

BIOETHICS SYLLABUS FOR MEDICINE 665 CLERKSHIP

Developed by Robert A. Pearlman, MD, MPH -- MED 665

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113 HUB, FK-10
University of Washington
Seattle, Washington 98195
(206) 543-1893

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Robert A. Pearlman, MD, MPH
University of Washington
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Introduction:

The purpose of this syllabus is to introduce medical students to ethical issues in medical practice. Each section presents case examples which are followed by several questions. The questions are intended to stimulate thought. Several articles are also included in each section. Their purpose is to complement the case and assist the student in thinking about both the topic area and the questions. The topics included in this syllabus represent common issues that arise in medical practice (university affiliated and community). The topics include physician values, euthanasia, paternalism, informed consent, and allocation of scarce medical resources.

This introductory guide to ethics also is intended to facilitate discussions with your hospital coordinator for the Medicine 665 rotation. On occasion the ethical dilemmas that arise during your clerkship will be the topics for group discussion. These discussions will involve the other students on the rotation and the hospital coordinator.

The last page of this syllabus is an evaluation form for the syllabus itself. Kindly complete the evaluation and send it to the mailstop indicated.

Note: This syllabus originally included photocopies of journal articles, which have been removed to avoid possible copyright violation. A list of those readings is appended to the end of The Syllabus.

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Ethics: Medicine 665

Ethics is that branch of philosophy that attempts to understand and distinguish right from wrong (motives and actions). Ethical analysis of medical practices is relevant because of multiple factors. One factor is the development of advanced medical technology. This not only permits the prolongation of biological life; it is also costly, consuming an increasing share of our societal monetary resources. Physician use and understanding of this technology places them in a position of authority and power which may lead to varying degrees of unwitting paternalism, coercion, and infringement on the patient's right to self-determination. Another factor that supports the inclusion of ethics in medical education is the increasing public awareness of 1) their right to self-determination and 2) ethically equivocal medical practices. The injection of tumor cells into uninformed elderly patients recently raised public suspicions about medical practices (1). Another case involved inducing mothers of retarded children with easy access to a mental institution and special medical care for their children in exchange for the mother's consent to inject their children with viral hepatitis (2). Perhaps the most important reasons for teaching ethics in medical school is to provide a framework for medical decision-making in ethically ambiguous clinical situations. Learning about ethics should foster principled and rigorous analysis of the ethical components of medical decision making. Most medical decisions have ethical components. IN ORDER TO SUCCESSFULLY PRACTICE THE ART OF MEDICINE, THE PRACTITIONER NEEDS TO APPRECIATE THE ETHICAL ISSUES AND EXPLICITLY MANAGE THEM.

There are five major points to be made. First, physician values interact with the scientific components of medical practice. For example, old age, cognitive dysfunction, poor quality of life and self-abuse (alcoholism, cigarette abuse) often minimize treatment interventions (3,4). Physician values are not restricted to patient characteristics; they contribute to a physician's concepts of health, physician role and best interests of the patient. Cultural background and socialization in one's specialty training affect these values. Health may mean freedom of disease or physical well-being or even physical, mental, economic and

social well-being. The perception of a physician's role may be similarly diverse; it may be seen as promoting health or preventing disease or even prolonging life. A patient's best interest may not be the same as what a physician considers to be a patient's best interest. There is supporting evidence that this is the case (5). Clearly, if physician values influence one's sense of purpose, the goals of therapy and one's sense of responsibilities, these values also influence the interpretation of data and application of science in medical practice.

The second point is that autonomy or self-determination is very important in our society. This is evidenced by the Bill of Rights, the judicial interpretation of a constitutional right to privacy, the right to obtain birth control devices, and even the right to bear arms and the right of women to obtain abortions (6,7). The right of self-determination affects the doctrine of informed consent, assists in determining justifiable paternalism, permits treatment refusal by a patient and influences the determination of incompetency. A competent adult patient's refusal of treatment is usually guaranteed legally, even if treatment would be life-saving. In fact, treating a competent patient against his/her wishes makes a physician liable for battery (unlawful touching).

The third point is that valid informed consent in clinical practice requires comprehension, competency and freedom. Informed choice requires the physician to explain potential benefits, risks and alternatives. Choice implies that the patient may voluntarily consent or reject the therapy or procedure. The principle affirms that patients have the final choice in deciding their treatment. Oftentimes physician values make it difficult for them to volunteer therapeutic alternatives that are considered medically inferior and to appreciate the coercive nature of being a patient in a hospital setting.

