Clinical Bioethics Small Group Session

Week of August 12, 2019

**LEARNING OBJECTIVES:**

1. Describe the elements of clinical bioethics
2. Understand and apply the major bioethical approaches of narrative and principle-based ethics
3. Distinguish common terms, such as informed consent, autonomy, beneficence, non-maleficence, justice, suffering, compassion and empathy
4. Demonstrate how a narrative ethics work-up facilitates moral reasoning in the analysis of clinical problems and gain skills in analyzing cases
5. To introduce the concept of service in medicine.

**ASSIGNMENTS DUE FOR THIS SESSION:**

- Turn in to your facilitators your summary of your expectations during this year.

Optional (this text is summarized in the handout):


**ASSIGNMENTS DUE FOR NEXT SMALL GROUP:**

1) Read the small group activities and be prepared to participate.
   You will need to read 8 chapters in Coulehan and Block, “The Medical Interview” for week #4, so please start reading that now.
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<th>SESSION ACTIVITIES:</th>
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<td>1) Report from the small group representative</td>
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<td>2) Discussion of readings/lecture, including <em>What Doctors Feel</em> study questions.</td>
<td>30-45 min</td>
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<td>3) Use the narrative ethical workup guide to analyze the cases provided</td>
<td>1 Hour</td>
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<td>4) Relationship of this small group session to the philosophy of patient centered medicine</td>
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**BACKGROUND – TO BE READ BEFORE COMING TO THE SMALL GROUP**

**What is Moral Reasoning and Clinical Bioethics?**

Moral reasoning is a process of deciding whether an action, judgment, or decision is right or wrong. One can also reason about the actions of a particular person and consider if he or she acted rightly or wrongly in a given situation, considering persons emphasize issues of character and virtue.

In considering an action or a decision, a formal approach to moral reasoning would proceed by:
1. establishing the facts of the clinical situation and the decision
2. considering if any rule can be discerned in the decision
3. looking beyond the rule to identify a broader principle
4. deciding if the decision, rule, and/or principle fit into a coherent ethical theory.

Obviously, we all make moral decisions without going through this process. The purpose of looking at a process like this is to help make apparent our often unexamined decision making process and especially in a moral dilemma, try to establish if our decision makes sense and can be justified, even if all may not agree.

When we apply moral reasoning in medicine, we are engaged in the activity of clinical bioethics. Clinical bioethics is a subfield of bioethics that addresses ethical decision making in caring for patients. Several theories have emerged in the past few decades to help ethicists and clinicians approach clinical ethics cases. The major ones that we will address in this section are 1) narrative ethics, 2) principle-based ethics, and 3) virtue ethics.

**1) Narrative Ethics**

Presenting clinical bioethics cases in narrative form explains the case in ordinary language and tries to convey its story-like quality. Presenting the case narratively is an attempt to trace and demonstrate the development of the themes that run through the case and that characterize the conflicts involved.

Narrating the case is much like what we do if we need to explain the case to a lay person. It is what we did all our lives before becoming health-care professionals. That is, we expressed things in ordinary language, usually beginning at some relevant point ("the beginning") and telling of
the important events at each stage ("the action") until a pinnacle in the story is reached ("the climax"). The pinnacle is usually the height of the conflict among the main "characters" or the point at which one of the characters (e.g., the physician) faces a dilemma. This climax is usually what occasions us to present a case for discussion. We want to know how to resolve the conflict and help the characters achieve an ethically acceptable "resolution" (the final stage of the story).

A narrative ethics workup has been emphasized as a way to approach moral reasoning in clinical situations. This approach will be what you will use for a future ethics paper during your third year.

It has six steps:

1. **The Narrative of the Case**: The student should attempt to present all relevant medical and social facts about the patient. Ethically sound decision-making is based on good medical care and a good factual basis regarding patient care. Much relevant information is easily obtainable from the patient's chart.

2. **The Language and Issues of the Case**: Cases are often discussed in terms of a particular topic, e.g., informed consent, the decision-making capacity of the patient, forgoing life-sustaining treatment, physician-assisted suicide, etc. You should not jargonize your write-up unduly. However, you should be able to identify the topic under which your case falls and to identify the duties to the patient that are involved in the case.

3. **Perspectives and Key Points of View**: This is probably the single most important part of any case analysis. You should go person by person and explain how each saw the situation. Very often, you will find that one or more of the points of view are not well understood by you or others involved in the case. Attempting to understand the reasons and preferences of the parties involved can help to identify important conflicts and their sources. On the other hand, seemingly irresolvable conflicts can be resolved when a sincere effort is made to understand the underlying reasons and values.

