Bringing The Special Perspective Of The Family Physician To The Teaching Of Clinical Ethics

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Background: **Medical ethics has traditionally been taught using dramatic, out-of-the-ordinary cases to illustrate principles. Little attention has been focused on the ethical decisions family physicians make routinely in the course of their practice.**

Methods: **As part of a multidisciplinary course in medical ethics at the University of Washington School of Medicine, one class section was taught by a family physician using cases from her primary care practice. Cases were presented up to the point of decision making. Students were then encouraged to consider what action they would take. Each case was concluded with the family physician sharing the outcome of the case.**

Results: **Five case examples were presented. A comprehensive, context-sensitive approach to patient problems was modeled. Ethical issues explored included financial constraints, resource utilization, substance abuse, truth telling, confidentiality, and patient autonomy.**

Conclusions: **Case-based teaching by a family physician was very effective at generating interest and enthusiasm among students and in encouraging their own thinking about ethical decisions. Students also valued the exposure to the family physician's style of practice. This teaching method created an excellent opportunity for learning about ethics and primary care that is applicable to many teaching settings. (J Am Board Fam Pract 1994; 7:38-43.)**

Clinical ethics and how best to teach the topic to health professionals have received considerable attention in recent years. Jameton and Jonsen[1] have given an eloquent description of the differing goals and objectives for ethics teaching, defining clinical ethics as "an attempt to devise methods which go beyond clarification and reach toward reasonable practical decisions about cases."

In reviewing the literature on the teaching of clinical ethics, common problems emerge. First, the philosophical principles, theories, and abstractions are not perceived as relevant to health professionals. For example Kapp,[2] a teacher in geriatric medicine, stated:

> Health care professionals are, for the most part, rather pragmatic in orientation and interested in conceptual analysis solely to the extent that it can be translated directly into specific guidelines that are applicable to everyday clinical practice.

But Fleischman and Arras,[3] in describing the problems of teaching ethics in perinatology, wrote:

> Ad hoc discussion of cases without reference to philosophical principles tends to yield aimless, ungrounded speech; abstract theoretical discussions of philosophical doctrines often prove irrelevant to the concrete and urgent concerns of physicians. Physician-educators and their philosopher colleagues thus need to work together to achieve a fruitful integration of philosophical theory with clinical case material.

Finally, health professionals might think that ethical problems are unusual. Belgum,[4] a professor of religion who studied teams of physicians and students on an internal medicine service in a teaching hospital, observed, "There is an assumption that medical ethics is needed only rarely in a few dramatic life-and-death issues such as the Karen Quinlan case or a Jehovah's Witness blood transfusion court case."

A group of nationally prominent medical ethicists[5] developed a consensus about what they believed was essential in teaching of medical ethics. They concluded:

> We believe that the basic medical ethics curriculum should be centered on the kinds of moral problems that

Submitted, revised, 1 July 1993.

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physicians encounter most frequently in practice rather than on sensational cases of the type that occur only rarely.

Family physicians, because of the breadth and context-sensitive nature of their practices, are thus an excellent resource for teaching clinical ethics. Using family practice cases that presented moral dilemmas, a section of an ethics course was designed to engage students in thinking about the common ethical problems they might themselves face in the course of their professional careers. The goal was to help them begin the integrative work of applying the principles they were learning in the course to specific everyday, nondramatic cases from a family physician's practice. The focus was on the kinds of decisions a conscientious family physician faces daily that might not immediately stand out as "ethical" but frequently require that a value-based decision be made on the spot.

Methods

A multidisciplinary course in introductory medical ethics taught by a faculty ethicist (TRM) is offered each year by the Department of Biomedical History and Ethics at the University of Washington School of Medicine. The class meets weekly for 3 hours in the evening for 10 sessions and focuses on such topics as truth telling, confidentiality, informed consent, resource allocation, and patient autonomy. The textbook for the course is Munson's *Intervention and Reflection: Basic Issues in Medical Ethics*.[6] For the last 10 years, after students have been exposed to basic ethics theory, principles, and vocabulary, one midcourse session has focused on common ethical problems in primary care. This segment is taught in a case-oriented manner by a family physician (NGS) in the Department of Family Medicine. The physician-instructor selects cases from her practice in which she has had to make an ethical judgment without benefit of an ethics committee or consultant.