The fourth point is that incompetency needs to be proven. Competency is presumed. Incompetency means that a person is mentally unable to perform his/her affairs. Incompetency to perform one task effectively prevents a patients from exercising his/her autonomy. Therefore determination of incompetency functions

similar to a sliding scale. It may be easier to prove incompetency for guardianship purposes than to prove incompetency for refusal of a foot amputation for gangrenous toes.

The fifth point is that discussion and analysis of ethical issues among members of a medical team is amenable to an analytical rigor. One needs to identify the dilemma, obtain necessary case information if possible, explicitly discuss the values, outcomes and impediments to action and then select a course of action that appears "most right".

In listing the values and outcomes, 2 distinct methods for justifying action may be expressed. Outcomes and consequences, such as survival time and sickdays, represent 1 class of considerations. Principles, such as respect for another person's autonomy and doing no harm, reflect a second class of considerations. Physicians tend to favor the use of outcomes or consequences. This represents a physician value.

Case #1 (page 0001) is presented below. The analysis might proceed as described beneath the case.

Case #1

An elderly male nursing home patient, wheelchair-bound secondary to his chronic obstructive pulmonary disease, was brought to the emergency room because of increased shortness of breath and an increase in his sputum production. He reportedly was taking appropriate dosages of aminophylline, prednisone, and metaproterenol inhaler. On his last admission, which occurred six months prior to this event, he was given 3 liters O₂ which suppressed his respiratory drive. It then took two months to wean him from the respirator. In the emergency room he had a respiratory rate of 30 and his lung examination revealed diffuse rales and expiratory wheezes. Sputum smear showed many leukocytes and gram negative pleomorphic organisms. His arterial blood gas showed hypoxemia, hypercarbia, and respiratory acidosis. The chest x-ray showed no acute changes. He was assessed to have hemophilus influenzae bronchitis and was started on appropriate dosages of O₂ (2 liters), ampicillin, aminophylline, prednisone, and metaproterenol inhaler as well as vigorous postural drainage and percussion. However, despite these interventions he became more fatigued and started to struggle with his breathing.

As his respiratory status worsened (pCO₂ increasing to 80mm Hg with a pH dropping to 7.19), additional evaluative information was obtained. His repeat chest x-ray, fluid and electrolyte status, and theophylline level did not reveal anything immediately reversible. Family members gave ambiguous messages regarding what they wanted to see done for the patient. The patient also had given an ambiguous message about intubation. When the physician returned to have a frank discussion with the patient, he was somnolent and unable to cooperate meaningfully.

Analysis.

1. What is the dilemma?

EXAMPLES:

- A. Should the physician opt for treatment when the patient and family wishes are either unknown or unobtainable?
- or B. If nonintubation leads to death (passive euthanasia) should the physician engage in this activity?
- or C. Should a physician give therapy that may prolong life and increase suffering?
- or D. Should a physician utilize scarce resources for end-stage conditions?
- or E. Should a physician intubate this patient even though he may not be weanable from the mechanical ventilator?
- or F. Should a physician withhold potentially beneficial therapy from a patient under his/her care?

2. Agree upon the primary dilemma

DILEMMA "A" AGREED UPON BY THE MEDICAL TEAM

3. Find missing data

Ask the wife if the patient ever expressed a clear message about his life values and ask the wife if that patient had any appreciable "qualities of life".

4. List relevant values and outcomes

EXAMPLES:

- † A. Respect for patient autonomy
- † B. Try to do more good than harm
- † C. Try to avoid harm
- † D. Serving as an advocate for the patient
- * E. Life prolongation may be suffering
- * F. May be unweanable
- * G. Intervention may be nonbeneficial and expensive
- * H. Intervention may permit the patient to express his wishes
- * I. Withholding of respiratory support can occur at a later date if the patient fails to improve
- * J. Nonadvocacy may diminish the patient/physician trust
- * K. Nonintubation will lead to death

4. List relevant values and outcomes

EXAMPLES:

- † L. Physicians responsibility to have developed guidelines for this type of situation prior to the acute event (physician responsibility to treat iatrogenic problems).
- M. No obligation to give meaningless therapy
- * N. Patient wishes unknown but possibly obtainable in future
- O. Patient was competent
- * P. Patient has limited life expectancy.
- † Q. Treatable acute medical problems (physician responsibility to treat the treatable
- * R. If death occurred from withholding therapy, euthanasia would be nonvoluntary.
- S. Patient had poor quality of life before the exacerbation
- T. Only two beds in the intensive care unit available.

