



Problems in Medical Ethics
SOM - 354

Center for Health Ethics
University of Missouri - Columbia
School of Medicine
Department of Health Management and Informatics
315 Clark Hall
Columbia, MO 65211

David A. Fleming, M.D., FACP
Associate Professor of Medicine
Director, Center for Health Ethics



Problems in Medical Ethics (SOM - 354)

This educational experience is designed to provide both scholarly and clinical experience in medical ethics for senior medical students. Areas of emphasis include, but are not limited to, experience with confronting ethical issues in end of life care, patient rights, professionalism, organizational health care, research, health care access, and genomics. Provided are a statement of goals and objectives, the *Ten Principles of Ethics and Professionalism* upon which this curriculum has been built, two guidelines to facilitate the "ethics workup", a suggested training grid and schedule, and suggested readings, all of which remains a work in progress. One key component of this curriculum is the development of a scholarly research paper, suitable for publication. This paper will be researched and an early manuscript completed by the student during the one month training experience and further developed and refined in the months that follow, with the aid and mentorship of the course director. The ultimate objective of this experience is for the student to gain ethical insight and skill through clinical experience, scholarship, reading, and didactics that will serve to aid them in dealing with the often difficult ethical issues of medical practice.

Problems in Medical Ethics
M4 Elective

Goal: To provide a tailored learning experience that will encourage and develop skill and a working knowledge about health care ethics and the ability to respond effectively when confronted with the difficult ethical dilemmas that may be encountered at multiple levels in the complex arena of health care.

Objectives:

1. to understand the history and foundational elements of health care ethics.
2. to identify ethical and professional concerns when they occur at the bedside and within health care systems.
3. to articulate and defend ethical arguments when confronted by ethical dilemmas.
4. to develop the skill of doing the “ethics workup”.
5. to critically review and discuss the ethics literature in pursuit of a research project.

Suggested evaluation: participation in seminars and conferences, discussions about cases and readings, case write-ups and presentation, completion of a selected research topic (paper, oral presentation, poster presentation, in-depth case write-up)

**Problems in Medical Ethics
M4 Elective**

Monday	Tuesday	Wednesday	Thursday	Friday
8-12 clinic UPMB 1-2 ethics rounds and workups	8-12 clinic UPMB Reading and Research Consults*	9-10 tutorial or ethics rounds 1-3:30 Ethics Seminar+	Reading and Research 1-2 didactic	9-11 ethics seminar or journal club Reading and Research
8-12 clinic UPMB 1-2 ethics rounds and workups	8-12 clinic UPMB Reading and Research Consults*	9-10 tutorial or ethics rounds 1-3:30 Ethics Seminar	Reading and Research 1-2 didactic 5-6 CEC	9-11 ethics seminar or journal club Reading and Research
8-12 clinic UPMB 1-2 ethics rounds and workups	8-12 clinic UPMB Reading and Research Consults*	9-10 tutorial or ethics rounds 1-3:30 Ethics Seminar	Reading and Research 1-2 didactic	9-11 ethics seminar or journal club Reading and Research
8-12 clinic UPMB 1-2 ethics rounds and workups	8-12 clinic UPMB Reading and Research Consults*	9-10 tutorial or ethics rounds 1-3:30 Ethics Seminar	Reading and Research 1-2 didactic 4-4:45 ELI 4:45-5:30 PCC	9-11 ethics seminar or journal club Reading and Research

*Ethics Consults are done daily as requested.