The instructional format consists of presenting a case from the instructor's practice up to the point of decision making. The case is then referred to the class for discussion of the issues raised and possible resolutions. Maximum participation is encouraged, and the instructor's role is mainly in clarification, pointing out new perspectives and expanding the historical and contextual data that influence decision making. At the outset students are informed that although they will be told the outcome of the specific case, there is no assumption on the instructor's part that this outcome is "correct." Rather the instructor is reporting her decisions and actions and the resolution of the case. The goals of each case presentation are (1) to present the case with a richness of detail that provides experience with a family physician's model of comprehensive care, (2) to develop in students the ability to define the issues and think about possible resolutions, and (3) to involve students in analyzing cases in sufficient depth so they can recognize their own moral reasoning and begin to integrate what they are learning in class into their own patterns of decision making.

Results

The class size varies each year to year from 35 to 50 students. Class members are students from a wide variety of health-related disciplines, including nursing, medicine, occupational and physical therapies, pharmacy, speech pathology, social work, health administration, and public health. A few students from non-health-related disciplines, including such areas as art, biology, and engineering, participate each year. Students' work experiences in their disciplines range from none to nurses in graduate school with many years of professional experience.

Examples of cases and the discussion they generated follow:

Case 1

A 52-year-old woman is a patient of my partner who is out of town. The patient works as a sailmaker earning modest wages and has no health benefits. She comes to my office today for a refill of her blood pressure medication, which ran out yesterday, and because she is not feeling well. Her blood pressure is quite high — and she is at risk for a heart attack or stroke. I would like to get some emergency laboratory tests, restart her medication, and watch her for the next few hours or at a minimum to see her the following day to make sure her blood pressure comes under control. The blood tests, the monitoring, and the time off work represent a major financial hardship for her. She is a person who always pays her bills and will pay for whatever we order. As her family physician, what should I do?

The class discussion explored risks and costs of various resolutions. Medicolegal issues concern-

ing not following the usual practice in her case were raised, as well as concerns about letting the patient's ability to pay guide decision making. The physician's dilemma of weighing uncertain medical risks against known financial ones was explored. Discussion also concerned the patient's ability to consent to the risk: to what extent should she be informed of rare but terrible outcomes? Students also discussed the influence a physician has on the patient's decision because of the physician's control over what information is shared and how it is presented.

Resolution

The patient was sent home with prescriptions, and a minimum number of laboratory tests were ordered on a nonemergency basis to minimize cost. The patient measured her own blood pressure several times during the next 12 hours and called in the results. She suffered no untoward medical effects, was stable on her usual medication, and had no loss of work time.

Case 2

A 22-year-old woman comes in for a quick 10-minute appointment requesting disulfiram to help her stop drinking. She gives a history of four blackouts in the last week following excessive alcohol consumption after work. Twice she found her car the following day where she had obviously abandoned it the night before. She has no recollection of even driving the car. She has a history of a driving-while-intoxicated conviction in another state. She feels medication is all she needs. She makes a verbal promise not to drink and drive and agrees to pursue alcohol treatment. After 10 days she has not followed through with alcohol treatment. As her family physician do I have any further responsibility?

The discussion centered around her right to refuse treatment weighed against her obvious risk to herself and the public if she persists in driving while severely intoxicated. To what extent should the physician pressure her to get treatment? Should her confidentiality be breached and family members involved? Does the fact she is abusing alcohol and unlikely to pursue treatment on her own mean protecting her confidentiality is less important then the potential benefit of involving important persons in her life in insisting she pursue treatment? To what extent is she like a patient who threatens suicide or homicide? Does the physician have a duty to protect her or her potential victims?

