Letter from the Editor

Ross White '09

The Ethical View is an annual publication released by the Medical Humanities program at Davidson College and is intended for a layperson audience. The goal of this publication, like the Medical Humanities program at Davidson, is to raise awareness about issues in medicine and their ethical ramifications.

The topic this year is “Authority and Responsibility in Medicine and Health Care,” which is also the topic of the Speas Symposium on April 5, 2008. Speas offers a great opportunity for any interested Davidson College students to interact with individuals in the fields of medicine and bioethics.

The articles in this newsletter address several issues dealing with the authority and responsibilities of actors in health care. Among the articles are two opposing arguments for disclosure of misattributed paternity. Also included are articles on the Hippocratic Oath, selective abortion, informed consent, and euthanasia. Some of the writers had personal experiences that motivated their choice in topics.

The patient-physician relationship and its associated obligations is a central theme running throughout this entire newsletter. The authors have chosen to focus on both the physician’s side of these issues, as well as the patient’s side. Even though physicians and other health care professionals often have a disproportionate amount of authority and power, patients must carry a certain burden for their own health outcomes.

Another thread unifying many of the articles is the role of law and the legal ramifications of the decision-making processes for health care professionals. Some physicians may err on the side of caution for fear of legal outcomes from misconduct or complications. Not only do physicians have a responsibility to do good (beneficence), but they also are bound to not do harm (maleficence). The fine line between these two principles could lead physicians to take conservative measures out of fear of litigation. For this reason physicians must use the authority that they hold in responsible ways, creating a somewhat cyclic element to this publication’s theme.

If you wish to respond to any article in this issue, please see the contact information on page 14.

About the Editor...

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Authority and Responsibility in Medicine and Health Care
Lance K. Stell, Ph.D. Charles A. Dana Professor of Philosophy and Director of Medical Humanities

"Every man should be responsible to others, nor should any one be allowed to do just as he pleases; for where absolute freedom is allowed there is nothing to restrain the evil which is inherent in every man." Aristotle, Politics, VI: Ch.4 1318b, 36-41.

Two sorts of inherent evil concerned Aristotle in this passage, arrogance and shirking. Arrogance is the tendency to exceed one's role-defined limits, to go over the line, to take more power, authority than one should in the circumstances. A shirker, by contrast, avoids taking the full measure of his role-defined power and authority, coming up short of what is expected of him by defect.

Aristotle's proposal for restraining these evils is to make each agent accountable to others for how he exercises his freedom of action. Each agent should be liable to others' power, to review what he has done (or omitted to do), and to demand his producing a proper accounting for his excesses and deficiencies when matters entrusted to his care don't turn out as well as they should have.

By implication we can infer that being liable to others' power to call one to account presupposes having the ability to live up to what's reasonably expected, having the ability to recognize what it means to be called to account for one's excesses and defects, having the ability to produce an accounting of the relevant sort, and thereby to own up to what one has done or omitted. One should also reasonably infer from Aristotle's responsibility principle that one's answerability should vary with the breadth of one's discretionary authority.

However, making people accountable to others for how they exercise their discretionary authority only restrains their tendency to evil (of arrogance or shirking), but doesn't eliminate it. People make errors. They are disposed to make different sorts of errors. Between arrogance and shirking, which is worse and on which side is it better to err?

Physicians, surgeons, nurses are charged to take care of others' important but somewhat vaguely-defined health care interests, sometimes under emergent circumstances. Would it be better to tolerate errors of arrogance or of shirking? If errors of arrogance are better, wouldn't moral hazard result? And by encouraging patients to rely on arrogant over-reaching, wouldn't we also encourage care-providers to medicalize patient tendencies to shirk. On the other hand, when someone shirks in his duties of self-care, doesn't he thereby unreasonably increase his own woe and unfairly increase others' concerns about his welfare? Shouldn't we call self-care shirkers to account and blame them for it? But what if their shirking results from weakness of will? Should we blame people for being weak-willed? Suppose our culture enables the weak-willed. What marks the limit of professional care-givers' authority/responsibility and patient's authority/responsibility?

The Arrogance Problem

It has long been appreciated that physicians, surgeons and other health care professionals are at increased risk for arrogance. The interests entrusted to them are very important but not clearly defined. Ill or injured patients typically need a skilled intermediary to act aggressively and proactively on their behalf. Doing this effectively requires broad discretionary authority whether to intervene, when, in what manner and how often. Having broad discretionary authority invites care providers to forego timely consulting with the patient (or his representative), to over-rate their own expertise, arrogating to themselves decisions that better planning and greater respect would have accorded to the patient (or his representative).

Because the clinician's expertise is specialized and because so many decisions are made out of the patient's sight, supervising or reviewing them in detail is out of the question. Indeed, a patient's attempting to exercise detailed oversight and review authority risks loss of agent-benefits to which he is entitled.

