MOUNT SINAI SCHOOL OF MEDICINE
September 1995
Rosamond Rhodes, Ph.D., Director, Bioethics Education

ETHICS CURRICULUM - Over-Arching (governing) Principles

Medicine is a Profession and as such it rests on a set of underlying moral commitments. Commitment to the profession entails adopting the moral commitments of medicine as one’s own.

- The End of Acting for the Patient’s Good (preserve life, cure disease, maintain function, alleviate suffering)
- Scientific Method
- Cooperative Model

To fulfill their professional commitments physicians must be:

- knowledgable/skilled (have professional competencies)
- compassionate/caring
- respectful of autonomy

Within the bounds of professional morality the individual physician must personally:

- develop a justified understanding of the goals of medicine
- acknowledge the moral issues that arise in medical practice
- appreciate the complexity of moral choice
- assess the weight of competing professional commitments
- adjudicate between conflicting professional commitments
MEDICINE - 3RD YEAR CLERKSHIP
three one hour sessions

The sessions have been designed to complement the clerkship activities at the Morchard Center by preparing the students to present a patient with bad news and by taking up end-of-life related ethical/legal issues. In turn they will focus on the subjects of telling bad news, Advance Directives, and DNR orders. Because these subjects are all essentially related to communication, we have decided to make role-play an integral element of each meeting. The aim in each session will be to develop an understanding of what is morally required of the physician in such interactions and to begin to develop skill in saying the right thing in the right way. These are the only third-year clerkship sessions that involve role-play.

In the first ethics meeting of the Medicine Clerkship we discuss a case (CASE-Info 1) in which the physician decides to recommend that the patient be tested for HIV. There is a short explanation of the psychological factors that make it difficult for physicians to tell bad news and another of the philosophical considerations that make telling a moral imperative. The central ethical issues for discussion are 1) the conflict between the principle of "do no harm" (by upsetting the patient with bad news) and the principle of respect for patient autonomy (by informing and thereby allowing the patient to make decisions that take the information into account) and 2) the communication problem of trying to show both compassion and respect in making the recommendation. Students have an opportunity to use role-play for exploring the doctor-patient interaction, developing and evaluating their personal approach. Time permitting, other related issues that might be discussed include: the legitimacy of the reasons for requesting the test (both the patient’s good and the well-being of others, namely, health care providers and patient contacts), the importance of taking a sexual history, problems raised by the patient who refuses testing, the ethical and legal implications of learning that a patient is HIV+ (e.g., who can or should be informed, the duty to treat).

In the second session we discuss whether choosing to accept dying rather than trying to live longer is always irrational and whether the physician’s professional commitments allow for cooperation with a patient’s choice of accepting a sooner death. There is also an explanation of how the Patient Self-Determination Act and the NYS Proxy Law aim at respecting patient autonomy, what they allow, and what they require. After a discussion of the doctor-patient communication involved in offering a proxy form students use role-play to offer and receive a proxy, first in the context of an uneventful annual check-up. Following a group review of the experience and sharing helpful and unfortunate approaches, the case is changed and roles reversed. Then, in the situation of a patient who has a medical problem that needs diagnostic tests which involve low risks (e.g., colonoscopy, endoscopy), students again use role-play to offer and receive a proxy and to evaluate one another’s communication.

In the third session we begin by explaining the underlying assumptions of the NYS DNR Law and the specific requirements of the law. The daughter of a patient who recently died after signing a DNR order (a secretary in the Department of Medicine) shares the personal experience of her mother’s DNR decision and explains the value of the choice to her and her mother. Students share and evaluate their recent experiences relating to the initiation of DNR orders. As a group we try to formulate some general advice for DNR discussions and consider how to
show compassion and respect in raising the question of DNR.

We then ask the students to recall their Morchand Center patient who had lung cancer and to imagine that he is now in the hospital for what his doctors believe is his final admission. Students use role-play to explore the experiences of presenting the DNR option and having one presented. Following a shared evaluative review, the case is changed and roles reversed. This time the students are told that although the patient had expressed a willingness to execute a DNR order, he said that he first wanted to discuss the matter with his family. Unfortunately, before he could have the discussion, he lapsed into coma. In the second role-play exercise one student takes the part of the physician while the other takes the part of a family member (i.e., spouse or child).

When time permits, this session concludes with a discussion of futility. "Medical futility" is explained according to the NYS DNR Law definition. The more controversial senses of futility are debated.
CASE - Info 1

Jonathan Reed, a 30 year old lawyer presents at your office. He complains that he has been sweating at night, that he has felt tired and sometimes has a low fever. He is also bothered by a persistent sore throat with a white film in his throat.

