MEDICAL HUMANITIES REPORT

MEDICAL HUMANITIES REPORT MICHIGAN STATE UNIVERSITY SPRING 1987

MEDICAL HUMANITIES AT MSU: TEN YEARS TOGETHER

The Medical Humanities Program at Michigan State was officially launched in the fall of 1977 under the leadership of Dr. Andrew Hunt, M.D., former Dean of the College of Human Medicine. The past decade has seen the MHP grow from a small, closely knit group of faculty and two "team-taught" courses to its present position as one of the leading programs of its kind in North America. Currently there are three full time and two part time faculty, three graduate assistants, two full time secretaries and nearly thirty associate faculty from 17 departments throughout MSU.

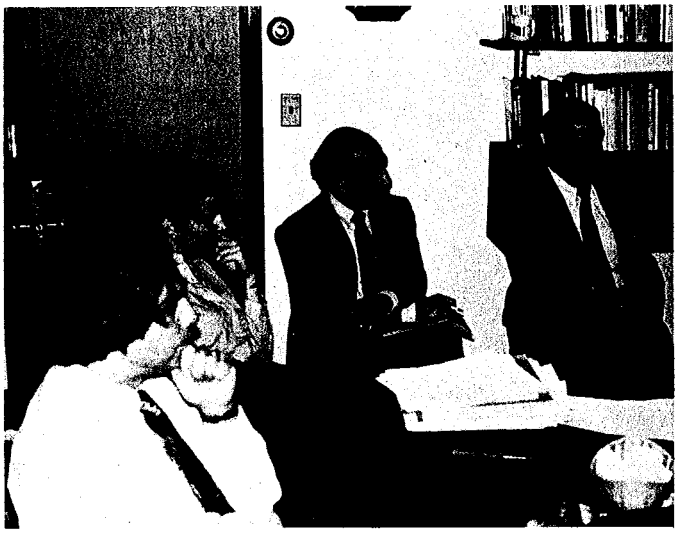
The range and depth of activities in the MHP was evident at a recent Associate Faculty Meeting. The following is a sample of the projects currently underway or recently completed by members of the MHP.

--The establishment of a state wide resource network for the teaching and study of medical ethics. In addition to the core faculty and staff from MHP, the network currently consists of some 30 clinicians and academics throughout Michigan and is growing rapidly. (See related story in Fall 1986 Medical Humanities Report).

--A recently completed empirical study concerning **"Proxy Consent in the Elderly", Tom Tomlinson and Ken Howe, MHP.**

--Development of a proposal to establish an undergraduate medical humanities specialization at MSU. **Peter Vinten-Johansen, History.**

--Investigation to develop a multi-disciplinary masters degree in medical humanities. **P. Vinten-Johansen, History.**



Pictured above are, L to R, Len Fleck, (MHP), Karen Ogle, (Family Practice), Fr. John Foglio, (Family Practice), Jim Waun (Philosophy grad. st.)

Some of those present at the recent MHP associate faculty meeting were, L to R, Tess Tavormina, (English), Deborah Mulrooney, (MHP grad. asst.), David Rovner, (CHM Dept. of Medicine), Bruce Miller, (Philosophy).

--Establishment of a medical humanities overseas summer study program in London, England. One of this program's special features is an opportunity to make home health care visits with medical practitioners in England. **Peter Vinten-Johansen, History and Tom Tomlinson, MHP.**

--One of the MHP's most active associate members, **Martin Benjamin, Philosophy,** is chairperson of the Ethics and Social Impact Committee of the Human Organ Transplant Policy Center at the University of Michigan. **Father John Foglio,** another MHP associate member, also serves on the committee which is regarded as one of the most productive at the Center.

--Bruce Miller, Philosophy, has recently completed several articles on the ethical issues in the design and use of advance directives in medical care, and ethical issues concerning randomized clinical trials.

--Karen Ogle, Family Practice, has developed and taught a new course "Health Care of Women" winter term, 1987 at MSU through CHM. Faculty from Family Practice, Medicine, Surgery and Psychiatry participated.

--Bill Weil, Pediatrics, is a consultant with the Federal Government over proposed changes in the child neglect statues which would mandate medical treatment for all severely handicapped newborns. Dr. Weil and Dr. Benjamin have also just finished a new book on pediatric health care, Ethical Issues at the Outset of Life.

--James Trosko, Pediatrics and Human Development, reporting from China, is currently interested in helping to develop an ethically sound institutional policy for the prevention and elimination of medical research fraud.