The arrogance problem further compounds because health care professionals are agents for themselves (and many others as well) besides for their patients. At every turn, the clinician is situated incrementally to advantage himself (and others to whom he owes loyalty) at the patient's expense. The tangle of conflicting loyalties is so extensive that taking time to explain them all prospectively might well cause patients to wonder whether the clinician's litany counts as warning, whining or boasting. For a few examples, loyalties conflict when:

- without the patient's knowledge, his payer-status (private indemnity, +/- co-pay, public prospective pay, or self-pay) decreases or increases to any degree the quality of service provided;
- despite patient (or representative) protest, the clinician unilaterally and without proper professional review imposes treatment or procedure OR refuses to provide services that may marginally extend the patient's life or hasten his demise;
- the clinician recommends enrollment in a study of a new medicine or device but neglects to explain that he is a paid consultant for the manufacturer who receives reimbursement per-patient enrollment. These relationships may or may not redound to the patient's benefit and the clinician may not reasonably know one way or the other;
- the clinician fails to consider critically whether attending a particular industry-sponsored drug/device talk or accepting industry-sponsored but professionally approved CME will detract from or improve the quality of his patient care;
- the clinician decides not to disclose to the patient the extent of his own training, experience and comparative outcome statistics;
- without the patient's or his representatives' specific informed consent, shares confidential health care information with a law enforcement authority for the purpose of taking away the freedom to accept or
refuse treatment/procedure; the patient is subjected to marginal discomfort, inconvenience and expense to assuage the clinician's malpractice anxiety ("defensive medicine");

A theory of responsibility for health care professionals and their patients must specify what acts and omissions each is answerable for, who has standing to review them, in what forum, and how those who perform the reviews are themselves to be held accountable. The theory must also set limits, for examples, by saying when an accounting has been duly and sufficiently made and when "Buzz off, mind your own business!" is an acceptable answer to someone who lacks standing to call one to account or whose demands for an accounting are untimely or improperly made.

A theory of responsibility should address the problem of over-imposing answerability with resulting over-employment in the accountability industry. Liability for being called to account tempers arrogance, but at some margin promotes too much permission-seeking and undesirable timidity. Accounting for explaining/justifying oneself takes time away from other things one might be doing instead. Increasing the number of occasions when one must account for and justify oneself creates an incentive to do less of what prompts such demands.

Sometimes ordinary due process for holding people accountable itself jeopardizes justice -- at law, motions in limine and the extraordinary writ of prohibition provide relief from this risk. Under some circumstances, the exercise of discretionary authority should be shielded by immunity. For example, in the United States, public officials such as police officers and judges are not liable in damages to those harmed by their wrong decisions, even when the harm results from an arrogant departure from the standards of good official conduct.

Aristotle would have appreciated that institutionalizing responsibility involves a trade-off -- too little increases unreasonably the risk of arrogance. Too much promotes timidity, destroys the blessing of liberty, needlessly sacrifices accomplishments requiring enterprise, boldness, and initiative.

There is no "right answer" to how much answerability good institutions should impose, on whom and in what circumstances. James Madison showed an acute appreciation for the problem when he wrote: "If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself. A dependence on the people is, no doubt, the primary control on the government; but experience has taught mankind the necessity of auxiliary precautions." [The Federalist, 51].

Constitutionally enumerated fundamental rights plus recognizing that there are indeterminately many more counts as one of those "auxiliary precautions." This year's Speas Colloquium invites further consideration how authority and responsibility should be balanced and apportioned in medicine and health care.

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The 21st Frederick Wombell Speas Symposium

"Authority and Responsibility in Medicine and Health Care"

April 5, 2008
C. Shaw Smith 900 Room

Keynote Address:

"Autonomy and Beneficence: Henry Beecher Revisited"
Alexander Capron, JD

Panel Discussion Sessions:

"The Medical Profession's Relationship with Industry"
Michael Oldani, Ph.D.
Robert Cook-Deegan, M.D.

"Decision Making Regarding Adolescents and/or Very Young Children"
Kevin Powell, M.D., PhD, FAAP
Philip Rosoff, M.D., FAAP

"Futility and the Law"
Laurence McCullough, Ph.D.
Nancy M.P. King, JD
Affirming the Modern Hippocratic Oath
Joel Fineman, Davidson College '10

The landscape of healthcare is rapidly changing. An M.D. should come accompanied by an MBA, since being a "good" doctor requires a business mentality. Physicians have switched their primary focus from good healthcare to efficiency in the chase to maintain their personal expenses against the raising healthcare costs. In this inevitable capitalist transition, physicians are faced with a central conflict—the traditional obligations and responsibilities to a single patient versus the service to their rising amounts of patients and their own financial situations. Susan Wolf raises the concern that recent healthcare proposals contain "no guidance to physicians on how to fulfill these responsibilities." 1

The Hippocratic Oath has been the backbone of physician's ethic for centuries. A modern version of the oath was penned by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and is used in many medical schools. This version, written in 1964, attempts to cover the ethical issues physician's face in modern medicine; however, even this relatively recent revision of the ancient code leaves much room for error.

One of the pillars of the Hippocratic Oath is that a doctor "will apply, for the benefit of the sick, all measures that are required." How can physicians adequately provide the best care to the all patients, when more patients are pounding at the door to be seen and practicing costs escalate? Wolf goes further to question how each bill alters the ethics appropriate to the situation. Doctors should not be the ones who are footing the bills, regardless of their moral obligation to follow the Hippocratic Oath. 2

Therefore, what are we do? Disregard the ethics of Hippocrates simply because they are bound to be broken? No, patients and physicians must reestablish this moral bond of obligation to each other, and together they must confront and solve the logistical and monetary problems of the healthcare system. It will require sacrifices from both sides, but certainly not the yielding of their moral codes. Neither party can expect to survive if the healthcare system runs its current course. Political action is required and must happen before too much damage has occurred.

