MEDICAL HUMANITIES REPORT

MEDICAL HUMANITIES REPORT MICHIGAN STATE UNIVERSITY WINTER 1987

THE MERCHANDISING OF MEDICAL ETHICS

On the envelope is written in large block letters: **"YOUR CAREER COULD BE DESTROYED BY ONE BAD ETHICAL DECISION...NOW THERE'S HELP...SEE INSIDE."** The return address is Medical Ethics Advisor, Atlanta, Georgia and inside you find a glossy, double-sided promotional piece heralding the advantages of subscribing to their newsletter. **"Each 12 to 16 page monthly issue is jam-packed with the latest information and advice concerning the challenges of medical ethics."** There is also a six page insert discussing the dangers of not subscribing; **"YOU COULD BE RISKING HUNDREDS OF THOUSANDS OF DOLLARS IN LEGAL FEES AND SETTLEMENTS."** Four sentence synopses of notorious cases: Elizabeth Bouvia, Nancy Ellen Jobes, etc.; **"nuts-and-bolts advice from interviews with the nation's leading attorneys...Handling the public relations challenge...when news gets out — and it will — how do you make your hospital look good?...GET SPECIAL INSIGHTS ON ETHICS FROM INTERNATIONALLY KNOWN SPECIALISTS — INCLUDING ROBERT JARVIK, DESIGNER OF THE JARVIK-7 HEART; 13 YEARS OF EXPERIENCE{*} ON YOUR SIDE; GIVE MEA A TRY — AT NO RISK TO YOU! FREE BONUS WHEN YOU ACT NOW!" ({*} as a publishing firm -editor).**

The question of interest here is not the quality or content of such a publication as the Medical Ethics Advisor, but rather the tone of the advertising and the impression it might give that MEA has "answers", or worse, the threatening implication that one's failure to pay the $158 subscription fee will place one at a higher risk for lawsuits and ethical disasters. These impressions raise questions about physicians' perceptions of ethical inquiry in medical matters, and the obligations of the editorial board of MEA to avoid manipulating those impressions unfairly.

COMMENT: Given the current national explosion of ethical controversies, I find it shocking that some professionals are so nervous about our aggressive marketing of our Medical Ethics Advisor newsletter.

The reasons for their skittishness are elusive; we hear vague objections to the "tone" of our sales message. Apparently, we have raised anxieties by emphasizing that ethical decisions in medicine can have real-world consequences, such as lawsuits, public relations disasters, career wreckage, etc.

The "old guard" of ivory towerites regarded medical ethics as pristine and as their exclusive province. Intense, though abstract, discussions were carried out quietly, behind closed doors. And above all, no ethicist was ever held accountable for what followed.

I am afraid the "good old days" are gone forever. To paraphrase, medical ethics is now too important to be left solely to the ethicists. Medical Ethics Advisor newsletter brings news and expert comments to administrators and caregivers "out on the firing line", besieged by lawyers, reporters, regulators, accountants, and the like.

Our prime readers are held accountable for the consequences of their medical ethics decisions. Our marketing speaks to these realities. Rather than sniffing disapproval, most of our readers say "Thank God there's a periodical that knows what it's actually like out there".

But why prolong the outmoded tradition of abstract debate? I invite any reader to write me for a free sample copy of the newsletter (and the controversial salesletter if you haven't yet seen it). Then judge for yourself. **Leslie C. Norins, M.D., Ph.D.,** Publisher of Medical Ethics Advisor newsletter. (Address: 67 Peachtree Park Drive, NE, Atlanta, GA 30309)

COMMENT: Virtually every professional code of ethics prohibits exaggerated representations of the efficacy of professional services. Just this kind of prohibition is needed for a profession in the kind of flux surrounding bioethics: for the protection of employers, who should not hire under false pretenses; and for employees, who should not be held responsible to fulfill the hopes and dreams of others.

