# Medical Ethics Curriculum for Family Medicine Resident Physicians

**Developed by**

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# Introduction
# Identification of the Need

## Start with the end:

Physicians have an ethical obligation to provide competent and compassionate care to their patients. Healthcare is primarily a moral enterprise where healthcare providers are making ethical decisions constantly. Physicians need to be both technically competent and morally competent. Most people can imagine in their minds a technically competent physician who they would not trust with the care of their parent, child or spouse.

Physicians need to possess both technical proficiencies as well as "moral proficiencies": They need to have a firm grasp of the foundational principles that should guide a physician's actions; they need to have developed the skills and ability to reason through the myriad of ethically complex circumstances that routinely develop in the practice of medicine; they need to possess the qualities, character traits and virtues that are necessary to be a compassionate physician, the kind we would trust with the care of our mother, father, son or daughter.

As medicine has become more technically advanced, it has become a more ethically challenging field in which to practice. Care at life's edges has taken on a life of its own. The management of the severely premature infant, and the advanced elderly patient in the context of medical technology has become an exceedingly morally problematic and uncertain adventure. End of life care has taken on complex dimensions with the widespread use of ventilators and Advanced Life Support. The decisions about when to initiate or withdraw care are rarely clear cut.

Reproductive technologies and genetic medicine are changing the very fabric medicine, and may indeed change the very nature of humans. Prenatal screening is forcing prospective parents to make difficult choices they often are not prepared to make. A plethora of genetic information will soon be available to doctors and patients, and it is uncertain if knowing this information will be helpful or hurtful.

The economics of healthcare has developed multiple conflicting interests and loyalties for the physician. HMOs, health care administrators, insurance companies, the pharmaceutical industry, and the government all have competing interests that often stand between the patient and physician. Natural disasters, and battlefield conditions force physicians to make decisions with moral implications in very unique circumstances.

## The ethical obligation of the medical educator:

Those tasked with educating the learners in healthcare have a duty (an ethical obligation) to meet the educational needs of their learners. They have been given a public trust to develop competent and compassionate physicians. The educators are obligated to ensure that their learners are both technically competent and morally competent. Resident education is more than a highly sophisticated trade school. Graduating medical technicians that do not possess the knowledge, skills and attitudes necessary to be a

morally competent physician is not acceptable. It is incumbent upon medical educators to develop curricular opportunities to develop the skills, knowledge and attitudes necessary to practice medicine ethically in today's environment.

## What is currently being done?

Family medicine residency directors in the uniformed services were asked via email if their respective residencies had an ethics curriculum. From those who responded, the following observations could be made: Most residencies do not possess a formal medical ethics curriculum. Issues that have ethical implications are often discussed in the context of behavioral science curricula or during "art of medicine" lectures. One residency did have a "medical ethics small group seminar" in the first year of training, which covers many ethical topics.

## What is required?

The Accreditation Council for Graduate Medical Education (ACGME) highlights some requirements pertaining to ethics in the general competencies.[1]

1. Under the core competency "Interpersonal and Communication Skills" residents are expected to "create and sustain a therapeutic and ethically sound relationship with patients."
    a. This would require the residents to develop the necessary qualities, characteristics and virtues that would enable them to do so.
    b. Educational opportunities should be offered that enable to resident physicians to develop these necessary attitudinal qualities.
2. Under the core competency "Professionalism" residents are expected to "demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices."
    a. This would require residents to become knowledgeable in core principles that should govern a physician's actions.
    b. Educational opportunities should be offered to enable residents to learn such principles

Certain specialties such as pediatrics and neurology are required to have a formal medical ethics curriculum. The ACGME and the corresponding Residency Review Committee for Family Medicine have not yet created an explicit requirement for a medical ethics curriculum. The American Academy of Family Physicians has drafted a recommended curriculum guideline for family medicine residents for medical ethics.[2]

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[1] ACGME Outome Project, General Competencies. Link accessed November 20, 2006: http://www.acgme.org/outcome/comp/compFull.asp

[2]Recommended Curriculum Guidelines for Family Practice Residents, Medical Ethics. Accessed November 20, 2006. http://www.aafp.org/PreBuilt/curriculum/Medical_Ethics.pdf

# Implementing a Medical Ethics Curriculum

## What would be the ideal approach for teaching medical ethics to residents?

The AAFP's guideline described their ideal approach for a medical ethics curriculum:

"*Residents should have access to an ethicist or an instructor with training in medical ethics, both for clinical consultation and instruction. Residents should have the opportunity to serve on institutional ethics committees. Instruction on ethical issues during the family practice residency should take place either through a concentrated block or longitudinally throughout the residency program and may take such forms as grand rounds presentations, small group discussions, ethical case studies or a formal rotation in medical ethics."*

The actual structure of the medical ethics curriculum will be dependent upon many variables: the content of the goals and objectives; appropriate educational strategies for each of the objectives; the information derived from the learning needs assessment; available time within residency curriculum; availability of persons to facilitate and teach; and availability of outside resources for the curriculum. To a large extent, the content of the curriculum will be limited primarily by the interest, expertise and creativity of the staff teaching the residents. There are multiple ways in which to cover the objectives of the curriculum.

## The best of learning begins with a case:

The most common and easiest method to teach bioethics is by starting with cases that highlight the ethical issues pertinent to the objectives to be taught. Cased based learning of medical ethics is most desired by the learners, and is likely the most valuable method.[3] Discussing the cases in a small group vs. a lecture format may promote greater gains in moral reasoning.[4]

Utilizing real cases from residents in the outpatient and inpatient arenas will make the content even more pertinent, but requires more work on the part of the facilitating faculty to couple the real case with pertinent topics in medical ethics. Regularly asking house staff for interesting ethical cases will prompt the residents to be more sensitive to ethical issues that arise in patient care. An ethics case log can be kept, perhaps on-line, where interesting cases can be submitted.

An example of a case based curriculum is the "Family Medicine Bioethics Curriculum; Clinical Cases and References, 2005," made available from the Ethics Committee of the College of Family Physicians of Canada.[5] There are also superb texts available with multiple cases to serve as a basis for discussion.[6]

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[3] Diekema D, et. al. An ethics curriculum for the pediatric residency program. Arch Pediatr Adolesc Med. 1991, 151:609. And Schuh L., et. al. Initiation of an effective neurology resident ethics curriculum. Neurology, 2004; 62:1897. And Vinas-Salas, et. al. Teaching through clinical cases: a good method to study bioethics. Experience at the Lleida Faculty of Medicine. Medical Law, 2000; 19(3):441. And Mariam A, et. al. Teaching medical Ethics: Iimplementation and Evaluation of a New Course During Residency Training [family Practice] in Bahrain. Education for health, 2004; 17(1):62.

[4] Self D, et. al. The effect of teaching medical ethics on medical students' moral reasoning. Academic Medicine, 1989; 64:755.

## Practical considerations for resident physicians:

Given the time constraints of residents, one of the most effective methods for implementing a medical ethics curriculum is to make it part of the ongoing lecture series. A monthly "Medical Ethics Grand Rounds" (or once during each rotation block) will capture the most residents possible. This could be married with already existing Behavioral Science or Art of Medicine Curricula if necessary. It is essential that core principles and concepts are repeated throughout the curriculum since a large percentage of the residents will be on away rotations, or in other settings on any given day.

## How do I measure if the residents are becoming more "ethical"?

This is one of the most difficult aspects of implementing an effective medical ethics curriculum. It is fairly easy to assess if the resident accurately diagnosed a myocardial infarction. It is more challenging to assess if the resident acted professionally and ethically in caring for the patient with the myocardial infarction.

The ACGME Outcomes Project is collating available tools on their website for assessing residents' competencies, including the competency of professionalism. They have several different tools that a residency could use or modify. See the link under resources. Objective Structured Clinical Exams (OSCE) have been developed for medical ethics as well (see Singer in the bibliography). They tend to be time and resource intensive. The faculty at McGill University in Toronto are studying a professional mini evaluation exercise (a P-MEX), and have graciously allowed their tool to be included in this curriculum (see Steinert in the bibliography and P-MEX at the end of the curriculum).

There is an old adage virtues are better caught than taught. Professionalism is best learned through modeling. Young physicians see behaviors in other physicians and decide if that is the behavior they will model. For assessing professionalism, it is recommended that formal observation of residents interacting with patients be performed. Consider utilizing the P-MEX in the appendix for evaluating the interactions. For residents in difficulty secondary to issues of professionalism, it is suggested they enter a remedial phase of shadowing a virtuous physician in the department, while receiving structured feedback regarding the types of behaviors expected. This could be followed by formal observations to assess for gains or changes in behavior.

# A Model Curriculum

## Overview:

What follows is a suggested skeleton curriculum by the writer. It is a two-year curriculum, and it is case based. There is a listing of goals & objectives for the curriculum with corresponding sessions to help meet the objectives. The goals and objectives were

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[5] Available on the web at www.cfpc.ca/local/files/Education/bioethics_en.pdf, accessed November 20, 2006

[6] See for example Horn, P, Clinical Ethics Casebook, 2nd edition, 2002; Wadsworth Publishing. And Ackerman T, Strong C. A, Casebook of Medical Ethics, 1989; Oxford University Press.

developed using the AAFP's recommended curriculum document as a template. Several additions, modifications and a few subtractions were made based on this writer's training in bioethics. A learning needs assessment (LNA) tool is also provided. The curriculum and the LNA tool are currently being piloted in the family medicine residency program at Madigan Army Medical Center. The LNA can function both as a needs assessment and a pre-test. A post-test is also provided which has the same set of 10 questions, followed by some program evaluation questions.

## Recommendations for using the curriculum:

The sessions do not necessarily need to follow a stringent timeline. The topic area and objectives covered are noted along with case examples and key discussion points. The suggested cases can be used as springboards for discussion or real cases from the residency can be used. Other educational strategies can be employed, which may enhance the session (role-play, patient interviews, movie clips, documentaries, selected readings, etc.). The curriculum could be completed in two years. This would increase the likelihood of a resident's ability to be exposed to any given session during their 3 year residency. Additionally, key concepts are repeated in several sessions.

A list of suggested general resources is provided. It is suggested that these texts and on-line resources be made available for the teaching faculty. The resources cover the topics discussed, as well as provide other cases that highlight the relevant issues. A list of relevant articles on the topic of curriculum development for a medical ethics residency is also listed.

At the end of the curriculum is the LNA tool and post-test. These can be used to assess particular areas of focus for a curriculum. They may also be used in order to evaluate the usefulness of the curriculum.

## The curriculum is under construction:

This curriculum is a work in progress. Any curriculum will go through continuous modifications, revisions and improvements in order to meet the overall goals and objectives. Even the goals and objectives may be changed based on experience of implementing the curriculum.

It is the intent of the writer to develop teaching notes for each of the sessions that will further enable prospective faculty to teach medical ethics in a relevant and engaging way. Completed teaching notes for several sessions are included. As subsequent teaching notes are completed, the curriculum will be updated.

In order to make this curriculum as useful and available as possible, it will be available on the web. It is currently available at the Association of Family Medicine Residency Director's website, http://www.afmrd.org/cms/. This is a restricted site and not available to everyone interested. It will also be available on the Family Medicine Digital Resource Library, http://www.fmdrl.org/.

# Collaboration, Input and Feedback

## Collaboration, the key to success:

One of the keys to successfully maintaining any curriculum is ongoing collaboration and feedback. If you are interested in receiving the teacher's notes as they are developed, if you have questions about developing a medical ethics curriculum in your residency, or if you have any feedback on the content of this curriculum please do not hesitate to contact the author.

Any experiences others have in implementing a medical ethics curriculum would be immensely valuable. Shared experiences will improve any curriculum, including this one.

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# Resources

## Key Resources:

1. *Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 5th ed. Oxford University Press, 2001.* Most widely read textbook in bioethics. Discusses in detail the four secular principles of medical ethics (beneficence, non-maleficence, autonomy, justice). It's a bit dry but a good resource.

2. *Jonsen AR, Siegler M, Winslade, WJ. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 5th ed. McGraw Hill, 2002.* Very practical short text which discusses all major issues in clinical medicine. Authors develop the "four quadrant method" of resolving ethical dilemmas, the most widely used method in clinical ethics.

3. *Pence G. Classic Cases in Medical Ethics: Accounts of Cases That have Shaped Medical Ethics, with Philosophical, Legal and Historical Backgrounds, 4th ed. McGraw-Hill, 2003.* Concise yet fairly comprehensive text briefly covering ethical theories, then providing an excellent overview of the cases that have shaped the field. Excellent reference for teaching.

4. *American Medical Association, Code of Medical Ethics; Current Opinions with Annotations, 2004-2005.* The AMA routinely updates their compendium of positions on virtually any ethical or social issue. It may be worth referring to the AMA's opinion when discussing ethical issues, but be aware they are simply the AMA's "opinions" without much justification for such opinions. Available online at http://www.ama-assn.org/ama/pub/category/2416.html; The AMA's "Virtual Mentor" is a electronic periodical addressing ethical issues in medicine, and has many valuable resources.

5. *National Reference Center for Bioethics Literature, Georgetown University – Kennedy Institute of Ethics.* Web site has a search engine for comprehensive searches of databases for bioethics / medical ethics topics. Excellent resource for teaching on a particular topic to find the most up to date literature. Available at www.georgetown.edu/research/nrcbl/databases/index.htm

6. *Junkerman C, Schiedermayer D. Practical Ethics for Students, Interns, and Residents: A Short Reference Manual, 2nd ed. University Publishing Group, 1998.* A useful and handy pocket guide that covers the major issues in medical ethics. May be a worthwhile investment (at $7/copy) for residents/students involved in a medical ethics curriculum.

7. *The ACGME Outcomes Project.* At the ACGME's website, there are several tools that have been collected from residency programs and published papers on tools for evaluating professionalism. There are evaluation tools to assess learners' knowledge of medical ethics as well as moral reasoning skills, and professional behavior.

http://www.acgme.org/outcome/assess/profIndex.asp, accessed November 20, 2006.

## Curriculum Development Bibliography:

The following citations are key articles on the topic of curriculum development for residency programs as of January 2006. They provide a solid overview of what has been done in the field of medical ethics education in residency programs.

*Al-Jalahma M. Teaching Medical Ethics: Implementation and Evaluation of a New Course During Residency Training in Bahrain. Education for Health, 2004; 17(1): 62-72.* The ONLY article describing a family medicine residency's medical ethics curriculum. Provides a great overview of the justification for such a program with a concise review of the ground breaking articles on the topic; demonstrates a positive response from the residents on the implementation of the program.

