nurse in General Medicine in Seattle, Washington since 1982 and charge nurse since 1985. Her special interest areas include alcohol detoxification, chronic obstructive pulmonary disease and AIDS and their related nursing problems.

P.J. Reitemeier, M.A.

## **Medical Humanities in London A Success**

"Medical Humanities in London: Ethics and History" made its debut in the summer of 1986 as an offering in the MSU Overseas Study Program. Student enrollment exceeded expectations for a first time course with 28 students enrolled--representing medical students, graduate students in history and philosophy, and undergraduates with predominantly pre-med majors. All but one of the students were from MSU. Howard Brody, (Family Practice and MHP) and Peter Vinten-Johansen, (History and MHP) shared teaching responsibilities.

The course met as a seminar every Tuesday and Thursday for five weeks in the Robin Brook Center of St. Bartholomew's Hospital, with a half day devoted each to ethics and history. Both instructors attended each session, so that team teaching and integration between the two disciplines was maximized. Field experiences on Wednesdays included visits to British physicians in their surgeries or attendance with home health visitors, and excursions to various historical museums. A one day trip to Cambridge was also included.

The students' response to the course confirmed the value of examining ethical issues in the allocation of scarce resources in the United States and Great

Britain in terms of the historical contexts in which the two systems of health care delivery emerged. Students who began the program with some skepticism about the value of studying either the history of medicine or medical ethics acknowledged by the end that viewing either discipline in isolation would have hampered the perspective they developed. The students listed as highlights of the experience the opportunity to visit a variety of British practitioners, to tour St. Bartholomew's Hospital and museums such as the Wellcome Collection at the Science Museum and to explore the 19th century surgical theater of Old St. Thomas' Hospital. We are particularly indebted to the advance work undertaken in England by Dr. Lesley Southgate (Department of General Practice, St. Bart's) and Janet Foster (Archivist for St. Bart's and Hackney District), as well as the numerous guest lecturers who appeared during the seminars to represent British perspectives. The students recognized their role as co-creators of a new course offering, and took an active part in shaping the experience for their own benefit. In particular, they were quick to point out that the instructors had overestimated the amount of required reading that was consistent with enjoying the attractions of London as a tourist and cultural center.

Based on last summer's experience, a number of improvements are anticipated for the 1987 course, which will be taught by Tom Tomlinson, (MHP) and Peter Vinten-Johansen. The reading packet will be streamlined, attempting to further integrate history and ethics by means of specific study questions for each class period. Improved access to home health visitors to allow each student to experience this part of the program will be negotiated through the district administrator at St. Bart's. Additional tours, possibly including a small, general practitioner run hospital in South London, may be added. We also intend to step up recruiting efforts to attract students both from outside Michigan State, and to attract a greater proportion of students from the medical colleges. Eventually, this course may succeed as an exchange program, which would allow British students to sit in on the course and to consider initiating similar experiences in the United States.

Anyone interested in receiving a brochure describing the 1987 summer course offering should contact the Medical Humanities Program, C-201 E. Fee Hall, 355-7550. Peter Vinten-Johansen, Ph.D. and Howard Brody, M.D., Ph.D.

## **MHP Involved at AAMC/SHHV Meetings**

Several MHP Faculty presented invited papers and commentaries at the 1986 Annual meetings of the American Association of Medical Colleges and the Society for Health and Human Values meetings, October 24-26 in New Orleans. MHP Assistant Professor Ken Howe, Ph.D. presented preliminary data analysis, co-authored with MHP Assistant Professor Tom Tomlinson, Ph.D. and Mr. Frank Jenkins, M.A. of their "Study of Proxy Decision Making for the Elderly." The study is a one year research project funded by the Retirement Research Foundation, due to be completed in Spring 1987. Dr. Howe presented a paper entitled "Medical Students' Perceptions of Pre-clinical Medical Ethics Teaching" at the Annual Conference on Research in Medical Education (RIME), and the paper was published in the Conference Proceedings.

Assistant Professor Tom Tomlinson, Ph.D. presented "A Demonstration of Computer Assisted Instruction in Medical Ethics," and served as chair of the Philosophy Disciplinary section which focused on "Bad Outcomes of the Doctor-Patient Relationship." Dr. Tomlinson served as commentator on a paper entitled "The Moral Basis of Medical Malpractice Policy" by Peter C. Williams, J.D., Ph.D.

Assistant Professor Len Fleck, Ph.D. presented a paper entitled "DRG's: Justice and the Invisible Rationing of Health Care Resources".

## **Literature Reviews**

**SHATTUCK LECTURE - THE POLITICS OF MEDICINE IN BRITAIN AND THE UNITED STATES** by JOHN LISTER, M.D., F.R.C.P. New England Journal of Medicine 315:(3); July 17, 1986, 168-73.