He also has had a girlfriend since last January. His girlfriend uses oral contraception.

After your examination you believe that he might have contracted HIV and that a test for the virus is in order. What would you say to him?
OB Case 1

Carol Barrett is recovering from a gynecological procedure and has been informed that a resident will be coming by to check her stitches. The resident arrives, authoritatively shifts the patient’s gown and, without a word, begins to examine her. Ms. Barrett, glaring, pushes the resident’s hand away.

OB Case 2

Shirley Carter is a 19–year-old African-American woman with little schooling and no job. She has been a reluctant participant in the clinic’s prenatal program. Upon admission, it becomes clear that a C-section is indicated. Dr. Ronsen, a resident, explains the procedure.

"Shirley, you have to have a C-section. Do you know what that is?"

"I guess so."

Dr. Ronsen pauses and asks, “Have you picked your baby’s name?”

“Yes. It’s Ruby.” Shirley watches Dr. Ronsen suspiciously.

“Well, Shirley, Ruby may become very sick—she might die—if we try to deliver her the regular way. So we’ll take you to the operating room and deliver her surgically. We’ll make a cut here and bring Ruby out. You may be a little uncomfortable, but it will be fast and very safe. Do you have any questions?"

The patient who has been looking away from the doctor, her lips tight, says “No.”

Dr. Ronsen presents a consent form and Shirley Carter signs it.
OB Case 3

Carmen Martinez, a 30-year-old Hispanic office worker, arrives at the OB examination room in the early stages of labor. She remains there for several hours, during which time she overhears hospital staff responding to the questions and concerns of several of the patients around her in a manner that is abrupt and devoid of sympathy. She also overhears the conversation, in Spanish, of a very frightened patient and her partner. This conversation stops when the voices of two residents conferring nearby become audible.

"Wait a minute! In the last ten hours we’ve had four C-sections, and I’ve gotten all of them. You’ll have to find someone else for the Señora”

"There is nobody else. I’ll be helping out with Dr. Smith’s patient. You’ve heard about her?"

"Yeah. So I do the shit work while you go learn something.”

Later that day, Carmen Martinez undergoes an emergency C-section. The following day, her obstetrician mentions that one of the residents will be removing her stitches. Immediately and firmly, she says “No.”
CASE 1

A disheveled man in his mid-40's was brought to the Emergency Department by the police. They requested that he be admitted to the psychiatry service. So far as the police knew, he was homeless. The man spent his days standing on street corners and appeared to be hearing and responding to voices. He sometimes frightened pedestrians by yelling at them, but did not appear truly menacing or dangerous. No one knew anything of his history. When the police searched him they found a few dollars and some candy, but there was no evidence of legal or illegal drugs. The police had seen him gathering food out of garbage cans.

The man refused to give his name and would not say more than a few words. He seemed tense and frightened and was obviously having almost continuous auditory hallucinations. He refused to be admitted to the hospital or even discuss taking medications. He had been brought in by the police because his screaming had caused people to call and complain.

CASE 2

Mr. Jones, a 67-year-old retired farmer who lives alone and has no close relatives is suffering from a recurrence of a malignant melanoma. Upon initial diagnosis he was treated with surgery and chemotherapy. At the time of his current admission he is judged to be terminally ill. His physicians are recommending further debulking surgery and another course of chemotherapy, feeling these procedures may afford him appreciable relief from pain and possibly extend his life by a few months. Mr. Jones has declined the treatments - he simply wants to go home and die in peace. He has been seen by a psychiatric consultant who feels he is not clinically depressed.

But is Mr. Jones competent? During the past year he has had two strokes, which have left him with some mild but definite cognitive impairment. He cannot perform mental calculations as he well as he once could, and his recent memory is impaired. However, he seems to understand his medical situation adequately. He knows the facts about the nature of his illness and about the probable course of his illness with and without further treatment.

Mr. Jones's physicians do not feel strongly impelled to attempt to force treatment upon him, or even to pressure him very strongly to have it. The dilemma they feel, and which they present to the psychiatric consultant, is whether it is justified to regard Mr. Jones competent to refuse treatment. Can a cognitively impaired man be competent?
Department of Surgery
Third Year Clerkship

Seminar in Ethics
Topic: Truth-telling

**Case** (Surg-2)

Matthew Stein, a 24-year-old stock trader, presents at your office complaining of abdominal pain, diarrhea, and fatigue. He has also noticed a recent weight loss. He would like a quick remedy for his annoying symptoms, as his job is very fast-paced and stressful.

Mr. Stein's full history and your sigmoidoscopy suggest strongly that he has Crohn's disease.