Since 1977 the core and associate faculty and staff of the MHP have published scores of papers and books, delivered public lectures throughout Michigan and the U.S., served on dozens of panels, committees and associations devoted to the study, teaching and development of medical humanities. Under the current leadership of Dr. Howard Brody (one of only a handful of physician-philosophers in the country) the MHP has established itself as an integral part of the MSU academic environment. In the fall of this year the Medical Humanities Program will celebrate 10 years of teaching, learning and growth in service to the people of Michigan. Look for our displays and announcements of special activities at MSU, East Lansing, and throughout Michigan.

P. J. Reitemeier

CASE STUDY

Mrs. M., a 78 year old widow, was admitted to the hospital to stabilize her uncontrolled diabetes, prior to surgery. After two days her serum glucose (blood sugar) was below the level requiring hospitalization for diabetes management according to DRG guidelines.

Mrs. M. was well known to the nursing staff, and it had been difficult in the past to manage her diabetes adequately on an outpatient basis. Mrs. M. lived alone and had no close relatives or companions to help monitor her diabetes.

Though she no longer qualified for continued hospitalization under current DRG payment formulas, the nursing staff urged the physician to keep Mrs. M. in the hospital until her diabetes was well under control. The physician, in anger and frustration at the rigid DRG regulations, ordered the nurses to make preparations for Mrs. M. to go home. He then discharged her.

What are the obligations and priorities of the nurse writing the discharge plans? Should she carry out the Dr's. orders without comment, or should she protest the Dr's. decision, and if so, how strongly? Is she obligated to try to find another means of keeping Mrs. M. in the hospital? What does she tell Mrs. M.?

Commentary #1: The case study is typical of the kind of situation nurses frequently encounter. It does not deal with major moral dilemmas that are presented in ethics textbooks, such as the right to die or refuse treatment. Rather, the patient, by seeking treatment now, is caught in a system that makes it difficult to receive the optimal method of treatment.

The nurse's ethical dilemma stems from the conflicts in nursing practice. The nurse is expected to function as a practitioner of the nursing profession, as an advocate for the patient, and as an agent of the physician.

The nurse's first priority should be to ensure that the rights and safety of the patient are not compromised. After urging the physician to disregard or "work around" the particular DRG regulations to

no avail, the nurse then has a responsibility to determine whether or not such a discharge is safe.

The second action the nurse should take is to explore with the patient the options for management at home, and to encourage the patient to ask questions and discuss any concerns with the physician, as well as with the nurse.

If issues of patient safety are resolved and the patient is fully informed and agreeable to the early discharge, then the nurse's responsibility is to facilitate the transition from hospital to home, to preserve the patient's right to participation and to continuity of care.

If the nurse determines that safety issues and continuity of care issues are not resolved, then another course of action is needed. The first step is to remember that the physician most likely has had a longer period of time to get to know the patient and the patient's capabilities, and therefore should be approached again. The second step would be to inform the hospital supervisor and pursue the issue of whether or not the hospital would be liable. Often this last step tends to delay the discharge, thereby obtaining at least a few more days of hospital management of the illness--possibly ensuring that the discharge will be a safe one.

Barbara Brown, RN, Home Care Coordinator, Ingham Medical Center

Commentary #2: Mrs. M., "well-known" to the nurses, has obviously been frequently admitted. Her main problem is home management of her diabetes and this is where the nurses attention should be focused. This is especially true if she faces a surgery in the near future and will be returning home subsequently.

The main question is, does the nurse have time before Mrs. M leaves to do what is needed to insure a safe discharge? At minimum, Mrs. M needs to know what steps to follow in the event of a crisis. Ideally, home health follow-up should be arranged so that an assessment can be made as to **why** she isn't managing at home. If there is not time to insure safe discharge, the nurse is obligated to try again for a delay. The physician should again be contacted. If she doesn't agree, the nursing supervisor should be notified and her help enlisted.

Mrs. M needs to be involved in the discharge planning and informed as to what is being done. Her concerns need to be addressed; she can probably give information as to what her most pressing needs are. The nurse, whatever the outcome, should document the discharge plan and any other information received from or given to Mrs. M and send it to the physician's office. She should see if one of the office staff would take responsibility for further follow-up to assure continuity of care.

M. L. McLeod, RN

KEN HOWE to Accept Position at University of Colorado

In 1981 the Medical Humanities Program had received funds to implement required medical ethics teaching in three health colleges at MSU, and needed an evaluator to assess the success and impact of that teaching. This was a tall order, as the number of people who thoroughly understand both evaluation research methodology and philosophical ethics can probably be counted on the fingers of one hand. The original proposal called for the hiring of a senior evaluator on a part-time basis. It took a while to realize that the best possible person for the job was then a graduate student completing his cross-disciplinary Ph.D. in Philosophy and in the College of Education at MSU.