Bioethics, lacking such a code on behalf of its own practitioners (though with no dearth of codes for others), is the proverbial shoemaker's barefoot child. Now comes Medical Ethics Advisor to remind us of the need to rectify the situation. Its present and previous promotional literature has been studded with such bumptious overstatements as: Promising to provide subscribers with "the answers and advice" for their "toughest medical ethics questions," e.g., "Just what is quality of life?"; Those who subscribe may "{B}e fully confident that the decisions you make today and in the future are the best possible for your patients, your facility, and yourself."; Those who fail to subscribe are warned by implication that they "could be risking hundreds of thousands of dollars in legal fees and settlements." Or, more pithily: "Don't risk your career over one bad ethical decision. Get the advice and information you need every month... Subscribe to Medical Ethics Advisor."

These are only a few examples. Read in toto and in context, and considering the lack of philosophical sophistication of much of the intended audience of this material, it is more offensive still. While some of these claims could in principle be satisfied with respect to legal and regulatory matters, the publication makes them undifferentiated across the entire scope of medical ethics. As such, this material strikes me as deceptive advertising. Over the short as well as long runs, moreover, it seems to me that these claims can be harmful to subscribers and society alike.

What is to be done? Some very distinguished persons are associated with this publication, who may well be unaware that these exaggerated claims have been made. They should dissociate themselves, and seek redress on their own behalf and on behalf of those subscribing under misapprehensions of what can be done about their "most difficult medical ethics decisions." The publication, whose contents may be entirely worthwhile, should modify its advertising practices towards the ethical aim of realistically representing what a couple of hundred pages a year can do for a reader. And this episode should spur the profession of bioethics as a whole into debating our own professional ethics. **Benjamin Freedman, Ph.D.** Assoc. for Bioethics Westminster Institute for Ethics and Human Values, Westminster, Ontario.

Medical Humanities in London: The Second Time Around

Plans are well underway for the 1987 offering of the program Medical Humanities in London: Ethics and History.

As it did last year, the course will study comparisons between the British and American health care systems, especially with regard to their different histories and to the kinds of ethical problems faced by policy makers and individual practitioners. The course instructors this year will be the battle-scarred veteran, Peter Vinten-Johansen, and the fresh-faced recruit, Tom Tomlinson. The instructors plan to make some improvements in last summer's successful debut, streamlining the required readings and striving for a better integration between the historical and the ethical issues.

Most of the arrangements in London are already complete. A seminar room has been reserved in the Robin Brook Centre at historic St. Bartholomew's Hospital, where the class will meet for group discussions and guest lectures on Tuesdays and Thursdays. The co-coordinators in London have selected the general practitioners and health visitors with whom the students will spend some Wednesday mornings, learning first-hand about British health care practices. Agreement has been reached with the museum directors and staff who will be facilitating the history-related field experiences. For those who desire, accommodations have been reserved in College Hall at the University of London, located one block north of the British Museum and near several "tube" stations for easy transportation around the city. And the instructors are still gathering information on the tremendous range of events and trips to be enjoyed on the extended weekends (Friday through Monday) in London, the British Isles, or the Continent.

Students enrolled this year come from a wide variety of backgrounds, and include a number from outside the State of Michigan. Such a mixture should result in a stimulating mix of backgrounds and perspectives. At least one student is known to have extensive

experience in medical economics. Enrollment is still open to undergraduate, graduate and professional students at MSU.

Anyone interested in receiving a brochure describing the summer program should contact the Medical Humanities Program, (517) 355-7550

Peter Vinten-Johansen, Ph.D. (History) and Tom Tomlinson. Ph.D. (MHP)

CONFERENCE SUMMARY

The Royal Society of Medicine and the University of North Carolina co-sponsored a conference on **Need, Demand and Resources: Health Care Provisions at a Time of Financial Constraint** in London, England Dec 2-4, 1986.

In the US, a sufficient proportion of resources is being devoted to health care, but leading policy makers are increasingly frustrated with the system that translates those resources into the actual care provided. In the United Kingdom, there appear to be only moderate dissatisfactions with the system, but an increasing dissatisfaction with the amount of resources society provides for that system. This is the impression created by the conference.

Based on comments by several American speakers representing medicine, economics and health research, pressures may soon build toward the adoption of some form of national or universal health insurance, though no one suggested the US should or would move toward a British-style nationalized health service. The estimated 25-50 million Americans now uninsured or underinsured, and the unmet needs of the elderly, children, and expectant mothers were repeatedly cited. The marketplace as the sole tool of access and efficiency in health care found no defenders.