Before proceeding with radiologic or other studies, what should Mr. Stein be told about the studies, about his differential diagnosis, and about the natural history of Crohn's disease?

**Case** (ICU-1)

Mr. Fields is a 65-year-old attorney who has just undergone laparotomy for a gastric tumor; he was found to have metastatic incurable disease. His family has vehemently demanded that he not be told his diagnosis, that he be told the tumor was benign. They also want "everything to be done."

What should the patient be told? Should the family's demand be respected? Who should decide on the extent and aggressiveness of treatment?

**Case** (Surg-3)

Rebecca Gold, a 21-year-old Orthodox Jewish woman from Brooklyn, has been diagnosed with breast cancer metastatic to one ovary. The oncologist recommended postoperative radiation and chemotherapy. The radiation oncologist who spoke to her father explained that the treatment would make her sterile.

Later, speaking with the surgeon, the father demanded that his daughter not be told that she would be unable to have children. He explained that his daughter was to be married in three months. Under Orthodoxy, an infertile woman may not marry a fertile man, so the treatment would make the marriage impossible. The father was concerned that Ms. Gold would refuse postoperative treatment if she knew it would make her infertile. He further explained that Orthodox fathers make all the decisions for the family. Whenever asked her opinion as to treatment, Ms. Gold would say, "Ask my father."

What should the surgeon tell Ms. Gold?
Department of Surgery
Third Year Clerkship

Seminar in Ethics
Topic: Learning on Patients

Case (Surg-1)

James Mitchell is a third-year medical student doing a month-long rotation in anesthesiology. He has been reviewing the records of Mr. Jackson, a 65-year-old man who is scheduled for surgery the next morning. He reasons that, because of the patient's age and his history of heavy smoking, a spinal anesthetic would be the safest option. The attending anesthesiologist agrees with James' choice and asks him if he's done lumbar punctures before.

"Yes, twice," James replies, "and I've seen probably three or four. I guess I'd still feel a little shaky doing one."

"Well, you won't get any better just by watching. I want you to do Mr. Jackson's tomorrow morning. I'll be around if you need any help."

James nods his agreement. The next morning, James introduces himself to Mr. Jackson as "Medical Student Mitchell, a member of the anesthesiology team." He proceeds to explain to Mr. Jackson what the procedure will be like, how it is done, and the risks that are associated with it. After Mr. Jackson has signed the consent form, he says, "Medical student, huh? You said this might be painful. I hope you've had some practice!"

James doesn't really want to lie to Mr. Jackson, but neither does he want the patient to believe he can't competently perform the procedure.

What should he say to Mr. Jackson?
OUTLINE - PROPOSED ADDITIONS TO THE ETHICS CURRICULUM

Medical School, Years 1-4

1st-year Additional 6 hr. Mini-course
JUSTICE & SOCIAL POLICY
2 hrs. - Right to Health Care: Justice or Charity (e.g., the rich, the under-class, doctors and their families, the rest)
2 hrs. - Allocation of Scarce Resources (e.g., ICU beds, transplant organs)
   Principles of Distribution
2 hrs. - Conflicts of Interest (e.g., under fee-for-service, under managed care, in medical research)

2nd-year Additional 6 hr. Mini-course
THE NATURE AND LIMITS OF AUTONOMY
2 hrs. - Autonomy & Paternalism (e.g., Jehovah’s Witness refusals, refusals by the incompetent, decisions for children)
1 hr. - Suicide, Physician Assisted Dying, Euthanasia
1 hr. - Abortion
1 hr. - Quarantine & Forced Treatment (e.g., TB)
1 hr. - Physician Autonomy: Personal Morality and Professional Responsibility

3rd-year Clerkships Additional 2 hrs.
Psychiatry: 1 hr. - Medical Research
Obstetrics/Gynecology: 1 hr. Maternal-Fetal Conflict/Behavioral Limitations or Forced Treatment of Women

4th-year Ethics Case Discussion Seminars
6 hrs. (in 3 sessions of 2 hrs.) - To improve students’ skills in:
   - appreciating the ethical dimension of clinical practice
   - adjudicating between conflicting professional commitments
   - developing a moral argument
   - communicating about ethical issues
WRITING ACROSS THE ETHICS CURRICULUM PROPOSAL
Rosamond Rhodes, Ph.D., Director, Bioethics Education
September 20, 1995

Besides attendance and participation, the submission of a (passable) written assignment should become a required component of the ethics curriculum. Adding written assignments to the ethics curriculum would serve several purposes:
- encourage students to attend more closely to the content of their ethics mini-courses and clinical conferences
- encourage students to further consider the subjects independently
- develop the ability to present a moral argument
- develop the ability to communicate about ethical issues
- provide an opportunity for our students to improve their writing skills
- develop the ability to research bioethical issues

The writing assignments would be designed to reflect the mini-course and clinical conference material. They would be case based. The assignments would be organized developmentally to encourage students to increase their skills in identifying and addressing the ethical dimension of clinical practice. The progression would move from writing about prescribed cases (1st-& 2nd-years), to writing about their own cases (3rd-year), to making a formal public presentation of one of their own cases (4th-year). The research demand would increase from reliance on course materials distributed in the first- and second-year mini-courses to library searches in the third-and fourth-years.