Len Fleck and Ken Howe good-naturedly indulge the MHP's intrepid photographer.

And so Ken Howe came to work with us. The wisdom of the choice is amply reflected by several papers on the evaluation of medical ethics teaching, groundbreaking works in many ways, produced by Ken and colleagues at the conclusion of that curriculum implementation project.

But Ken's teaching and research skills extended far beyond the rather narrow job for which he was recruited. He eventually came to manage for us most of our teaching in the College of Human Medicine, including innovative ways to introduce ethics material into the nontraditional Track II program. Not infrequently he was on the road to conduct ethics seminars for clinical students in our community campuses.

Ken, now an Assistant Professor in the MHP,. recently completed co-investigation with Tom Tomlinson, of proxy consent in the elderly, a project which, I immodestly believe, can serve as a model for well-designed, creative empirical research in clinical medical ethics. His statistical knowledge also served him well in recent service on the Governor's special task force on AIDS policy. Ken was able to point out--and to back up his observation with quantitative estimates--that the real reason to oppose mandatory AIDS testing in low-risk populations is not a public health vs. civil liberties issue, but a scientific and epidemiological judgment.

For all of these accomplishments (to say nothing of good fellowship and collegiality), Ken will be sorely missed here. We hope that his new faculty position in the School of Education at the University of Colorado, which will include both work in philosophy of education and opportunities in the public policy arena, will bring him the career rewards and recognition that his talents deserve.

Howard Brody, MHP Coordinator

Medical School Admissions: Some Rethinking Has Begun

The **University of Pennsylvania** has eliminated all course requirements for admission to its School of Medicine and will no longer even recommend undergraduate courses. The policy takes effect for applicants to the fall, 1988 freshman class and is part of a general trend to encourage medical school applicants to take more liberal arts courses in an effort to lead to "very compassionate, humane physicians." U of Penn still requires all applicants to take the standardized entrance exams including the Medical College Admissions Test (MEDCAT) which traditionally focuses on knowledge of the physical sciences (physics, biochemistry, chemistry, biology, etc.) **Dr. A.G. Swanson,** V.P. for academic affairs of the Association of American Medical Colleges, was quoted in a recent N.Y. Times article as saying "I think it may be the trend of the future. It gives much more flexibility to college programs. And that could permit a better balance between science and the humanities."

In a similar attempt to encourage students to sample a broader range of courses in the undergraduate curriculum, **The Johns Hopkins University School of Medicine** announced in May, 1985 that it would no longer require applicants to take the MEDCAT exam. Johns Hopkins has also begun to guarantee admission to its medical school to some college juniors, giving them more time to indulge their intellectual appetites. **Southern Illinois University** and the **University of South Carolina Medical Schools** are dropping or have eliminated course requirements similar to the University of Pennsylvania, but continue to make course recommendations. According to the N.Y. Times article such recommendations "become a de facto requirement in the view of many undergraduates".

Dr. Katherine E. White, Ph.D., MSU COM, Director of Admissions and Asst. Dean of COM reports that the COM Admissions committee is currently considering dropping the interview requirement as part of its admissions procedure, but not the required courses or MEDCAT exam. "The exam", Dr. White said "is the only thing all the applicants have in common" and is "one of those sacred cows" in medical school admissions procedures.

Dr. Geraldine Purcell, Ph.D., MSU CHM Assistant Dean Dept. of Preclinical Curriculum and Student Affairs, said the Admissions sub-committee which is reviewing the CHM admissions procedure was not considering dropping the MEDCAT requirement. They were, however, investigating establishing clearer guidelines for course requirements, so that applicants would know, for example, which type of chemistry courses would fulfill the chemistry course requirement and which would not. In addition, the sub-committee is considering adding basic life support (CPR) training as a requirement prior to admissions. If the final recommendations of the sub committee are accepted, it would only affect applicants to the fall of 1988 or possibly 1989 entering class.

P. J. Reitemeier

To The Editor:

The exchange between Leslie Norins and Benjamin Freedman in the Winter 1987 issue of the Medical Humanities Report is very unsatisfying-- some ad hominem grunting from Norins, some vague sermonizing from Freedman. The question posed is whether the advertising used by Medical Ethics Advisor is deceptive or not, a question impossible to answer without some characterization of the true nature of the content being (mis)represented. But neither Norins nor Freedman says much at all about what one actually finds in MEA.