The Modern Hippocratic Oath
I swear to fulfill, to the best of my ability and judgment, this covenant:
I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over-treatment and therapeutic nihilism.
I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
I will prevent disease whenever I can, for prevention is preferable to cure.
I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.
If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.


"will apply, for the benefit of the sick, all measures that are required."

There has always existed a principle bond between patient and physician. Grodin and Sosower establish that "when a patient enters a physician's office, an implicit contract is established with regard to the exchange of monetary reimbursement.

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http://www.pbs.org/wgbh/nova/doctors/oath_modern.html
Autonomy in the Eyes of Doctors and Judges
Daniel Griffin, Davidson College '08

Brenda Payton was 34 and lived alone in West Oakland, unable to care for her children. She was an alcoholic and had been addicted to heroin and barbiturates for over 15 years. Aside from her alcohol and drug problems, she was also morbidly obese and emotionally unstable. The medical condition that brought her to Biomedical Application of Oakland Inc. (BMA) several times per week was her chronic end-stage renal disease, which is a permanent and irreversible loss of kidney function. In order to stay alive, the disease requires undergoing hemodialysis, connecting her circulatory system to a machine that removes excess liquids and impurities from her blood.

After Dr. Weaver went through the necessary steps to release her as a patient, litigation settled that Dr. Weaver would continue to treat her on an outpatient basis as long as Brenda met certain conditions: she be on time to her appointments, refrain from alcohol and drug use, keep prescribed dietary habits, and cooperate with her health care providers. Dr. Weaver again tried to terminate her treatment citing that Payton violated every one of the stipulations of the litigation. During the 11 months between trials, she had 30 emergencies needing hospitalization, appeared for treatment intoxicated, and had a "gross non-cooperation with her treating physician." 1

When Payton v. Weaver was brought to court in 1982, Dr. John Weaver tried to terminate the treatment of his patient, Brenda Weaver. Her counsel recommended that the court force her to go into voluntary treatment at a full time psychiatric facility because of her narcotic addictions, alcoholism, and emotional problems. The court saw her as an autonomous individual and would not make her submit to consenting to a caretaker who could make Brenda receive this psychiatric treatment. While the court is right to hold the belief that a person's autonomy and integrity is of the utmost importance, the court should have recognized her inability to care for herself and should have placed her in an addiction treatment program.

In this case, we are concerned with Brenda's autonomy of person. To accuse someone of incompetence, the standard of proof must be clear and convincing. This reflects the ideals of the court that if they are incorrect in judging the competence of an individual, they will err on the side of autonomy- as the court did in Payton v. Weaver. In general, the court is more concerned with the protection of the individual's rights, while the medical profession places a greater emphasis on the patient's well-being. Doctors also recognize the importance of the right to refuse treatment, but are more inclined to look at a patient in a non-autonomous way.

If the habits of alcoholism, drug use, poor dietary habits, and cooperation with the doctors were detrimental to Payton's health, they would still be her choices to make as an autonomous person. Brenda Payton still had the right to privacy and could go about her treatment as she wished, assuming as the court did, that she was competent. The court did note that Brenda Payton was disruptive and uncooperative in her treatment at BMA. "Her conduct has been disruptive, abusive, and unreasonable such as to trespass upon the rights of their patients and to endanger their rights to full and adequate treatment" 1 She did not have the self-control needed to be autonomous.

A person can be competent in some abilities and incompetent in others. For example, In the Matter of Mary Moe, the 25 year old woman with an IQ of 80 was pregnant for the fifth time and again needed the court to help decide if she was competent enough to have the child. She lived at home with her young daughter and parents, whom she relied heavily upon for support and assistance. Her neurologist's expert testimony in the case was that the ward was not able to take care of herself, but was able to realize that she could not raise another child.

This case is an example of the court using the doctrine of substituted judgment to decide what the ward would choose if she was able. The ward's incompetence was also much more obvious than Brenda Payton's. Brenda was addicted to narcotics, but she could still articulate to the court that she wished to remain in control of her person- signifying she did have the ability to comprehend that she could lose her autonomy.

Medical paternalism accounts for some doctors viewing a patient as non-autonomous. Without specific consent, a doctor may perform some action on a patient if it seems that it is in the best interest of the patient. In Schloendorff v. Society of New York Hospital, the doctor removed a fibroid tumor during an examination under anesthesia from the plaintiff without her consent. Medical paternalism is not a reason to force Brenda Payton into treatment even though it may be in her best interest, but it does show the beliefs of doctors to lean towards non-autonomy when treating patients in some cases. A better rationalization for forcing Brenda Payton to be committed to substance-abuse treatment is the doctrine of substituted judgment. This doctrine was discussed in Mary Moe, and should still apply here- not because of a deficient IQ score or ability to care for herself, but because of Payton's impaired judgment due to addiction to narcotics.

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The Ethics of Genetic Testing in Regards to Selective Abortion and Eugenics
Michelle Jester, Davidson College ‘09

For better or for worse, genetics has made significant advancements in the past few decades—most notably in the area of genetic testing with the completion of the Human Genome Project. Although genetic testing has led to numerous advancements and benefits in terms of prevention and treatment of disease and safer reproductive practices, it has also unleashed a myriad of ethical issues. One of the most prominent issues to date is the possibility of using genetic information for selective abortion against “undesirable” traits and implementing eugenic practices to genetically enhance offspring with desirable qualities.