*Diekema D, Shugerman R. An Ethics Curriculum for the Pediatric Residency Program; Confronting Barriers to Implementation. Archives of Pediatric and Adolescent Medicine, 1997; 151: 609-14.* Probably the most practical and useful description of a residency curriculum to date; comes from University of Washington which has one of the strongest medical ethics departments; reflects depth of understanding of competing demands on residents and how to incorporate medical ethics into the training program. The curriculum is still going strong, and Dr. Diekema is more than willing to share his curriculum with those who request it: douglas.diekema@seattlechildrens.org

*Eckles R, et.al. Medical Ethics Education: Where are We? Where Should We Be Going? A review. Academic Medicine, 2005; 80(12):1143-52.* Although a review of the literature focusing on medical student education, this provides a good overview of the general approach to the types of curricula out there and the ways to evaluate performance.

*Markakis K, et. al. The Path to Professionalism: Cultivating Humanistic Values and Attitudes in Residency Training. Academic Medicine, 2000; 75:141-150.* A paper describing in detail how one residency has taken great strides to cultivate the values ascribed to caring & compassionate physicians. Has many practical examples and methods worth exploring; has excellent ideas about incorporating professionalism at initial orientation and at resident retreats.

*Perkins, H. Teaching Medial Ethics during Residency, 1989; 64:262-6.* One of the first major articles on the topic of teaching medical ethics to residency by one of the major authors in the field. Provides the rationale for such a curriculum; it is referred to frequently in the literature.

*Paulman A. The Physician as Ethics Educator. Family Medicine, 2000; 32(6): 381-2.* One of the very few articles published in the family medicine literature on the topic of ethics education. Its focus is primarily to physicians educating medical students.

*Siegler M. Training Doctors for Professionalism: Some Lessons from Teaching Clinical Medical Ethics. The Mount Sinai Journal of Medicine, 2002; 69(6):404-9.* An overview of teaching medical ethics to residents from one of best known physician experts in the field (co-author of Clinical Ethics noted above), who has taught the topic for 30+ years. A practical, important overview.

*Silverman H. Description of an Ethics Curriculum for a Medicine Residency Program. Western Journal of Medicine, 1999; 170:228-31.* One of the two best practical articles for those wanting to develop a medical ethics curriculum for a residency; provides a wealth of tips from a residency that has had a positive experience.

*Singer P, et. al. The Ethics Objective Structured Clinical Examination. Journal of General Internal Medicine, 1993; 8:23-8.* One of the major authors in the field of evaluating learners "ethical competence" describes an OSCE for medical ethics; it's a time and resource intensive method of evaluation but is something to consider (or some variation thereof) for evaluating the learners.

*Steinert Y, et. al. Faculty development for teaching and evaluating professionalism: from programme design to curriculum change. Medical Education, 2005; 39:127-136.* Fascinating article describing a faculty development project on figuring out how to incorporate professionalism training and evaluation into medical education; provides excellent definition of professionalism and elements to be taught and evaluated; alludes to a professionalism mini-evaluation exercise (P-MEX) they have developed and are piloting.

*Sulmasy D, Marx E. Ethics education for medical house officers: long term improvements in knowledge and confidence. Journal of Medical Ethics, 1997; 23:88-92.* Article from leader in the field which describes an ethics curriculum as well as an evaluative tool that has been used extensively in other studies and thought to have some validity. Is one of the few studies to have objectively demonstrated some "improvement" in ethics knowledge as well as confidence, albeit, it's unclear if the house staff became more "ethical." The tool (which has gone through some minor iterations since being given to the ACGME) is available at the ACGME's Outcomes Project website: http://www.acgme.org/outcome/downloads/prof_12.pdf

*Wartman S, et. al. The Development of a Medical Ethics Curriculum in a General Internal Medicine Residency Program. Academic Medicine, 1989; 64:751-4.* An example of a medical ethics curriculum in an internal medicine residency; worth reading to see how they utilized "ethicists" as faculty, much the way programs have Behavioral Scientists. Notes that case based teaching is the way to go.

*Wayne D, et. al. Developing an Ethics Curriculum for an Internal Medicine Residency Program: Use of a Needs Assessment. Teaching and Learning in Medicine, 2004; 16(2): 197-201.* About the ONLY article written on the use of a targeted learning needs assessment for developing a medical ethics curriculum in residency. Utilizes a good format that could be duplicated and could be used as a pre and post test assessment of a curriculum for curriculum evaluation.

# Medical Ethics Curriculum for Resident Physicians
# Goals and Objectives[7]

## Goals

1. To develop morally competent, virtuous and caring physicians who provide outstanding patient care.
2. To cultivate in residents the necessary attitudes, knowledge and skills that will enable them to weigh competing values, goals, interests, benefits and burdens, and consistently come to reasoned, defensible, and principled resolutions of ethical conflicts in clinical practice.

## Objectives

**By the end of the residency program, the resident should meet the following objectives.**

### *Attitudes:*

1. Articulate the following
    a. His or her understanding of the value and dignity of human life, and how that affects clinical decision making
    b. His or her worldview and how it affects his or her clinical decision making
    c. An understanding of opposing worldviews and how they are different from his or her own
    d. How competing world views, including social, cultural and religious customs result in different conclusions in ethical decision making
2. Exemplify the characteristics of a virtuous physician
    a. Benevolence & unconditional positive regard
    b. Fidelity to trust (faithfulness and trustworthy)
    c. Compassion
    d. Intellectual honesty
    e. Effacement of self-interest
    f. Prudence/practical wisdom
3. Embody in words and actions a commitment to doing what is best for the patient in every patient encounter
4. Rate as valuable the presence of institutional ethics committees and a willingness to serve on such bodies

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[7]Format adapted from the American Academy of Family Physicians "Recommended Curriculum Guidelines for Family Practice Residents, Medical Ethics." There are many similarities and differences in the content of this and the AAFP's proposed curriculum. Accessed November 20, 2006. http://www.aafp.org/PreBuilt/curriculum/Medical_Ethics.pdf

5. Recognize and express a willingness to embrace the ethical dilemmas presented by his or her patients
    a. Reflect a desire to resolve those dilemmas while respecting the patient and family members.
    b. A willingness to consult colleagues or an ethics committee when necessary to resolve those dilemmas.

### *Knowledge*

6. Delineate and discuss the essential elements of a worldview
    a. The set of assumptions a persons holds about the basic make up of the world
    b. Who are we (the nature of humans), where do we come from (origins), what is wrong with the world we live in (the problem of pain and suffering), and how can it be fixed?
    c. Is morality something that is transcendent to humans and objective or solely a human invention and purely subjective?
7. Possess a working knowledge of the primary methods of moral reasoning used in ethical decision-making and demonstrate the ability to integrate these modes of moral discourse in making ethical decisions.
    a. Deontological ethics
    b. Consequential / utilitarian ethics
    c. Virtue ethics
    d. Case based ethics
8. List or recite the primary principles thought to be central in medical decision making, and explain their meaning
    a. Beneficence – the duty to do good
    b. Nonmaleficence – the duty to do no harm (*primum non nocere)*
    c. Autonomy – respecting patient's freedom and choices
    d. Justice – fair distribution of resources & treating people the same
9. Discuss the core content of the Hippocratic Oath and other more modern oaths taken by physicians
    a. Articulate the differences in the oaths and the potential significance
    b. Explain the relevance of physicians taking oaths
10. Discuss the meaning and significance of medicine as a profession
    a. To articulate the key differences between medicine envisioned simply as a trade versus as a profession
    b. To express a firm understanding of the purpose of medicine
11. Describe the importance of confidentiality in patient care, its limits and potential threats to confidentiality

12. Discuss the importance of the principle of truth telling in patient care
    a. Comprehend the changing attitude to its relative importance
    b. Articulate the limitations of the principle in particular clinical circumstances and in certain cultural contexts
    c. Comprehend the tension of truth telling in the context of the partially trained physician and in medical education

13. Discuss the potential conflicts of interests physicians face that may compromise patient care
    a. Pharmaceutical industry detailing of physicians and direct to consumer advertising
    b. Physician ownership of diagnostic and pharmaceutical facilities
    c. Health maintenance organizations and health insurance companies
    d. Capitation versus fee for service care
    e. Competing loyalties to other organizations (e.g., a military/government physician or a company physician)
    f. The uninsured patient
    g. Gifts from patients
14. Articulate a working knowledge of advanced care planning documents and specific local regulations concerning those documents
    a. Living wills
    b. Health care power of attorney
15. Discuss the key elements necessary to write an ethically permissible do not resuscitate order.
16. Describe practical approaches to resolve ethical dilemmas that arise in patient care
    a. Content methods: e.g., the four quadrant method (medical indications, patient preferences, quality of life, contextual features)
    b. Process methods: e.g. the CARER method (Clarify, Analyze, Resolve, Enact, Reassess)
17. Articulate the difference between the concepts of decision-making capacity and competence, and implications in patient care
18. Discuss when it is necessary to utilize substituted judgment in compromised patients and list in order of precedence (based on local laws when applicable) those parties who could make decisions on behalf of the patient
19. Demonstrate an understanding of the ethically relevant issues in the following areas of medicine and the legal regulations regarding those issues:
    a. Withholding or withdrawing of treatment
    b. Informed consent and the right to refuse treatment
    c. Brain death versus heart-lung death
    d. Persistent vegetative state and the minimally conscious state
    e. Medical Futility and inappropriate care requests
    f. Organ donation
    g. The extremely premature infant and the limits of viability
    h. The fetus as patient and fetal abuse

i. Euthanasia and physician assisted suicide
j. Adolescents and emancipated minors and consent for treatment
k. Reproductive technologies to include in-vitro fertilization, artificial insemination by anonymous donors, stem cell therapy and research, cloning, and pre-implantation genetic diagnosis
l. Elective abortion
m. Prenatal screening (quadruple screen, Cystic fibrosis prenatal screening and other future tests) and medical genetics
n. Research in medicine
o. Contraception methods and emergency contraception
p. Military and wartime medicine

20. Discuss the importance of the concept of eugenics
    a. Demonstrate understanding of the eugenics movement of the 20th century
    b. Discuss the potential relationship between the eugenics movement of the 20th century and the evolving practice of medical genetics
21. Identify common forms of unethical conduct and causes of physician impairment, and know how to respond to such behavior when recognized in colleagues or self
    a. Sexual impropriety with patients and staff
    b. Lack of balance (excessive/unnecessary time at work, or overemphasis of commitment to one's own "lifestyle" at the cost of patient care)
    c. Drive for wealth accumulation, economic self-interest placed above patient's best interests
    d. Alcohol and drug abuse
    e. Unhealthy desire for power or recognition

## *Skills:*

**Demonstrate competence in completing the following tasks:**

22. Identify the key ethical components of any particular case
23. Care for patients with differing worldviews from his or her own
24. Act in the patient's best interest when the patient requests a treatment that the physician is morally opposed to providing
    a. Express his or her own beliefs and biases to a patient as necessary when they are affecting the clinical decisions the physician will make
    b. Transfer of care when appropriate to prevent patient abandonment
25. Obtain adequate informed consent from a patient
26. Provide care for a patient who lacks decision making capacity, and appropriately utilize substituted judgment
27. Act appropriately when a patient refuses treatment
28. Determine when it is ethically permissible to withhold information from a patient

29. Determine when it is ethically permissible to breach patient confidentiality
30. Deliver bad news to a patient and family
31. Care for terminally ill patients or those with a poor prognosis
32. Discuss advance directives with a patient
33. Complete an appropriate DNR order and note for a patient
34. Resolve an ethical dilemma that arises in the context of patient care utilizing the four quadrant and CARER methods
35. Moderate a family conference to discuss ethical dilemmas for a patient lacking decision-making capacity
36. Act in the patient's best interest when the resident has reached his or her confidence/competence envelope
    a. Determine if he or she should perform a particular procedure given the current level of training
    b. Consult appropriately so as not to compromise the patient's best interest
37. Act in a colleague's best interest when made aware of unethical conduct by that colleague
38. Evaluate a potential employment contract for unethical content
39. Discuss with a patient the economic considerations that may influence his or her care
    a. Capitation versus fee for service care
    b. Insured (covered) versus uninsured (out of pocket) care
    c. Trade versus generic medicines
    d. Formulary versus non-formulary medications
40. Consult with or participate on an ethics consulting committee