So permit me. MEA features two sorts of articles. The first is the factual report--of a law, court ruling, policy, or what have you. In the April, 1987 issue, the reader finds "New criteria for infant brain death due for publication within the year", "Best interest standards apply to withdrawal of life-support care", and shorter pieces under the heading "News Briefs." As long as they are reasonably accurate, these news pieces are unobjectionable and often helpful. I have used information from MEA in my own research and teaching.

But although MEA may indeed be "jam-packed with the latest information", information is not advice, which is what the MEA ad copy and masthead promise. Perhaps that is to be found in the second sort of article, the "Ask the Expert" feature. In April's issue, these include "Experts examine impact of Vatican denouncement", "IECs should set institutional policies for surrogate motherhood programs", among others. These pieces are constructed by stringing together short quotes from various sources (with varying claims to expertise), usually with the apparent goal of representing, in a superficial way, several different "perspectives" on an ethical problems.

But again, where is the advice? Neither MEA nor the articles themselves offer the reader the background and skills necessary for judging whether any single expert's summary conclusions are worth following, let alone which to follow when the experts disagree. Should a reader of April's issue, looking for help in developing a hospital policy for handling surrogate mothers, follow the lead of an anonymous physician, the Sisters of Bon Secour, or Lori Andrews, each of whom suggests something different? The undiscriminating editors of MEA offer no guidance, despite the title of their publication.

So MEA stands convicted of false advertising. It offers no advice worth taking, at least not before it has been ratified by one's own independent and informed judgment. But is it deceptive--has anyone been fooled? I doubt it. In America today, not even the most benighted bumpkin believes everything he's told by an advertisement, let alone the urbane sophisticates who can command MEA's subscription rate. The inflated ad copy might lure some people to send away for their free sample, which they can then judge for themselves. If they decide to subscribe, it will be because MEA serves other worthy purposes (as it does for us in the MHP), not because they look to it for the answers to their ethical problems.

Tom Tomlinson, MHP.

Court Rulings on R_x Withdrawal Surprisingly Concensual

The recovery of 44-year-old **Jacqueline Cole** from what had been diagnosed as an "irreversible coma" on day 47 -- six days after her husband had sought a court order to allow life-sustaining treatment to be withdrawn, in accordance with Cole's previously expressed wishes-- has led to questions about the wisdom of a policy that allows discontinuing life support for some coma victims. Medical Ethics Advisor (March, 1987) quotes the patient's attending neurologist as stating that the recovery from her cerebral hemorrhage was a near "miracle" and that her chances had been less than 1/100,000. But neurologist **Ronald Cranford** claimed that a mistake had been made and that it was too early in the patient's course for an adequate prognosis.

A panel of expert neurologists, in an Appendix to the President's Commission Report on Deciding to Forego Life-Sustaining Treatment (1983), claimed that **one could make a diagnosis of permanent loss of consciousness with very high, but not complete, reliability after two weeks of unconsciousness.** The only accounts of the Cole case we have seen are a Time magazine article and the MEA commentary; neither provides sufficient detail on the patient's medical condition to conclude whether the diagnosis and prognosis were arrived at properly. In any event, no one has ever claimed 100% accuracy for such a diagnosis. It is not yet known how full

Ms. Cole's recovery will be; she apparently suffered residual paraplegia and memory impairment.

It is not known how much, if any, influence the Cole case will have on future court rulings on treatment withdrawal from patients. To date, however, rulings in several state courts have been surprisingly consensual in both their decisions and published opinions. In Rasmussen v. Fleming, a 1986 case in the Arizona Court of appeals, Arizona joined the several other states with high-court rulings that permit the withholding or withdrawing of life-prolonging food and fluids. Ms. Rasmussen was a nursing home patient who had had three strokes and suffered from a severe organic brain syndrome. She had never made her specific wishes known regarding life-prolonging therapy.

The court ruled that artificial means of providing food and fluids to a patient without hope of cure could be included in the category of "extra-ordinary" measures. These could be refused if the patient had so indicated when competent at an earlier date. In the absence of such expressed wishes, a guardian, family member, or physician could request withdrawal of "extra-ordinary" means if this withdrawal seemed to be in the patient's best interest, taking into account the patient's prognosis and the intrusiveness or risk associated with the intervention.

We know of no court decision in the U.S., affirmed at a higher court level, that has ordered the use of food and fluids in all cases for adult patients. The courts are unanimous so far in viewing food and fluids as analogous to respirators-- usually beneficial to the patient, but withdrawable either at the request of a competent patient or when they provide no real benefit. Given the apparently controversial nature of decisions to forego food and hydration, this degree of court unanimity is quite striking.