4. **Facilitating Resolution**: What approaches might have been taken to bring about case resolution? e.g., family and caregiver conference? Ethics case consultation? A discussion among certain members of the health-care team? Is there any way you could have contributed to the solution?

5. **What actually happened?** Please be sure to include the outcome of the case.

6. **Commentary**: Your commentary should highlight the professional duties that physicians have to patients and how these duties were respected or compromised in the case resolution. One of the purposes of this lecture is to provide you with the knowledge and vocabulary to approach the steps of the ethics workup.

**Why is narrative form important?**

On the one hand, there are mundane reasons for preferring a narrative account to a medical record (i.e., the chart) of "facts" concerning the case. For instance, narrating the case tends to make it more approachable to the non-specialist or non-professional. Specialists in various medical fields often have their own jargon and abbreviations that are not readily accessible to other medical specialists and health-care professionals must include lay persons in the decision-making and review process (e.g., the patient, the patient's family, medical ethics consultants, ethics committee members, etc.). Obviously, the more approachable format makes the case more usable by this wider variety of persons.
Of greater philosophical import is the notion that "facts" need to be interpreted and narrative form is the easiest way of including the reader in that process. For example, large numbers of tests are often run on patients. Simply reporting the results of all tests will frequently not give the reader insight into which test results the health-care team is viewing as relevant or what conclusions they are drawing from them. Thus, the reasoning of the health-care professionals from the "facts" is hidden from us without a narrative account that highlights the thought process.

Further, the health-care institution can be viewed as the junction of many "stories." The first or primary story is usually told from the perspective of the health-care team. It begins with the presentation of the patient for treatment and includes whatever information concerning the patient's medical history is available. This story features a climax and resolution in which the antagonist is the illness. This antagonist is overcome or triumphs over the patient and the health-care team. In this story, the health-care team aids the protagonist (the patient) by helping him/her against the illness.

From the patient's perspective, the illness and the current presentation at the hospital are usually seen as one episode in the larger story of his or her life. This life includes dreams and goals, various significant relationships, beliefs and values, and a medical history that must be interpreted within the framework of this larger context, i.e., the patient's life. Within this context, an illness may not be the enemy to be defeated at all costs. For instance, a patient might authorize treatments because they offer hope of a cure but might decline these same treatments if he finds that they preclude a present quality of life that allows for certain highly-valued daily activities. Further, the patient's sense of the "dignity" that characterizes his or her life is quite varied from one story to another. Thus, when the health-care team treats a patient only from the perspective of the primary narrative, they fail to recognize that the same actions may be valued differently in the patient's story. For example, what is considered a benefit in the primary narrative may be paternalistic from the patient's perspective?

In sum, narrating the case allows us to make sense of it as if it were a novel. Simply reporting the "facts" often leaves us with the sense that characters are performing inexplicable or seemingly irrational acts for which the motivations are concealed. Narrative provides us with the motivations and reasoning of the health-care workers and helps us to find our first clues to the larger narrative that accounts for the actions and decisions of the patient. Once we frame the conflict within these larger stories, we often find that resolution is a matter of improved communication.

**What points should I keep in mind to improve my case narrative?**

There is no simple formula to make us perfect narrators of cases in clinical ethics any more than there is a rulebook that can make us novelists. However, just as there are conventions of writing fiction, there are some guidelines we should attempt to observe in writing case reports. For instance:

1. Medical jargon and abbreviations can be employed but translations usable by lay persons should be provided as well. Parentheses often come in handy for this purpose. However, jargon should never be used simply for its own sake even if you provide translations. This is also true of ethical jargon - use it when it can help convey meaning, never for its own sake.

2. Most case presentations begin the story with the patient presenting for treatment. Keep in mind the larger narrative of the patient's life and try to include, what, if any, of this story (the
3. Try to include the conclusions that the health-care professionals are drawing from their diagnostic work and tell how much of this information is conveyed to the patient. This is very important because the two stories may be developing independently based upon different information and conclusions.

4. No story is complete without an end. At various points in every story, the characters base their actions on what they believe will be the outcome. Medicine calls this outcome the prognosis. Surprisingly, this is often omitted from case reports. This happens because health-care workers often try to act as if they are dealing only with the empirical situation present at hand and not venturing into future probabilities. However, in real life, we usually base our actions to some degree on our expectations of the future. This is true in both the medical narrative and the patient's life story. Hence, it is important to understand as much about the prognoses at the decision-making points as we can and to know how much of that information was conveyed to the patient/family.

