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<td>9:00-10:15</td>
<td>P. Lanken</td>
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<td>C. Bosk</td>
<td>G. Gorton</td>
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<td>10:30-12:00</td>
<td>Small Group # 1</td>
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<td>Small Group # 5</td>
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<td>12:00-1:00</td>
<td>Luncheon Seminar: [Limited Enrollment]</td>
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<td>Abortion and Other Ethical Issues at Beginning of Life</td>
<td>Ethical Issues in Children</td>
<td>Physician-Assisted Suicide</td>
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# ID 390
## BIOETHICS AND PROFESSIONALISM
### January 6-10, 1997

## AFTERNOON SCHEDULE

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<td>1:00-2:30</td>
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<td>(Unless otherwise noted)</td>
<td>J. Merz and P. Wolpe</td>
<td>A. Hillman</td>
<td>1:00-2:15</td>
<td>H. Delisser</td>
<td>Small Group #8: (Center Faculty)</td>
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<td></td>
<td>Legal, ethical and cultural aspects of informed consent</td>
<td>Managed Care and Potential Conflict of Interests</td>
<td>C. McClafferty</td>
<td>Diversity and the Doctor-Patient Relationship</td>
<td>Student Case Presentations</td>
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<td></td>
<td>Video (30 min)</td>
<td>J. Hansen-Flaschen: Business Ethics vs. Medical Ethics</td>
<td>Break</td>
<td>S. Kinsman: Diversity Issues in Children</td>
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<td>2:30-2:45</td>
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<td>2:15-2:30 Break</td>
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<td>2:45-4:15</td>
<td>Small Group #2 (Bioethics Center Faculty)</td>
<td>Small Group #4 (Bioethics Center Faculty)</td>
<td>2:30-3:30 Break</td>
<td>Small Group #7 (Bioethics Center Faculty)</td>
<td>2:45-4:00</td>
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<td>(Unless otherwise noted)</td>
<td>Informed Consent</td>
<td>Conflicts of Interest</td>
<td>M. Stein</td>
<td>Diversity, Duty to Treat and Equity in Access to Health Care Services</td>
<td>Small Group #8 (continued)</td>
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<td>4:15-5:00</td>
<td>4:15-5:00</td>
<td>3:30-5:00</td>
<td>4:00-5:00</td>
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<td>Self-Directed Reading Time</td>
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<td>Preparation Time for Student Presentations</td>
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COURSE INFORMATION

A. Course Goals

1. That participants will begin to acquire the skills and knowledge to identify and analyze ethical issues in medical practice and house staff/medical student training.
2. That participants will have the opportunity to process and integrate their experience as physicians-in-training with relevant ethical, social, legal and economic issues relating to professionalism and to being physicians in an evolving health care environment.

B. Course Requirements

1. Attendance in all classes is expected. Attendance for all Small Group Sessions is required unless the student is excused from the class by the Course Director. Attendance in the Small Groups will be documented by a sign-in list.
2. Satisfactory completion of Team Project (details below).

C. Team Project

1. Students in each Small Group will divide themselves into teams of 4-5 students per team during the first meeting of the Small Groups.
2. Each team will be responsible for working together in selecting a Case Study for ethical analysis from the list provided or from a case of their own choosing subject to Course Director's approval. Teams in the same Small Group must choose different cases.
3. Each team will work on their analyses during the week. The team's goal should be to function like an consulting Ethics Committee and, in their consultation, to provide ethical justifications (i.e., weighing the pros and cons) for the alternative courses of actions faced by the health care providers in their particular Case Study. The team should also make a recommendation as to which alternative is most appropriate and why. Team members are expected to work collaboratively within their own team (but not between teams if both select the same case). Each member of the team is expected to contribute to the Project in a meaningful way.
4. Each team will give an oral presentation of their ethical analysis and lead a discussion
during the Small Group Session on Friday afternoon. This should be for about 30 minutes
including sufficient time for discussion of their analysis. Teams can organize their
presentation how they wish; for example, some teams may want each of their team
members to speak while others may want only a few team members.

5. Each team will also write a 3-5 page summary (double-spaced, size 12 font type on 8.5" x
11" paper with 1" margins) of their Case Study analysis and give this to their Group
Leader at the same Friday Small Group session. The name of each team member should
be listed on the paper as indication of their meaningful involvement in the project and
paper.

D. Course Grading

1. The course is graded as Honors, Pass/Fail. To pass the course you must complete the
course requirements as described above. If you are absent from a Small Group Seminar,
you must have a valid excuse and inform the Course Director.