British commentators laid great stress on the need for further research to allow quantitative comparison of the health benefits produced by alternative expenditures. The quality-adjusted-life-year (QALY) was proposed as a means of cost-effectiveness analysis sensitive to both mortality and subtler aspects of quality of life. A study cited most frequently was a recent comparison among technologies in the UK, showing among other things that spending money on hip replacements or pacemaker insertions produced 14 times as many QALYs as renal dialysis. Serious methodological and ethical questions relating to the QALY concept were not, however, minimized by these speakers.

Historian **Rosemary Stevens** claimed that the US mix of private providers and insurance with public entitlement programs may appear irrational but in fact promotes a set of coherent and deeply valued social goals: protecting individual income from the effects of illness; promoting private enterprise and technological innovation; and encouraging health-care productivity. It is notable, however, that neither social equity nor actual health outcomes are high on this list.

Economist **Uwe Reinhardt** added that while it is now commonplace to hear US physicians and hospitals bemoaning an "age of contracting resources," health care in terms of both real dollars and GNP percentage has continued to rise since 1980; "What has been contracting in American health care is thus not society's allocation of generalized purchasing power to the providers of health care, but society's ability to extract from them in return an equitable distribution of real health-care resources among the nations sick." **Howard Brody, M.D., Ph.D.**

Medicine in Literature: Call for a Beginner's Cookbook

Papers presented at meetings of the Society for Health and Human Values and in the journal Literature and Medicine attest to both the vibrancy of the field of literature and medicine and the high level of scholarship among its relatively few practitioners. Amateurs like me view this with mixed feelings. In addition to the welcome scholarship, I sometimes wish I had some "quick and dirty" advice on how I could better use poems, short stories, etc. as teaching devices when presenting medical and medical-ethical topics to students. And yet such advice might easily be perceived as inappropriate debasement of the discipline, assuming that such a teaching use is unlikely to lead to the students' full appreciation of the literary work as a piece of literature.

I am willing to take the heat from scholars and compile an "Amateur's Cookbook" specifically for the purposes of teaching medical ethics by using literary examples, if readers of the Medical Humanities Report are willing to jot down and send in their favorite "recipe". Recipes might look like these two examples from my own teaching:

"The Heart Asks Pleasure First" (poem, Emily Dickinson)--re: truth-telling. Use to answer the objection that telling the truth denies any hope to terminal patient; show

how "hope changes as death approaches."

"Mercy" (short story, Richard Selzer)--re: active/passive euthanasia distinction. Challenges both the active/passive distinction and how much of the reaction to the distinction (and euthanasia itself) is "gut level" rather than reflective.

The form in which we might compile the cookbook would take shape depending on the number and type of submissions; but we promise to make them available to our readers in some form. All "recipes" will be duly credited to the person submitting them unless we receive contrary instructions.

Howard Brody MHP Coordinator

LITERATURE REVIEWS

Coping with Entitlement in Medical Education" Steven L. Dubovsky, NEJM, 315, no. 26, 1672-1674, Dec 25, 1986: In a recent article, Dr. Steven Dubovsky deplores what he believes is a rising attitude among medical students --"entitlement". Entitlement is the view that one is owed something for nothing. Despite "increased elective time, decreased night call, ethics courses, and other efforts" entitlement has become "pervasive". Dubovsky offers examples from his own experience to demonstrate the nature of this new phenomenon: the students who wanted a course in advanced cardiac support, but who didn't want to be held to the same examination requirements as nurses and paramedics; those who demanded that the pathology instructor provide an outline of the material they needed to know, since the textbook had too much information in it; the student who demanded repeated reexamination because the exams did not fit her "test-taking style", and others. Entitlement threatens to undermine the profession's "commitment to personal excellence", and encourages physicians to think of themselves before their patients.

After a passing acknowledgment that "unnecessarily harsh requirements" should be reexamined, Dubovsky proposes his own remedies. Among these are the **suggestions that faculty model more selfless behavior and that they treat students as colleagues who have a right to affect their own education.**

These positive proposals are as reasonable as any other platitudes, and undoubtedly there are obnoxious students who exemplify the "entitled" attitude that Dubovsky describes. But is this attitude "pervasive"? Dubovsky offers only individual cases, and his footnoted references, which cover almost 20 years and the whole range of physician and medical student vices, offer no more general evidence. My own experience is that only a small minority of students is afflicted.