On a basic level, many humanists criticize eugenics and selective abortion because they create a perception that reduces humans to alterable molecules rather than living and feeling beings. Humans become products that can be assembled or discarded at the designer’s (or in this case, parents’) discretion. Having children is no longer a natural process of reproduction but a selective manufacturing system. This is part of the larger argument that eugenics and selective abortion undermine human nature. Because these practices manipulate what is genetically determined by nature, they destroy the sacred value of human nature and ultimately, what it is to be human. If human traits could be selected for or against, people could select against diseases and disabilities.

Having children is no longer a natural process of reproduction but a selective manufacturing system.

As our society becomes more homogenized through genetic selection, traits considered “abnormal” or “defective” could become stigmatized since they will become “undesirable” minorities. While acknowledging these possibilities, Francis Fukuyama focuses more on the social implications. Because genetic counseling and testing on average cost around $2000, people of middle or upper socioeconomic classes are typically the ones who can afford these treatments. As a result, the social status of a person will become more definable by genetic determinations, such as physical looks and intelligence.

Although there are those that believe these practices will ultimately benefit society as a whole through the elimination of diseases and “undesirable” traits, most of the support behind the permissibility of selective abortion and eugenic practices stems from the protection of procreative liberties. Thus, their argument is not necessarily that we should allow these practices but more why shouldn’t we allow these practices based on current legislation and childrearing methods? Under the provisions of Roe v. Wade, women have the constitutional right to reproduce or not reproduce because it is an integral part to a woman’s personal autonomy. Consequently, women can legally abort unequivocal fetuses regardless of the reason. John Robertson makes the argument that if women can abort a normal fetus with no health problems simply because the pregnancy is unwanted, women could also end pregnancies because the fetus has undesirable genetic defects or qualities.

According to Cleveland Board of Education v. LaFleur, “personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment.” Dov Fox goes one step further and argues that if it is permissible for parents to shape their children’s characteristics, personalities, and talents through childrearing practices and lessons (such as punishments or piano lessons), then it should be permissible for parents to just genetically select for these qualities.

However, there are problems with several of these arguments. Anna’s criticism that eugenics and selective abortion reduce humans to assemblies of molecules that can be altered makes a sweeping generalization that humans should not be changed. However, humans are all about adaptation and evolution in order to alleviate the difficulties of life. Fox’s argument that parents should have the right to mold their children genetically if they can mold their children through childrearing practices or lessons also has faults. By equating genetic enhancement of offspring with childrearing practices, she is essentially associating nature with nurture.

One may also argue that cosmetic technologies such as hair dye, botox, and liposuction ultimately alter human characteristics that were predetermined by nature; however, these are personal decisions chosen by the individual himself/herself—not decisions imposed upon an unborn child. I believe a person has every right to alter or enhance his/her own traits as he/she desires. I also believe that parents or guardians have every right to utilize certain childrearing practices as they see fit. However, I disagree with the notion that parents have the right to select genetic traits for their children because I do not believe that these individual rights extend to selecting certain genetic traits for others. Just as we have laws preventing interference with other people’s property or rights, we should also have laws preventing interference with other people’s genetic makeup. After all, what more is a person’s personal property than his/her own body?

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Many critics of eugenics and selective abortion believe that selective abortion and eugenic practices will lead to a "slippery slope" of abuse. First, genetic predispositions to diseases will be selected against, then shorter height, then brown hair, etc. However, this "slippery slope" can go both ways. We need to establish limitations so that people do not take advantage of the genetic information and technology available and also so that the government cannot restrict everything and possibly encroach upon people's rights.

In my opinion, the government should allow genetic testing and genetic selection if it is for medical purposes, such as testing for diseases. However, genetic enhancement of particular traits for unborn fetuses, on the other hand, should not be allowed. Furthermore, carrier screening before conception should be strongly encouraged among the populace so that these situations could be avoided or prevented. To me, genetic enhancement would lead to an unattainable quest for perfection which, in turn, would lead to a society devoid of diversity and acceptance.

References:


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The doctor is responsible for reasonably disclosing risks and deciding what not to tell the patient. The full disclosure of risks is unreasonable (Canterbury v. Spence) because in any treatment there are a number of small risks that may deter the patient from choosing to undergo a required treatment. Ethically, it is equally bad to mistakenly label an autonomous person as non-autonomous and visa versa. Do you infringe upon an individual's right to be secure in their person? Or do you let someone who is incapable of deciding a course of treatment harm themselves by refusing?

The court was correct in initially presuming that Brenda Payton was an autonomous individual. Doctors and courts should hold the patients personal integrity at a high level, but be open to explore evidence to the contrary. The California courts were too biased towards regarding a person as autonomous, the courts and doctors should have a more similar view of autonomy. There was enough testimony showing Brenda's impaired judgment and self-control that lead to her emergency hospitalization to suggest that she was not competent to control her medical care.

The court had stipulated that she seek psychotherapy and/or counseling, but she discontinued her sessions. The court should have heard the testimony of the psychologists and perhaps requested that Brenda seek further counseling. With more expert testimony, they could have decided whether or not Brenda was autonomous. After a decision that she was unable to control her actions the court should then take her away from outpatient care with Dr. Weaver and into an inpatient rehabilitation clinic.