Resolution

To consider the alternative of involuntary treatment, I consulted an attorney. She reported that in our state alcohol abuse did not fall within the psychiatry protections, and neither could the patient be committed to treatment as a danger to herself or others, nor would I be protected if I breached her confidentiality in enlisting others in encouraging her to seek treatment. I decided that maintaining my on-going relationship with her, continuing to encourage her to pursue treatment, was the option with the most potential to help. I refused her request for disulfiram unless she agreed to a concomitant alcohol treatment program. To date she has not entered treatment, and her situation continues to remind me that in such cases effective medical intervention is dependent on the patient's cooperation.

Case 3

A 45-year-old woman who is alcoholic lives and works on a commercial fishing boat where alcohol abuse is the norm. After a hospitalization for acute alcohol intoxication, she enters outpatient alcohol treatment and has been alcohol-free for 1 year. She has no other work skills. She applies to receive publicly funded vocational rehabilitation to learn office skills. She comes to me requesting the necessary physician's statement that she cannot physically work. She has no outside resources and badly needs the vocational rehabilitation. Her physical health, however, is the best it's been for years. What should I do?

Discussion focused on the frustration of being society's gatekeeper for these kinds of programs, of feeling manipulated by both the patient and the system. Would telling the literal truth about her health be in anybody's best interest? Should the physician's belief about the prospect for rehabilitation affect decision making? Should the physician's knowledge of her absence of other resources and the near certainty that without new training she will return to the drinking environment of the fishing boat influence what is written in the physician's report?

Resolution

Her alcoholism is a serious disease and returning to the fishing boat and drinking is life threatening.

I therefore decided the only decision that avoided harm and had some potential to do good was to state she was physically unable to return to work. She entered the vocational rehabilitation program and has now been without alcohol for 8 years, works as a court clerk, has bought her own home, has reconciled with members of her family, and is thriving.

Case 4

The patient is an 80-year-old woman with a local recurrence of her breast cancer after 10 years without disease. The consultant surgeon and oncologist recommend a battery of scanning and blood tests every 6 months. She has no other signs of cancer recurrence, but she is a woman with a continuous set of somatic complaints. I talk with the consultants, and they are clear she will not be cured by early diagnosis, but that palliative treatments could be begun sooner. The patient has only Medicare for insurance and so pays part of the cost of everything. She lives on an extremely limited pension, but she has always paid her bills on time and places a very high value on this effort. If she has more medical bills, she will be unable to buy heating oil for the winter. We have explored all the resources for financial assistance, and she does not qualify. I inform her what the consultants have recommended. She says, "Doctor, I'll do whatever you recommend." What should I, as her family physician, recommend?

Discussion centered around the role of consultants' advice and the medical and legal, as well as interprofessional, problems if the advice is not followed. Students explored the problem of dealing with a patient who defers to the physician's judgment despite efforts to involve her in the decision. A heated discussion developed around autonomy and paternalism and whether insisting the patient make her own decision could represent the physician's failure to take responsibility for a decision that the physician is much better equipped to make. Others believed that regardless of whether a patient wishes to be autonomous, the patient should make the decision.

Resolution

Knowing the patient would agree to anything I recommended, I made the decision to order only those tests indicated by symptoms. This decision allowed her to save her limited financial resources for daily living. I concluded that I could better decide the marginal benefit of the recommendations than she could. She had made an autonomous decision to trust my judgment and I honored that.

Case 5

Two years later the patient described above now has metastatic breast cancer involving her liver. She has developed severe nausea and vomiting, and the radiation oncologists believe palliative treatment will help her symptoms. She is fiercely independent and lives with her mildly demented 92-year-old husband. I call her with the results of her liver test, and she falls on the way to the telephone. She reports she is not keeping food or fluids down and states she is not feeling well enough to come to the clinic. When I ask about someone coming to the house to help her or at least assess her condition, she refuses because "her house is not clean enough for visitors." She refuses to allow me to contact her children or her neighbors to help. I talk with her husband, who says she should be in the hospital. The patient says, "He doesn't know anything!" I have no doubt of her competence. There is no way to start treatment. Her children are unaware of her terminal condition, and I suspect they would like to help. What is my responsibility as her family physician?