One should also ask whether what Dubovsky deplores as "entitlement" is always unjustifiable. Many commentators on medical education would share the frustration of the pathology students who were reacting against the fact-cramming format of too many courses, where test-mastery is pursued at the expense of developing skills of problem-solving and research which can be usefully applied in actual practice. Finally, **Dubovsky's call for a rededication to the ideal of the selfless physician should be tempered by the recognition that devotion to this self-image has led many physicians into self-destruction.** At least part of the blame for the high rates of stress-induced drug abuse, suicide, and divorce among physicians lies in the inevitable failure to be a superhuman saint. **Tom Tomlinson, Ph.D.**

"Levels and Sources of stress in Medical Education," Jenny Firth, British Medical Journal: In this important and disturbing study, the author, a British psychology researcher, used a questionnaire to assess levels and sources of stress in medical students in three British medical schools. 318 of the 405 questionnaires distributed were completed, a response rate of 79%, well above the 70% considered minimal for survey research. The two critical findings of her study were: (1) the estimated prevalence of emotional disturbance in medical students was 31.2% (compared with 9.7% in young, unemployed people in other studies); (2) alcohol intake had increased over the past two years for 141 (48%) of the students.

Of the types of events reported as stressful, the four most common categories were **talking with patients, effect of medical school of student's private lives, presenting cases, and dealing with death and suffering.** However, it should be noted that 90% of students who cited talking to patients as stressful related an incident involving talking or failing to talk to a psychiatric patient. And, paradoxically, students rated talking to patients as one of the things they most liked to do. The stress of school on personal lives, according to the author, has not been reported in previous questionnaire studies. She conjectures, "It may be that open ended questions (which were included in this study) permit a lowering of defenses against more stressful

:uations as compared with the direct ques-
)ning used in previous studies." In addi-
)n, she notes that **overwork was not**
)orted as a major source of stress, con-
ary to American studies.

The author comments parenthetically
at the stress of effects of school on pri-
:e lives and of presenting cases "may be
:hangeable aspects of training." However,
e offers no further explanation and I dis-
ree with this off-the-cuff comment. Her
udy found that the category of events that
st strongly aroused feelings of any kind
)t just negative feelings, which defined
tress" in this study) was relationships
th consultants, "students usually describ-
g occasions when they had been humiliated
fore their fellows." This type of humil-
tion often occurs when students are pre-
nting cases. Thus, while intimidation may
a deeply ingrained part of the medical
tablishment, the stress of presenting
tients can perhaps be mitigated by re-
ucating physicians. The reduction in sub-
ctive stress in this area and in the area
effects on students' private lives
pends in part upon the commitment of the
stitution to the psychological well-being
its students. It would be instructive to
peat this survey at American medical
hools with different degrees of accessi-
lity to counseling services. The author
ggests in her conclusions that counseling
rvices may be an important way to reduce
udent stress. She also suggests small
)ups for teaching and support and emphasis
"what students like -- for example, talk-
g to patients," as ways to mediate the
fficulties of medical training.
seph Alfano, 4th yr CHM student

Dear Doctor: A Personal Letter to a ysician, C.E. Odegaard, (1986) Henry J. iser Family Foundation, Manlo Park, Cali-rnia This book is a recent message to erican physicians as they attempt to prac-ce with what remains of their intellectual d behavioral equipment after completion of aining in the conventional medical school d residency program. It decries the fortunate linkage with but one of the "two ltures", and bemoans the poverty of repre-ntation in the modern medical curriculum behavioral sciences and humanities. A otation from a speech by Donald Seldin, air of Medicine at University of Texas uthwestern, proclaims the biological iences as the sole bases of medicine. ile his speech received a standing ovation from the academic internists present, quotes from Drs. Gerald Perkoff, Lloyd Smith, and James Wyngaarden reveal attitudes and descriptions of patient care which make a strong case for the relevance of humanities and social sciences. The chapter in which these differences are stated, called "Reform or Rebuff", introduces the idea of a continuing debate on the issues of the relevance of various studies for medicine.