References:
131 Cal. App. 3d 38

Daniel Griffin '07 is President of the Bioethics Society. He is a Psychology major with a Medical Humanities concentration at Davidson College. He will attend medical school in the fall.
Medical Disclosure: The Truth About The Truth
Alex Kim, Davidson College '09

If doctors are obligated to disclose unsought information to whom and how should it be presented? Take the case of a daughter who wished to donate her kidney to her supposed father. In transplant surgeries, it is standard practice to have a different doctor for the donor and the recipient to avoid a conflict of interest. After performing an HLA typing, it turns out that the two patients are not biologically related. In such a dilemma, the course of action depends on whose doctor it is. The donor's doctor has a sworn duty to inform the daughter that the man who she is about to give her kidney to is not her biological father. Since the kidney that is being donated initially belongs to the girl, she must be told the truth about her relations to her father so that she is able to make an informed medical decision.

By withholding such information, both of the doctors cannot proceed since she has not given either of them informed consent. If the transplant was to go ahead without informing the donor the truth about her father they will be taking her kidney under false pretenses. If the father is told, there is always the possibility that he might try to coerce her into giving up her kidney thus violating her bodily integrity and preventing her from giving the physician informed consent. This may also carry possible legal ramifications. However, by telling the donor the truth about her father, the physician might be brought to court for causing negligent infliction of emotional distress upon the daughter. In order to respect a patient's bodily integrity and to obtain informed consent, it is the donor who must be told the truth about their father-daughter relationship.

Several famous cases have laid out the importance of bodily integrity and informed consent and how the two go hand in hand. In the case of Cruzan v. Missouri Department of Health, "bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment." It is not only unethical but illegal for a physician to even touch a patient without obtaining informed consent because by doing so, he would be violating the patient's bodily integrity by withholding information that might give or deny the doctor an informed consent. This was also reiterated in the case of Salgo v. Leland. According to that case, "a physician violates his duty to his patient and subjects himself to liability if he withholds any facts necessary to form the basis of an intelligent consent by the patient to proposed treatment." Therefore, in our case the physician will be failing to perform his duties if he does not inform the daughter that the potential recipient is not her father.

Unfortunately, the recipient's doctor is presented with an even more troubling dilemma. If the father's doctor releases his patient information to the other donor or to her doctor without the transplant recipient's permission, the recipient's physician is practicing outside of the standard of care and is also in breach of confidentiality. But there is also another problem. By not telling the donor or her doctor, the recipient's physician is at risk of being found guilty of contributory negligence should a lawsuit ever arise. Contributory negligence is defined in the case of Guerra v. Jaeger as "conduct on the part of the plaintiff which falls below the standard to which he should conform for his own protection and which is the legally contributing cause, cooperating with the negligence of the defendant, in bringing about the plaintiff's harm." Since the two patients have separate doctors, it is not within the standard of care to tell the other patient. In other words, the physician can incur a lawsuit regardless of whether or not he tells the donor the truth about her father.

Obtaining informed consent and respecting the patient's bodily integrity are key to treating any patient and by violating one; a doctor will ultimately violate the other. However, in the case of the daughter who wished to donate a kidney to her alleged biological father, there are legal consequences if either the donor's or recipient's doctors withhold or give information. Whether the doctor is acting in order to obtain informed consent, respect the patient's bodily integrity, or to reduce the legal ramifications of his actions, this is a situation in which the doctor is potentially a victim. Once hailed as saviors, doctors today are seen by many to be lawsuits waiting to happen.

References:
1 Cruzan v. Missouri Department of Health 497 U.S. 261
2 Salgo v. Leland 154 Cal. App. 2d 560
3 Guerra v. Jaeger 204 Kan. 309

Alex Kim '09 is a biology major at Davidson College. After graduation, he plans to attend medical school.
A Case Against Medical Disclosure
Whitney Mudd, Davidson College '09

Surgeons perform over 15,000 kidney transplants a year in the United States with over 6,500 from living kidney donors. While living kidney donations yield an impressive five-year 78.7% graft survival rate, they occasionally yield unanticipated ethical considerations. Specifically, routine donation exams on a donor daughter and recipient father, such as human leukocyte antigen testing (HLA), can reveal misattributed paternity. In cases in which misattributed paternity do not preclude the donation, doctors face an ethical dilemma on whether to disclose this unsought information. On the basis of sustaining family accord, respecting the mother’s right to privacy, and upholding the physician-patient relationship, I believe that physicians have neither the responsibility nor obligation to reveal false paternity.

Arguing on the basis of nonmaleficence, my family doctor when presented with this scenario observed, “You learn many things as a doctor that are best kept quiet. In this case, nothing is gained by disclosing the information, and there could be lots of negative repercussions by doing so.” Disclosure of false paternity can have detrimental effects on the family and destroy family harmony. The father, for example, may feel betrayed and resentful, having sacrificed his life for another man’s child. As Dr. Lainie Ross, a pediatrician and medical ethicist at the MacLean Center for Clinical Medical Ethics at the University of Chicago, points out, “partners may not want to support a child that they did not sire.” Conversely, the daughter may feel stigmatized and distance herself from the family. Either way, disclosure will forever alter and harm family relationships and ties.

Secondly, disclosure violates the mother’s right to privacy and may threaten her safety. The mother hid the false paternity from the father and daughter for a reason and has not given consent for the doctors to share this information. She may, for example, feel that disclosing the misattributed paternity will place her in physical danger. A recent study found a correlation between infidelity and spousal abuse, and such disclosure by the physician may put the mother in harm. Consequently, out of concern for the mother’s privacy and safety, doctors should not disclose the misattributed paternity.