# Medical Ethics Curriculum for Family Medicine Residents: Syllabus

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 1 | Introduction to Key topics in Medical Ethics<br>2; 8; 16; 17; 34 | A 67 year old widowed female with moderately severe COPD is admitted for an acute exacerbation; her condition deteriorates to the point of needing intubation; she's expressed a desire to be able to return home, but is reluctant to be intubated; she continues to tell the attending, "not yet;" the attending asks you to determine if the patient is competent | • Reasons why ethical dilemmas develop in health care<br>• Foundational principles guiding medical decisions<br>• Methods to resolve ethical dilemmas in clinical medicine<br>• Characteristics of a virtuous physician |
| 2 | Medical Ethics & Worldviews<br>1a-d; 6a,b; 19a,f,j; 23 | 65yo female advanced stage Parkinson's dementia; bed bound, doesn't tolerate p.o.; recurrent aspiration pneumonia; husband insists on feeding tube<br><br>45yo male with moderately severe M.S. in office after discharge for recurrent pneumonia; uses arm crutches; may need wheel chair soon; He says to you, "Doc. I am really getting sick and tired of living with this damn disease. I think I'm ready to end it all." He asks you to prescribe him a lethal dose of medicine. | • Relationship of person's worldview and method of ethical decision making<br>• The relationship of ethical dilemmas and competing worldviews<br>• Competing views of human dignity<br>• Medical futility or inappropriate care requests<br>• Withholding or withdrawing treatment<br>• Passive and active euthanasia and physician assisted suicide |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 3 | Training Issues & Truth Telling<br>2; 3; 8; 12; 25; 36 | A one month old needs a spinal tap; You're an intern who has performed one (unsuccessfully as a medical student), and The parent asks you, "you've done lots of these right?"<br><br>You are a 2nd yr. resident about to perform an amniotomy on a 33yo laboring patient. She asks if a fully trained physician can perform the procedure; the staff is attending another delivery. You are comfortable performing the procedure. | • Informed Consent<br>• Competing ethical principles (autonomy vs. beneficence vs. non-maleficence vs. justice) and utilitarian reasons for trainees performing procedures<br>• Benefits vs. harms from partially trained physicians performing procedures<br>• Truth telling in patient interactions<br>• Characteristics of a virtuous physician |
| 4 | Parental refusals of medical treatment; worldview & ethics; religious beliefs in medical decision making;<br>1c,d; 3; 8; 19b | Christian Scientists parents refuse IVF & insulin for their child with DKA<br><br>Parents refuse chemotherapy for their 1 yo child with AML; the child has a 30% chance of disease free survival if treated.<br><br>A 14yo Jehovah Witness adolescent is refusing a blood transfusion prior to surgery for a septic knee. Her Hgb is 6.1<br><br>Parents to refuse to immunize their infant, stating immunizations do more harm than good | • Conditions when parents may refuse potentially beneficial therapy on behalf of the child<br>• "Best interest" standard for decision making in children<br>• Competing ethical principles<br>• Ethics Committees and courts roles in ethical dilemmas<br>• Role of religious beliefs in medical decisions for children |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 5 | Hippocratic Oath and Medical Ethics<br>7a-d; 9a,b | You're having lunch with a fellow resident; the topic of euthanasia & abortion come up; he says they're both wrong alluding to the Oath; you wonder if the Oath has any relevance for today. | • The history and content of the Oath<br>• Competing Modern oaths<br>• The meaning and significance in taking oaths<br>• Enduring principles in the Oath<br>• Competing methods of moral reasoning |
| 6 | Refusal of Medical Care in chronic technologically dependent diseases<br>7; 16; 19a,b,j; 27 | You admit a 34 yo male for pneumonia; he has a history of chronic Guillain-Barre diagnosed 11 years ago who has been on a respirator and a quadriplegic ever since; he's been admitted for pneumonia in the past and done well; he's currently improving and could go home tomorrow; he requests that he would like to shut off the respirator; will you do it? | • Withholding versus withdrawing medical care<br>• Physician assisted suicide and euthanasia<br>• Quality of Life issues in ethical decision making<br>• Utilizing the 4 quadrant method of resolving ethical dilemmas |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 7 | Confidentiality and privacy<br>8; 11; 29 | A 39yo female sees you in the clinic; she admits to being physically beaten by her husband, an active duty sergeant, and a patient of yours, who you have seen and like; She doesn't want you to say anything to him.<br><br>A 40yo businessman who you know well sees you in the office; he admits to visiting a prostitute while in Thailand; an HIV test returns positive; he requests that you do not tell his wife or anyone about the test. | • Patient Confidentiality and its limits<br>• When is it necessary or legally required to breach confidentiality<br>• Tarasoff case<br>• Public Health reporting requirements<br>• Adult Protective Services reporting requirements |
| 8 | Decision-making capacity, substituted judgment and ineffective treatments<br>15, 17; 18; 19f; 26; 31; 35 | A 70yo previously healthy widowed female is admitted for treatment of acute leukemia; she has a severe reaction to chemo and goes into multi organ failure; although she had requested full treatment and full code, just prior to being intubated she expressed "just let me go" to her daughter; she was intubated, briefly improved & extubated; while coherent she expressed a desire to try a round of another chemo; the next day, she worsened again and would need to be intubated; she's obtunded and the children are uncertain what to do. | • Care of patients with poor prognosis<br>• Decision making capacity and substituted judgment<br>• State laws surrounding surrogate decision makers<br>• Medical futility |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 9 | Contraception in minors<br>19k,p | You recently prescribed an OCP to a 16yo female; she expressed to you that she didn't want her parents to know; the following week the mother has an appointment with you; during the appointment, she is suspicious about her daughter's visits to see you and wants to discuss the issue with you. | • Patient Confidentiality<br>• Emancipated minors<br>• Fidelity to Trust<br>• Birth control for unmarried patients/minors |
| 10 | Advance Care Planning and Substitutive judgment<br>14; 18; 26 | John, a 42yo male, is brought to the ED after an MVA; he's unstable with abdominal bleeding; he's being prepped for urgent surgery; his male lover arrives stating that John would not want heroic surgery or to be admitted to the ICU; John's son arrives, is angry at the presence of the lover and exclaims everything should be done for John and he'll sue if it's not | • Advance Care Planning: health care power of attorneys and living wills<br>• Substituted Judgment and hierarchy of decision makers<br>• Contextual features in ethical dilemmas |
| 11 | Philosophical Foundations in Medicine; conflict of Interests<br>2; 3; 10; 13b,c | You join a group of 3 physicians; you soon realize they order an excessive number of unnecessary tests, which are done at their own lab; when you approach the senior physician of the group and ask him about the practice, he states it's necessary if they want to stay at their current income level. | • Primary purpose in medicine<br>• Meaning of a profession<br>• Virtue in medicine<br>• Conflicts of interest in medicine |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 12 | DNR<br>15; 33 | Mrs. Reed a 69yo patient was admitted to the ICU in pulmonary edema and intubated; she had an episode of Ventricular fibrillation and was successfully resuscitated; she had a protracted & complicated ICU course, but she's now on the ward, awake and alert. Her daughter pulls you aside, and tells you that she would like her mother to have a DNR order put in her mother's chart. | • Discussing DNR with patients and family members<br>• Writing DNR notes and orders<br>• Deciding when it is appropriate to recommend a DNR status for a patient |
| 13 | Gifts from pharmaceutical representatives and patients; economics and healthcare<br>13a,g; 39c,d | Tim, a Pfizer pharm. rep. routinely visits the clinic, and provides donuts, muffins, pens and books to staff & residents in the break room. He invites you to a talk on "Advances in the treatment of Osteoporosis" which will by at the Hyatt's 5 star steak house.<br><br>You see Mrs. S. in follow up after being hospitalized for pneumonia; she had been very sick, but recovered; She expresses deep gratitude to you for "saving her life." She gives you certificate for a two-night stay at a local resort for you and your spouse.<br><br>A 25yo with ADHD is well controlled on generic Ritalin; he's seen an add for Straterra and insists on trying it. | • Ethical implications in receiving gifts from pharmaceutical representatives<br>• Federal laws and professional societies statements on receiving gifts<br>• Appropriate limits on receiving gifts from patients<br>• Direct to consumer advertising<br>• Escalating costs of healthcare |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 14 | Lack of balance in personal & professional life; physician impairment<br>21b,c,d; 37 | You join a large fee for service group practice of family physicians; after joining you are pressured to see patients every 10-15 minutes to maximize profits; you also begin a cosmetic laser practice on Saturdays to increase your RVUs; you are not getting home to your family until after 8p.m. each night, and you are becoming very distant from your wife and children; your spouses brings up the topic of divorce<br><br>Your partner in your two physician practice begins to have marital difficulty; he's not answered his pages when on call for your patients on two occasions; he shows up to work on Monday morning with alcohol on his breath<br><br>One of the residents in your year group is not "carrying his load;" he regularly leaves the inpatient service promptly at 4 p.m., leaving work undone on the patients he's responsible for; when approached, he declares, "I've got a life outside of this residency;" He takes weeks to answer his telephone consults, and has incomplete charts from a month ago. | • Life balance<br>• How to respond to physician impairment<br>• Discuss reporting responsibilities of impaired physicians<br>• Necessity of strong work ethic in health care<br>• Duty to patients under a physician's care |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 15 | Intimate relationships with patients; sexual impropriety with patients and staff; physician impairment<br>21a,c; 37 | A male resident performs a pap smear on a young single woman; he finds her attractive and would like to take her out; he obtains her phone number from her chart to call her<br><br>You're seeing a female in the clinic for f/u depression; she was seeing a psychiatrist, but stopped seeing him because "things didn't work out;" on further discussion it's apparent the psychiatrist encouraged a sexual relationship with the patient | • When if ever is it permissible for intimate relationships to develop between physician and patient?<br>• Patient confidentiality & privacy and appropriate use of information from patient's charts<br>• Reporting requirements for physicians who are acting unethically |
| 16 | Truth telling; cultural sensitivity; worldviews and decision-making<br>1c-d; 8; 12a-b; 28 | A 58yo Navajo man is experiencing angina; evaluation shows 3 vessel disease; the resident discusses the risk of surgery with the patient, including death; the patient listens silently, returns home and refuses to return. The daughter tells the resident, "those words were like a death sentence for my dad."<br><br>A 72yo Japanese speaking woman came to the U.S. 10 years ago with her family; she develops weakness, nausea and a 15-pound weight loss. Her son tells you, "in case you find cancer, we prefer that she not be told. That is the way with our older people." She's found to have ALL, which has a 5% response rate to chemo. | • Respecting cultural traditions and the tension of the principle of truth-telling<br>• Informed Consent<br>• Changing attitude towards benign paternalism and beneficent deception<br>• Competing moral principles |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 17 | Competing loyalties and conflicts of interests; the uninsured patient & economics in healthcare<br>8d; 10; 13d,f; 21c; 38; 39a,b | You're joining a group practice and reviewing the contract; it's a fee for service HMO; you will receive a bonus for "increased productivity," which includes maximizing RVUs by ordering tests that are performed in the group's laboratory and radiology suite<br><br>You're seeing a 45yo male complaining of blood mixed in with his stool; he has a family history of colon Ca; he needs a colonoscopy but he works in a minimum wage job and is uninsured; he cannot afford the thousand-dollar test | • Fiduciary responsibility in medicine<br>• Self-interests vs. the interests of patients<br>• Conflicts of interests that may compromise patient care<br>• Barriers to healthcare<br>• Justice in healthcare |
| 18 | Abortion, emergency contraception and right of conscience<br>1a-d; 19m,p; 24 | You're seeing a 24yo G2P1 female at her 1st prenatal visit; she and her husband have a son, and they strongly desire a girl; she would like to know the gender of the child at the earliest possible time; if the fetus is a boy, she and her husband intend to abort the child<br><br>A 21yo female comes to see you requesting Plan B; she was out with her friends last evening, met a man and had a sexual encounter without a condom; she's 15 days from her LMP | • The moral status of the embryonic and fetal human<br>• Right of conscience in healthcare<br>• Relationship of person's worldview and method of ethical decision making |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 19 | Conflicting principles in military medicine; International Humanitarian Law<br>13e; 19q | You're deployed to Iraq as a general medical officer; an injured insurgent is brought to the company; interrogators take him into a neighboring tent to speak with him; you here yelling from the tent and peak in; the insurgent is naked and in four point restraints; the interrogators are on both sides of patient screaming and banging on the cot; one interrogator strikes the insurgent in the abdomen<br><br>The U.S. is planning to invade Iran as part of the war on terror; a military family physician is morally opposed to the actions and wonders if the invasion has anything to do with supporting and defending the constitution of the U.S. | • The ethics of treating the enemy<br>• The Geneva Conventions<br>• The right of conscience in the setting of the military<br>• The duty to care for the sick vs. the duty to serve one's country |
| 20 | Brain Death; medical futility; withholding care; competing principles<br>8; 19c,f; 16; 18 | A 50 year old woman suffers a cardiac arrest at home; 911 is called and she is resuscitated after being down for 15 minutes; after 5 days in the ICU she is declared brain dead and the attending informs the husband; he insists that she remain on the respirator and states he'll sue the physician if it is shut off; he's expecting a miracle | • The definition of brain death and the steps to diagnosis<br>• Competing principles in medical decision making<br>• Resolving ethical dilemmas using the four quadrant/CARER method<br>• Medical futility<br>• Substituted judgment |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 21 | Persistent Vegetative State & altered levels of consciousness; 1; 19f; 31 | A 21yo female went to a party where she ingested both valium and large quantities of alcohol; she suffered a cardiopulmonary arrest and was resuscitated after 20 minutes; after a protracted hospital stay she's determined to be in a persistent vegetative state; her family is uncertain if the feeding tube should be removed, and they ask your opinion as the family's physician. | • Definition of PVS and the minimally conscious state<br>• Relationship of worldview and ethical decision making<br>• End of life care<br>• Substituted judgment |
| 22 | Organ Donation; Informed Consent vs. Assent; competing ethical principles 8; 19b,g; 25 | You are the physician for a family whose 45yo father has end stage renal disease; it's determined that his 10 year old daughter is the only available match for a kidney donation; the family wants your advice on whether it would be appropriate for the daughter to donate the kidney | • The Ethics of organ donation<br>• Obtaining informed consent from a minor vs. assent<br>• Mature minors<br>• Competing principles in ethical dilemmas |
| 23 | Research in medicine; power and recognition in medicine 2; 8; 19o; 21e | A resident physician is assisting in a research study on an intervention for preterm labor; he is enthusiastically recruiting every available prenatal patient in the clinic and discussing it regularly with his peers and staff | • Review the Tuskegee Syphilis Study and/or other research initiatives with ethics violations<br>• The Nuremburg Code and ethical standards for research on human subjects<br>• The pursuit to publish competing with the care of patients |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 24 | Premature infants; fetus as patient<br>4; 5a,b; 19h,i; | A 30yo G1 female at 20 weeks gestation presents to L&D with SROM; there are no signs of infection and the cervix is closed; the attending recommends starting pitocin to induce labor, stating that the infant is pre-viable and there is no chance of survival; as the resident, you're uncertain what's the right course of action; an ethics consult is placed<br><br>A 25yo G1 female is in active labor; her problem list says she has a needle phobia, and her birth plan includes no IV's; a severe fetal bradycardia develops, not relieved with standard maneuvers; an urgent C/S is necessary; the patient refuses to get an IV in preparation, and exclaims, "F- the baby, I'm not getting an IV!" | • Roe v. Wade language<br>• Moral status of the fetus<br>• Conflicting principles for mother and fetus<br>• Role of ethics' committee in resolving dilemmas |
| 25 | Delivering bad news; truth telling<br>12a,b; 30 | You're seeing a 52yo male in f/u; he was having vague abdominal pain and you ordered a CT; it shows pancreatic Ca, spread to regional lymph nodes; at the beginning of the visit, he says, "Doc, my wife and I are going on the cruise of our lives tomorrow; I don't want any bad news; if you have good news, great; otherwise let me know the results after the cruise. | • Conflicting principles<br>• The duty to tell the truth<br>• Successful ways to deliver bad news |

| Session # | Topic Area and Objectives Covered | Example Cases | Potential Discussion Points |
|---|---|---|---|
| 26 | Eugenics; medical genetics; human dignity; quality of life<br>1; 19m; 20 | A 40yo in your practice is diagnosed with Huntington's disease; you also take care of his 3 children (10, 15 and 20 yo); He is uncertain if he should inform them; if so when, and whether they should be tested<br><br>A 20yo female has Sickle cell disease; her husband is a carrier of the trait; she's uncertain if they can or should have children; they want your opinion | • History of the eugenic movement in the U.S. in the 20th century<br>• Ethical dilemmas that arise as a consequence of genetic technology<br>• Potential eugenic nature of genetic technologies<br>• Parties who should be entitled to genetic information |
| 27 | Prenatal genetic screening; assisted reproductive technology (ART); eugenics | A 27yo nurse has a son with cystic fibrosis (CF); she is pregnant and her OB provider strongly recommends that she be tested antenatally for CF; she declines; he RN colleagues chastise her for possibly bringing a diseased child into the world intentionally<br><br>You send an infertile couple for ART; they return with questions; the infertility doctor recommended IVF with pre-implantation genetic diagnosis to improve the chances for a successful live birth and for a "healthier baby;" They're uncertain if it's right to destroy their embryos; it also will be several more thousand dollars for the intervention | • The ethics of assisted reproductive technologies and prenatal screening<br>• Prenatal screening and coercion<br>• Potential eugenic nature of prenatal testing<br>• Implications of genetic technology portrayed in the movie Gattica |

## Session # 1 Teaching Notes
## Resolving Ethical Dilemmas in Patient Care
## Introduction to Medical Ethics

**Objectives Covered**: 2; 8; 16; 17; 34

What I hope you get from our time together:
1. Increased understanding of why ethical dilemmas arise in the care of patients
2. Tools to help you resolve the dilemmas you encounter
3. Increased confidence in approaching the dilemmas you encounter

*The best of learning begins with a case…*

Ms. S., a widowed 67 yr. old female with moderately severe COPD, was admitted to the ICU two days ago for an acute exacerbation. Up to the point of admission, she was living on her own in a home in the community. Her family lived out of state, but her grand daughter would visit regularly.