5. Often, conflicts seem irresolvable at first glance. We look at the choices expressed by each party and it seems that they cannot be reconciled. Often the choice of one of the parties seems irrational and unreasonable. In such cases we must ask "why" they are making the choice they are. There are many possible motivations for a decision but motivations often can be traced to the larger narrative context of the patient's life. Asking the person directly why they have made the choice they have is always the preferred course of action. However, sometimes that is not possible. Attempt to provide as much of the patient's history as you deem may be relevant to understanding their motivations.

2) Principle-Based Ethics

Principle-based bioethics has emerged in the last few decades as one dominant approach to addressing various bioethical issues. These principles are respect for autonomy, non-maleficence, beneficence, and justice. These principles are used in support of some of the common rules that are followed in hospitals and physicians' offices, e.g., obtain informed consent before treatment, do not lie to patients, etc. The principles can be part of different types of ethical theories. This can be a bit confusing, but what is important to remember is that if someone uses respect for autonomy as justifying a decision, then the person could further ground that principle in one of several differing ethical theories.

Given that different ethical theories often appeal to the same principles, is it worth going to the trouble to learn about the theories? Although physicians make many moral decisions without going through a laborious process of ethical analysis, there are times when this type of analysis is useful—-a difficult decision, a consideration of new treatments, or a review of some commonly accepted practices that may be questionable. As an example of this last category, it was once a common practice in this country not to tell individuals a diagnosis of a fatal cancer.

Rethinking this practice, however, suggested that this was wrong. Just as in biology, going over
seemingly familiar territory in ethics can reveal new insights. Most individuals would hold that these principles are *prima facie* principles, that is, they are to be followed at first glance. In other words, one would need a very good reason not to follow what the principle appears to encourage or discourage.

The key principles:

1. **Autonomy:**
   An individual is a law unto himself/herself; the desires, values and preferences of an individual are self-determining.
   a. Informed consent
      1. Explanation, risks and benefits, alternatives, outcomes
      2. Patient demonstrates understanding
   b. Competence
      1. Competence as a legal concept. Only courts of law can deem someone incompetent.
   c. Capacity
      1. Capable of handling information as a medical concept. Physicians and other health care professionals routinely assess patients’ capacity to make health care decisions. Although competence and capacity are routinely used interchangeably, it is best to use capacity in the clinical context.

To expand a bit on the concept of *prima facie* principles, assume that an individual is brought to the emergency room who is inebriated, suicidal, and with multiple lacerations requiring suturing. The individual refuses medical assessment and appropriate treatment. The principle of autonomy might, at first glance, suggest that the physician should honor this refusal. But it does not take much thought to understand that a person who is drunk, suicidal, and bleeding is not capable of autonomous decision making, that his/her life is at risk, and that it is reasonable to err on the side of life and stop the bleeding.

2. **Beneficence:** The acting out of a genuine desire to do what is good for the patient. The obvious problem is that one person's beneficence may be another's paternalism.
   There are three elements to beneficent behavior for a physician:
   (a) *technical*, one possesses appropriate skills and knowledge;
   (b) *human*, a willingness and ability to behave compassionately
   (c) *ambiguous*, the attempt to choose and recommend therapeutic options in a way that respects patient autonomy.

3. **Non-maleficence:** avoid evil or harm. This is an ancient precept, going back to the notion of *primum non nocere* (“first, do no harm”)

4. **Justice:** Treating individuals equally. There is a substantial literature on “distributive justice” which addresses how we as a society allocate scarce health care resources. We will spend more time on this principle in the spring semester in another small group session on justice and health care reform.

Principles are often used to analyze individual actions and decisions. They provide a means of weighing right or wrong.
Additional Note:

Many other ethics topics are important for physicians such as decision-making capacity surrogate decision making and confidentiality. These issues will be taught in PCM-2 and 3.

SMALL GROUP ACTIVITIES:

1. Report from the small group representatives – any announcements? Items to bring back to the course directors?

2. Discussion of mentor/preceptor activities – Third year student mentors will be assigned in early September, and physician preceptors will be assigned in October. So at this point, there will be no mentor or preceptor activities to discuss.