Finally, disclosure of the false paternity damages the physician-patient relationship. It is necessary for doctors to exercise caution in disclosing information that is upsetting to the patient. Admission of misattributed paternity will only disturb and emotionally damage a physician’s patient. The patient did not ask for a paternity test and the doctor should therefore not disclose such information. However, to prevent doctors from having to face such difficult decisions in the future, I believe that transplant centers need to warn patients of the unsought paternity information testing can reveal. Prior to HLA testing, patients must decide whether, if applicable, misattributed paternity should be disclosed. But, in the meantime, out of respect for family harmony, the rights and safety of the mother, and the upholding of the physician-patient relationship, healthcare professionals must not disclose misattributed paternity.

References:


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Informed Consent: Lessons from the Past

Eva Foegeding, Davidson College '09

The Tuskegee Syphilis Experiment is one of the most blatant violations of informed consent in United States history. It resulted in the death of twenty-eight men and at least one hundred more experiencing side effects of syphilis. Under the study, three hundred and ninety-nine black men remained untreated for syphilis between 1932 and 1972, without any information about the severity of their disease. The doctors considered it a research experiment to observe the side effects of the disease on patients.¹

As a result of Tuskegee, patients' rights to informed consent have become a valuable part of our medical community. Informed consent is easier to define in research experiments than physician-patient relationships. The legal community has begun to define the grey areas of informed consent, but lawyers, instead of the medical community, are establishing these standards. The system of legal precedent has become a double edged sword for physicians, who are misled by the problems of defining informed consent and then emotionally and financially hurt by the legal procedures that ultimately stipulate its applications.

The Patients Bill of Rights states, “The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.”² Hippocrates urges physicians to “apply, for the benefit of the sick, all measures which are required,” and as physicians do this, they attempt to follow the standard of care for informed consent.³ The Patient’s Bill of Rights, Hippocrates and standard of care do not address all of the variables within informed consent. Before patients begin treatment, physicians must decide what information is important for the patient’s decision making. The physicians try to define informed consent by creating a standard of care, but the legal system takes action when the patient does not agree with the care that the physician gives.

In the case Johnson v. Kokemoor, it was decided that “a reasonable person in the plaintiff’s position would have refused surgery,” if given all the information on the surgeon’s qualifications. The plaintiff was referred to the defendant for surgery, because she had a bifurcation aneurysm in the posterior circulation of her brain. The defendant was a neurosurgeon and took on the plaintiff as a patient, although he had only performed thirty aneurysm surgeries during his residency and they were all in the anterior circulation of the brain. After surgery, the plaintiff was “rendered an incomplete quadriplegic” and was unable to walk. The court’s ruling determined that the surgeon must inform his patients of more qualified surgeons than himself when necessary. This case helps set a legal precedent for jurisdictions using the material risk standard of disclosure pertaining to the amount of information necessary to inform a patient on the qualifications of their physician.⁴

The precedent for informed consent must be set, because it is important to establish a more thorough definition and ethical guidelines for physicians to follow. Currently verdicts from malpractice cases, like Johnson v. Kokemoor, define different areas of informed consent and determine the guidelines for standard of care. Canterbury v. Spence stated that “Respect for the patient’s right of self-determination, in particular, demands a standard set by law for physicians rather than on which physicians may or may not impose upon themselves.”⁵ Therefore, the court gave the right to create the standard of care to the legal community instead of the medical community. This is difficult for the medical community, because people who are not medically trained, such as lawyers and jury members, are determining what is ethical and necessary within medical practice.

Physicians and lawyers will not agree on every informed consent verdict, because they have different goals and perspectives. Lawyers have a reactive point of view because they always work to solve the problem after it happens. They get a case and try to defend it. Doctors want to practice proactive medicine, although sometimes they get a patient for whom they must constantly fight to save their life. Doctors do not always know which patients will survive or which ones will have complications; but they are doing their job with the risk of being sued. Doctors consistently practice with time constraints and sometimes they make quick decisions to save their patient’s life. Doctors are however human and cannot always perform perfectly, which can lead to life threatening consequences.
On the other hand, lawyers have time to build their defense and double check their work. The legal community does not understand the struggles of a physician. The medical community is hurt with every malpractice case and informed consent issue that could be avoided if the standards were predetermined.

The system in place also takes advantage of physicians by using their mistakes to define the legality of issues. In cases like Bowlin v. Duke University, the physician won the case but was probably hurt emotionally and monetarily from defending himself. Dr. Jones had claims brought against him, because he had not informed the plaintiff which assistants were still in school. The trial court supported Dr. Jones' defense, because the plaintiff had signed a waiver that allowed medical students to participate in her treatment. Even though Dr. Jones won the case, he lost some of his perseverance and trust in his practice and his patient-relationships.

At the minimum, physicians who have claims filed against them hire a lawyer. Next, their insurance will go up, and the litigation process will be time consuming and emotionally draining. If the case goes to court, whether or not the physician wins, he or she will have to put in even more effort. Winning the case is bitter-sweet, because there are no fines but the physicians won't get any of their time and money back.

Informed consent is part of the everyday practice of medicine. Patients have the right to decide what will happen to their bodies, what treatments they will receive, and what physician they will work with. To be in full control of all these things, the patient must be informed. It is ethical to let the patient decide on their own medical care, but is it ethical to allow lawyers to decide on this standard of care? Each state determines their standard of care, because the laws of each state are created separately. Since the legal community is given the right to determine the standard of care, standard of care has become different for each state.