Discussion focused on her right to refuse treatment or intervention and the related issues of competence and informed consent. Students wondered whether the likelihood of the success of treatment should influence a physician's behavior in this situation. They raised the issue of the physician's vulnerability to the family's anger that they were not told of her impending death, particularly if she were to succumb at home in the next day or so. Students discussed the frustration for the health care provider when a patient refuses care based on concerns that do not seem important to the provider, such as "my house isn't clean."

Resolution

I called the patient the following day and suggested I personally make a home visit. She accepted. I was able to assess both her condition and present my perspective on her family's possible wish to know. She contacted them, and they were very willing to help. She died several weeks later in an inpatient hospice. I felt best, not about palliative treatments for her, but that my extra efforts had allowed her family a chance to say goodbye. Whether saying goodbye was what the patient wanted I am less sure.

Discussion

This method of case presentation and analysis allowed this diverse group of students to experience empathetically the comprehensive, context-sensitive practice of a family physician. Many of the students' comments after class and in written evaluations reflected their appreciation of the chance to see this perspective in an ethics course. When the only model that students are exposed to is that of the subspecialty or intensive care environment, they miss much of the richness and complexity of decision making in primary care settings. These cases raise such issues as caring for more than one family member, financial constraints of patients and physicians, the physician's knowledge of a patient's home and work environments, and how generational and cultural differences affect the patient-physician relationship. Perhaps most of all, students grew to understand how the on-going patient-physician relationship and knowledge of the patent's context have an impact on moral decision making.

We agree with those who suggest our goal as teachers should be helping students to discover and consider ethical issues.[7,8] As Fleischman and Arras[3] pointed out:

> Cases do not come with identifying labels affixed to them. It is thus extremely important for physicians [health professionals] to develop skills in the art of discernment or "moral diagnosis."

In the family practice cases presented in this course, it has been our primary goal to encourage students in the process of case analysis by providing an opportunity for them to describe ethical issues and to recognize the interaction of their own and their patients' values in decision making. The class discussion provides an opportunity to reflect gently the students' responses and to help them recognize the principles involved and to be more conscious of their own choices.

Several comments are warranted on the usefulness of the teaching method. Some authors have suggested the combination of an ethicist and clinician as the ideal teaching arrangement.[5,9] Cases allow us to build this bridge between philosophy and clinical practice. A family physician who has basic knowledge of ethical principles and is a good observer of his or her own behavior can quickly collect enough cases for presentation. The use of these everyday cases allows for simulation of real experience better than standardized or textbook cases. Students can imagine themselves in the practitioner's position and consider their own likely behaviors. Because the cases arise in the instructor's own practice, additional details clarifying the complexities and ambiguities of the case are readily available to students. In describing his own evolution in thinking about case-based ethics teaching, Jonsen[10] summarized, "The case must be not merely an illustration but the matrix of the problem and its resolution." This method facilitates this use of cases.

Southgate, et al.[11] and Wartman and Brock[12] reported on ethics teaching using student- or resident-generated cases, respectively. Both comment on the strengths of this method in terms of the freshness of the case and the availability of case details and nuance. They acknowledge a weakness in the loss of control of case content and presentation. The method we describe captures the strengths of in-depth knowledge of the specific case, as well as context and freshness, but also allows the instructor much more control of class content and quality. In a smaller classroom setting or a highly trusting environment, such as might occur in a residency program, students could bring in their own cases for discussion using the method we describe.

Carson[13] has suggested that in using actual examples, it is important to share with students what was actually done, not because it is the right answer but because it is important for students to realize these are not just exercises but real events in which decisions had to be and were made. We found an additional benefit. By allowing oneself to be vulnerable to criticism of one's actions by students, the clinician-teacher can model a willingness to examine and discuss personal ethical behavior. It is important to stress that the security of the clinician-teacher is essential to the success of this teaching method. If the physician adopts a dogmatic or defensive approach, discussion will be limited and more polarized. The physician must be prepared for the possibility that the class discussion will lead to questioning earlier decisions.