She had been initially treated with BIPAP, but her respiratory status was worsening. Her attending physician felt she needed to be intubated to get her over the hump. When then doctor discussed the situation with Ms. S., she expressed to the doctor that she didn't want to make that decision yet. Her respiratory status continued to be very tenuous, and the physician instructed the patient several times that it was necessary for her to be intubated if she wanted to survive. Ms. S. continued to express a reluctance to go on the ventilator, and continued to say, "not yet." The attending calls you, the ethics consultant and asks you to see Ms. S., and states, "Please determine if Ms. S. is competent."

You speak w/ Ms. S., who is working to breath but able to converse. She's worried about the loss of control when intubated, and is not ready to consent. She wants to live and hopes to return home. Her grand daughter would make decisions if she becomes incapacitated. When asked if her grand daughter decided for her to be intubated – in the event she becomes incapacitated – she said that would be OK.

*What information do you need to gather to help resolve this dilemma? What competing principles are at stake? What concepts will you use to sort this out? What personal resources might you draw upon to help resolve this dilemma? What are you going to recommend?*

**Why do ethical dilemmas arise in health care?**

- Clinical decisions are value-laden
- People have different worldviews and beliefs about life that result in differing values

- Complex circumstances often result in the conflict of competing principles
- Medical technology has increased treatment options, making decisions more complex

**What are some basic concepts and principles we need to know to solve ethical dilemmas?**

- Decision making capacity vs. competence
    - Clinical judgment vs. a legal declaration
    - Decision making capacity
        - Determined by clinicians
        - More focused in determination
        - Essential elements of decision making capacity:
            - Can the patient receive new information?
            - Can they express an understanding of the choices they are facing?
            - Can they make a meaningful choice?
- Substituted judgment and surrogate decision makers
    - What would the patient want?
- Foundational Principles:
    - Beneficience: the duty to do good for your patient
    - Nonmaleficience: first do no harm, (*primum non nocere)*
    - Autonomy: freedom for the patient to make choices
        - "The sovereign state"
        - Inherent dignity of the person
    - Justice: treat all patients the same; distribute limited resources fairly
- Other Principles:
    - Fidelity
    - Truth-telling

**How can we systematically approach ethical dilemmas?**

- Content vs. process methods
- Utilize both! The Pocket Card Approach
- See the EthicsConsultGoBy.pdf file for a copy of the Pocket Card

**What are some key ingredients for resolving ethical dilemmas?**

- The family physician is the ideal ethics consultant!
- S2OE
    - Sit down, seal your lips and open your ears (after one or some artfully composed open ended questions)
- Presence / undivided attention
- Be quick to listen, slow to speak and slow to become frustrated
- USE THE CARD!
- Be a virtuous physician
    - Benevolent, trustworthy, self-effacing, compassionate, humble (intellectually honest), prudent/wise
    - The physician that can be trusted

**Concluding thought:**

"The end of medicine is a right and good healing action taken in the best interests of the patient." – Pellegrino

**Resources/References:**

Link to Ethics Consult Go-by Card

-Jonsen AR, Siegler M, Winslade W. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 5th edition, 2002.

-Orr R, Chay F. Medical Ethics a Primer for Students, published by CMDA, available on www.cmda.org

-Pence, G. Classic Cases in Medical Ethics: Accounts of Cases That have Shaped Medical Ethics, with Philosophical, Legal, and Historical Backgrounds, 4th edition, 2003.

## Session # 2 Teaching Notes
## Medical Ethics and Competing Worldviews

**Objectives Covered**: 1a-d; 6a-b; 19a, f, j; 23

## Background:

"Whether we realize it or not, all of us possess a worldview. A few years after birth, we all gradually formulate our philosophy of life. We make one of two basic assumptions: we view the universe as a result of random events and life on this planet a matter of chance; or we assume an Intelligence beyond the universe who gives the universe order, and life meaning…Our worldview informs our personal, social and political lives. It influences how we perceive ourselves, how we relate to others, how we adjust to adversity, and what we understand to be our purpose. Our worldview helps determine our values, our ethics, and our capacity for happiness."

-Armand Nicholi in *The Question of God*

See also "Worldview" at the Wikipedia free encyclopedia: http://en.wikipedia.org/wiki/Worldview

Worldview is a term borrowed form the German word *Weltansschauung*, meaning a "look onto the world." "It refers to the framework through which an individual interprets the world and interacts in it…The term denotes a comprehensive set of opinions, seen as an organic unity, about the world as the medium and exercise of human existence. Weltanschauung [worldview] serves as a framework for generating various dimensions of human perception and experience like knowledge, politics, economics, religion, culture, science, ethics." A worldview encompasses the primary assumptions we have about life.

A world view attempts to answer the most fundamental questions we as humans face:
1. Who are we? Where did we come? This is a question of origins.
2. What are we? That is what is the nature of humans?
3. What is wrong with humans and the world (the dilemma of pain and suffering)?
4. How can humans and the world be fixed?

Worldviews can be broadly broken into three categories: Naturalism, Pantheism and Theism; each of these broad categorical worldviews have multiple subcategories with sometimes similar and sometimes divergent beliefs.

## Suggested Strategies:

The following are suggested strategies for approaching the above objectives. Given the subjective and personal nature of the topics, small groups would encourage the greatest discussion. Break the residents into groups of 4-6 and have a designated facilitator (preferably a staff member). The time can begin with a brief introduction in the large group setting. The lead facilitator could read the above quote and briefly delineate the central elements of a worldview, describe the most common competing worldviews, then break the learners into small groups.

Another strategy would be role playing. Elicit the small group members' worldviews, then have individuals attempt to defend the following cases from their opposing worldview.

Case Discussion:

Case A:

You are the physician caring for a 65 year-old female with an end stage Parkinson's dementia complex syndrome. She is non-verbal, having difficulties swallowing and is bed bound. She is being admitted for the 2nd time in a month for aspiration pneumonia. Given her poor prognosis, you discuss the treatment options with the patient's husband. You recommend against placing feeding tube given recent data that suggest feeding tubes do not prolong lives in patients like his wife.

You believe in the sacredness of human life and that life has inherent dignity, but believe that prolonging biological life should not be the only end to achieve. You suggest treating the patient with antibiotics for now, but suggest that primarily comfort care would be the best treatment option after discharge, and if the patient is unable to swallow, then "nature can take its course."

The husband is a devout Catholic (as was his wife when she was competent) who believes life should be prolonged no matter the cost, and that it would be wrong not to feed his wife. He insists on a feeding tube being placed.

The tube is placed, and despite your predictions, the patient continues to exist in a well-nourished state for the subsequent two years during your care of her. On regular home visits, you note she is meticulously cared for by round the clock support of her husband, family members and hired help.

Questions for Discussion:

1. How were the physician and the husband's worldviews similar? How were they different? How did those differences result in different beliefs about what should be done for the patient?

2. How has technology forced people with fairly similar worldviews come to different conclusions on how to act?

3. What do you believe about life? Describe your beliefs by describing the essential elements of your worldview.

4. How would your worldview affect the recommendations you would have made in this case?

5. What are some other circumstances in medicine where your worldview will affect what recommendations you make to patients?

Case B:

You're seeing a 45 year-old male with moderately severe MS in the office. He has been hospitalized three times in the last year for pneumonia. He needs to use arm crutches for ambulation, and will likely need a wheel chair in the next year. During the visit, he says to you, "Doc. I am really getting sick and tired of living with this damn disease. I think I'm ready to end it all." He goes on to ask you to prescribe him a lethal dose of medicine.

Questions for Discussion:

1. How are you going to respond?

2. How does your worldview affect how you will respond?

3. Many people describe human life as having dignity. What do you think is meant by the phrase the dignity of human life? Do you believe human life has any inherent value? Why or why not?

4. Competing worldviews have different perspectives on the nature and origin of moral laws or principles. Do you believe there are transcendent moral laws, which are not derived simply from human thought, or do you believe that moral laws are something crafted by human reason. Justify your answer, and discuss the implications.

5. Do you believe giving the man described in the case a lethal prescription of narcotics would violate any ethical principles? If so, which one(s)?

## *Session # 3 Teaching Notes*
## *Training Issues and Truth Telling*

**Objectives Covered**: 2; 3; 8; 12; 25; 36

**Background:**
There is an ongoing tension between training physicians and subjecting patients to procedures by partially trained physicians (or medical students).

It is important we train residents – in the context of their level of training and comfort level – to act in the best interest of the patient when it is necessary to perform any given intervention or procedure. Upholding particular ethical principles and exemplifying professional virtues are the necessary tools for the partially trained physician to always act in the best interest of the patient.

**Educational strategies:**
Most residents at some point in their medical education will have been faced with the uncomfortable circumstance of performing a procedure they didn't feel quite ready to perform. If not, they've seen such a case.

Query the house staff about any such cases. At the beginning of the talk, describe the case, or consider doing a brief "re-enactment" of the case. Use the case as a springboard to discuss the issues below. Then consider returning to the case to reflect on what could be done differently in future similar cases.

If there are no real cases to discuss, the below cases can be used.

**Consider the following cases:**

1. A one month old needs a spinal tap. You're an intern who has performed one (unsuccessfully as a medical student). The parent asks you, "I assume you know what you are doing. You've done lots of these right?"

- How are you going to respond?
- Does it matter that you've done only one spinal tap?
- How many spinal taps will you tell the patients you have done?

2. You are a 2nd yr. resident about to perform an amniotomy on a 33yo laboring patient. She expresses concern that you are not an attending physician. The staff is attending another delivery. You are comfortable performing the procedure.

- How are you going to respond?

**Discussion Points:**

1. What is required by Informed Consent?

Informed consent is a legal doctrine with ethical justification. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." (Justice Cordoza, 1914)

Essential components of informed consent: The physicians have a duty to disclose all information that a "reasonable" person would have found important in making a decision.

- Diagnosis
- Procedure description
- Prognosis with and without procedure
- Risks, benefits and alternatives to the procedure
- Patients have the capacity to understand what is discussed (they have decision-making capacity)
- The consent is voluntary

What are some exceptions to the requirement to obtain adequate informed consent?

- Medical Emergencies: "Presumed Consent"
- The Incompetent patient: default to a surrogate decision maker
- Patient's expressed waiver of consent
- Therapeutic privilege: providing patients with the information would result in undo stress

2. What are some duties the physician has to the patient in the context of performing any intervention or procedure?

- The duty to respect the dignity or autonomy of the patient
- The duty to do good for the patient
- The duty not to harm the patient

- The duty to truth-telling – to be honest with the patient

3. What are some of the inherent tensions between the above principles and the need for partially trained physicians to perform procedures on patients?
   - There is a necessity to train physicians to perform procedures
     - Society has an implied social contract with the medical establishment
     - It is in the benefit of patients *as a group* to have some procedures performed by inexperienced persons, so they may gain experience
   - Patients (and parents of patients) would assume to have the most experienced person available perform the procedure
     - It is in the best interest of the patient to have the most experienced person do the procedure
   - Utilizing patients as means to an end versus treating them as ends
     - When we begin to do this, we are at increased risk of violating the patient's dignity and fundamental right to freedom (Nazi doctors, Tuskegee)

4. What are some specific actions we can take to minimize risks to patients who need to have procedures performed on them?
   - Only have persons who will ultimately need to perform the procedure in practice be allowed to perform the procedure (decrease the burden of the inexperienced)
   - When possible, require *simulated training* of the procedure before performing the procedure on a live person
     - Avoid practicing on "newly dead" patients
     - Required time in Simulation Center Training (e.g. IV's, LP's, intubations, episiotomies, endoscopy, etc.)
   - Ensure close supervision of the partially trained physician by an attending who is clearly competent to perform the procedure
     - If a resident is supervising, he must have proven him/herself competent
   - Perform procedures utilizing the least risky approach possible
     - U/S guided central lines and thoracentesis versus "blind" approaches

5. What are some specific professional virtues that, when exemplified, will ensure that partially trained physicians act in the best interests of the patient?

- Benevolence & unconditional positive regard
  - The habit of seeking to do what is best for someone regardless of how you feel
- Fidelity to trust
  - The habit of being faithful to your patients; a willingness to stick with them when the going gets tough
- Compassion
  - The capacity to "suffer with" the patient you are treating. To appreciate the patient as a person in need
- Intellectual honesty
  - The habit of speaking the truth, even when it is difficult to do so
- Effacement of self-interest
  - The practice of putting your patient's interests ahead of your own
- Prudence/practical wisdom
  - The capacity to make good decisions and to implement those decisions well.

6. How best are the professional virtues taught?

- Virtues are "caught" more than taught
  - Modeling by senior physicians
  - I want to be like that doctor…I don't want to be like that doctor!
- Cultivated in our personal life of piety and devotion
- Habits require practice

**Conclusion:**

Medical educators have a duty to train resident physicians to perform procedures in a way that upholds the dignity of the patient, and allows the resident to get the training necessary to become competent. Adhering to the principles particular to patient care and exemplifying professional virtues will ensure the patients are cared for and protected, and that resident physicians will be adequately trained.

# Session #4 Teaching Notes
# Not over my Child's Dead Body
# Parental Refusal of Beneficial Treatment for their Children

## Objectives Covered: 1 c,d; 3; 8; 19b

**By the end of this session you should be able to**

1. Articulate the competing worldviews, principles, beliefs and values that can create conflicts in treatment decisions for children
2. Articulate the concept of the mature minor and how it will affect ethical decision making for certain adolescents
3. Apply the strategies discussed to a real case where there is parental refusal of treatment

**Suggested strategy to cover material**

Below are three cases that highlight the different issues relevant to parental refusal of therapy. They will be used as springboards for small or large group discussion followed by didactic large group discussion. If in small groups, appoint a spokesperson. Each group should reflect on one of the cases to decide the core issues at stake and how the dilemma might be resolved. At the large group time, each case will be read then the spokesperson will verbally list the issues at stake and how the dilemma might be resolved (other eager participants are welcome to throw in their two cents). If additional information is necessary to resolve the case, the facilitator will provide the information to the groups.