The author heralds as a "leap forward" the 1985 publication of the "Guide to Awareness and Evaluation of Humanistic Qualities in the Internist", which specifies the nature of some of the disciplines from which interpersonal skills and understanding of patients can be derived. The 1984 GPEP Report, however, he finds equivocal in its presentation, but useful in its recommendations on how medical school teaching should be conducted. He feels the report to be weak on the "what" of medical education. The debate's continued presence, however, is attested to by the vigorous reaction to the Report, which was generally interpreted as a downgrading of bioscience, and which was clearly spelled out in the "Commentary" issued by the COD-CAS working group. He refers with enthusiasm to a recent article by Schwartz and Wiggins which advances a phenomenological approach to the science of medicine; it is reprinted in Appendix I and is surely a cerebral device to bring the various relevant sciences together in the interest of humanistic patient care.

Odegaard is appropriately admiring of Abraham Flexner, and recognizes his educational wisdom and sophistication. However he perpetuates the error of referring to the "Flexnerian curriculum", which actually had been in place over ten years before publication of the Flexner Report. In the mind of this reviewer, Odegaard misses a golden opportunity to question the wisdom of the Liaison Committee on Medical education (LCME), whose accreditation policies continue to retard and complicate development of precisely the kind of educational change he is recommending. The book is well written and reveals itself as the product of an informed and dedicated scholar; and it is entirely possible that his debate-stimulating approach is the way to go, since as President of the University of Washington he must have endured many accreditations visits. **Andrew D. Hunt, M.D.,** St. Simons Island, Georgia, Associate Dean for Glynn-Brunswick Programs, Mercer School of Medicine.

The End of Life: Euthanasia and Morality. James Rachels, Oxford University Press, 1986. Few contributions by philosophers to medical ethics have had both the immediate impact and the staying power of James Rachels' "Smith and Jones example," designed to show that the "bare difference" between killing and allowing to die was not of moral significance, which first appeared in the New England Journal of Medicine in 1975. To some critics, it might have seemed that Rachels was playing quick-and-dirty philosophy, trying to dismiss with one analytic handwave a complex medical-legal-emotional issue. If so, this new booklength treatment should reassure readers that Rachels takes the matter seriously and can provide an extended discussion of euthanasia in terms of positive policy suggestions as well as dismissals of irrelevant distinctions.

Fundamentally, Rachels seeks to justify some instances of euthanasia by calling into question the basic Judeo-Christian rule that euthanasia seems to violate-- that it is wrong to intentionally take innocent human life. Rachels meets this rule head-on and tries to show that virtually every term (intentional; innocence; human) takes us down a side track and away from the compelling reasons that justify or fail to justify killing. Rachels thinks this is so because our culture has forgotten what is really important and worth protecting about life. **He states that we ought to have great respect for lives, construed biographically, and ought to attach value to life, construed biologically, only when the later makes the former possible.**

On euthanasia specifically, Rachels no longer relies solely on the "Bare Difference Argument" and now adds a "No Relevant Difference Argument" to show why the active/passive distinction fails to carry moral weight. In the process he replies to several critics of his 1975 argument. **Howard Brody, M.D.,Ph.D.**

"ETHICAL ISSUES: A Means for Generating Interest in Science" Theodore Lopushinsky, Ph.D., Michigan Academician, vol. XIX, 143-147 (Winter '87)

A case is made for values education becoming a necessary component of all science courses, especially those for the nonscience major. Because of the pervasiveness of the mutually beneficial interrelationship between science (the idea) and technology (the application), no one can escape its biosocial impacts. If learning is a self-generated process dependent upon learner interest, few better ways exist to develop an interest for science in the nonmajor than to challenge personal beliefs that too often result from thinking with one's heart rather than one's brain.

Ecology is selected as the single most important science for values education. No matter how excellent the education experience, it must be found wanting if all involved are not aware of the fact that humans need the biosphere and not the reverse. A view is presented that the best way to ensure appropriate ethical considerations are given to the individual is first to ensure such considerations are given to the community (as defined in the ecological sense of Aldo Leopold). A specific example using the parameters of population dynamics illustrates how this can be implemented. **Theodore Lopushinsky, Ph.D.** is an Associate Professor, Dept. of Natural Science, MSU.