+Graduate Seminar: *Health Ethics* (HMI 7041)

Wednesday 1:00 - 3:30 PM (Winter Semester)

Clark Hall 426

The 10 Principles of Ethics and Professionalism:

- The Principle of **Primacy of Patient Welfare**--balancing our notion of benefit to the patient while minimizing the pain, fear, and suffering that seems inevitable in what we ultimately do to patients. Balancing benefits, costs, risks. Trying to "do no harm"--this means being competent, honest, disclosing mistakes, and maximizing comfort. Being empathetic and compassionate are important virtues in personifying these actions. Good communication and being aware of what the patient wants or doesn't want is also important. Killing vs. letting die. Quality of life assessments. Bedside manner-taking time with the patient. Remaining "loyal" to the patient, even if they aren't compliant.
- The Principle of **Research Integrity**. Protection of research subjects. The dual role of clinician and investigator who has conflicts of interest; knowing "who the patient is"--the research protocol or the research subject. History of research abuses. Honesty, integrity, sharing information and research findings for the greater good.
- The Principle of **Respect for Patient Autonomy**. Informed Decision-making, honest and open communication, minimizing undue influence (avoiding coercion) in decision-making, respecting privacy and confidentiality, encouraging advance directives. Knowing when to be open and honest--and when not to "for the patient's good". Capacity-consent-refusal.
- The Principle of **Respect for Professional Autonomy**. Health care providers have personally held beliefs and values that must be considered. Mentoring and the "hidden curriculum" of shame, secrecy, and blame often guides the developmental process of "becoming" a professional. Respect and communication between and among professionals of different callings--the "team" approach top patient care. Placing the interest of others ahead of one's own as a physician (denying selfish self interest). Accountability to one's self and one's peers. Conflict resolution.
- The Principle of **Justice**. Fairness to the individual through nondiscrimination practices; social justice in the systemic distribution of resources. Ethics and health policy--how one informs the other. The access and use of genetic information--the potential for good and harm.
- The Principle of **Commitment to Professional Responsibility**. Sustaining trust by maintaining competence, honesty, having appropriate patient and collegial relations, advocacy for the good of patients and the profession, and fidelity. Improving quality of care, access to care, concern for equitable distribution, minimizing conflicts of interest that may jeopardize the patient or the profession.
- The Principle of **Concern for Social Welfare**. Preparedness to deal with societies emerging needs (HIV, bioterrorism, aging), sensitivity to escalating health care costs and expenditures, 41 million uninsured, uncompensated care.
- The Principle of providing **Good End of Life Care**. Management of pain and suffering, understanding the needs of the caregiver curing active caring and bereavement, DNR/DNI, futility, withholding/withdrawing treatment, understanding that death is inevitable (not necessarily the "enemy").
- The Principle of **Economic Constraint**. Dealings with industry, using patients as "things" to generate income, selling products out of the office, questionable practices to generate income (dermabrasion), defensive practices to prevent law suits, fiduciary responsibility to the patient. Balancing obligations as outlined in the contract with the hospital or managed care system with those to the patient when they are in conflict. Parsimonious use of diagnostic tests and drugs.
- The Principle of respecting **Family and Personal Needs**. Even today we tend to forget that persons in the health professions are still people with needs, who have families and other personal interests. These should be nurtured and encouraged to make the person as a professional complete. We must rest, cry, love, laugh, and consume from time to time, in order to remain whole. If we loose sight and grasp of these important components of our lives there is a tendency to loose those human qualities of empathy and compassion that make health care a caring profession

The Clinician's Ethics Workup

Edmund D. Pellegrino, M.D., MACP
Adjunct Professor of Medicine and Ethics,
MU Center for Health Ethics;
Professor Emeritus of Medicine and Medical Ethics, Georgetown University;
Chairman, President's Council on Bioethics

What is the Right and Good Decision for this Patient?

- What is the ethical issue or decision that must be made?
- What are the clinical facts?
- What are the clinical options?
- Ethical reasons for and against each option.
- Which option should be taken?
- Arguments against this option
- What is the final action to be taken?

Can the Decision be Implemented?

- If not, why not?
 - Physically impossible
 - Conflict among decision makers
Who? Why?
- Is conflict resolvable?
- How?

If not resolvable, what options are open?

- Is compromise possible without loss of personal or moral integrity?
- **If Not:**
 - Patient or family may discharge physician
 - Physician may withdraw from case as soon as another physician is employed

If no physician is available or none agrees to take the case...