When approaching the cases, consider utilizing the 4 quadrant content method to break the information down: **medical indications** for all relevant medical information for the case; **patient preferences** to delineate what the parents and possibly the child are desiring regarding the treatment; **quality of life** issues for the patient in the context of the treatment refusal; and **contextual features**, those religious, social, family, societal and cultural issues that are relevant to the case.

**Case #1**

A 14 and 1/12 year old girl developed a staph knee infection 2 weeks ago. She developed toxic shock (now resolved) and osteomyelitis and bilateral pleural effusions. The osteomyelitis responded to surgical drainage and antibiotics. The pleural effusions have persisted despite standard therapies. The next step is decortication, which may involve significant blood loss. She is already very anemic (Hgb 6.1), and the pediatric surgeon is unwilling to operate without giving her blood. She and her family are Jehovah's Witnesses, and they are refusing administration of blood products.

**Case #2**

A mother brings in her 2 month old infant. He is healthy and due for his routine immunizations. As you finish up the visit you begin to discuss the different shots that the boy will receive. The mother becomes defensive and states that her son isn't going to receive any shots. She learned on "Shirley's Wellness Cafe" (www.shirleys-wellness-café.com/vaccine_support_org.thm) that the MMR vaccine causes autism, and that other conditions like ADD and diabetes have skyrocketed since the number of immunizations has increased.

**Case #3**

You are caring for a 4 year old child on the Family Medicine In-patient Team. She has been admitted for one month and is being treated for Acute Myelogenous Leukemia. She did not have a response to primary chemotherapy. She has had several episodes of neutropenic fevers, and two episodes of sepsis. The oncologists are now recommending salvage chemotherapy. They told the parents there is a 20% chance of disease free survival with the salvage chemotherapy. The child appears ill and is somewhat listless. The parents express they have reached their limit for chemotherapy, and would like to take their daughter home.

**Important Points**

- There is a different locus of decision-making and a different standard for decision making in children
  - Decisions are made by a **surrogate**, usually one or both parents
  - As children mature the locus of decision making gradually shifts from parents to child
  - Legally, children can make decisions for themselves starting on their 18th birthday
    - Everyone agrees this line is arbitrary and doesn't recognize the variation between children or the gradual development (vs. the sudden appearance) of moral authority.
    - There has been legal and ethical precedent to determine if an adolescent is a "mature minor": an adolescent who is less than 18, but who has the capacity to make medical decisions for him or herself. This has usually been in the setting of refusals of treatment for chronically ill patients or for adolescents refusing therapy for religious reasons
    - The following are age ranges that can be used as rules of thumb for considering if an adolescent is a mature minor: < 12yr, usually not a mature minor; 12-15yr on a case by case basis; > 15yr usually will be found to be a mature minor
  - Decisions for children are considered on the **best interests** of the child (vs. "substituted judgment" in adults)
- Ethical dilemmas arise when there are differences of opinion about which treatment decisions are in a child's best interest
- Physicians have a responsibility to report a suspicion of medical neglect to child protective services
  - Is failing to f/u for an appointment considered neglect? Is letting a child eat all fast food and watch violent TV considered reportable neglect? Obviously a good deal of judgment is necessary when deciding what should be reported
  - To determine if medical neglect is occurring in the context of parental refusal of therapy, explore the reasons behind the refusal
    - Financial; over-busyness; differing values; misinformation; mistrust of medical profession; philosophical differences; religious beliefs; idiosyncratic beliefs

- Refusal of treatments based on religious beliefs
    - Typically adults have been given the freedom to refuse treatments, even if they are life saving
    - The legal system has typically prevented parents from refusing life saving treatment for children because of the parents religious beliefs – when the necessity of such treatment is brought to the attention of the medical and legal systems
    - Typically such parents want good treatment for their children but have specific beliefs about particular treatments
        - Classic example is the Jehovah Witness' refusal of blood products based on an interpretation of particular Bible passages: it's believed that transfusion will lead to eternal separation from God
        - Eternal or spiritual "health" is held in higher esteem than physical health
    - For the adolescent, it will be necessary to determine if they are a mature minor regarding their religious beliefs
        - Are they refusing treatment based upon their own personal convictions? Or are they simply parroting what they've been taught? Do they understand the ramifications of not treating?

**Strategies to successfully resolve parental refusals of treatment**

- Always remember your **ultimate goal**: a good and right healing action taken in the best interests of the patient
- Approach the parents in a sympathetic, nonjudgmental, compassionate manner
- Establish trust: show the parents that you really care (sit and talk, good eye contact, appropriate physical contact, healthy sense of humor); show them you want the best for their son or daughter
- Seek to fully understand the reason behind the treatment refusal; listen more than talk initially
- Gently correct misinformation and misconceptions; provide accurate, easily understood information
- When you believe medical neglect is clearly occurring, involve the ethics committee, and the JAG; report the situation to CPS; depending on the situation, an emergent court order may be necessary
- Remember the virtues (benevolent, self-effacing, faithful/trustworthy, compassionate, intellectually honest, prudent/wise)! The virtuous physician can navigate the stickiest of ethical dilemmas

**Resources**


1. American Academy of Pediatrics, Committee on Bioethics [policy statement]. Informed consent, parental permission, and assent in pediatric practice. *Pediatrics* 1995; 95(2):314-17.
2. American Academy of Pediatrics Committee on Bioethics [policy statement]. Religious objections to medical care. *Pediatrics* 1997; 99:279-81.
3. Asser SM, Swan R. Child Fatalities from relition-motivated medical neglect. *Pediatrics* 1998; 101(4):625-9.
4. Diekema D, and the Committee on Bioethics. Responding to Parental Refusals of Immunization of Children. *Pediatrics* 2005; 115:1428-31.
5. Frader, Joel. Younger Yet Wiser: Courts allow mature minors medical autonomy. *The Park Ridge Center For Health, Faith, and Ethics*, July 2000. Accessed online at www.parkridgecenter.org/Page395.html.

## Session #7 Teaching Notes
## Patient Confidentiality
## A time honored moral duty or an old decrepit concept?

**Objectives Covered:** 8; 11; 29
By the end of the session, participants should be able to

1. Articulate the importance and limitations to the principle of confidentiality
2. Describe the competing principles at stake when addressing a patient's confidentiality
3. Determine when it is ethically permissible or legally sanctioned to breach a patient's confidentiality

**"Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse) that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets."** *-Hippocratic Oath*

- What is meant by patient confidentiality and why has it been considered so important in the doctor-patient relationship?
    - Trust leads to confidence; *confidential* from *confidere* 'to have full trust'
    - Full and frank disclosure of "holy secrets"
    - Facilitates proper diagnosis and appropriate treatment
    - Respects the inherent dignity of the patient
        - Not to speak of the patient in a dishonoring manner: "junkies, gomers, dirtballs, drunks, bounces, hits, or vegetable…"
- What are some ways that physicians might breech a patient's confidence?
    - Elevator scuttle butt
    - The family unit versus the individual patient
    - The computer or chart peek when there is no "need to know"
    - Sharing information with nonessential persons
        - How was your day honey?
        - I saw that R-2 in the clinic the other day…
        - Nellie neighbor saw me in the office today for a pelvic…

**"Medical confidentiality, as it has traditionally been understood by patients and doctors, no longer exists. This ancient medical principle…has become old, worn-out, and useless; it is a decrepit concept."** *-Mark Siegler, MD*

- How has the traditional understanding of patient confidentiality become outdated?

    - Inpatient hospital experience: specialization; auditing; quality control
        - Upwards of 75 personnel have access to the chart!
    - Information technology
        - Research databases
    - Interested third parties
        - Parents
        - Employers
        - Government agencies
        - Payers of healthcare
        - Hospital executives and Quality Improvement

- How has technology and culture seriously threatened patient confidentiality?
    - Medical genetics and other "hidden information"
    - Information technology
    - Un-dignifying humans: pure utilitarian thinking
- What has the government enacted to try to fend off this threat?
    - HIPAA: AMA ethics section has good overview
    - Current law in the area of patient confidentiality has been described as a "crazy quilt of state and federal law."

**"…the protective privilege (of confidentiality) ends where the public peril begin."** – *Tarasoff v. Regents of Univ. Cal*., 1976

- Is patient confidentiality an unlimited or absolute obligation?
    - Concern for safety of others and concern for the public welfare
    - State and federal laws vary widely on when confidentiality may be divulged in particular circumstances

**The following cases illustrate the tension between patient confidentiality and the safety of others. Discuss how you might decide on each case and why.**

Case I: A 61yo man is diagnosed with metatstatic prostate cancer. He refuses any treatment, and he asks the physician not to inform his wife. The next day, the wife calls to inquire about her husband's health.

Case II: A 40yo businessman who you know well sees you in the office. He admits to visiting a prostitute while in Thailand. An HIV test returns positive. He requests that you do not tell his wife or anyone about the test.

Case III: A 39yo female sees you in the clinic. She has been seen for a variety of injuries in the last 6 months. After a long discussion, she admits to being physically beaten by her husband – an active duty sergeant, and a patient of yours, who you have seen and like. She doesn't want you to say anything.

Case IV: A 72yo male is seen in the clinic for evaluation of forgetfulness. The daughter notes that her father is leaving the stove on in the house, not completing his bills and has gotten lost coming home in the evening. You initiate an evaluation for dementia. Despite the daughter's prodding, he is reluctant to quit driving.

**Resources:**


1. Jonsen AR, Siegler M, Winslade, WJ. Physician Confidentiality in *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 5th ed. McGraw Hill, 2002, 159-162.
2. AMA Ethics Resources, *Patient Confidentiality*. www.ama-assn.org/ama/pub/category/print/4610.html. Accessed 15 Aug 2006.
3. Miles, SH. Discretion in Speech in *The Hippocratic Oath and the Ethics of Medicine,* Oxford University Press, 2004, 149-160.
4. Siegler M. Confidentiality in Medicine – A Decrepit Concept, in *Contemporary Issues in Bioethics, 6th ed.* Editors Beauchamp and Walters; Wadsworth – Thomson Learning, 2003, 116-127.

## Session # 11 Teaching Notes
## Philosophical Foundations of Medicine

**Objectives Covered:** 2; 3; 10; 13b-c

### Background

As medicine has become increasingly technical, there has been a decreasing emphasis on teaching the philosophical foundations of medicine. Time is spent mastering surgical techniques and intensive care medicine, but time is not typically allotted to discussing the overarching goals of the medical profession.

The newspapers and TV media provide regular examples of physicians and health care organizations that violate what most would believe are the basic assumptions of medical care: patients come to physicians in time of need, and that physicians will strive to do what is best for the patients. Physicians are frequently making decisions not based on the patient's best interest but on other factors: What needs to be done to protect myself from litigation? How can I obtain the most RVU's in this visit to maximize returns?

The purpose of this session is to prompt the learners to reflect upon what are the most fundamental goals of medicine with the hope that it may inspire them to make decisions that are in the best interests of the patients that come to them in times of need.
This session can be run in a variety of methods. There are case vignettes that can be used for springboards for discussion. There is a handout that facilitates a discussion on the topic. There are small group questions that can be used. There is a power point presentation that incorporates the handout and the small group questions. A list of suggested resources are noted at the end of the handout.

# Purpose Driven Medicine
# What on earth are we health care professionals for?

## Reflections on the goals of medicine and the principles, which should direct those goals

*To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.*
Sir William Osler

**Providing we head to sea, what bearing should we take, and what serves as our rudder to keep us on that bearing?**

Objectives:

1. To generate discussion regarding what are the goals of medicine
2. To differentiate medicine from other professions and trades
3. To discuss what is the primary end of the practice of medicine
4. To discuss what principles should direct us in achieving that end.

**Illustrative Case Vignettes:**

1. You get a letter from a colleague in family medicine, asking you to join his new laser cosmetic surgery practice. He says it promises to be a rewarding and lucrative venture.

**Would embarking on this medical-business venture with your colleague be in keeping with the goals of medicine?**

2. You're seeing a 45y.o. male with moderately severe MS in the office. He has been hospitalized twice in the last year for pneumonia. He needs to use arm crutches for ambulation, and will likely need a wheel chair in the next year. During the visit, he says to you, "Doc. I am really getting sick and tired of living with this damn disease. I think I'm ready to end it all." He goes on to ask you to prescribe him a lethal dose of medicine.

**Would prescribing this man a lethal dose of Morphine be in keeping with the goals of medicine? Would it violate any code of ethics?**

3. A twenty five year old female is seeing you in the office today. She thinks she's depressed, stating that she's more moody than usual, happy one minute, crying and angry with her kids the next. She feels overwhelmed by the stress of her husband at war. She doesn't meet criteria for depressive or anxiety disorders. She asks you to prescribe her a medicine to smooth out her mood swings. Her neighbor is on Lexapro and has found it very helpful. She feels very strongly that she needs a medicine.

**Would prescribing this young lady Lexapro be in keeping with the goals of medicine? Would it be acting on behalf of the patient's good?**

4. You're seeing a 52 y.o. retired Flight Surgeon. His wife is a radiologist. They are currently in retirement and travel a good bit. You're treating him for hyperlipidemia. He has a normal BMI. Towards the end of his visit, he asks for a plastic surgery consult so he can get a "chin tuck." He doesn't like the bit of excess tissue underneath his chin. On exam, you note a very subtle amount of excess adipose tissue under his chin.

**Does this patient's request have anything to do with the goals of medicine? In referring this patient are you going to be improving his health in any meaningful way? Should the profession of medicine be spending its time on such matters?**

5. A 45 year-old male comes to your office requesting assistance. He is recently divorced ($2^{nd}$ divorce), and is in a new relationship. He is requesting Viagra to improve his performance with his partner. He is able to have spontaneous erections, but after trying his buddy's Viagra, he found their sex life "really took off."

**Should you prescribe him Viagra? What principles will you use to decide?**

6. You're having lunch with your colleagues. RVU's are the topic of conversation (as is often the case). Someone commented on cryotherapy being a great RVU generator. Several others chimed in, stating they make a point to find something to freeze on their geriatric patients each visit.

**Are RVU's a primary or secondary goal of medicine? Is the above practice ethical?**

**What is medicine?**

**How is medicine different than the franchise Kentucky Fried Chicken, from the work of a plumber or a CPA?**

Asymmetric relationship

Ontological assault on the person

"Medicine and physicians exist because humans become ill." **Pellegrino**

Illness: an altered state of existence in which the patient perceives he/she has departed from health.

**What does it mean that medicine is a *profession*?**

Trade: habitual occupation, whose regularity is related to certain skills and crafts

Profession: *pro + fateor…to confess before*

"to declare publicly; to own freely; to announce, affirm, avow"

An activity or occupation to which its practitioner publicly professes, that is confesses, her/his devotion. Taking an Oath!

The three traditional professions: theology/ministry, law, and medicine

*All touch humans at a deeply personal level – body, mind and spirit – in a time of need*

Characteristics of a profession*al*: (You know you're a professional if….)