3. Questions or Concerns for your Advisor – Discuss any questions or concerns you may have for your advisors.

4. Discussion of readings/lecture

Lectures:
Catholic Bioethics: Dr. John Hardt
Clinical Bioethics: Dr. Kayhan Parsi
Assigned readings and Vimeo, plus any additional resources the students bring in

Please discuss the assigned “What Doctors Feel” readings. You may center your discussion around these questions.

1. Introduction, p. 4: “…the doctor-patient relationship is still primarily a human one. And when humans connect, emotions by necessity weave an underlying network.” Given the breadth and depth of factual information that a medical school needs to dispense to its graduates, how should emotional skills be taught and fostered? What time is appropriate to devote to this pursuit?

2. The author discusses her inability to act with empathy when presented with a homeless sexual assault victim. What emotions would you feel in a similar situation? How would those emotions affect your actions? How was the nurse’s aide able to act so effectively when the author wasn’t?

3. In Julia, part one, the author discusses the delay in telling her patient the severity of her prognosis. The physician’s positive emotions towards her patient and the grave implications of the diagnosis resulted in a delay in the patient understanding her own condition. How does emotional distance between physicians and patient enhance or hinder medical care? What role does empathy play here?

4) If not already done, review the definitions of the ethical principles and give examples.
5) Use the narrative ethical work-up guide to analyze the cases provided. Divide into two groups. Each group should consider one of the following 2 case scenarios and analyze it using the narrative guide to the ethical workup. (20 minutes) Each group will present their analysis to the class and the other members will consider the course of action chosen as well as the reasoning. (20 minutes)

**Discuss the process of ethics case analysis**

Review each step of the 6 step process (described in detail above):

1) The narrative of the case
2) The language and issues of the case
3) Perspectives and key points of view
4) Facilitating resolution
5) What actually happened?
6) Commentary

6) Analyze ethics cases

Break up into two smaller groups to analyze the following cases and then discuss as a whole group

**Case A**

An eighty three year old man with a long history of diabetes and peripheral vascular disease is admitted to the hospital with evidence of ischemia (lack of blood flow) and infection of his right lower leg. In the past, he has had an amputation of the right foot and also a leg artery femoral-popliteal bypass on the right (from the groin to behind the knee). The patient, Mr. Irving, has been meticulous in his efforts to control his diabetes and careful in the care of his feet. Unfortunately, on the day prior to his admission, he noticed purulent (infected) drainage from the amputation site on his right foot with surrounding erythema (redness) and red streaking up his leg (signs of infection). Over the next day, the erythema progressed up to his knee and the lower leg became swollen and warm. He called his physician who saw him later that afternoon and admitted him to the hospital with the diagnoses of cellulitis (a severe skin infection), diabetes out of control (likely secondary to his infection) and peripheral vascular disease. Mr. Irving was very concerned about the infection and felt quite ill. He was begun on intravenous antibiotics and a vascular surgeon was called in consultation.

Despite aggressive therapy, Mr. Irving’s infection was barely held in check. The consulting vascular surgeon felt it likely that an above the knee amputation would be required to save Mr. Irving’s life.

Mr. Irving’s primary care physician, Dr. Smith, spoke with his patient about the surgeon’s recommendations. Dr. Smith explained that the antibiotics would be continued for a few days but it seemed unlikely that the infection would respond. She agreed with the surgeon’s recommendation and urged Mr. Irving to agree to the proposed above the knee amputation. During the discussion, at Mr. Irving’s request, his three children were present. Mr. Irving’s wife had died five years previously. After the death of his wife, he requested to be DNR (Do-Not-Resuscitate). He lived alone with help from his children who were all supportive, loving, and concerned.
Mr. Irving thanked Dr. Smith for her concern and understood that she and the surgeon felt it likely that he would die if he did not have the amputation. Mr. Irving made it clear; however, that he felt he had lived a long and good life, that he was tired of fighting the diabetes, and that he recognized that an above the knee amputation would likely mean that he would need to go to a nursing home. He found that an unacceptable option. Mr. Irving also expressed his feeling that he was born with two legs and two arms and "I damn well plan to die with two legs and two arms. I know I may well die if I do not have this amputation but I will not have it done." Mr. Irving’s children were visibly upset by their father’s response. His older son spoke with Dr. Smith and told her: "My Dad is just depressed, he must have this operation. You have to make him have it."

What should Dr. Smith do?

Be sure to discuss the idea of “Informed Consent” as it applies to Mr. Irving’s decision to not have an amputation.