NOTE: (*) Denotes outcome considerations

(†) Denotes principled considerations

5. Explicitly assign values to the items on a list of considerations.

EXAMPLE: I placed high values on A, C, H, I, and N.

6. Selection of a course of action

EXAMPLE: I chose intubation.

7. Barriers to implementation

EXAMPLE: Pressure from several members of the team for creating "meaningless" work.

References - Ethics, Medicine 665

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PHYSICIAN VALUES

Case #1

An elderly male nursing home patient, wheelchair-bound secondary to his chronic obstructive pulmonary disease, was brought to the emergency room because of increased shortness of breath and an increase in his sputum production. He reportedly was taking appropriate dosages of aminophylline, prednisone, and metaproterenol inhaler. On his last admission, which occurred six months prior to this event, he was given 3 liters O₂ which suppressed his respiratory drive. It then took two months to wean him from the respirator. In the emergency room he had a respiratory rate of 30 and his lung examination revealed diffuse rales and expiratory wheezes. Sputum smear showed many leukocytes and gram negative pleomorphic organisms. His arterial blood gas showed hypoxemia, hypercarbia, and respiratory acidosis. The chest x-ray showed no acute changes. He was assessed to have hemophilus influenzae bronchitis and was started on appropriate dosages of O₂ (2 liters), ampicillin, aminophylline, prednisone, and metaproterenol inhaler as well as vigorous postural drainage and percussion. However, despite these interventions he became more fatigued and started to struggle with his breathing.

As his respiratory status worsened (pCO₂ increasing to 80mm Hg with a pH dropping to 7.19), additional evaluative information was obtained. His repeat chest x-ray, fluid and electrolyte status, and theophylline level did not reveal anything immediately reversible. Family members gave ambiguous messages regarding what they wanted to see done for the patient. The patient also had given an ambiguous message about intubation. When the physician returned to have a frank discussion with the patient, he was somnolent and unable to cooperate meaningfully.

Two hundred five King County physicians were presented with this case as a patient management problem. Twenty-nine % of physicians who indicated a preference to intubate and 49% of physicians who indicated a preference not to intubate explained their decision on their perceptions of the patient's quality of life.

Questions to Consider

1. Why do some physicians use quality of life as an explanation for intervention, while some use it as an argument against therapy?
2. What other physician values affect clinical decision making?
3. How many times during hospital rounds with your housestaff team do physician values influence treatment plan and orders?
4. Should quality of life be a consideration in medical decision making?

EUTHANASIA

With reference to Case #1, 205 physicians in King County, Washington, indicated a choice between intubation (sustaining life of dubious quality) and nonintubation (allowing to die). Forty-two % chose to withhold therapy. University of Washington housestaff was the only group in which a majority indicated a preference to withhold therapy.

Questions to Consider

1. What would you do in this clinical situation, and why?
2. In withholding therapy different from giving this patient a bolus of intravenous morphine? That is, is allowing to die different from mercy killing?
3. As a physician, what is your role and responsibility?
4. What role does the patient have in this decision?

PATERNALISM AND TRUTH TELLING

Case #2

Mrs. Olson came to the emergency room with severe pain and a mass in the lower right quadrant of her abdomen. This was the second such attack. During her medical workup, the patient indicated fear of cancer to the house officer. Both her mother and older sister had died of a form of cancer. The presumptive diagnosis before exploratory surgery was either a walled-off periappendicial abscess or an ovarian cyst. However, the subsequent exploratory laparotomy revealed a tumor had spread to the pelvic wall. It was determined that she had a 0-20% survival rate over five years. Surgery was recommended to reduce tumor load and, presumably, to prolong survival time. One of the physicians approached Mrs. Olson to obtain consent for surgery. The resident requested a nurse serve as a witness. Before they entered the room the house officer told the nurse not to use the word "cancer" with this patient because it would depress, frighten, and probably make her suicidal. The nurse felt it was unfair not to answer Mrs. Olson's questions frankly, since any form of therapy (including chemotherapy and radiation therapy) would probably not change the fact that this woman had a limited time to live. When she raised this point with the house officer, she was informed that he knew what was best for the patient, that Mrs. Olson should not know she had cancer, and that surgical intervention was the optimal form of therapy. Despite the nurse's hesitation, she finally did as she was asked and witnessed the patient's consent for surgery.