1. Articulates a commitment under oath: a confession before others who are one's witnesses
2. Freely promises continuing devotion, not merely present preferences
3. Commits to a way of life not just a livelihood
4. Acting in service to some high good, which calls forth devotion and is demanding and difficult
   *The master word in medicine is work…Though a little one, it looms large in meaning.* Olser
5. Engages one's character, not simply one's intellect and hands

**What is the goal(s) or purpose(s) of medicine?**

Prolongation of life?
Preventing premature death?
To treat disease?

**Health: What is it? What are your notions of health?**

"Fit as a fiddle" "A picture of good health"

Health's Definition

English word means "wholeness"; "to heal" = to make whole

Greek: *hygieia* = living well or "a well way of living"
*Euexia* = "well-habited-ness" or a "good habit of body"

All these words are totally unrelated to all words for disease, illness and sickness

"The well-working of the organism as a whole" – Kass

The end of medicine is the restoration of health, which leads to wholeness and integrity of the body, mind and spirit. Health requires a well way of living. - Sams

"Curiously, it will soon become apparent that even if we have found the end of medicine, we may have to go **beyond** medicine in order to find the best means of attaining it." - Kass

"It's not the healthy who need the doctor but the sick" – Jesus

It is most often in the context of medicine that we are attempting to restore health.

**What then is your primary goal to attain in any given patient encounter as a physician?**

"The end of medicine is a right and good healing action taken in the best interests of the patient" – Pellegrino

**Are there any principles (*foundations)* that guide us as we attempt to achieve this end of medicine?**

Comparing the Oaths

Below is a sampling of oaths that have been or are being taken by graduating medical students.

Discuss the underlying principles in the oaths. What are the similarities? What are the differences? Why are some of the principles being discarded or ignored? How has this affected medicine?

## Hippocratic Oath

I swear by Apollo the physician, and Aesculapius, and Hygeia, and Panacea and all the gods and goddesses, making them my witnesses that I will fulfill, according to my ability and judgment, this Oath and covenant:

To hold him, who has taught me this art, as equal to my parents, and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage, and to teach them this art if they desire to learn it without fee and indenture; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me, and to pupils who have signed the covenant and who have taken an oath according to the physician's Law, but to no one else.

I will strive to help the sick according to my ability and judgment, but I will never injure or wrong them.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness, I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men, as are craftsmen therein.

Into whatever house I enter, I will do so to help the sick, keeping myself free from all intentional wrongdoing and harm, especially from fornication with woman or man, bond or free.

Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse) that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.

If I fulfill this Oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

**World Medical Association's Declaration of Geneva Physician's Oath**

- I solemnly pledge myself to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude which is their due;
- I will practice my profession with conscience and dignity; the health of my patient will be my first consideration;
- I will maintain by all the means in my power, the honor and the noble traditions of the medical profession; my colleagues will be my brothers;
- I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;
- I will maintain the utmost respect for human life from the time of conception*, even under threat, I will not use my medical knowledge contrary to the laws of humanity;
- I make these promises solemnly, freely and upon my honor.

*Amended in 1968 to "I will maintain the utmost respect for human life from its beginning…"

**Modern Hippocratic Oath by former professor of Tufts University, Dr. Lasagna (1964)**

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 which 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 the 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 the 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, or 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.

**Recommended Reading**:


1. Physician and Philosopher: The Philosophic Foundation of Medicine. Essays by Dr. Edmund Pellegrino, Carden Jennings Publishing 2001.
2. Leon Kass: Toward a More Natural Science, Free Press 1983
3. Beyond Therapy, Biotechnology and the Pursuit of Happiness. A report by the President's Council on Bioethics, 2003.
4. Sir William Osler: Aphorisms from his beside teachings and writings, Charles Thomas publisher, 1968. Available at Virtual Hospital online: www.vh.org

# Purpose Driven Medicine Discussion Questions

🌍As a small group you will be asked to discuss one or more of the following questions.

🌍Assign a spokesperson for the group who can jot down some notes and be prepared to share the groups' thoughts to the larger group.

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1. How is medicine different from other lines of work? How is it different from say, Kentucky Fried Chicken, Ranier Plumbing or a CPA (certified public accountant) Associates of Tacoma? How is a local organization dedicated to healthcare different from Honda of Fife?

2. What do we mean when we say that medicine is a profession? What is a profession? Is medicine a profession? What are the characteristics of a professional?

3. What is medicine's primary purpose? Is there a single unifying purpose? Is it the prolongation of life? Is it the treatment of disease? What is health? What is the chief end of every patient encounter?

## Session # 12 Teaching Notes
## Discussing DNR Orders with Patients

**Objectives Covered:** 15, 33

**Background**

Both patients and providers are uncomfortable with discussing DNR orders. The language surrounding the discussion is complex to patients and difficult for physicians to articulate in a clear and concise manner. There are unrealistic expectations of patients regarding the success of CPR. There is mistrust of the medical community by patients, and when any limitations of treatment are suggested, abandonment is feared. Because of these complexities, it is essential that educators of providers provide practical strategies in how to address this important issue with their patients.

**Suggested Strategies and Resources**

The Medical College of Wisconsin's End of Life and Palliative Care Center has a nationally recognized palliative care curriculum that deals with a myriad of end of life issues that patients and providers face (www.eperc.mcw.edu). They have several "Fast Facts" information sheets that adeptly cover the "how to" of discussing DNR. These could be given to the residents in preparation for the talk. Further resources are noted at the end of this document.

An interactive handout available in this document could be used to facilitate a discussion on the topic. It incorporates an opportunity for the residents to practice discussing DNR orders with one another, with one resident playing the patient and the other playing the physician.

Ideally, one of the residents has had a difficult experience in addressing DNR orders with a patient and family. This case could be used as a springboard for the below discussion. Survey the residents 1-2 weeks before the planned talk, and have them present the case in the conference.

# DNR Orders and the Forest Before the Trees
# Keeping the big picture in mind when discussing DNR orders with patients and families

Case Examples:

1. Mrs. Reed a 69yo patient was admitted to the ICU. She was having an acute coronary syndrome and was in pulmonary edema and intubated; she had an episode of Ventricular fibrillation and was successfully resuscitated; she had a protracted & complicated ICU course, but she's now on the ward, awake and alert. Her daughter pulls you aside, and tells you that she would like her mother to have a DNR order put in her mother's chart.

2. Mr. Johnson is a 55 year male with lung cancer metatstatic to the liver, brain and bones. He's admitted to your service for pain control. You attempt to discuss placing a DNR order with the patient and family. He is emphatic that "everything should be done."

*How are you going to approach these two situations? Do the situations make you feel uncomfortable? If so, why?*

**What makes discussing DNR orders with patients and families so difficult?**

- Autonomy vs. beneficence and benign paternalism
- Mistrust of medical community
- Unrealistic expectations of CPR
- No CPR $\neq$ no to other life sustaining therapies or aggressive care before death
- The way the information of presented is VERY important
- Fear and denial of death or causing death
- Guilt by family members or patient

**What are the facts about ACLS/CPR? For what condition(s) was it originally developed? How effective is it?**

- Sudden Death from cardiac cause
- Time to resuscitation and associated co-morbidities greatly affect prognosis
- On average 15% of in-patients survive to discharge after a cardiac arrest
    - Those with ESRD not on dialysis, metastatic cancer, and overwhelming pneumonia virtually never survive
    - < 5% of elderly with serious illness survive

**Keys to successful discussions about CPR and DNR orders:**

- Establish a good setting with the right people
    - Inpatient versus outpatient
- Start with the end in mind
    - What does the patient understand about his/her illness and prognosis?
    - What goals does the patient have for whatever time is left on the planet?
        - Time with family, comfort, longer life "at all costs"; ready to meet their Maker, last special trip, etc.

**Do's and Don'ts of discussing a DNR order**

- Do:
    - Use open ended questions to get at root issues more effectively
    - Use language that patient will understand in small bits
    - Use the word die: "In the event that you die before our eyes despite our best efforts, do you want us to use heroic measures in attempt to bring you back?"
    - Shepherd the conversation: When prognosis is exceedingly dismal (e.g. metastatic cancer, terminally ill), don't leave the decision on the shoulders of the patient or family
    - Ensure that the patient and family have an adequate understanding of CPR
    - Respond to emotions: address hopes, fears, guilt and mistrust in a compassionate manner
    - Establish a plan to accomplish the goals discussed
    - Ensure that those carrying for them will continue to provide the best possible care to meet those goals (life-sustaining therapy; aggressive comfort care)
- Don't:
    - Introduce CPR in mechanistic terms: "if your heart stops, do you want us to put you on a breathing machine?"
    - NEVER say "Do you want us to do everything?"
    - Mix CPR with other life sustaining therapies
    - Get bogged down with the CPR order; overall goals are more important

**The persistent CPR request**

- Are you confident that CPR would be futile?
    - You are not legally or morally obligated to participate in such care
    - Some institutions have unilateral DNR order policies
- Plan to perform CPR, but keep the discussion open
- Address the family as to how they will respond if and when their family member is on life support following a resuscitation

    - Ensure the surrogate decision maker is identified
- Transfer care to another physician if you feel the therapeutic relationship is or will be jeopardized.

**Practice discussing a DNR discussion**

- Spend the next 5-10 minutes practicing a DNR discussion; one person is the patient, one is the doctor, and one is an observer
    - Utilize one of the cases above
    - After practicing, discuss how it went
        - What do's did you put into practice?
        - What don'ts did you use?

**Resources:**


1. Weissman DE. Discussion of DNR orders – Parts 1 and 2. Fact Fact and Concept # 23 and 24; 2nd edition, July 2005. End-of-Life Palliative Education Resource Center www.eperc.mcw.edu.
2. Junkerman, Charles and Schiedermayer, David. *Practical Ethics for Students, Interns and Residents,* 2nd edition. University Publishing Group, 1998.
3. Cantor MD et al. Do-Not-Resuscitate orders and medical futility. Arch Int Med 163:2689-94, 2003.

## Session # 16 Teaching Notes
## Cultural Diversity, Full Disclosure and Family Structure
## To Tell or Not to Tell: That is the Question

**Objectives Covered:** 1c-d; 8; 12a-b; 28

By the end of this session you will:

1. Possess a greater understanding of the ways different ethnic groups approach end of life care and delivering grave medical news to patients.
2. Comprehend the competing principles at stake in such settings.
3. Be able to approach such settings with culturally sensitive / patient centered questions in order to competently care for patients and their families in such contexts.

**Let's begin with a case:**

A 72yo Korean speaking woman came to the U.S. 10 years ago with her family; she develops weakness, nausea and a 15-pound weight loss. Her son tells you, "in case you find cancer, we prefer that she not be told. That is the way with our older people." She's found to have Acute Leukemia, with a predicted 5% response rate to chemo.

- In groups of 3-5 people discuss the above case. Answer the following questions:
  - How are you going to respond to the son's request?
  - What principles are you relying on in framing your response?
  - What do you know about some Asian cultures that will affect how you will approach this case?

**Differing Priorities:**

- In the United States what principle is held in highest regard in the context of medical decision-making?

- How is this reflected in the way we approach delivering bad news and disclosing medical information?
  - Health Care Power of Attorneys and Living Wills reflect our focus on maintaining autonomy, even when we have lost our autonomy

- Other non-Western cultures de-emphasize autonomy
  - It's perceived as isolating rather than empowering
  - Believe that communities and families, not individuals alone are affected by life-threatening illnesses
  - Value nonmaleficence or beneficence above autonomy
    - Desire to protect patients' emotional and spiritual well being from the "harm" caused by directly addressing death and end-of life care
    - See the doctor's obligation to promote welfare of patient by encouraging patient hope even in the face of terminal illness

- The value of Advance Directives varies among different people groups
  - 40% elderly whites vs. 16% elderly blacks; few if any Koreans and Hispanics; mirrors other cultural issues being discussed

**Delivering Bad News:**

- How might the delivery of bad news not be fully disclosed by the doctor in other cultures?
  - African & Japanese physicians may use medical terminology that obscures diagnosis
  - Hispanic, Chinese, Pakistani, Bosnian-American and Italian American families protect terminally ill patients from knowledge of their condition

- How might the process of translation be unwittingly brought into this process?

- Reasons why some cultures value non-disclosure:
  - View discussion of serious illness as disrespectful or impolite
  - May provoke unnecessary anxiety in the patient
  - May eliminate hope
  - The spoken word becomes reality (Native American, Filipino & Bosnian cultures); need to speak in a "positive way"

**Case in point:**
A 58yo Navajo man is experiencing angina; evaluation shows 3 vessel disease; the resident discusses the risk of surgery with the patient, including death; the patient listens silently, returns home and refuses to return. The daughter tells the resident, "those words were like a death sentence for my dad."

**Navigating the cultural differences to act in the best interest of the patient and family**

- Recognize the different ways of decision making:
  - Patient centered; family centered; physician centered; shared family-physician centered
  - Recommend a patient-family-physician based approach (shared decision making)
- Recognize that the above descriptions are not hard & fast stereotypes
  - Recent research suggests many Asians want to know their diagnosis

- How might you frame questions regarding serious illness & end-of-life care in order to uphold the dignity of the patient and simultaneously recognize family as integral in making decisions?

**Resources:**


1. Searight H, Gafford J. *Cultural Diversity at the End of Life: Issues and Guidelines for Family Physicians*. American Family Physician 2005; 71(3): 515-21.
2. Gold M. *Is honest always the best policy? Ethical aspects of truth telling.* Internal Medicine Journal 2005; 34(9-10): 578-80.
3. Wang S, Chen C, et. al. *The attitude of truth telling of cancer in Taiwan.* Journal of Psychosomatic Research 2004; 57(1): 53-8.

## Session # 26 Teaching Notes
## Eugenics

**Objectives Covered**: 1; 19m; 20

**Background:**

Historian and philosopher George Santayana said, "Those who cannot remember the past are condemned to repeat it."[8] This admonishment is apropos to a contemporary discussion on eugenics.

In the early part of the 20th century in the U.S. and Europe the scientific community and the cultural elite embarked on an ambitious program of racial betterment.[9] The intent of the movement was to guard the future welfare of society by encouraging the "desirables" to reproduce, and to discourage the "undesirables" from doing so. Inspired by the writing of Charles Darwin's cousin, Francis Galton, the United States enacted laws restricting the marriage of the "mentally deficient." Forced sterilization laws for the "feebleminded, insane, criminalistic, epileptic, inebriate, diseased, blind, deaf, deformed and dependent", followed these laws. The dependent included "orphans, ne'er-do-wells, tramps, homeless and paupers."

These laws swept the nation. Their constitutionality was upheld by Supreme Court Justice Oliver Wendell Holmes in 1927, when he infamously declared in Buck v. Bell, "three generations of imbeciles are enough."