Dr. Lister reports on several features of current British health policy. Britain's recent conservative government, in many ways following the lead of the Reagan administration in the U.S., has sought to encourage the small but growing

private practice sector and to limit government expenditures in the National Health Service. However, since a boom in the early 1980's, the demand for private health insurance has leveled off as the American experience was repeated (absence of incentives to cut costs producing exponential rise in costs of health care and insurance in the private marketplace). Both physicians and the public increasingly perceive the NHS as underfunded. Lister comments however on the absence of data to show that, in a developed country, the population gets any healthier when more money is spent on medical care. Still, given long waiting lines for elective surgery like hip replacement, Lister agrees that reduction in morbidity, not mortality, might be the outcome of increased funding for NHS.

The British public is becoming somewhat "Americanized" in demanding increasing services from the NHS. Lister states the primary problem as that of separating needs from demands, ignoring the latter in the name of cost but providing incentives within the NHS to meet needs better and more efficiently. The prized "clinical freedom" of British physicians has limited both cost-effective medical care and new research to document the most beneficial use of limited resources. **H. Brody, M.D., Ph.D.**

**"The Doctor, the Patient, and Their Contract"** by **D.P. Gray et al**, British Medical Journal 292: 17 May 1986

These authors, two general practitioners and a social scientist, are responding to a recent report of the British National Health Service calling for reforms in how general practitioner's contract with the NHS to be reimbursed for services to patients. Currently the "contract" is a modified capitation scheme based on the number of patients on the physician's "list." Considering a number of options, the authors reject pure capitation, pure salary, fee for service, open market, and a US-like system of HMO's. Instead they advocate a "good practice allowance" in which up to 20% of the physician's income would be based on evidence that the organization of the practice and the physician's charts reflect high standards of care, including preventive and anticipatory care. The authors argue that the care now provided by British general practitioner's is reasonable, but that it could

be improved substantially by articulating clear standards and backing the standards with financial incentives. **H. Brody, M.D., Ph.D.**

## **Notable Notes**

**Tom Tomlinson, Ph.D.** has received a grant from the Center for Public Policy and Research on Organ Transplantation to investigate **How Health Professionals Understand and Communicate the Status of Brain-Dead Patients**. The study is scheduled to be conducted during the first half of 1987, and will use semi-structured interviews with ICU physicians and nurses to analyze methods of communication between health professionals and family members of brain-dead patients. The results of the study should be useful in designing successful strategies for professional education and for the design of hospital policies concerning the management of these situations.

In addition to regular teaching responsibilities and public service addresses throughout the state of Michigan, the MSU Medical Humanities Program staff and Associate Faculty have recently had the following works accepted for publication:

**Ken Howe, Ph.D.** "Why Mandatory Screening for AIDS is a Very Bad Idea" in **D. Van De Veer and C. Pierce (eds), AIDS: Ethics and Public Policy**, Wadsworth Publishing, (forthcoming, 1987): "Medical Students' Evaluations of Different Levels of Medical Ethics Teaching: Implications for Curricula", forthcoming in Medical Education.

**Martin Benjamin, Ph.D. (Philosophy, MHP)** Ethical Issues at the Outset of Life with **Dr. Wm. Weil, M.D. (Pediatrics, MHP)** by Blackwell Scientific Publishing (forthcoming, 1987).

**Bruce Miller, Ph.D., (Philosophy, MHP)** "Experimentation on Human Subjects: The Ethics of Random Clinical Trials" in **Regan and Van De Veer (eds), Health Care Ethics**, Temple Univ. Press, (forthcoming, 1987): "Autonomy and the Elderly Patient" in **J. O'Brien (ed) Ethical and Legal Issues in the Care of the Elderly**, (forthcoming, 1987); "Autonomy and Decision Making: The Institution and the Patient" in **M. Wykle (ed) Decision Making in Long Term Care**, Springer Publishing (forthcoming, 1987).

Margot E. Kurtz, Ph.D., Shirley M. Johnson, Ph.D., Tom Tomlinson, Ph.D. and Ken Howe, Ph.D. (Family Medicine and MHP) "Students' Stereotypes of Patients as Barriers to Clinical Decision Making" in the September, 1986 Journal of Medical Education.

Martin Benjamin, Ph.D. with Joy Curtis, M.A. (Nursing, MHP) "Recent Changes in the World of Nursing" in the 1987 Medical and Health Annual of the Encyclopedia Britannica.

**MEDICAL HUMANITIES CALENDAR**

- December 3 **Use of Animals in Laboratory Research**  
 Panel Discussion  
 MSU Ecology Club  
 Tom Tomlinson, Ph.D.
- December 16 **No Code Policies**  
 Jackson Prison Medical Staff  
 Jackson, Michigan  
 Tom Tomlinson, Ph.D.
- January 29 **Quality of Care in the Nursing Home**  
 Panel Discussion - OMERAD  
 University Club  
 Tom Tomlinson, Ph.D.

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