The class format described creates an excellent teaching environment. The diversity of age and experience of the students added considerable vitality to the discussions. Written description cannot adequately portray the effectiveness of this

method in generating reflection, dialogue, and enthusiastic class participation. These classes of 35 to 50 students intently concentrate on the cases, and everyone participates in the discussion, even those who have never participated before. Lively discussions between students with differing views usually continue into the break periods. The presence of representatives of many different disciplines enriches the discussion by bringing different perspectives and curbs the tendency to blame other disciplines for ethical lapses. The wide differences in students' clinical experiences strengthen the discussion. Combining the depth of experience of some students with the idealism of the novices allows both groups to view their own behavior through the other's eyes. As needed, the instructor facilitates understanding and perspective between groups.

In a separate study we evaluated the impact of this method of teaching.[14] After a presentation of a specific case, students recorded their thoughts on the case before and after discussion. We were able to show that following class discussion, the students became aware of more ethical issues, and many changes in the proposed resolutions occurred. In course evaluations students consistently rate this session as one of the best of the course. They comment on the session as a useful opportunity to discuss cases themselves and to see how what they are learning fits into the daily work life of a physician. In particular, students express that exposure to a family physician has been helpful to them in understanding context-sensitive, comprehensive care.

Summary

This primary care, case-based method proved very effective in generating interest and enthusiasm in a rather large class. The method succeeded in engaging students in thinking about their own ethical behavior and in exposing them to the family physicians' case-based approach to ethical decision making. Family physicians, sometimes in cooperation with a medical ethicist, will find the method described useful in teaching medical students, residents, or other professional or lay groups. Most of the students we teach will not be involved in highly publicized cases. Instead, they will be making hundreds of ethical decisions every year regardless of whether they are recognized as such. Our job as teachers is to help students recognize ethical dilemmas and consider their actions in the context of their own and their patients' values.

References

1. Jameton A, Jonsen AR. The evaluation of curriculum in medical ethics in schools of medicine. Report to the National Endowment for the Humanities and the Josiah Macy, Jr., Foundation, Institute for Health Policies, University of California, San Francisco for circulation to members of the Society for Health and Human Values, October, 1983, 133 pages.
2. Kapp MB. Geriatric medical education: integrating legal and ethical issues. Med Law 1985; 4:401-8.
3. Fleischman AR, Arras J. Teaching medical ethics in perinatology. Clin Perinatol 1987; 14:395-402.
4. Belgum D. Medical ethics education: a professor of religion investigates. J Med Ethics 1983; 9:8-11.
5. Culver CM, Clouser KD, Gert B, Brody H, Fletcher J, Jonsen A, et al. Basic curricular goals in medical ethics. N Engl J Med 1985; 312:253-6.
6. Munson R. Intervention and reflection: basic issues in medical ethics. Belmont, CA: Wadsworth, 1992.
7. Bergsma J, Thomasma DC. The contribution of ethics and psychology to medicine. Soc Sci Med 1985; 20:745-52.
8. Basson MD. Bioethics in the medical center: an exploration. Hosp Pract 1984; 19:177-181, 184 passim.
9. Self DJ. A model for teaching ethics in a family practice residency. J Fam Pract 1983; 16:355-9.
10. Jonsen AR. Medical ethics teaching programs at the University of California San Francisco and the University of Washington. Acad Med 1989; 64:718-22.
11. Southgate LJ, Heard SR, Toon PD, Salkind MR. Teaching medical ethics symposium. A student-led approach to teaching. J Med Ethics 1987; 13:139-43.
12. Wartman SA, Brock DW. The development of a medical ethics curriculum in a general internal medicine residency program. Acad Med 1989; 64:751-4.
13. Carson RA. Case method. J Med Ethics 1986; 12:36-9.
14. Stevens NG, McCormick TR. What are students thinking when we present ethics cases? An example focusing on confidentiality and substance abuse. J Med Ethics. In press.