Most Americans do not realize that the seeds of the euthanasia movement in Germany were sown on U.S. soil. The German government adopted model laws from Virginia in 1933 that provided the legal basis for the eventual forced sterilization of 350,000 Germans.

Ultimately there were 33 states in the U.S. at one time or another that had sterilization laws. The forced sterilization of the mentally ill and mentally retarded continued through the mid 1970's. The final case of forced sterilization occurred in Oregon in 1981. Ultimately through the eugenics movement more than 60,000 Americans underwent forced sterilization.

The crux of any eugenics practice can be summed up with one word, "desirable." Any eugenics practice is meant to decrease the number of undesirable individuals and increase the number of desirable ones. This was the intent of the cultural elite and the scientific community in the first half of the 20th century.

There is a good deal of debate in the medical and bioethical community about the contemporary practice of medical genetics, and whether this practice is the same or similar to the previous practice of eugenics. In particular is prenatal screening (or screening of embryos via preimplantation genetic diagnosis – PGD) and selective abortion of "defective" nascent human life simply the old

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[8] The Quotations Page, accessed December 2005, http://www.quotationspage.com/quotes/George_Santayana/.

[9] See The Eugenics Archive, accessed December 2005, http://www.eugenicsarchive.org/eugenics/.

eugenics with a new mask? Is this practice not the same intent of prenatal diagnosis and selective abortion? This process singles out the same classes of individuals that were singled out by our predecessors: the mentally retarded and the diseased. Scientists, physicians and others working in the field of genetics typically reject the idea that eugenics is being practiced. Their codes of conduct disavow any such practice. They claim that no legislative or social coercion is occurring, so to describe such practice as eugenics is wrong.

> Is such disavowal and distancing from our country's recent tainted past justifiable? Song asserts, the new eugenics is not taking place in mental institutions or immigration stations. It is not being promoted by Conferences for Race Betterment or fostered by worries about the future civilization…Yet it may still have the same upshot – of decreasing the number of 'undesirable' individuals and increasing the number of 'desirable' ones. The location for the new eugenics is rather the pre-natal screening suite, the genetic counselor's office, the general practitioner's surgery, the abortion clinic.[10]

He asserts that though there is the rhetoric of neutrality, this is not the impression most women get. The woman's relationship to the process of prenatal testing

> might best be described not so much as informed consent as acquiescence, in which the medical practitioner trades on an assumed agreement with the pregnant woman about what will be the best outcome (p. 53-4).

Proponents of medical genetics and prenatal screening and selective abortion disagree that the practice is the same as the previous eugenics movement. It is believed by supporters that the contemporary practice of medical genetics is non-coercive, and that people are simply asserting their autonomous reproductive choices when practicing prenatal screening and selective abortion.[11]

**Suggested Strategies for Covering Topic:**

There are multiple ways and a plethora of resources to cover such a topic. A Medline search on eugenics brings up over 2000 articles, many of which are excellent starting points for learning more about the topic. The Eugenics Archive (web address cited in the references), is an award winning, comprehensive and easily usable website that covers the history of the eugenics movement.

The movie Gattica is a 1997 movie depicting a society "in the not too distant future" that fully embraces the idea that humans should be perfected via eugenic practices. Clips of the movie could be viewed then discussed.

There are multiple links to resources the writer has used in discussing the topic of eugenics: a power point presentation and paper addressing the relationship between the eugenics movement of the 20th century and the practice of medical genetics, with a particular focus on prenatal cystic fibrosis testing as an example; discussion questions for the two scenes of Gattica; an interview with a mother of a child with Down's Syndrome; a skit that can be acted out; and links to newspaper and journal articles on the topic.

**Resources:**

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[10] Song, R. *Human Genetics; Fabricating the Future. (*Cleveland: The Pilgrim Press, 2002), 50.

[11] See Parens E, Asch A. *Prenatal Testing and Disability Rights, Hasting Center Studies in Ethics Series.* (Georgetown University Press, 2000).

- Link to power point presentation: Prenatal Cystic Fibrosis Testing and the New Eugenics
- Link to Aborting Beethoven flyer
- Link to paper on Prenatal Cystic Fibrosis Screening and the New Eugenics
- Interview of mother of child with Down's Syndrome
- Link to discussion questions for scenes from Gattica
- Link to prenatal screening skit
- http://www.eugenicsarchive.org/eugenics/
- Kristol E. Picture Perfect: The Politics of Prenatal Testing. *First Things*, 1993; 32: 17-24. Link: file:///Users/Rick/Documents/Curriculum%20Development/Bioethics%20Curriculum%20Teaching%20Notes/Session26Eugenics/Picture%20Perfect-%20The%20Politics%20of%20Prenatal%20Testing.webarchive
- Bernstein A. Outspoken Geneticist H. Bentley Glass Dies. *Washington Post,* January 21, 2005. Link: http://www.washingtonpost.com/wp-dyn/articles/A25321-2005Jan20.html

# Medical Ethics Curriculum for Resident Physicians
# Learning Needs Assessment

The residency is developing a medical ethics curriculum, and we need your valuable input. Could you please take a few minutes to complete the following questionnaire? Please be candid in your sense of comfort level regarding the cases. This will help gauge what should or should not be taught in the curriculum.

There is a section at the end of the assessment tool for you to provide any comments you have regarding the potential curriculum or the tool in particular. Your potential interest or lack thereof is valuable information. Any comments on the utility of the tool would be immensely helpful as well.

Thank you for taking time to complete the assessment. Please drop it in the assigned staff's mailbox when complete.

# Medical Ethics Curriculum Questionnaire

**1.** Mrs. S. is a 65yo female with advanced stage Parkinson's dementia. She is bed bound, and cannot effectively swallow food or liquids by mouth. She is currently admitted with her 2nd bout of aspiration pneumonia. You discuss palliative care options with the husband, a devout Catholic. He and his wife had not previously discussed end of life issues. You explain that a feeding tube would not prolong his wife's life because of the continued risk of aspiration. You recommend antibiotics, then palliative care after discharge. He insists on placing a feeding tube.

How comfortable are you with the husband's request and how to respond to it?

1 2 3 4 5 6 7 8 9 10

not at all comfortable — somewhat comfortable — extremely comfortable

What do you think affected the husband's decision the most?

a. His religious beliefs and certain assumptions about life and death (his worldview).
b. He doesn't believe the evidence you presented to him.
c. He is certain he knows what his wife would have wanted, and he is exercising reasoned substituted judgment.
d. He didn't understand the facts you presented to him.

**2.** A 45yo male with moderately severe multiple sclerosis is following up in your office after being discharged for recurrent pneumonia. He uses arm crutches and will likely need a wheel chair within the next year. He says to you, "Doc. I am really getting sick and tired of living with this damn disease. I think I'm ready to end it all." He goes on to ask you to prescribe him a lethal dose of narcotics, which he would like to take himself at home.

How comfortable are you with the patient's request, and how you would respond to it?

1 2 3 4 5 6 7 8 9 10

not at all comfortable — somewhat comfortable — extremely comfortable

The patient's request is an example of which of the following?

a. A request for passive euthanasia
b. A request for physician assisted suicide
c. A request of active euthanasia
d. A request for palliative care

**3.** The ER physician calls you to evaluate a patient. He is a 5yo boy, and his parents are devout Christian Scientists. The boy has newly diagnosed type 1diabetes and is in diabetic ketoacidosis with moderately severe dehydration. His parents refuse IVF & insulin for their child and would like to take him to their religious leaders for prayer and healing.

How comfortable are you with the parent's request, and how you will respond?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

What is the correct answer regarding this situation?

a. The parents have the legal right to refuse care for their child, and should be allowed to leave with their son.
b. The parents have the legal right to refuse care for their child, but the hospital should contact the ethics committee for an emergency consult for assistance in persuading the parents to have their son admitted.
c. An urgent court order should be sought for temporary guardianship. The judge will rule in favor of treatment for the child based on the "best interest standard."
d. Legal precedent has shown that if a court order is sought, it will likely be rejected by the judge, and it will put the hospital at risk for a civil lawsuit.

**4.** A 40yo businessman who you know well sees you in the office. He admits to visiting a prostitute while in Thailand. His HIV test returns positive. He requests that you do not tell his wife or anyone else about the test.

How comfortable are you with the man's request and how you should respond?

1 2 3 4 5 6 7 8 9 10

not at all comfortable — somewhat comfortable — extremely comfortable

a. Patients with HIV have the right to keep their diagnosis confidential, and this right is protected in all 50 states
b. The state of Washington requires that you report the case to the state health department within one week. It's up to the state health department to notify any partners.
c. There are currently no reporting laws for HIV in the state of Washington, but there are in 33 other states. The principle of justice would oblige you to urge the man to inform his wife.
d. Washington state law requires you to report the positive results to your local health department in 3 days, and that you assume responsibility for discussing partner notification or you should request assistance from the health department.

**5.** You recently prescribed an oral contraceptive to a 16yo female. She expressed to you that she didn't want her parents to know. The following week the mother has an appointment with you. During the appointment, she is suspicious about her daughter's visits to see you and wants to discuss the issue with you.

How comfortable are you with this situation and what you will say to the mother?

1 2 3 4 5 6 7 8 9 10

not at all comfortable — somewhat comfortable — extremely comfortable

What is the correct answer regarding this situation?

a. Because the patient is taking oral contraceptives, she is considered an emancipated minor by federal law, and you cannot tell the mother about the prescription.
b. Certain states have laws protecting minors' reproductive privacy. You will need to determine the state's laws regarding what must remain confidential.
c. The principle of autonomy and first amendment rights to privacy preclude you from informing the mother about the prescription.
d. The girl still lives with her parents; therefore federal law requires the parents to be informed of all reproductive healthcare interventions by the physician.

**6.** John, a 42yo male, is brought to the ED after an MVA; he's unstable with abdominal bleeding. He's being prepped for urgent surgery. His male lover arrives stating that John would not want heroic surgery or to be admitted to the ICU. John's 20yo son arrives, is angry at the presence of the lover and exclaims everything should be done for his father, and he'll sue if it's not.

How comfortable are you with this situation and how you will proceed?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Regarding who will be John's surrogate, which is the correct answer?

a. The lover has the legal right to act as John's surrogate based on his personal relationship with John.
b. Washington law states that in this circumstance where there is conflict over lifesaving care, a court appointed guardian should provided substituted judgment for John.
c. According to WA state law, the patient's ex-spouse should be notified, as she would have the highest authority for surrogate decision-making.
d. Washington state law states that if no durable power of attorney is available, and there is no spouse, children who are least 18 years of age would be the surrogate decision makers. Therefore, John's son would act as his surrogate.

**7.** Tim, a Pfizer pharm. rep. routinely visits the clinic, and provides donuts, muffins, pens and books to staff & residents in the break room. He invites you to a talk on "Advances in the treatment of Osteoporosis" which will by at the Hyatt's 5 star steak house.

How comfortable are you with the legal and ethical stipulations regarding gifts from pharmaceutical representatives?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Which is the correct response regarding how you should respond to Tim?

a. If you are certain that pharmaceutical detailing does not affect your prescribing habits, it would be appropriate to attend the talk.
b. Federal law prohibits you from attending such a talk if the cost for your attendance was in excess of $40. If your meal costs less than this, it would be permissible for you to attend.
c. There is no evidence that pharmaceutical detailing affects provider prescribing habits. Therefore you can comfortably attend the dinner.
d. There are specific laws for federal employees regarding receiving gifts from companies like pharmaceutical companies, and if those laws are violated, you could be punished.

**8.** A 72yo Japanese speaking woman came to the U.S. 10 years ago with her family; she develops weakness, nausea and a 15- pound weight loss. Her son tells you, "in case you find cancer, we prefer that she not be told. That is the way with our older people." She's found to have acute lymphocytic leukemia, which has a 5% response rate to chemo.

How comfortable with the son's request and how you will respond?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Which is the most appropriate response regarding the son's request?

a. There is general consensus in the field of medical ethics that truth telling trumps the notion of benign deception, so the mother should be told her diagnosis.
b. Based upon the 1990 Patient Self Determination Act, federal law requires that the patient be informed of her diagnosis, so that she can make appropriate healthcare decisions.
c. Patient autonomy is the fundamental principle in this case. Based upon patient autonomy, you have a duty to inform her of any important medical information.
d. Some cultures do not hold truth telling in as high regard as western cultures. It would be reasonable to ask the patient if she wants to know the details of her diagnosis. If she doesn't, it would be reasonable not to provide full disclosure.

**9.** A 21yo female went to a party where she ingested both Valium and large quantities of alcohol. She suffered a cardiopulmonary arrest and was resuscitated after 20 minutes. After a protracted hospital stay she's determined to be in a persistent vegetative state. Her family is uncertain if the feeding tube should be removed, and they ask your opinion as the family's physician.
How comfortable are you in discussing this situation and the advice you would give?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Which landmark case(s) set the precedent on how to advise this young lady's family?

a. Tarasoff
b. Cruzan and Quinlan
c. Quill v. New York
d. Roe v. Wade

**10.** A 25yo G1 female is in active labor at term. Her problem list says she has a needle phobia, and her birth plan includes no IV's. A severe fetal bradycardia develops, not relieved with standard maneuvers. An urgent C/S is necessary. The patient refuses to get an IV in preparation, and exclaims, "F- the baby, I'm not getting an IV!" You're the attending family physician managing her labor to this point.

As the attending, how comfortable are you with this situation and how you will respond?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Regarding this situation, which statement is most true?

a. The patient has the legal right to privacy regarding reproductive issues, so she cannot be compelled to get an IV or the C/S if she chooses.
b. The competing principles most relevant to this case are the principles of autonomy vs. beneficence.

c. Roe V. Wade declared the fetus has no rights as a person, and therefore if the patient chooses not to have a C/S, and the child dies, the patient has acted lawfully.
d. You and the consulting obstetrician and anesthesiologist have a duty to protect the life of the fetus. She should therefore be forced to get an IV.

## Comments Section:

Please indicate your year in training:

a. Intern
b. Second year resident
c. Third year resident
d. Staff physician

1. How well has your training in this residency program prepared you to address issues similar to the ones presented in the questionnaire?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all | | | | somewhat | | | | | extremely well |

General comments: _____

_____

_____

2. How valuable would an ethics curriculum be that addressed issues similar to those presented in the questionnaire?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all valuable | | | | somewhat valuable | | | | | very valuable |

Please provide any general comments you have regarding this tool that may improve its use in the future.

_____

_____

_____

**Thanks so much for completing this questionnaire!! ☺**

# Medical Ethics Curriculum for Resident Physicians
# Post Test & Curriculum Evaluation

The included questionnaire is a post-test for the medical ethics curriculum and an evaluation tool for the curriculum. Please be candid in your comments and rating of the curriculum. Any input you provide will greatly improve the educational experience in medical ethics for incoming house staff.