- The physician cannot be expected to compromise professional and moral integrity
- The physician cannot be expected to help patient or family find a physician who will do what attending physician takes to be seriously immoral (question of moral complicity)

Practical Ethical Reasoning

David A. Fleming, M.D., FACP

MU Center for Health Ethics

Center for Health Ethics
Dir, David A. Fleming, MD
University of Missouri
School of Medicine

The ability to effectively address ethical dilemmas is an essential component of health care. The emphasis in ethical reasoning is on a sensible progression from the facts of the situation to a morally sound decision. An ethics “workup” (this one or a similar version) may be used by a variety of health care professionals at both the organizational and individual clinical level. Health executives, physicians, nurses, social workers, and other health professionals use similar techniques to assess ethical dilemmas with the goal of gaining a shared sense of what is morally acceptable. With some adjustments, it may also be used by lay persons. Using the five principal steps of the ethics workup, health professionals holding a variety of philosophical and religious positions regarding ethics can share a basic framework for thinking about and discussing morally troubling cases:

1. **WHAT ARE THE FACTS?**: It is vitally important to clarify the facts of any situation in order to anchor the decision. These facts relate to the organizational, medical, and social circumstances of the case. For example, at the bedside both an estimate of prognosis and an understanding of the patient's wishes are relevant to an ethical decision about what is in the patient's best interest.

Persons involved or affected (who?)
Diagnosis, prognosis, therapeutic options (what?)
Personal preferences, beliefs, values (what?)
Resources available (what?)
Chronology of events, time constraints (when?)
Medical setting (where?)
Organizational policy (what?)
Reasons supporting claims, goals of current care (why?)

Clear and effective communication about the facts is crucial. Nurses and social workers may be instrumental in ensuring that the patient/family and other nonmedical health professionals understand the medical facts while also making sure the health care team understands pertinent nonmedical information about the patient and family. Administrators may be as concerned for the welfare of the organization and those it serves as that of an individual patient.

2. **WHAT IS THE ETHICAL CONCERN?**: Identify the specific ethical issue in the case, and there may be more than one. Ethical claims may be competing, such as the welfare of one patient vs. that of many when considering resource allocation. The issue may not be ethical at all, but rather a legal issue, a placement issue, or simple miscommunication about the clinical facts.
3. **FRAME THE ISSUE**: Some health professionals may explore the issue using one moral approach (e.g. personal belief or faith). Others will eclectically employ a variety of approaches (good of the patient, good of society, personal belief, etc). But no matter what one's underlying moral orientation, the ethical issue at stake in a given case can be framed in terms of several broad areas of concern, representing aspects of the case which may be in ethical conflict. It is therefore useful, if somewhat artificial, to dissect the case apart along the lines of the following areas of concern:
 - a. Identify the appropriate Decision maker(s). Patient, family, court, the health care team?
 - b. Apply the criteria to be used in reaching clinical decisions.
 - 1) The specific biomedical good of the patient: One should ask, what will advance the biomedical good of the patient? What are the medical options and likely outcomes? What is the prognosis?
 - 2) The broader goods and interests of the patient: One should ask, what broader aspects of the patient's good, i.e., the patient's dignity, religious faith, other valued beliefs, relationships, and the particular good of the patient's choice, are pertinent to the decision at hand?

The physician explains the medical options to the patient/surrogates and if indicated makes a recommendation. The patient/surrogate makes an uncoerced, informed decision. Limits to patient/surrogate autonomy include the bounds of rational medicine/nursing/social work, the probability of direct harm to identifiable third parties, and violation of the consciences of involved health care professionals. Deviation from the organization's mission. Limitations based on direct harm to the organization financially and structurally. In problematic cases the interdisciplinary team may meet to ensure consistency in their recommendations to the patient/surrogate(s).

c. Establish the health care professionals' moral/professional obligations.

Each health care professional, including health care executive, must decide what she/he owes the patient, herself/himself, the health care team, the health care institution, and other third parties. Conflicts may present and must be accommodated.

