Saint Louis University

Center for Health Services Education and Research

HEALTH CARE ETHICS IN A PLURALISTIC SOCIETY:

ISSUES IN COMMUNITY HEALTH

HA 314-542-02

Professor: Philip Boyle, OP, S.T.L.

One Credit Hour

Spring Semester, 1986

Nurses Building

3525 Caroline Street

Mondays

4:20pm
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OBJECTIVES OF COURSE

This course is designed to introduce the student to some of the major areas of health care ethics and community health. Problems with ethical decision making in relationship to patient responsibilities, patients' rights and decisions about life and death will be discussed. In addition, topics which raise issues in public health, public education and the relationship between society and health knowledge will be examined.

COURSE REQUIREMENTS

Each student is expected to participate in all class discussions and case resolutions through preparation of ethics cases and assigned readings. All required readings are contained in the syllabus. Additional reading materials will be found in the Medical School Library and on the reserve shelf of the library.

The final grade is a composite score of class discussion and participation (30%), plus a brief logical analysis of specified articles (40%) and a final exam to be given on a date yet to be determined (40%),

The logical analysis should be no more than two pages. It shall include a synopsis of the argument and the major premises and a brief critique of argument. It is due no later than the day of the assigned readings.

OFFICE: Caroline Building, Room C-307

Phone: 557-8195
INTRODUCTION TO HEALTH CARE ETHICS

Case Development

Ethics Work-Up for Case Studies

Readings:

ETHICS WORK-UP FOR CASE STUDIES

The following three steps are designed to help you reflect critically upon the ethical issues (value conflicts) that can arise in medicine and which need to be resolved.

1. **Identify** the various facts and values that arise in the case.

   The facts and values can be those of the health seeker or provider. These can include medical facts about the diagnosis and the prognosis that would include possible risks and outcomes of treatment. Important medical facts would also include social history. Besides medical facts there are philosophical facts that could be important to a case, such as the definition of personhood, religious beliefs, etc. Both the medical facts and the philosophical facts can be ambiguous or uncertain.

2. **Evaluate** the conflicting facts and values which are at issue.

   As the facts and values are determined there will be conflicting claims. The values of the patient will come into conflict with the values of the provider. The evaluation of the conflict requires that one set of the values be chosen (which values ought to be realized in this situation) where not all values can be realized.

3. **Justify** the choice that you have made.

   Justification requires that you identify the ethical framework that is used to make your choice for certain values. What ethical principles, norms or rules are you following, and why?
RIGHTS AND RESPONSIBILITIES OF HEALTH SEEKERS AND PROVIDERS

Case Study:
"Choosing a Therapy When Doctors Disagree"

Readings:


CHOOSING A THERAPY WHEN DOCTORS DISAGREE

A 31-year-old man was admitted to the hospital with a recurrent skin tumor. Several years earlier he had noticed that a mole, which had been present for at least five years, was beginning to change in color and bleed. He visited his private physician who recommended its removal and referred him to a nearby surgeon. After excision, pathological examinations showed that the skin lesion was a malignant tumor. This led to the surgical removal of a larger portion of adjacent skin and lymph nodes draining the area. Just before the current hospital admission a lump appeared a considerable distance away from the initial site of disease. When the patient's physician examined him in his office he considered this to be evidence of the return of the tumor and arranged for his entry into the hospital's surgical ward.

A series of consultations have now been arranged, both by the surgeon and by the intern and resident staff. These are intended to clarify the medical issues of the case, not only in the patient's own interests, but as an exercise needed for the training of young physicians.

A group of internists has arrived and at this moment is considering the facts in this case and management alternatives. There are two approaches possible to the existing medical dilemma. Cure is unlikely once the disease has escaped regional confines defined as the lymphatic drainage area of the original tumor. The new nodule may be surgically excised, but there is a very high likelihood that another one will appear elsewhere within a short time. On the other hand, an experimental immunological approach may be used which involves the injection of material directly into the malignant tissue in an effort to evoke an immune response that may have long-lasting benefit. A suitable period of discussion is closed by a statement from the senior immunologist who says, "In my opinion, while the outlook is grim either way, at least the experimental approach gives the patient a new chance not offered by conventional therapy. I would therefore favor its use. However, since this case is on the surgical service, I have no doubt that the malignant tissues will be excised. Our recommendation, however, should be recorded."