Thanks so much for taking time to complete the assessment. Please drop it in the mailbox of the assigned staff when completed.

# Medical Ethics Curriculum Questionnaire

**1** Mrs. S. is a 65yo female with advanced stage Parkinson's dementia. She is bed bound, and cannot effectively swallow food or liquids by mouth. She is currently admitted with her 2nd bout of aspiration pneumonia. You discuss palliative care options with the husband, a devout Catholic. He and his wife had not previously discussed end of life issues. You explain that a feeding tube would not prolong his wife's life because of the continued risk of aspiration. You recommend antibiotics, then palliative care after discharge. He insists on placing a feeding tube.

How comfortable are you with the husband's request and how to respond to it?

1 2 3 4 5 6 7 8 9 10

| | | |
|---|---|---|
| not at all comfortable | somewhat comfortable | extremely comfortable |

What do you think affected the husband's decision the most?

a. His religious beliefs and certain assumptions about life and death (his worldview).
b. He doesn't believe the evidence you presented to him.
c. He is certain he knows what his wife would have wanted, and he is exercising reasoned substituted judgment.
d. He didn't understand the facts you presented to him.

**2.** A 45yo male with moderately severe multiple sclerosis is following up in your office after being discharged for recurrent pneumonia. He uses arm crutches and will likely need a wheel chair within the next year. He says to you, "Doc. I am really getting sick and tired of living with this damn disease. I think I'm ready to end it all." He goes on to ask you to prescribe him a lethal dose of narcotics, which he would like to take himself at home.

How comfortable are you with the patient's request, and how you would respond to it?

1 2 3 4 5 6 7 8 9 10

| | | |
|---|---|---|
| not at all comfortable | somewhat comfortable | extremely comfortable |

The patient's request is an example of which of the following?

a. A request for passive euthanasia
b. A request for physician assisted suicide
c. A request of active euthanasia
d. A request for palliative care

**3.** The ER physician calls you to evaluate a patient. He is a 5yo boy, and his parents are devout Christian Scientists. The boy has newly diagnosed type 1diabetes and is in diabetic ketoacidosis with moderately severe dehydration. His parents refuse IVF & insulin for their child and would like to take him to their religious leaders for prayer and healing.

How comfortable are you with the parent's request, and how you will respond?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

What is the correct answer regarding this situation?

a. The parents have the legal right to refuse care for their child, and should be allowed to leave with their son.
b. The parents have the legal right to refuse care for their child, but the hospital should contact the ethics committee for an emergency consult for assistance in persuading the parents to have their son admitted.
c. An urgent court order should be sought for temporary guardianship. The judge will rule in favor of treatment for the child based on the "best interest standard."
d. Legal precedent has shown that if a court order is sought, it will likely be rejected by the judge, and it will put the hospital at risk for a civil lawsuit.

**4.** A 40yo businessman who you know well sees you in the office. He admits to visiting a prostitute while in Thailand. His HIV test returns positive. He requests that you do not tell his wife or anyone else about the test.

How comfortable are you with the man's request and how you should respond?

1 2 3 4 5 6 7 8 9 10

not at all comfortable — somewhat comfortable — extremely comfortable

a. Patients with HIV have the right to keep their diagnosis confidential, and this right is protected in all 50 states
b. The state of Washington requires that you report the case to the state health department within one week. It's up to the state health department to notify any partners.
c. There are currently no reporting laws for HIV in the state of Washington, but there are in 33 other states. The principle of justice would oblige you to urge the man to inform his wife.
d. Washington state law requires you to report the positive results to your local health department in 3 days, and that you assume responsibility for discussing partner notification or you should request assistance from the health department.

**5.** You recently prescribed an oral contraceptive to a 16yo female. She expressed to you that she didn't want her parents to know. The following week the mother has an appointment with you. During the appointment, she is suspicious about her daughter's visits to see you and wants to discuss the issue with you.

How comfortable are you with this situation and what you will say to the mother?

1 2 3 4 5 6 7 8 9 10

not at all comfortable — somewhat comfortable — extremely comfortable

What is the correct answer regarding this situation?

a. Because the patient is taking oral contraceptives, she is considered an emancipated minor by federal law, and you cannot tell the mother about the prescription.
b. Certain states have laws protecting minors' reproductive privacy. You will need to determine the state's laws regarding what must remain confidential.
c. The principle of autonomy and first amendment rights to privacy preclude you from informing the mother about the prescription.
d. The girl still lives with her parents; therefore federal law requires the parents to be informed of all reproductive healthcare interventions by the physician.

**6.** John, a 42yo male, is brought to the ED after an MVA; he's unstable with abdominal bleeding. He's being prepped for urgent surgery. His male lover arrives stating that John would not want heroic surgery or to be admitted to the ICU. John's 20yo son arrives, is angry at the presence of the lover and exclaims everything should be done for his father, and he'll sue if it's not.

How comfortable are you with this situation and how you will proceed?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Regarding who will be John's surrogate, which is the correct answer?

a. The lover has the legal right to act as John's surrogate based on his personal relationship with John.
b. Washington law states that in this circumstance where there is conflict over lifesaving care, a court appointed guardian should provided substituted judgment for John.
c. According to WA state law, the patient's ex-spouse should be notified, as she would have the highest authority for surrogate decision-making.
d. Washington state law states that if no durable power of attorney is available, and there is no spouse, children who are least 18 years of age would be the surrogate decision makers. Therefore, John's son would act as his surrogate.

**7.** Tim, a Pfizer pharm. rep. routinely visits the clinic, and provides donuts, muffins, pens and books to staff & residents in the break room. He invites you to a talk on "Advances in the treatment of Osteoporosis" which will by at the Hyatt's 5 star steak house.

How comfortable are you with the legal and ethical stipulations regarding gifts from pharmaceutical representatives?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Which is the correct response regarding how you should respond to Tim?

a. If you are certain that pharmaceutical detailing does not affect your prescribing habits, it would be appropriate to attend the talk.
b. Federal law prohibits you from attending such a talk if the cost for your attendance was in excess of $40. If your meal costs less than this, it would be permissible for you to attend.
c. There is no evidence that pharmaceutical detailing affects provider prescribing habits. Therefore you can comfortably attend the dinner.
d. There are specific laws for federal employees regarding receiving gifts from companies like pharmaceutical companies, and if those laws are violated, you could be punished.

**8.** A 72yo Japanese speaking woman came to the U.S. 10 years ago with her family; she develops weakness, nausea and a 15- pound weight loss. Her son tells you, "in case you find cancer, we prefer that she not be told. That is the way with our older people." She's found to have acute lymphocytic leukemia, which has a 5% response rate to chemo.

How comfortable with the son's request and how you will respond?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Which is the most appropriate response regarding the son's request?

a. There is general consensus in the field of medical ethics that truth telling trumps the notion of benign deception, so the mother should be told her diagnosis.
b. Based upon the 1990 Patient Self Determination Act, federal law requires that the patient be informed of her diagnosis, so that she can make appropriate healthcare decisions.
c. Patient autonomy is the fundamental principle in this case. Based upon patient autonomy, you have a duty to inform her of any important medical information.
d. Some cultures do not hold truth telling in as high regard as western cultures. It would be reasonable to ask the patient if she wants to know the details of her diagnosis. If she doesn't, it would be reasonable not to provide full disclosure.

**9.** A 21yo female went to a party where she ingested both Valium and large quantities of alcohol. She suffered a cardiopulmonary arrest and was resuscitated after 20 minutes. After a protracted hospital stay she's determined to be in a persistent vegetative state. Her family is uncertain if the feeding tube should be removed, and they ask your opinion as the family's physician.

How comfortable are you in discussing this situation and the advice you would give?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Which landmark case(s) have set the precedent on how to advise this young lady's family?

a. Tarasoff
b. Cruzan and Quinlan
c. Quill v. New York
d. Roe v. Wade

**10.** A 25yo G1 female is in active labor at term. Her problem list says she has a needle phobia, and her birth plan includes no IV's. A severe fetal bradycardia develops, not relieved with standard maneuvers. An urgent C/S is necessary. The patient refuses to get an IV in preparation, and exclaims, "F- the baby, I'm not getting an IV!" You're the attending family physician managing her labor to this point.

As the attending, how comfortable are you with this situation and how you will respond?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all comfortable | | | | somewhat comfortable | | | | | extremely comfortable |

Regarding this situation, which statement is most true?

a. The patient has the legal right to privacy regarding reproductive issues, so she cannot be compelled to get an IV or the C/S if she chooses.
b. The competing principles most relevant to this case are the principles of autonomy vs. beneficence.

c. Roe V. Wade declared the fetus has no rights as a person, and therefore if the patient chooses not to have a C/S, and the child dies, the patient has acted lawfully.
d. You and the consulting obstetrician and anesthesiologist have a duty to protect the life of the fetus. She should therefore be forced to get an IV.

## Evaluation and Comments Section:

Please indicate your year in training:

a. Intern
b. Second year resident
c. Third year resident
d. Staff physician

1. How well has your ethics training in this residency program prepared you to address issues similar to the ones presented in the questionnaire?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all | | | | somewhat | | | | | extremely well |

1. How valuable has the medical ethics curriculum been for you personally and professionally?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| not at all valuable | | | | somewhat valuable | | | | | extremely valuable |

General comments: _____

_____

_____

_____

2. There have been about 13 seminars. About how many of the sessions have you been able to attend?

a. None of them
b. Less than half of them
c. More than half of them
d. Most of them
e. All of them

3. Regarding the frequency of the sessions, what are your thoughts about the amount of teaching in medical ethics?

a. There were too many sessions and there was too much emphasis on medical ethics in the residency curriculum
b. There were too few sessions, and there could be more emphasis on medical ethics in the residency curriculum
c. There were the right amount of sessions, and there was appropriate emphasis placed on medical ethics in the residency curriculum.

Please provide specific feedback regarding the curriculum:

_____

_____

_____

_____

_____

**Thanks so much for completing this questionnaire!! ☺**

# Appendix 1
## Assessing Professionalism
## Mini-Evaluation Exercise
## P-MEX Evaluation Forms

Assessing Professionalism continues to be a difficult task. The ACGME now expects residencies to have mechanisms in place to evaluate residents' professionalism. Faculty researchers at McGill University and the University of Toronto developed a professionalism evaluation tool modeled after the successful "mini CEX" used in evaluating residents. Their preliminary work was noted in the bibliography (Steinert et. al.), and they have recently completed a study (pending publication), utilizing the "P-MEX." The developers of the P-MEX graciously gave permission for their tool to be reproduced in this curriculum. It is reprinted below. It was originally developed by the creators to be a pocket tool, making it more user friendly. It has been reformatted to fit this curriculum's template. Email Dr. Richard Cruess (richard.cruess@mcgill.ca) or Dr. Yvonne Steinert (Yvonne.steinert@mcgill.ca) for further information or for permission to obtain the pocket version.

**GUIDELINES FOR USING THE P-MEX**

The Professionalism Mini-Evaluation Exercise (P-MEX) focuses on the healing and professional behaviours that students/residents demonstrate in various settings during their daily professional activities. It is designed to be easily implemented and to encourage early feedback. It is to be used following an observation of a minimum of 15-20 minutes of a student/resident activity. This assessment will become part of the student's/resident's permanent record and is meant to encourage feedback.

**FORM AND RATING SCALE**

For each encounter, each behaviour should be categorized utilizing the following rating scale. Utilize the **N/A (not applicable)** category if the behaviour was **not observed** or if the category is **not applicable** to the setting.

| Rating | Description of Behaviour |
|---|---|
| **Un**acceptable | Lapses of professional behaviour that are intentional, are likely to harm, and for which there are no mitigating circumstances. |
| **BEL**ow expectations | Lapses of professional behaviour that are unintentional, result in minimal to no harm, or for which there may be mitigating circumstances. |
| **MET** expectations | Demonstrated the performance expected for the level of the student/resident. |
| **EXC**eeded expectations | Exceptional performance, demonstrating the behaviours expected of an outstanding physician-to-be. |

| | |
|---|---|
| **Critical Event** | A clear breach of professional boundaries. Documentation of a critical event is sent directly to the appropriate authority for immediate action. |

Please rate the student's/resident's performance during THIS encounter: **UN**acceptable, **BEL**ow expectations, **MET** expectations, **EXC**eeded expectations, **N**ot **A**pplicable.

**PROFESSIONALISM MINI-EVALUATION EXERCISE**

Evaluator:_____
Student/Resident:_____

Level: (please check) **3rd yr 4th yr res 1 res 2 res 3 res 4 res 5**
Setting: **Ward Clinic OR ER Classroom Other**_____

| | N/A | UN | BEL | MET | EXC |
|---|---|---|---|---|---|
| Listened actively to patient | | | | | |
| Showed interest in patient as a person | | | | | |
| Recognized and met patient needs | | | | | |
| Extended him/herself to meet patient needs | | | | | |
| Ensured continuity of patient care | | | | | |
| Advocated on behalf of a patient | | | | | |
| Demonstrated awareness of own limitations | | | | | |
| Admitted errors/omissions | | | | | |
| Solicited feedback | | | | | |
| Accepted feedback | | | | | |
| Maintained appropriate boundaries | | | | | |
| Maintained composure in a difficult situation | | | | | |
| Maintained appropriate appearance | | | | | |
| Was on time | | | | | |
| Completed tasks in a reliable fashion | | | | | |
| Addressed own gaps in knowledge and/or skills | | | | | |
| Was available to colleagues | | | | | |
| Demonstrated respect for colleagues | | | | | |
| Avoided derogatory language | | | | | |
| Maintained patient confidentiality | | | | | |
| Used health resources appropriately | | | | | |

► Please rate this student's/resident's overall professional performance during THIS encounter: UNacceptable MET expectations

BELow expectations EXCeeded expectations

► Did you observe a critical event? no yes (comment required)

| Comments: |
| --- |
| |

Evaluator's signature:_____
Student's/Resident's signature: _____
Date & Time:_____

## GUIDANCE FOR EVALUATORS

Most students/residents will on most occasions "meet expectations". Some will demonstrate behaviours which exceed expectations on selected occasions. A few individuals will consistently demonstrate behaviours which exceed expectations.

Individuals may, at times, demonstrate behaviours which are "below expectations". It is extremely important to identify these occasions, because if they occur frequently, remedial action may be necessary. Behaviours classified as "unacceptable" will always require remedial action.

## EVALUATING BEHAVIOURS

It is believed that the behaviours on the evaluation form are self-evident and that descriptors are not necessary. However, each behaviour observed must be placed in the context of the person, the situation, and the potential for harm caused by behaviours that deviate from the norm. For example, being late on a single occasion could either be acceptable, below expectations, or unacceptable

depending upon the context. If the student/resident is late because they were giving patient care in an emergency situation it may be acceptable, while if they are late for frivolous reasons, it is not.

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