4. **DECIDE:** In clinical ethics, as well as organizational ethics, a decision must ultimately be made. There is no simple formula. The answer will require clinical or managerial judgment, practical wisdom, and moral argument. The health care professional must ask herself/himself, "What should I do? Where can I get help? How can I best serve the interests of all interested parties?" She/he must analyze the data, reflect on it morally, and draw a conclusion. She/he must be prepared to explain her decision and the moral reasons for it. Sources of justification include:

a. The nature of the health care is patient-centered. For physicians and nurses it is in the professional-patient relationship; for the health executive it is in ethically balancing the interests of the patient with those of many patients as well as the organization. Consider the compatibility of a recommended course of action with the aims of profession [the *internal morality* of profession].

b. Approaches to ethical inquiry: principle-based ethics, virtue-based ethics, casuistry, feminist/caring/existentialist ethics, theological ethics

c. Ethically relevant considerations:

- 1) Balancing benefits and harms in the care of patients
- 2) Disclosure, informed consent, and shared decision making
- 3) The norms of family life and personal belief
- 4) The relationships between clinicians and patients
- 5) The professional integrity of health professionals
- 6) Cost-effectiveness and resource allocation
- 7) Issues of cultural and religious variation
- 8) Considerations of power (Fletcher, Brody, Miller & Spencer)
- 9) Organizational mission, goals, and needs
- 10) Research subjects
- 11) Vulnerable populations-access
- 12) Health literacy

d. Grounding and source of ethics: philosophical (based in reason), theological (based in faith), socio-cultural (based in custom)

5. **CRITIQUE:** It is important to be able to critique the decision that has been made by considering its major objections and then either responding adequately to them or changing one's decision. The health care professional should also seek her/his colleagues' input when time permits. Some cases can be taken to an ethics committee for further reflection.

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Selected Readings

Texts: *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*
Jonsen A, Siegler M, Winslade W (Ed) Fifth Edition. 2002. McGraw Hill
Geriatrics at Your Fingertips. Reuben D et al. Am Geriatrics Society.
Fifth Edition. 2003
Core Competencies for Health Care Ethics Consultation. ASBH. 1998
*Life Choices. Understanding the Importance of Planning now for Your Needs at
the End of Life*. Nixon, J. MO Attorney General's Office. 2004.
(Texts are provided)

Journal Articles: (on file in the CHE)

The Healing Relationship: (1-3)
Ethics Consultation: (4-7)
End of Life: (8-14)
Health Care Directives: (15-19)
DNR: (20, 21)
Informed Consent and Refusal: (22-25)
Privacy and Confidentiality: (26-28)
Palliative Care: (29-31)

1. **Pellegrino ED.** What the philosophy of medicine is. *Theoretical Medicine & Bioethics*. 1998;19(4):315-36.
2. **Quill TE, Cassel CK.** Nonabandonment: a central obligation for physicians.[see comment]. *Annals of Internal Medicine*. 1995;122(5):368-74.
3. **Pellegrino ED.** Nonabandonment: an old obligation revisited.[see comment][comment]. *Annals of Internal Medicine*. 1995;122(5):377-8.
4. **Aulisio MP, Arnold RM, Youngner SJ.** Health care ethics consultation: nature, goals, and competencies. A position paper from the Society for Health and Human Values-Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation. *Annals of Internal Medicine*. 2000;133(1):59-69.
5. **McGee G, Spanogle JP, Caplan AL, Penny D, Asch DA.** Successes and failures of hospital ethics committees: a national survey of ethics committee chairs. *Cambridge Quarterly of Healthcare Ethics*. 2002;11(1):87-93.
6. **Pellegrino ED.** Withholding and withdrawing treatments: ethics at the bedside. *Clinical Neurosurgery*. 1989;35:164-84.
7. **Singer PA, Pellegrino ED, Siegler M.** Ethics committees and consultants.[erratum appears in J Clin Ethics 1991 Spring;2(1):75]. *Journal of Clinical Ethics*. 1990;1(4):263-7.
8. **Anonymous.** Medical futility in end-of-life care: report of the Council on Ethical and Judicial Affairs.[see comment]. *JAMA*. 1999;281(10):937-41.
9. **Pellegrino E.** Decision at the end of life: the use and abuse of the concept of futility.