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REFUSING, WITHHOLDING AND WITHDRAWING TREATMENT: ALLOWING TO DIE

Case Study:

"Withholding Treatment from the Incompetent"

Readings:


WITHHOLDING TREATMENT FROM THE INCOMPETENT

Mr. Saikewicz has lived all of his 67 years in institutions for the severely mentally retarded. With an IQ of 10, he has the intellectual capacity of a 3-year-old child. On April 19, 1976, he was diagnosed as having acute myelogenous leukemia.

You are the hospital administrator called in by the institution to advise on Mr. Saikewicz's treatment. You know that this form of leukemia is incurable, but that with aggressive chemotherapy the patient has a 30 to 50 percent chance of achieving a remission lasting from 2 to 13 months, after which the leukemia will recur. The chemotherapy involves several weeks of treatment with potent drugs, which entails severe discomfort and nausea, and could be fatal. Because of the patient's inability to understand or communicate other than by grunts and gestures, he could not cooperate in the therapy and would probably have to be physically restrained. Without treatment, he would live some weeks or months and would probably die of infection.

What course of treatment do you advice for Mr. Saikewics?
Class 7
Class 8

GENETICS, TRUTHTELLING AND HEALTH

Case Study:

"Sickle Cell and Black Genocide

Readings:


Wilbur Johnson and Mae Sanford, both black, had met while working on a community action project in a large Eastern city. After going together for a year, they decided to get married and have a family.

When they appeared for the premarital blood test, which their state required for venereal diseases, they discovered that the state also required black marriage license applicants to be tested for the carrier state or "trait" of sickle cell disease. The disease itself is an inherited abnormality in the structure of hemoglobin, which at a minimum almost always severely handicaps its victims, and kills half of them before the age of 20. It is an autosomal recessive; that is, both parents must be carriers (heterozygotes) before there is a risk of producing children with the disease (homozygotes). When both parents are carriers, the risk of bearing such a child is 25 percent with each pregnancy. Carriers themselves are almost symptomless and have no idea of their status unless they are screened.

Mr. Johnson's younger brother had died in adolescence from the disease after many painful and debilitating attacks. He thus knew something about it, including the fact that there was a good possibility that he himself was a carrier. Since both his parents were carriers, there was a 50 percent chance that each of their children would be one. Mr. Johnson also knew that the trait is fairly common among black Americans, about one in twelve of them being a carrier, so there was a good chance his financee was a carrier too.

There is currently no widely available, low-risk prenatal diagnosis for sickle cell disease, and although treatments are available, they are not satisfactory enough to make possible a near-normal life for most victims. Thus, two prospective parents who know they both are carriers have only three options~ they can risk a 25 percent chance of having a child with the disease itself with each pregnancy, living with the attendant anxiety; they can resort to artificial insemination with a noncarrier donor; or they can forego childbearing altogether, perhaps adopting if the short supply of adoptable babies permits.

Mr. Johnson found each of these alternatives infuriatingly unacceptable. He argued that the compulsory premarital screening of blacks for the sickle cell trait which is not a clinical condition and about which nothing can be done was just another government attempt to cripple black reproductive capability. In the context of black history, he viewed it as an attempt by white society to control his fecundity in the beneficent guise of providing free medical information. Since he could do nothing with the information except undergo great anxiety or refrain from fathering children, he charged that the law was simply camouflaged genocide. He was particularly annoyed that while the state rushed in to mandate compulsory screening--screening which might suggest that blacks should have no children--it paid no attention to the need for counseling connected with that screening which would help those identified as having a sickle cell trait to understand their situation and the alternatives for having children.

Ms. Sanford did not feel so strongly, but she agreed that there was a danger whenever the state singled out black citizens as targets for a compulsory medical program. She decided that she wanted to oppose the test too.