Case B
Susan is a two-year-old girl who suffered a severe anoxic (lack of oxygen) brain injury six months ago when she fell into a swimming pool and nearly drowned. She was resuscitated after a prolonged period of absent respirations and pulselessness. She has been in the hospital continuously over the last six months with multiple complications. Initially, she had a very severe pneumonia as a complication of the near drowning. The pneumonia resulted in severe lung damage, and Susan is now mechanically ventilated through a tracheostomy (breathing tube in the throat). There have been multiple problems with recurrent lung infections, hospital acquired urinary tract infections and severe diarrhea. Currently, a recurrent pneumonia has developed in the left lung. There is concern that Susan may have developed an infection in the pleural space around the lung (empyema) and even more fears that she has developed an infection in the pericardial space (space around the heart) showing signs of hemodynamic compromise with increased heart rate, decreased blood pressure and decreasing urine output. A culture of sputum (respiratory phlegm) is growing methicillin resistant *Staph aureus* and blood cultures have returned positive for the same organism. The working diagnosis is that Susan has pneumonia with an empyema caused by *Staph aureus* as well as a probable infected pericardial effusion and systemic sepsis (disseminated infection throughout her body). Even without this latest crisis, the team caring for Susan feel she has no chance of leaving the hospital. They also feel that this latest infection may well result in her death. Treatment will require placing a chest tube in the pleural space as well as a catheter in the pericardial sac to drain the fluid and pus. The pericardium may well have to be surgically drained and stripped if the catheter does not adequately drain the infected material. Treatment of the pneumonia will require increased amounts of oxygen, likely further damaging Susan’s already damaged lungs.

The health care team feel that these treatments are invasive, painful, and not of benefit for Susan. Susan’s parents, however, feel strongly that everything must be done for their daughter. They have been constantly at their daughter’s side and are confident that a miracle will occur and that their daughter will recover.

The health care team has explained that they will give antibiotics to Susan but that they feel the other therapies are too aggressive and will likely not result in improvement. Susan’s parents are angry and demand that everything be done.

*Clinical Bioethics, Week 2*
You are called as the ethics consultant. What are the major issues involved? What can be done?

During your analysis, consider the four principles: Beneficence, Justice, Autonomy, and Non-maleficence and discuss how they may apply to the patient, the family, the physician and health care team, the health system and society.

**Service In Medicine**
As you have often heard, a profession is different from a job. Professions demand high degrees of knowledge and skill. As a result, society asks that professions be largely self-regulating through peer review processes. Furthermore, society provides vast resources to the medical profession and health-care institutions through tax exemptions for non-profit institutions, direct aid to students, funding of biomedical research (e.g., through the National Institutes of Health), funding of residency programs and resident salaries through Medicare, and a host of other direct and indirect subsidies. In return, society asks that the health-care professions demonstrate care for the common good, including providing some assistance to those without access to care. Additionally, it is clear that the opinions of physicians are still generally well-respected, and individual physicians and medical societies can be influential regarding health-care policy or in calling attention to health-related issues.

This implicit “social contract” between medicine and society does not specify what is required of each physician, and we can easily see that the responses of physicians vary widely. There are those who recognize no duty beyond their own self-interests (and thereby treat medicine as a mere job), and those who toil ceaselessly in the service of others from whom they can expect little pecuniary reward. You must decide where along this continuum you will live and practice. Such a decision is seldom made once and for all but is a process of discovery that we would like you to begin considering today.

**The Jesuit and Catholic Heritage of Service**
The Jesuit tradition of education emphasizes the formation of “men and women for others.” This tradition emphasizes that our vocations are ultimately callings to use our talents to serve others as well as ourselves. The educational philosophy of the Society of Jesus places a commitment to social justice at the center of this service. We serve others because we share a common humanity with an implicit duty to respect and foster the dignity of those around us, especially those who are most cut off from the resources of society and the means to help themselves. This concern for the poor and disenfranchised is sometimes termed the “preferential option for the poor” in Catholic social teaching.

As part of the PCM-1 course, you are **required** to participate in some type of service activity during the course of the academic year. Please discuss any issues that would keep you from participating in this component of PCM-1 with the course directors. [A description of the program is linked here](#).

8) Relationship of this small group session to the philosophy of patient centered medicine—All physicians face ethical issues surrounding their patients at some point in their career. This small group session provides an overview of different theoretical frameworks by which to approach these ethical issues.