2. To receive Honors, in addition to the above, you must submit a satisfactory original
scholarly paper (at least 10 pages long, double-spaced with size 12 font type on 8.5" x 11"
pages with 1" margins) on an ethical topic of your choice (subject to approval by Course
Director). The manuscript should list at least 6 pertinent references. The deadline for
completing and submitting the paper is 2 weeks after the course ends (1/17/97). Please
talk with the Course Director if you want to write such a paper.

E. Small Group Assignments (On separate sheet to be handed out at beginning of course)

Note: Students need to stay in the same Small Group as assigned for tracking their
attendance and for Team Projects.

F. Optional "Meet the Professor" Luncheon Seminars

1. From Monday, 1/6/97 to Thursday, 1/9/97, from 12 noon to 1:00 p.m., there will be
optional "Meet the Professor-type" luncheon seminars with lunch provided free.
Enrollment will be limited to a maximum 20 per seminar, first come, first served.

2. Students who are interested in attending should sign up on Monday during breaks. The
Sign-up Sheets will be located on clip boards at the front of the Auditorium.

3. Except if a seminar is not totally filled by Monday afternoon, please Sign up for a
maximum of two luncheons.
G. Bioethics References

This course book contains many reprints of articles and chapters that relate to the course's curriculum. No specific textbook is required for the course. However, the general bioethics books listed below are recommended for further study. They will also be useful for ideas and sources of other references for Team Projects and Honors Papers.

3. Council on Ethical and Judicial Affairs. Code Of Medical Ethics: Current Opinions With Annotations, American Medical Association, 1994. (One free copy is available to all ID390 students, courtesy of the AMA)

H. Other Administrative Issues

1. Cancellation of classes due to the weather. Classes will be held unless the University officially closes classes for a morning or a day (Call 898-MELT to find out the University's status).
2. Contact the Course Director or Course Coordinator, listed above for other administrative questions.

I. Acknowledgment of Support

This Course Syllabus was funded by a grant from the John Aglialoro Fund for Ethics Education of the Department of Medicine, University of Pennsylvania School of Medicine.
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Professor of Pediatrics
Children's Hospital of Philadelphia

Paul Wolpe, Ph.D.
Adjunct Assistant Professor of Sociology
Department of Sociology

Guest Faculty

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Assistant Professor of Medicine
UMDNJ-Robert Wood Johnson

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Philadelphia, PA 19102-5092

Gregg Gorton, M.D.
Assistant Professor of Psychiatry &
Human Behavior
Jefferson Medical College

Mary Stein, Esq.
Legal Affairs
Hospital of the University of Pennsylvania
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<td>1. Lanken PN. Glossary of Ethical Principles and Terms.</td>
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I. BASIC PRINCIPLES UNDERLYING BIOMEDICAL ETHICS

It is often helpful to analyze ethical issues in medicine in terms of the four following basic principles:

A. Respect for Patient Autonomy: Respect for patient autonomy refers to the ethical principle that capable patients should have the right to decide what will happen to themselves and their bodies. For example, in the context of medical care, autonomy refers to whether they agree or not with a proposed medical intervention. Autonomy corresponds to the legal right of self-determination.

B. Beneficence: Beneficence refers to the ethical principle that the goal of medicine and the other health professions is to provide medical care to patients in order to assist them in recovery from illness, to reduce disability and to treat pain and suffering. It relates to the Hippocratic principle of promoting the patient's well-being that has been the traditional underlying principle of medicine.

C. Non-Maleficence: Non-maleficence is the ethical principle that states that health care providers have a moral duty not to injure patients. This is viewed as more stringent than the duty to benefit patients and this relationship is embodied in the Hippocratic maxim, primum non nocere which means first of all do no harm. It is a prohibition against the infliction of harm vs. the positive acts of beneficence.

D. Justice: Justice refers to the ethical principle related to what is fair or just based on certain values, held by individuals, an institution or society as a whole. This usually refers to the principle of distributive justice, which relates to how one should allocation of limited benefits among individuals. Among many theories of justice, all have a common principle, The Principle of Formal Justice (attributed to Aristotle): that equals must be treated equally and unequals treated unequally. Stated in other words, that no person should be treated unequally unless it can be shown that he/she differs from others in a particular respect relevant to the treatment at hand. Unfortunately, although profound, the Principle of Formal Justice lacks substance, i.e., specifics as to what is relevant and by what criteria equality or inequality is judged. Different ethical theories interpret which criteria are valid differently.