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Class 9
Class 10

OCCUPATIONAL HEALTH

Case Study:

"Black Lung Disease and National Health Insurance"

Readings:


BLACK LUNG DISEASE AND NATIONAL HEALTH INSURANCE

The Harris County Coal Company operated ten small mines in West Virginia with an average of thirty miners each. National health insurance had just been passed by Congress providing government-financed health care for all, with a provision that the insured pay the first $50 in any given year. Within the past year it had also happened that a number of techniques were developed to minimize the impact of coal dust on miners who developed black lung disease from prolonged exposure. The problem was that the most effective prevention techniques were expensive. They required both massive ventilation systems and costly hourly monitoring of the air quality throughout the mine. It was estimated that the full prevention program would cost $750 per miner. The union had demanded that the program be initiated by the company, but recognized that these small-scale West Virginia mines were marginal operations. The added cost, according to management, would close the mines. By coincidence, a government study had just shown that the predicted cost to the government for treatment of the black lung disease from the mine under present conditions would also be about $750 per person pro-rated over all mine workers.

Serious policy questions were raised for the government. Should it require the mine to install the black lung disease prevention program in order to protect the miners as well as to promote the public interest by lowering the cost of national health insurance? Should the mines be allowed to pass the cost along in the form of a pay cut?

The mine management proposed another plan, giving the miners a choice of either working in the mines with the prevention program installed and taking a $750 pay cut, or working in the mines in their present conditions without taking the pay cut. Those working in the mines without the prevention program would not be covered for black lung disease in the national health insurance program.

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VOLUNTARY HEALTH RISKS

Case Study:

"Should States Require Child Passenger Protection"

Readings:


SHOULD STATES REQUIRE CHILD PASSENGER PROTECTION?

Motor vehicle accidents are the leading cause of death and injury in children over one year of age in the United States. In response to this problem, bills have been introduced in the legislature of more than twenty states that would require children to be restrained when riding in motor vehicles. Details such as age limits and types of allowable restraint devices have varied with the individual proposals. Laws have been passed in Tennessee and Rhode Island requiring child passengers to be restrained under certain circumstances. In both states, as well as in many other states where similar laws have been proposed, objections have been raised on the basis of individual and family rights.

A state legislative commission has drafted a Proposed Model Law: Every driver transporting a child under the age of five years in a motor vehicle registered in this state and operated on the roadways, streets, or highways of this state shall provide for the protection of the child by properly using a child passenger restraint system meeting applicable Federal Motor Vehicle Safety Standards. Is such a law a necessary protection, or does it violate due process, privacy, and the right of parents to raise children as they see fit? Does it also discriminate economically?

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RIGHTS TO HEALTH CARE

Case Study:

"Forced Transfer to Custodial Care"

Readings:


FORCED TRANSFER TO CUSTODIAL CARE

Mrs. B, seventy-four years old, has diabetes and is partially blind. She has lived in a nursing home for the past ten years, and the state Medicaid agency pays her expenses. She feels secure in the home and she has made many friends there.

The state is trying to save money by caring for its elderly medical patients at the lowest possible cost. Many patients are being transferred from nursing homes to less costly facilities that basically offer only custodial care. The goal is to move as many patients as possible out of facilities providing inappropriately intensive medical support to institutions offering maintenance meeting state-approved standards of quality, but without the medical services now deemed unnecessary.

An arbitrary grading system has been established to evaluate nursing home patients to determine their suitability for transfer. Patients are assigned a certain number of points according to their ability to dress, feed, clothe themselves, and the like. If the number of points the patient receives is higher than a designated total, officials feel that the patient can be transferred without any harmful effects.

When she is evaluated, Mrs. B receives more than the designated number of points and the decision is made to transfer her. She is not consulted, nor is she given a voice in the decision. She is simply moved--forcibly and against her wishes--to a custodial care institution. The evaluation does not take into account the psychosocial impact of the move or the personal dimensions of Mrs. B's adjustment to the home she had been in for the last decade.

Is the state's conduct ethical? Since it is paying the costs of care, and since it has assigned a higher priority to other areas of medical care for funding, does it have the right to disregard individual patients' wishes concerning the location of their care?

* * *
AIDS: PUBLIC HEALTH AND MORALITY

Readings:
