Saint Louis University
Center for Health Care Ethics

THE CUTTING EDGE
ME-1

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

One Credit Hour
Third Trimester, 1986

Learning Resource Center
Room L-104
Mondays
1:00 - 200pm
ME-1

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OBJECTIVES

This course is designed to introduce the student to the issues on the "cutting edge" of health care ethics. Issues not covered in the required bioethics course, Basic Concepts of Medical Ethics, and current in news media coverage will be considered.

REQUIREMENTS

Each student is expected to participate in class discussion by reading assigned material and preparing cases for particular classes. Assigned readings are contained within the syllabus.

There will be no final examination. However, to pass the course, class attendance and participation in discussion is strongly urged.

The final grade is a composite of class discussion and participation (60%) and two brief topical analyses of specified articles (40%).

The topical analysis should be no more than four (4) pages in length. It shall include a synopsis of the argument and the major premise as well as a brief critique of the argument. It is due no later than the day of the assigned readings.

OFFICE: Caroline Building, Room C-307

Phone: 577-8195
AIDS

Case Study:

"If I Have AIDS, Then Let Me Die"

Readings:


Dr. Lois Dorsey, a psychiatry resident, was paged by an intern from the Medical Intensive Care Unit (MICU) for an emergency psychiatric consultation. Gary Davidson, a twenty-eight-year-old gay man, had been hospitalized eleven days before for a first episode of Pneumocystis carinii pneumonia (PCP). One week earlier he had been told that the presumptive diagnosis for his illness was Acquired Immunodeficiency Syndrome (AIDS).

On the day Dr. Dorsey was called, the medical team discussed with Mr. Davidson the need for a Swann-Ganz catheter, which would be inserted in his pulmonary artery. Mr. Davidson refused permission for placement of the catheter and requested that medical treatment be stopped. "Take the tubes away and let me die with dignity," he declared.

The medical team discussed in detail with Mr. Davidson, his lover, and his parents and sister his clinical status and prognosis: Mr. Davidson had, they believed, a 50 percent chance of surviving the current illness. However, people with AIDS rarely survive more than two years and Mr. Davidson could expect several bouts of severe illness during his remaining lifespan. They also pointed out that rapid advances were being made in understanding the pathophysiology of AIDS and offered the prospect for a future treatment as a result of current research efforts.

With the support of his lover and family, Mr. Davidson continued to insist on cessation of treatment, citing as his reason "quality of life" and the "right to die with dignity." In the presence of witnesses he signed a living will and statement of competency. The legal formalities were carried out: however, for "legal reasons" and "completeness," before complying with the patient's request, the medical team was waiting for a psychiatric assessment.

Dr. Dorsey reviewed Mr. Davidson's records and interviewed him. Mr. Davidson reaffirmed his belief that quality of life was more important than quantity of life and that he wished to die with dignity. He admitted that he was feeling pain, fear, loss of control, extreme discomfort on the respirator, and sleeplessness. He added that he was distressed by his inability to eat (on the respirator). When Dr. Dorsey asked how he might feel should he recover from the pneumonia, the patient noted that he knew he had AIDS and that he would die within one or two years. Therefore, he said, he did not deserve to take up a bed in the hospital and continue to receive medical treatment that could better benefit another patient.

The patient had no psychiatric history and had never attempted suicide. He had never had any personal experience with death or dying among family or friends. He could not speak because of the respirator tubes, but he communicated by writing notes and nodding his head. He was alert, not disoriented, wrote clearly and logically, and initiated his own statements and topics for the interview. He was not tearful but appeared anxious. In his own eyes he did not want to commit suicide, but wanted to be allowed to die.

Dr. Dorsey concluded that the patient showed no evidence of confusion.
psychosis, or delusional thinking, but that he did show symptoms consistent with depression, probably secondary to his underlying medical condition.

Mr. Davidson, then, was legally competent, understood the consequences of his decision to refuse treatment, and had the support of those closest to him. Yet, because of his age and depression, the availability of treatment for his current illness, and the possibility that some treatment for AIDS may become available within the next few years, Dr. Dorsey hesitated.

Should Dr. Dorsey accept Mr. Davidson's answer?

Is it paternalism for the provider not to take the patient's answers at face value?

What would you have done?

* * *
ECONOMICS AND HEALTH CARE

Case Study: "The Doctor, the Patient, and the DRG"

Readings:


Lakeview Hospital in central New Jersey has been reimbursed on the basis of "diagnosis related groups," or DRG's since May 1980. The hospital's medical director, Jared Lapin, M.D., acts as a liaison between the hospital's managers and the medical staff. In addition, Dr. Lapin and Ellen O'Connor, director of finance, periodically review the performance of individual physicians from a financial viewpoint.

At a recent meeting, Dr. Lapin and Ms. O'Connor analyzed a lengthy computer report that matched, for each physician, the revenue the hospital received with the costs incurred for treating patients in each of the DRG's in one month. While studying the fifteen DRG's under Major Diagnositis Category number 14 (Pregnancy, Childbirth, and the Puerperium), they noticed that Dr. Daniel Weiner admitted seventeen patients who were later determined to be in DRG 373 (vaginal delivery without complicating diagnosis) but only two in DRG 371 (cesarian section, without complication and/or comorbidity). Yet for the other three obstetricians on staff, fifty-eight came under DRG 373 and nineteen under 371. Across all deliveries, the costs of treating Dr. Weiner's patients exceeded the revenue received from the DRG rates. But the total cost incurred in providing care to the other obstetricians' patients was considerably below revenue and hence the hospital was able to earn a "profit."

The computer report also revealed that the reimbursement rate the hospital received for routine deliveries fell just short of covering all the incurred expenses, whereas the rate paid for cesarian sections was substantially greater than the actual cost to the hospital. The reason for Dr. Weiner's comparatively poor overall "fincial performance," Dr. Lapin and Ms. O'Connor concluded, was that he performed many fewer cesarians than did his colleagues.

Dr. Weiner explained that he did not agree with his colleagues that once a woman had a cesarian delivery, all subsequent deliveries must be cesarian; he felt that most of these women could have normal deliveries. He cited a number of recent studies that found no differences in outcomes (in terms of health risks to both mother and child) associated with the different delivery modes. Dr. Lapin countered that the tradition of performing repeat cesarians was strong and that more time and research were needed before large number of physicians changed their practices. He noted too that, if a complication were to arise, the attending physician would likely be faced with a malpractice suit.

Finally, he pointed out to Dr. Weiner that the hospital was losing money on almost every patient he treated. "Dan," he said, "it's in all our interests to look out for the financial health of the hospital. And since it is unclear which of the two approaches benefits the patient more, I urge you to reconsider the way you handle these cases."

Was it ethical for Dr. Lapin to approach Dr. Weiner if there was no indication he was delivering poor quality care? How should financial considerations, both those related to the hospital and society at large, be weighed against physician judgement? What if Dr. Weiner could convincingly demonstrate that his patients were actually at less risk than those of his colleagues?
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Class 3
March 17, 1986

ALLOCATING RESOURCES

Case Study:

"The Last Bed in the ICU"

Readings:


THE LAST BED IN THE ICU

At the age of seventy, Mrs A had been admitted to the hospital for the fifth time in as many years for treatment of respiratory difficulty. The last time she was in the hospital she had nearly died. She has severe emphysema, and when she developed a cold, her deterioration was so rapid that only artificial respiration in the emergency room saved her life. However, it proved very difficult to wean her from the respirator. She spent four weeks in the Intensive Care Unit and required constant care from the hospital staff, principally Intern B. After she was discharged, she remained short of breath even while watching television.

Now, five months later, she has contracted another cold, but this time Intern B has managed to treat her without resorting to the ICU and the respirator. During her illnesses, Mrs. A’s two sons have been in constant contact with the medical staff. They have been anxious, agitated, and demanding.

It is now 2 a.m. and Intern B is again called to see Mrs. A, who is becoming increasingly lethargic. It is obvious that she is in respiratory failure, and will probably die before morning if she is not given a respirator.

However, hospital policy requires that respirators be used only in the ICU where the required supporting staff and facilities are available. There is only one bed open in the ICU. The residents like to save one bed for an emergency. As Intern B approaches, Mrs. A's sons are waiting. He knows their questions: What's wrong now? What will you do?

What should the intern do? And on what basis should he make his decision?

* * *
Class 4
March 24, 1986

GENE SPlicing

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.

* * *
Class 4
March 24, 1986

GENE SPLICING

Case Study:

"Sickle Cell and Black Genocide"

Readings:


ME-1

Class 5

April 14, 1986

**INVITRO FERTILIZATION**

**Reading:**


Case Studies:

1. "The Real Brophy Issue"
2. "In the Matter of Nancy Ellen Jobes"

Readings:


Paul Brophy, a 48-year-old firefighter who has laid silent and probably unconscious in a Stoughton hospital bed for two years will continue to receive food and fluids, Judge David Kopelman has decided.

Brophy's family believes that he would not want further medical or surgical care in his present condition. Brophy's wishes, as reported by his family, are indeed important, and Kopelman gave them appropriate weight by stopping all further surgical or medical care.