Howard Brody

Literature Review

1. Robert L. Schiff, et al. **Transfers to a public hospital: a prospective study of 467 patients.** New England Journal of Medicine, 314:552-557, 1986. 2. George J. Annas, at Law: **Transferring the ethical hot potato.** Hastings Center Report, 17(1): 20-21, February 1987.

With increased concern about how cost containment may impact on quality of patient care, one area to come under special scrutiny is the transfer of patients between hospitals. Schiff and colleagues, from Cook County Hospital in Chicago, describe the problem of transfers to an inner city public hospital. They studied 467 patients transferred from another hospital's emergency department to Cook County Hospital between November 1983 and January 1984. 87% of these patients were transferred because they lacked adequate medical insurance. (Perhaps more surprising than this number is the fact that they were able to obtain explicit admission of this from the emergency room physicians interviewed.) 24% of these patients were in unstable clinical condition at the hospital of origin, and 22% required admission to intensive care on arrival at Cook County. The authors were reluctant to guess how many patients actually suffered harm because of the transfer, but they felt that clearly a number of deaths, which occurred in 9.4% of the patients, were partly due to the delay in treatment because of the hospital transfer. In only 6% of the cases was patient consent obtained for the transfer. The vast majority of patients had no understanding of why they were transferred.

Since this study was conducted, the general trend has been to move strongly against "dumping" of patients for strictly economic reasons. Several courts have ruled that a hospital is liable for damages if it transfers a patient for economic reasons, when the patient later suffers harm because of the transfer; and at least one state (Texas) has passed a law specifically prohibiting dumping patients.

Annas deals with a novel sort of patient dumping - the dumping of a patient because of ethical conflicts between hospital staff values and the care requested by the patient. He discusses a New Jersey case In re Requena, involving a woman with amyotrophic lateral sclerosis (ALS). The patient was felt to be incurable, and accordingly requested that her life not be prolonged with a feeding tube. By the time this decision was reached, she had established good relationships with hospital staff and felt comfortable and supported in that institution. The hospital, however, decided that discontinuation of tube feedings was contrary to the moral values of the institution, and if the patient wished that modality of care, she

should be transferred to another hospital. The court ordered the hospital not to transfer the patient, ruling that her right to refuse tube feeding was valid, and that the emotional burden of transfer was inappropriate. Annas argues, **"if hospitals are to become the humane institutions they often claim to be, they must remain flexible enough to honor the competent wishes of their patients without forcing them to return home or engaging in "ethical dumping" by transferring them to other institutions. They must also learn to distinguish between "ethical" issues and patients who do not accept everything they offer."**

Annas' rather strong defense of patient rights, and the insistence that hospital staffs have a duty to provide patients with almost any form of treatment they request, potentially could create problems for hospital staffs (especially in religious hospitals) who have deeply held moral objections to discontinuance of tube feedings and other controversial modalities. Other court rulings suggest that hospitals can effectively institute policies to say that certain treatment refusals will not be honored in their institution. The problem is that they must announce these policies in advance of the admission of a particular patient making that request. That is, **patients must be forewarned that certain things are not available at the hospital in question, and they must have an option at admission of seeking care elsewhere.** It is too late, in the views of some courts, for an institution to suddenly decide it has those moral values once the patient has been admitted.

Howard Brody

MEDICAL HUMANITIES PROGRAM CALENDAR

June 18	Kellogg Center MSU Campus	"Hospital Ethics Committees: Moral and Educational Challenges." Michigan State Medical Society and MHP Workshop. Keynote: E. Grochowski, M.D. (Not open to the public).
July 7-Aug 6	London, England	Medical Humanities in London. Summer courses. T. Tomlinson, P. Vinten-Johansen
Aug 18-22	Snow Mountain Ranch Granby, Colorado	"Hospice Care in Terminal Illness", International Hospice Institute. MHP faculty.
Sept 17	Clarion Hotel Conference Center Lansing, Michigan	"Ethical Issues in the Treatment of AIDS Patients" MSMS Health Care Assn. Drs. Kately, Tomlinson.

Number of Americans who have someone else's heart: 300
Number of Americans who were conceived in a test tube: 400
% age of Americans who say birth control info should be available on T.V.: 78
Value placed on a human life by OSHA: $3.5 Million
Value placed on a human life by FAA: $.65 Million
Value placed on a human life by a contract killer in the Bronx: $5,000
(Source: Harper's Index 2/86 and 1/85)

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

Volume 9 No 3

MEDICAL HUMANITIES PROGRAM
MICHIGAN STATE UNIVERSITY
SPRING 1987