Case #3

Ms. Burke is a 43-year-old with a recent history of recurrent urinary tract infections. Her physician has referred her to a radiologist for an intravenous pyelogram. The radiologist explained the procedure but omitted telling her of certain risks that he thought might make her anxious, such as anaphylaxis and death. When questioned about this abbreviated review of risks associated with the procedure he stated, "I've done 500 IVP's since I came on the staff without a serious adverse complication. If I told the patient about these risks it wouldn't affect the outcome; it would only make her worry. She would still have to have the IVP."

Case #4

A 45-year-old patient presented to his physician with a history of cough and minimal blood tinged sputum production approximately three days

prior to this visit. The physician determined that he had a solitary lung nodule. A biopsy was obtained showing bronchogenic carcinoma. The therapeutic options for this problem include surgical extirpation, radical radiation therapy, folk remedies, and nontreatment. The physician informed his patient that he had a solitary lung cancer and recommended surgery.

Questions to Consider

1. How does one determine what is "best" for a patient?
2. Under what conditions might paternalism be acceptable?
3. Why is truth telling important?
4. Imagine that you go to the bank to deposit money into a savings account for the purpose of collecting interest. When you return to withdraw the money (principal and interest), you find that your money is "tied up" and inaccessible. Your inquiries determine that your banker decided that investing your money in a condominium in Lynnwood, Washington, had a better rate of return than only earning 5.5% in a savings account. How do you feel about this? Is paternalism in this situation similar to paternalism in a medical situation?

COMPETENCE/INFORMED CONSENT

Case #5

Mrs. Blue is an 80-year-old diabetic widow living in a nursing home. She has a history of three cerebrovascular accidents, three episodes of pneumonia, and atherosclerotic heart disease. In an emergency admission to the hospital she was treated for gangrene of the right leg with secondary infection. Amputation was advised for this life threatening condition. Mrs. Blue was violently opposed to the surgery but also expressed a desire to live. At the family's insistence a psychiatrist was brought in to do an evaluation. The psychiatrist found her incapable of understanding the permit for surgery. Two of her three sons wanted to sign a permit for the surgery to proceed, but the third son disagreed. This case went to court. The judge said that regardless of the mother's mental status, she was aware of her bodily integrity and wanted no amputation. Therefore, the judge would not issue a court order for surgery.

Questions to Consider

1. What constitutes competency?
2. What are the components of informed consent?
3. Why do you think a patient's competency is never questioned by a physician when he/she signs a permit for a recommended procedure?
4. What are the fundamental reasons for informed consent?

ALLOCATION OF SCARCE MEDICAL RESOURCES

Case #6

Mrs. Norgaard is a 78-year-old with diabetes, degenerative joint disease, and a recent history of syncope. Her evaluation demonstrated that she had aortic stenosis. After much debate about the value of a left-sided heart catheterization, this procedure was accomplished and it revealed an aortic valve opening area of 0.8 cm². Members of the house-staff team caring for her at the hospital were evenly split as to whether this patient should receive aortic valve replacement.

Case #7

A 68-year-old male alcoholic was suffering from biventricular cardiac failure (alcoholic cardiomyopathy). The housestaff entertained afterload reduction as a final measure to improve this patient's cardiac performance. This would require transfer to the ICU and placement of a Swan-Ganz catheter. After discussion between the housestaff and the cardiologist it was decided that this patient was not a candidate for this type of aggressive therapy.

Case #8

Mr. Rerg is an 86-year-old nursing home patient with mild dementia. One and a half years ago he sustained a right intertrochanteric hip fracture which required surgical pinning. Since that time he developed worsening pain on motion of his right leg. During evaluation for this increased pain two problems were noted: aseptic necrosis of the femoral head and a preleukemic syndrome. Due to the preleukemic syndrome the hematology/oncology physicians felt that Mr. Rerg would probably not live for more than a few years. The orthopedic surgeons scheduled Mr. Rerg for a total hip replacement. However, Mr. Rerg's primary care physicians queried whether this was appropriate, due to his abbreviated expected survival time, baseline mental status, and physical condition.

Questions to Consider

1. What comprises scarce medical resources?
2. Are expensive technologies a scarce medical resource? Why, or why not?

3. Should the issue, allocation of scarce medical resources, affect individual physician/patient interaction? If so, when?
4. If allocation of scarce medical resources is a responsibility of the physician, how does this fit with your understanding of the physician's role with respect to the patient?
5. How should allocation of a limited resource be accomplished?
6. How should physicians respond to increasing costs of health care?

The following articles were removed from the syllabus that was received by the Syllabus Exchange Project:

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