1st- and 2nd-year mini-courses: In conjunction with their ethics mini-courses, students would be given a choice of two cases relevant to the course curriculum. Students would be asked to select one of the cases and encouraged to add some details to it. They would be instructed to frame a question about an ethical issue raised by the case and told to write a short essay (2-3 pp.) arguing for a particular answer. Arguments should make reference to the mini-course reading materials.

3rd-year: Within the context of their clinical clerkships, students would be asked to identify one of their own cases that raises some ethical issue. They would then write a brief description of the case, pose a (non-technical) question about the case, and write a short essay (2-3 pp.) arguing for a particular answer. Over the course of the year, students would be required to submit one essay during three of their major clerkships (for a total of three essays within the year). Arguments should make reference to some of the relevant bioethics literature.

4th-year: Our 4th-year students currently receive no formal education in medical ethics. This need can best be met by requiring that 4th-year students take an Ethics Case Discussion seminar. Ethics Case Discussion seminars (approximately 15) would be offered throughout the year. They would meet for 2-hour sessions in three successive weeks. There would be one physician and one non-physician faculty member leading each seminar of no more than nine students. Each student would be required to register for one seminar and to bring a written case presentation to the first seminar meeting. At each seminar meeting two or three students would present their cases and arguments and then lead the group in a discussion of the ethical issues raised by the case. Seminars would be open so that interested students from any year could attend.
THE ETHICS DIMENSION PROPOSAL
Mount Sinai School of Medicine, September 1995
Rosamond Rhodes, Ph.D., Director, Bioethics Education

Introduction - Nearly every article written on medical ethics education discusses the importance of teaching medical students to integrate an appreciation of ethical considerations into their clinical decision-making. While our ethics curriculum has focused on achieving that goal through ethics mini-courses and clinical conferences, more can and should be done. The change I am suggesting could make a dramatic difference in our student’s thinking about their clinical practice and foster physician competence in tackling ethical issues. It would not require a modification in the overall curriculum.

Proposal - Because the practice of medicine involves commitments to both a cooperative model and to the scientific method, and because its activity is focused on the moral goal of acting for the patient’s good, medicine is essentially concerned with ethics. Dedication to these professional obligations is the distinctive mark of the physician. Good doctors, feeling sincere concern for the well-being of their patients typically consider an array of relevant ethical issues in addition to the pharmacological, treatment and procedural alternatives when making their clinical decisions.

In medical education we must communicate to our students the significance of doctors’ expressing their sincere concern for their patients’ good and the importance of taking a broad and farsighted perspective on the issues involved in clinical decisions. We need to teach our students to do what good doctors do in their doctor-patient interactions. But unless we clearly identify the kinds of considerations that need to be considered and accord them attention in clinical discussions, students get the opposite message. They learn to narrowly focus their attention on a heart or a kidney and learn to miss the importance of the patient as the key figure in determining what is for the patient’s good. Explicitly including the ethics dimension in teaching rounds would strengthen our commitment to holistic medicine.

To remedy this situation and to make our teaching behavior more closely reflect the official stand, I suggest that the ethical dimension of each case be integrated into case presentations at attending rounds and in other settings where students would be expected to make full case presentations. In some circumstances the ethical dimension may be the critical area that needs to be addressed. In other circumstances, reporting that no obvious ethical questions are at issue would be sufficient. Just as it is always important to consider a patient’s cardiac function, and just as it is frequently sufficient to report that the cardiac function is normal, it is always important to be alert to the ethical dimension of patient care.