The medical community can no longer work by the same ethical guidelines, or determine their own guidelines in a unified fashion. Instead, the lawyers, who are not united, determine the medical standards for informed consent. Even though, lawyers are not liable every time a physician is sued for not informing a patient. Lawyers are suing the physicians because they have yet to create the laws before the case happens. The legal community has created a trap for physicians by leaving large gaps in informed consent issues undefined and more lingering opportunity for a malpractice lawsuit. This reactive method for creating the standard of care is best for the lawyers, not the physicians or the patient; because when the day is done the lawyer is still paid.

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The West Virginia Medicaid plan threatens to violate all three principles of the Physician Charter on Medical Professionalism: the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice. The very nature of the program puts physicians in a position where they may be called upon to report their patient to the government knowing that it may result in the removal of certain services. This practice runs counter to physician obligation to do no harm. As physicians become agents of the state, patient distrust of the medical community increases and patients have less of an incentive to comply with physician recommendations.

There is no doubt that there are serious problems in the health care system today regarding patients not taking responsibility for their health care. While West Virginia has attempted to create a Medicaid plan that encourages better behaviors and greater compliance by patients, it suffers first and foremost from serious social justice concerns. The very nature of the plan punishes those individuals who are already disadvantaged and runs the risk of thwarting them even farther into health crises. With existing social and economic problems these individuals will be more likely to not understand the requirements of the program and find it harder to meet all of its conditions. While the plan is still in its infancy, one can easily imagine that the long-term consequences will only be an exacerbation of prevailing social disparities. Is the ultimate goal of medicine to help those in need or to punish those who lack the resources and access to care? The current Medicaid plan in West Virginia runs the risk of falling into this latter category.

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Ross White '09 – Editor
Justifying Euthanasia in Times of Crisis: A Look at Hurricane Katrina

Matthew DeNiear, Davidson College ’11

During the night on August 28, 2005, Hurricane Katrina struck the city of New Orleans and Gulf Coast region as a category 4 storm. On the following morning, a thirteen and a half foot storm surge that accompanied the hurricane caused the levees that protected New Orleans to breach in numerous locations around the city. Water subsequently began to pour through these breaches in the levees, leaving most of New Orleans submerged under several feet of water. In the coming weeks, the vast devastation caused by Hurricane Katrina in New Orleans and along the Gulf Coast would render the storm as one of the largest disasters in U.S. history.

Located in the center of New Orleans, the Memorial Medical Center became refuge for those civilians who were unable to evacuate before the storm and the 2,000 patients who were unable to be evacuated due to an unavailability of adept medical transport. With the breaching of the levees, the floodwaters began to submerge the hospital’s parking lot and fill the lower levels of the hospital causing electricity and plumbing to fail. With these failures, the Memorial Medical Center became a crowded concrete island filled with civilians, sick and critically ill patients, defunct medical apparatuses, and the doctors who had chosen to remain through the storm.

For three days after the storm, doctors and patients waited for rescue in the horrid conditions at the hospital. On the fourth day after the storm, plans for a makeshift evacuation were made; however, these plans did not include evacuating the critical, immovable patients. It was at this point, after days without electricity, of limited food and water, and 110 degree heat inside the hospital, that Dr. Anna Pou and two of her nurses injected four patients with a lethal cocktail of the painkiller morphine and the sedative Versed before they left the hospital.

In the months after hurricane Katrina, stories of “mercy killings” at the Memorial Medical Center surfaced in the media. Louisiana Attorney General Charles Foti soon after indicted Dr. Pou and her nurses on charges of homicide.

A law passed in Louisiana in 1995 made assisted suicide a criminal offense and stipulated a maximum penalty of 10 years hard labor for offenders. Physician assisted suicide was illegal or considered homicide in all fifty states until the state of Oregon passed the Death with Dignity Act in November of 1994. The Death with Dignity Act allows citizens of Oregon who are afflicted with “an incurable and irreversible disease that has been medically confirmed and will produce death within 6 months” to receive a prescription from their physician for a lethal medication that they can administer to themselves. The law also provides that a minimum fifteen day grace period exist between initial consent to receive the lethal medication and a second consenting process prior to receiving the medication. Witnesses must observe each time consent is given.

The objective of the Death with Dignity act is to allow individuals to choose to avoid suffering the pains of their lethal condition by ending their own life prior to these events. The case of the New Orleans “mercy killings” differs from the form of euthanasia legalized in Oregon because there was no patient consent to end suffering. Dr. Pou denies what she and her nurses did was mercy killing or euthanasia. Dr. Pou said in an interview “I do not believe in euthanasia. I don't think that it's anyone's decision to make when a patient dies.

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Personal Responsibility: Examining West Virginia’s Medicaid plan
Ross White, Davidson College ’09

When one examines responsibility in health care the emphasis tends to be on the physician and their obligations within the clinical setting, specifically the patient-physician relationship. It is however very important to remember that the patient-physician relationship is not single directional, but rather an ongoing exchange back and forth between the patient and physician. While it is easy to focus on the actions of the physicians because of the often disproportionate authority in favor of the physician, in order to have a meaningful and healthy relationship the patient must play an active role in decision making and following through on clinical recommendations.