NOTABLE NOTES

Howard Brody had **"Cost Containment as Professional Challenge"** published in the February issue of Theoretical Medicine and expects this fall to have his new book Stories of Sickness (Yale University Press) released. He also has had his article "Teaching Clinical Ethics: Models for Consideration" published in the book Clinical Medical Ethics: Exploration and Assessment, (Terrance Ackerman, et al, eds.) University Press of America, 1987.

Dr. Brody has also been active speaking this winter, giving addresses to the Queens University Medical School Faculty on **"Cost Containment and Quality of Care"** January 15 at Queens University, Kingston, Ontario and to the Ten State Leadership conference sponsored by the Michigan Academy of Family Physicians a talk entitled **"Ethics and the Case Manager Role"** on January 24 at the airport Hilton in Romulus, Michigan. On February 21, Dr. Brody spoke to the medical students at the Northeast Ohio University's College of Medicine in Youngston, Ohio on **"Ethics and the Gatekeeper Role".**

Leonard Fleck will have his article **"DRGs: Justice and the Invisible Rationing of Health Care Resources"** published in the May, 1987 issue of the Journal of Medicine and Philosophy. He will also have his article **"Justice and Health Care: Ethico-Legal Issues in Health Policy Decisions Regarding Older Adults"** in the March issue of the Journal of Gerontological Nursing and **"Pricing Human Life: The Visibility Issue"**

forthcoming in spring in a book entitled ilosophy and Social Policy, (James Sterba, .), to be published by the University ess of America.

Dr. Fleck also participated in the cent conference **Just Health Care: The terface of Ethics, Economic and Health licy**, sponsored by the Jacksonville Health ucation Programs Inc. at the University of orida in Gainesville, February 17-18. Dr. eck's talk was entitled **"Justice, HMOs and e Invisible Rationing of Health Care sources"**

Daniel Bronstein published his article ome Ethical Issues in Toxicology" in Fun- mental and Applied Toxicology 7, 525-530 986).

Special Note: Aids in the Workplace: w Fact Sheet Available

The Southeast Michigan Coalition on cupational Safety and Health has designed factsheet to be used in workplaces in ich workers are **not** at high risk for the ansmission of AIDS. Up to 25 copies of e fact sheet are available at no charge om SEMCOSH, 1550 Howard Street, Detroit, chigan 48216.

Two bills on medical advance directi- s-- **Rep. Hollister's "Medical Treatment cision Act"** to amend durable power of attorney provisions to include medical treatment decisions, and **Rep. Bullard's "Michigan Medical Self-Determination Act"** to provide a document or "living will" to apply to the permanently unconscious or terminally ill but incompetent patient--died in the Michigan Legislature from lack of action when it adjourned last year. Both bills have now been reintroduced for the current session.

Rep. Bullard's bill is essentially unchanged from last year's version. The Hollister bill has been substantially rewritten, in order to spell out more explicitly how the attorney-in-fact (the patient's appointed agent) should function and how the courts can review decisions to make sure that no abuses occur. According to Rep. Hollister, these issues were simply taken for granted in the old draft of the bill, but have now been spelled out to satisfy some critics who felt that the language left loopholes. The basic idea of the bill remains unchanged.

Michigan is still among the minority of states-- 11, on last count-- that do not have some sort of advance directive legislation. Reps. Hollister and Bullard have emphasized in the past that their bills are not contradictory, and might offer two alternative mechanisms for Michigan patients to make their wishes known before they become incapable of choosing.

MEDICAL HUMANITIES CALENDAR

y 10-13	Howard Brody Dale Singer	Int'l Working Conference on Withholding Lifesaving Treatment	Lawrence University Appleton, WI
y 16	Leonard Fleck	"Justice and Health Care Rationing: How Extensive a Right to Health Care Resources do Drug Addicts Have?"	Wayne State Medical School Alumni Assn. Detroit, MI
y 21	Tom Tomlinson	"Informed Consent and the Mentally Handicapped"	Functional Assessment of the Developmentally Disabled Conference, MSU Kellogg Center
y 22	Tom Tomlinson Kenneth Howe Mark Notman	"Proxy Consent for the Elderly"	Michigan Gerontological Society, Western Michigan University, Kalamazoo, MI

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