To implement this proposal, clerkship directors, attending physicians, and supervising residents would have to expect the inclusion of the ethics dimension as part of the case presentation model. They would also have to be willing to discuss the ethical issues when they are crucial to the management of the case. This change in case presentation would certainly increase students’ ability to recognize the ethical issues in their cases, but it would also increase the willingness of medical students and physicians to discuss and address a range of issues that too frequently have been overlooked or haphazardly and inadequately addressed. The ethics dimension innovation would transform our current pattern, of having ethical issues addressed directly by only a remarkable few, to training all of our students (as well as house staff and attending physicians) to habitually address the ethical concerns that are inherent in their cases.
THE ETHICS DIMENSION: Sample Issues - what, why, when, how

Communication - telling a patient about his/her condition; who should be present; explaining what a patient should expect (e.g., in the course of a procedure, after a procedure, in the course of a disease); explaining the rationale for tests or medications; telling vs. teaching;

Inter-Professional Relationships - communicating with a patient’s primary care physician to learn the patient’s history, condition, treatment plan; were referrals made for the patient’s good or the physician’s interest; can you refuse to respond to a consult request from another service; the medical hierarchy; consensus and disagreement about clinical decisions; other health care professionals; what should be communicated on charts; honest reporting of test results; providing care for a colleague;

Surrogacy - who decides for a patient; when should a surrogate’s decision be questioned;

Allocation - who should be denied limited resources (e.g., ICU bed, transplant organ); should you give all patients equal time and attention; what kinds of differences deserve attention; should a history of noncompliance be considered in allocation decisions;

Difference - did the obese patient get as thorough an examination as another would have; should the rich get special treatment; should cultural differences, requests for alternative medicine or nurses from a particular racial group be accommodated; should a patient’s definition of death be accepted;

Financial - when should money make a difference in medical decision making; should doctors know the cost of the medications they prescribe and the tests they order; should those who cannot pay be given medical care; do the poor have a greater obligation to allow themselves to be used as learning tools;

Privacy/Confidentiality - what steps should be taken to maximize patient privacy and confidentiality; do discussions with family members violate patient privacy and confidentiality; do warning signs on the doors of patient rooms betray confidentiality; confidentiality/the duty to warn (e.g., HIV); do genital and rectal examinations and questions about sexual behavior violate privacy;

Autonomy/Paternalism - who should choose between alternative treatments; when a patient refuses crucial tests or necessary treatment, can a doctor override a patient’s choice; can doctors say no to patient requests; when is it appropriate to restrain a patient; what is the role for concern over patient safety;

Reactions to Patients - dangers of caring too little or caring too much; should doctors care for their family members or friends;

Scientific - do you have enough information to justify your action; do you have a justification for the diagnostic procedure; should you be studying the effectiveness of your treatment;

Research - are research subjects patients; should you enroll your own patients in your research trials; what do patients need to be told; do patients have to be informed about studies in which they might participate; when should a study be stopped; what level of risk/harm is acceptable in a study;

Legal - Proxy Law; DNR Law; what law applies to this situation; should you comply with the law;

Family (Friends) - how should you treat family members and friends of your patient; can you ask family members for information about a patient; should you follow family instructions about withholding information from a patient; what should you tell family members about a patient’s condition; who should tell family member about a patient’s death;

Death and Dying - should a patient be told that s/he is dying; how much pain medication should you give to a dying patient; if the pain medication necessary to alleviate suffering would also hasten death, should it be given; should a doctor respond to a patient’s or family member’s request for aid in dying;
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<td>1</td>
<td>2/5/96</td>
<td>Introduction, Semmelweis, Hempel, Aristotle</td>
<td>Hempel pp. 3-69</td>
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<td>Harvard Case Study (Thermometer) Handout</td>
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<td>Pasteur - Handout</td>
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<td>Paper of D. Moros - Handout</td>
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<td>Explanation, Empiricism. Observation,</td>
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<td>Theory</td>
<td>Hempel to p. 84</td>
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<td>History of Med.1800-50 (Ackernecht) Handout</td>
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<td>4</td>
<td>3/4</td>
<td>Ethics</td>
<td>Beauchamp and Walters, pp. 1-34</td>
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<td><em>Contemporary Issues in Bioethics, 4th</em></td>
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<td>3/11</td>
<td>Ethics</td>
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<td>Animal Experimentation &amp; Human Experimentation</td>
<td>Beauchamp and Walters (No class 3/25)</td>
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<td>Old Issues in New Dress</td>
<td>Beauchamp and Walters</td>
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<td>Withdrawing and Withholding Care. DNR. Euthanasia</td>
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<td>9&amp;10</td>
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<td>Control of Reproduction &amp; Bioengineering and the Human</td>
<td>Beauchamp and Walters</td>
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<td>Genome Project</td>
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<td>Definition of Disease, Trans-cultural Issues, Alternative Care</td>
<td>Beauchamp and Walters and Handouts</td>
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<td>Organ Transplantation, Scarcity, Rationing and Triage</td>
<td>Beauchamp and Walters</td>
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