The argument goes that if an individual takes personal responsibility for their health care, follows a healthy lifestyle, and is a good patient; they will be rewarded by feeling better and spending less money. While programs to encourage personal responsibility would seem to be beneficial, they have a propensity to challenge individual freedom and patient autonomy. Examples of such behavior are not hard to find: the World Health Organization no longer hires people who smoke, chew, or snuff any tobacco product; some U.S. employers target smokers and sometimes even fire employees who smoke when they are not at work; and a growing number of companies charge lower health insurance to nonsmokers or people who complete weight loss program, and give financial incentives to participate in health screenings and fitness programs.1

The federal government has taken a more active role in promoting personal responsibility through their “Roadmap to Medicaid Reform” under the Deficit Reduction Act of 2005, which gives states increased flexibility in designing and implementing Medicaid programs. Nowhere has this redesign been more controversial than in West Virginia, which has a population of 1.8 million and a higher percentage of residents with Medicaid coverage than the United States as a whole.1 In May 2006, the federal government approved the state’s plan to provide reduced basic benefits to most healthy children and adults who are eligible for Medicaid because of low income. At the same time it offers the option of enhanced benefits for signing and abiding by a “Medicaid Member Agreement.”

In order to remain in the enhanced plan, members are obligated to keep their medical appointments, receive screenings, take their medication, and follow health improvement plans. Those who meet these goals will receive credits to be placed in a Healthy Rewards Account to purchase services not provided by Medicaid, while those who fail to comply have their benefits reduced. Because there is no comparable program that exists it is difficult to gauge the real consequences of the programs implantation, but many raise concerns that Medicaid recipients will not change their health behavior simply as a result of signing a member agreement.1

Children are also dependent upon their parent or guardian to carry out many of the conditions of the plan, which unfairly puts them at the mercy of others.5

Secondly, the plan in West Virginia holds Medicaid patients to a standard that is not even expected of other patients. The population rate of compliance for medication ranges from 43 to 78 percent, which suggests that individuals under the plan are unfairly restrained by standards that a considerable percentage of average patients cannot even uphold.5 Privately insured patients are able to outright reject the advice of their physicians without fear of punishment, while Medicaid recipients are expected to be model patients. In reality, Medicaid recipients are less likely to be compliant and can often claim to have more legitimate reasons for noncompliance. Poverty results in reduced access to child care, transportation, healthy foods, and exercise facilities. Additionally, those in poverty are more likely to have lower literacy, more life crises, and higher rates of untreated psychiatric illnesses.

While such a program may be applauded by some as an important move toward more responsible behavior and ultimately an improvement in health outcomes and reduction in health care costs, the plan raises important issues of fairness. First, the plan places responsibility on patients for factors that may be out of their control. This is perhaps best exemplified by individuals who must depend on public transportation or transportation provided by Medicaid. These individuals are hurt by the sometimes limited evening and weekend hours of many primary care offices, forcing them to visit emergency rooms after they have worked a full day.

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However, what I do believe in is comfort care. And that means that we ensure that they do not suffer pain." 3 On the other hand, Attorney General Foti maintains what Dr. Pou did was not euthanasia or in the best interest of her patients, but "plain and simple homicide." 4 Regardless of how one classifies the actions of Dr. Pou and her nurses, the incident still begs the question of what should be done with critical patients in the event of a disaster scenario and collapse of the healthcare system.

In a recently published article, Kenneth Kipnis argues that the New Orleans doctors were faced with a dilemma typically only observed in a military setting. Kipnis argues that military doctors occasionally are forced to carry out "battlefield euthanasia" when abandonment of severely injured soldiers is necessary to retreat from an approaching enemy to ensure the survival of themselves and other more able-bodied soldiers. Kipnis claims that the New Orleans doctors carried out a similar form of euthanasia when they were forced to evacuate the hospital. Like military doctors who end the lives of soldiers who will most likely die painful natural deaths or be killed by enemy combatants, Kipnis claims Dr. Pou chose to end the lives and suffering of her patients who would die after she evacuated. Kipnis concludes that dire circumstances in which care cannot be delivered to patients excuses euthanasia on the part of the physician. 5

The New Orleans case raises the point of what actions are ethical when physicians are forced to abandon their critical patients in the event of a disaster that threatens the lives of the physicians. Should patients be given the choice of either physician-assisted suicide or producing a written statement asking to be euthanased under such conditions or is it not the choice of the patients to choose to end their lives when they face pain and suffering without the relief of medical care? Even if a law similar to the Death with Dignity Act existed in the state of Louisiana prior to Katrina, the doctors at the Memorial Medical Center would still not have been able to perform physician assisted suicides according to protocol because of the nature and limited time frame of the crisis. With the inevitable prospect of disaster conditions similar to Katrina, medical and government officials must discuss what physician actions are ethical and in the best interest of the patient under such circumstances.

During the past spring break, I visited New Orleans as part of the Davidson Bonner Scholars freshmen service trip. In talking with numerous residents of New Orleans, I learned that those who had stayed in the city during the storm and required rescue thereafter felt terrified, abandoned, and hopeless as they waited to escape the catastrophic scene. I cannot imagine what the doctors at Memorial Medical Center were thinking as they waited days for rescue, but I can suppose that they felt desperate as well.

Whether the actions of Dr. Pou and her nurses were euthanasia, providing comfort, or murder, I believe she must have acted with good intention in the face of the crisis. I hope that medical ethicists will explore this issue in the future so that there can exist a protocol for treating critical patients in times of crisis so that no physician has to deal with the dilemma the doctors of Memorial Medical Center faced.

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