II. TERMINOLOGY:

A. Deontology: This refers to the ethical system which is based on a set of duties as expressed by rules against which behavior of the particular group of individuals is judged. For example, the ethical principles embodied by the Ten Commandments is a deontologically based system. A deontologist would assert that a physician should never tell a patient a lie since the physician has a duty to be truthful to patients. Another rule might be that a physician should not perform active euthanasia. There is disagreement as to how these duties or rules originated, e.g., divine revelation, common sense, contractualism or, in the case of physicians, traditions of medical ethics.
**B. Utilitarianism:** This refers to the ethical system in which value is determined by assessing how much benefits are provided for the greatest number of people. The over-riding principle in this theory is the principle of utility which, in simple terms, can be expressed as "the greatest good for the greatest number". Utilitarianism is one form of Iconsequentialism (see below) or teleology in which the end ("telos") is given most importance. The maxim, "the end justifies the means" reflects this emphasis.

Utilitarians come in two types: those concerned with the specific consequences of an action (Act Utilitarians) and those concerned with the consequences of the rules that govern the acts (Rule Utilitarians).

Like a deontologist, a utilitarian might also argue that a physician should not lie to his/her I patient but on different grounds: not because the act is wrong per se but that lying to patients would eventually undermine the physician-patient relationship. As a consequence, this would lead to more distrust of the medical profession leading to poorer health of the public. For the same reason, a utilitarian might consider active euthanasia unethical, once again, not because it is inherently wrong, but because performing voluntary euthanasia might lead to involuntary euthanasia and a diminution of value for life in general. This would eventually lead to society being worse off. This latter rationale is also referred to as a "wedge" or slippery slope" argument.

**C. Consequentionalism:** This refers to those types of ethical theories that are concerned primarily with the consequences of an action or rule rather than the inherent morality of the action or rule. One example is utilitarianism.

**D. ‘Slippery Slope’ Argument:** This refers to a type of consequentialist argument in which a specific act is judged immoral, not because the act itself would be harmful, but because acceptance of that act as moral would lead to immoral acts. See the utilitarian's argument against euthanasia, above.

**E. Egalitarianism:** An ethical theory that holds foremost the equality of individuals based on the equality of their intrinsic worth as human beings. This corresponds to the ideal of democracy in political world. One example, as applied to distributive justice, is the concept that a basic minimim of health care should be a right for all citizens regardless of ability to pay.

**F. Libertarianism:** An ethical theory that holds foremost the freedom of the individual to choose among alternatives. One example, applied to distributive justice, is that individuals should have the choices among different degrees of health care coverage according to ability to pay.

**G. Ethical Dilemma:** A situation in which proceeding with any of the alternative courses of action available would violate one or more ethical principles. An ethical analysis aims to determine which principle is overriding in a particular situation.

**H. Paternalism:** The traditional approach in medicine in which a patient's autonomy is compromised in order to protect the patient. Paternalism is the opposite of respect for patient autonomy.

**I. Therapeutic Priviledge:** A physician's intentional withholding of clinical information from the patient in order to protect the patient from harm arising from the new knowledge, e.g., a diagnosis with a poor prognosis. It is a tradition justified by paternalism.
**J. Decision Making Capacity:** This indicates that the patient has the requisite cognitive abilities to understand the medical situation related to the decision, to judge the alternative decisions in relation to his/her values and goals and to communicate consistently his/her opinions and judgment. Minors legally are not considered to have full decision making capacity. A given patient may lack of full decision making capacity with regard to some specific decisions but not others; for example, a patient may not be able to confront decisions related to his/her resuscitation status.

**K. Competency:** The legal term corresponding to "decision making capacity"; however, one is presumed competent unless deemed incompetent by the judicial body. Everyone is presumed to be legally competent, unless judged formally incompetent by a judicial decision. Thus, patients can be competent but grossly not capable. Conversely, even legally incompetent patients may have some degree of decision making capacity that should be taken into account in their medical decisions.

**L. Informed Consent:** The concept of informed consent is derived from the principle of respect for patient autonomy; it is the legal term to indicate that a capable adult patient has consented to a medical intervention after being informed of all aspects of that treatment as well as alternative treatments that would be important to that individual. The legal standard for informed consent varies according to different jurisdictions.

**M. Surrogate Decision-Maker:** The generic term for the person who has the responsibility to participate in medical decision-making on behalf of a patient who lacks decision-making capacity. It may be a family member, friend or legally appointed patient representative. In some states, there is a prescribed legal hierarchy for who should be the patient's surrogate decision-maker. The surrogate decision-maker may be a previously designated legal proxy, such as a patient having a legal durable power of attorney. Their judgment should ideally reflect what the patient would have decided under those circumstances if known; this is described as substituted judgment. If what the patient's preferences, values and goals are unknown, a second standard of decision making, what is in the patient's best interests, should be used. This best interests standard should try to balance the burdens of the proposed therapy with its benefits.