10. **Fleming D.** A Global Perspective on Healthcare Decisions at the End of Life. *Regulatory Affairs Focus*. 2001:14-18.
11. **Singer EA.** Medical Futility: Hippocratic Fact or Contemporary Fiction? [Master of Arts in Liberal Studies]. Georgetown University; 2001.
12. **Quill TE, Lo B, Brock DW.** Palliative options of last resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia.[see comment]. *JAMA*. 1997;278(23):2099-104.
13. **Helft PR, Siegler M, Lantos J.** The rise and fall of the futility movement.[see comment]. *New England Journal of Medicine*. 2000;343(4):293-6.
14. **Winter SM.** Terminal nutrition: framing the debate for the withdrawal of nutritional support in terminally ill patients.[see comment]. *American Journal of Medicine*. 2000;109(9):723-6.
15. **Lynn J, Goldstein NE.** Advance care planning for fatal chronic illness: avoiding commonplace errors and unwarranted suffering. *Annals of Internal Medicine*. 2003;138(10):812-8.
16. **Phipps E, True G, Harris D, et al.** Approaching the end of life: attitudes, preferences, and behaviors of African-American and white patients and their family caregivers. *Journal of Clinical Oncology*. 2003;21(3):549-54.
17. **Fleming DA.** Cultural sensitivity in end-of-life discussions. *Missouri Medicine*. 2003;100(1):69-75.
18. **Fagerlin A, Schneider CE.** Enough. The failure of the living will.30-42, 2004 Mar-Apr.
19. **SUPPORT.** A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). The SUPPORT Principal Investigators. *Jama*. 1995;274(20):1591-8.
20. **Berger JT.** Ethical challenges of partial do-not-resuscitate (DNR) orders: placing DNR orders in the context of a life-threatening conditions care plan. *Archives of Internal Medicine*. 2003;163(19):2270-5.
21. **Alemayehu E, Molloy DW, Guyatt GH, et al.** Variability in physicians' decisions on caring for chronically ill elderly patients: an international study. *CMAJ Canadian Medical Association Journal*. 1991;144(9):1133-8.
22. **Veatch RM.** Why get consent? *Hospital Physician*. 1975;11(11):30-1.
23. **Emanuel EJ, Wendler D, Grady C.** What makes clinical research ethical? *JAMA*. 2000;283(20):2701-11.
24. **Annas GJ.** Informed consent, cancer, and truth in prognosis.[see comment][erratum appears in *N Engl J Med* 1994 Mar 3;330(9):651]. *New England Journal of Medicine*. 1994;330(3):223-5.
25. **Miyaji NT.** Informed consent, cancer, and truth in prognosis.[comment]. *New England Journal of Medicine*. 1994;331(12):810; author reply 811-2.
26. **Laurie GT.** Challenging medical-legal norms. The role of autonomy, confidentiality, and privacy in protecting individual and familial group rights in genetic information. *Journal of Legal Medicine*. 2001;22(1):1-54.

27. **Eisenberg JM.** Can you keep a secret? Measuring the performance of those entrusted with personal health information.[comment]. *Journal of General Internal Medicine.* 2001;16(2):132-4.
28. **Kennett MR.** Now is the time for HIPAA compliance. *Missouri Medicine.* 2001;98(11):499-502.
29. **Abraham JL.** Update in palliative medicine and end-of-life care. *Annual Review of Medicine.* 2003;54:53-72.
30. **Snyder L, Sulmasy, Daniel.** (American College of Physicians-American Society of Internal Medicine). Physician-Assisted Suicide. 2000 August 17, 2000.
31. **Hanson LC, Danis M, Garrett J.** What is wrong with end-of-life care? Opinions of bereaved family members. *J Am Geriatr Soc.* 1997;45(11):1339-44.