By order of Kopelman, Brophy will receive no medical or surgical care whatsoever. Brophy will, however, continue to receive the minimal nursing care to which every resident of this commonwealth is entitled: a clean, warm bed and food and water.

Kopelman, properly following the Massachusetts cases of Saikewicz, Candura, Dinnerstein, Spring and Hier, has ordered that Brophy not be dialyzed if his kidneys fail, nor resuscitated if his heart fails, nor medicated if his liver fails, nor even given antibiotics for simple pneumonia. Neither will Brophy be subjected to any surgical intervention to sustain or prolong his life.

Patricia Brophy's suit did not ask that her husband, Paul, be allowed to die; the medical record and the testimony at the trial show that the hospital had long agreed to this request. Patricia Brophy's suit asked that the Commonwealth of Massachusetts compel Dr. Lajos Koncz and Dr. Richard A. Field to starve Paul Brophy to death despite their judgment that to do so would be inimical to their roles as ethical physicians. They simply refused to starve a human being to death.

Judge Kopelman, ordering only that Brophy be fed, declined to compel Koncz and Field to violate their deeply held professional commitments.

* * *
IN THE MATTER OF NANCY ELLEN JOBES

Nancy Ellen Jobes has had a feeding tube since admission from Riverside Hospital, July 28, 1980. Food, water and medicine are administered through the feeding tube. Nancy Ellen Jobe's medical status is that of a thirty-year-old, semicomatose woman. She is not terminally ill. She occupies a resident room with no special equipment or facilities. She responds to touch and sound stimuli. To our knowledge testing has not been done to determine taste response. She follows the movements of a person with her eyes. Her visual acuity is not known. Pupils are equal and react to light. Sense of smell status is unknown. She breathes without difficulty on her own and has good cough reflex. She is incontinent of bowels and has a Foley catheter for uninvary drainage. Her vital signs are stable, blood pressure one hundred ten over seventy; pulse seventy-two; temperature ninety-eight to ninety-nine. She expectorates freely. She has contractures of her arms, hands and right leg. She is not in severe or unremitting pain. She is not on any support systems such as a respirator or dialysis and she does not require artificial (nutrients) assimilation. She reacts to pain with facial grimace and shrinking to stimuli such as neurological testing and use of needles in lab tests. In June, 1985 she was transferred to the Morristown Memorial Hospital for closing or the gastric opening (which was causing irritation) and reinsertion of a new tube into the jejunum. Periodic replacement of the tube is necessary. She has had the tube changed on November 15, 1984. June 4, 1985. July 9, 1985 and October 12, 1985. The surgical placement of the jejunostomy tube, as was done in June, 1985, may be compared to an uncomplicated appendectomy.

Since June, Nancy has become more comfortable. Her skin condition is good, her color is good, and she has no bed sores. She is alert now as at any time since her admission.

Providing nutrients and water for this patient is not medically extraordinary care. The procedure is common and simple to perform and, once the tube is in place requires only nursing maintenance. Nancy receives routine Level III care, 2.75 nursing hours per day. There is no competent evidence that Nancy would want to terminate care of the kind being received. The administrators of the nursing home believe that withdrawal of Nancy's feeding tube is not in her best medical interest and would be an illegal act. This would result in the patient’s painful imminent death by starvation and dehydration.

The Jobes family including the patient's husband and her parents, sought a court order directing the nursing home to remove the tube. While she is a "relatively healthy" young woman and cannot be considered terminally ill, since she could survive in her comatose state for many years, doctors advised the family there was no hope she would ever men-
tally recover. Even if she were to emerge from the coma—which one
doctor said was "possible" since nothing is impossible—Mrs. Jobes
would remain in a chronic vegetative state indefinitely, the family's
doctors contend.

But the nursing home officials contested the diagnosis, questioning
whether her condition can be labeled a "persistent vegetative state."
The nursing home owners have four nursing homes with hundreds of patients,
many on feeding tubes. Granting the request to remove the feeding tube
would set precedence placing many patients in danger of loss of their
lives by active euthanasia. Long standing medical and nursing principles
and sentiments, i.e., to heal, comfort and sustain life, through common
medical procedures and care, would be jeopardized.

This vital matter which deals with moral and ethical issues has vast
ramifications affecting public policy and the patient's basic constitutio-
nal right to life. These rights are universally basic to humanity.
It is the opinion of the nursing home owners that the legislature is the
proper forum for this debate. The policy which the legislature estab-
ishes should reflect society's values and standards.

* * *
LIVING WILLS

Readings:


PAIN MANAGEMENT

Readings:
