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Virtual Mentor

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From the Editor Whose Values?

There is a moral component in the decision to enter the field of medicine, or at least an argument can be made that there ought to be. There are much easier ways to make a living—ways that do not involve years of education, mountains of debt, and a lifetime of helping people through their most difficult days. The medical school applicant's personal statement is a prospective physician's first attempt at showing his or her commitment to the values of medicine. Indeed, medical students around the country are quick to criticize colleagues who seem to have gone into medicine "for all the wrong reasons."

People enter medicine out of concern for the sick and, for the more ambitious of them, the betterment of society as a whole. These values are critical to maintaining high standards of professionalism in the medical community. They are the values that have earned medicine its reputation as a noble profession.

But medicine is not an insulated profession, and the question of how to help the sick is becoming an increasingly complex one. Growing political debates over stem cell research, abortion, end-of-life care, and a host of other moral concerns surround the practice of medicine. For better or worse, debates about these topics are not restricted to the political arena. The conflicts of values these subjects reflect often arise in the most private of relationships—the delicate encounters between a patient and physician.

As the push away from paternalism and toward patient autonomy continues, conflicts of values take on greater meaning. More attention is being paid to the power differential between physicians and patients and to the potential of a paternalistic relationship to subvert a patient's sense of his own best interest. As patients become more vocal partners in the clinical encounter, the physician's once-unquestioned values are being challenged by patients, and sometimes there is no apparent common ground.

What is a physician's role in this complicated medical landscape of shared decision making when interpersonal value conflict arises? What happens when a patient's values and the health care choices that stem from them are at odds with the values of a physician? Is it ethical for a physician to opt out of treating a patient with conflicting beliefs? More pragmatically, can a physician rightfully use his or her authority to influence not only the behaviors but also the values and beliefs of patients?

Physicians may wish the best for their patients, but there is a great deal of subjective judgment wrapped up in one's notion of "the best." This issue of *Virtual Mentor* considers those moments when physicians and patients disagree, on moral grounds, about the desired course of treatment. It draws from a diverse group of experts in the health care profession in an attempt to shed light on these difficult medical conflicts.

In the first case commentary, Drs Kelly Brownell and Rebecca Puhl look specifically at the effects that societal and, more specifically, physician bias can have on the treatment of obese patients. In case 2, Dr Jack Drescher reminds us that the conduct of a physician who refuses to accept patients for who they are may diminish their willingness to seek medical care in the future. Commenting on the same case, Dr Andrew Fergusson urges physicians not to lose sight of the whole patient in their rush to treat what they think is the problem. Commenting on the final case, Dr John Lorenz explores how 2 rational parties can arrive at different decisions, and he considers the ethical obligations of physicians who find themselves at odds with the wishes of surrogate decision makers.

In this month's journal discussion, Helen Harrison takes a hard look at a quality-of-life study of people with severe disabilities and asks difficult questions about the quality-of-life assessments that physicians and patients make. Dr Sayantani DasGupta's contribution to the medical education section explains the Columbia University Community Pediatrics Program's unique approach to teaching cultural responsiveness, suggesting that many of the conflicts that arise in clinical settings are rooted in cultural or religious misunderstandings rather than in true clashes of values. In the clinical pearl, Drs Nicholas Fitzsimons and Stephen Freedland share expert opinions on the screening, diagnosis, and treatment of prostate cancer in obese men.

The remainder of this issue looks at some broader consequences of value conflicts in the clinical setting. Dr Mahendr Kochar examines the commitments physicians make when choosing to enter medicine and expresses the belief that those commitments take priority over personal values. Dr June McKoy compares the public defender's professional obligation to serve indigent clients who need representation with the absence of a similar professional obligation for physicians. In the law and medicine section, Allison Grady examines the conscience clause movement, focusing on the efforts taking place in the state of Michigan.

Finally, in the op-ed section, Dr Paul Hoehner questions physicians' ability to practice value-neutral medicine, and Rebecca Cook and Bernard Dickens consider the use, and perhaps abuse, of "conscientious objection" as a way to avoid performing professional services that would violate one's personal beliefs.

Values, be they religious or secular, are integral to a physician's commitment to his or her patients. As long as there are diverse beliefs and cultures, there will be at least occasional clashes of values in the clinical encounter. It is my hope that considering these difficult conflicts will contribute to the discussion of values in medicine. I would like to thank all of the contributors to this issue for their expertise and wisdom. Their

contributions are an excellent starting point that will enhance our ability to provide care for an increasingly diverse patient population.

Manish Tushar Raiji

Second-year medical school student at Michigan State University in East Lansing.

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Clinical Case

Stigmatized Patients' Right to Equal Treatment

Commentary by Kelly D. Brownell, PhD, and Rebecca M. Puhl, PhD

Travis Jones had always been healthy, a high school athlete and active in outdoor landscaping before becoming owner of the business. When he began to work full-time in the office, however, the long hours and decrease in physical activity began to take a toll. At 50 Travis weighed 284 pounds. For years, his physician, Dr Kowey, had urged Travis to exercise more and change his diet in order to avoid many of the health complications associated with severe obesity. When Travis's lipid profiles began to change for the worse, Dr Kowey had a serious heart-to-heart with him. Travis acknowledged his need to lose weight and be more concerned about his health, but admitted that he often couldn't force himself to refuse good food. "Hell, doc," he said, "who wants to live to be 100 on a diet of shredded wheat and trail mix? If I can't have a decent burger and a few beers from time to time, what's the use of living?"

Dr Kowey noted Travis's lack of commitment to losing weight in his medical record and became increasingly frustrated. At one annual physical, Travis's PSA had increased to 4.5. Dr Kowey performed a digital rectal exam, and, when that indicated no change in the prostate, he suggested that they continue to monitor Travis's PSA carefully.

Two years after the first elevated serum level, Travis's PSA level was 7.5—high enough to warrant a needle biopsy. When the pathology report came back, Dr Kowey called Travis in to inform him that he had a moderately differentiated prostate cancer with a Gleason score 4.

Dr Kowey explained to Travis that, along with increased cardiovascular risks, obesity was also a risk factor for a variety of cancers, including prostate cancer. "Since you are at such high risk for a variety of different dangerous diseases, I'm going to suggest we watch and wait. In the meantime, I want you to commit yourself to losing weight. Then we'll discuss surgery and other options."

Shaken by the news of his diagnosis, Travis set up a diet based on what Dr Kowey had been urging him to do for so long and even established a mild exercise regimen. He also researched prostate cancer on the Internet and was concerned to see that, at age 52, he was more likely to have an aggressive form of prostate cancer. Though he found a "watchful waiting" approach mentioned in several places, he got the impression that such therapy was reserved for older patients with less aggressive cancers.

During his next visit, Travis told Dr Kowey about his diet and exercise and then brought up the research findings he had discovered on the Internet. Dr Kowey was surprised and pleased. “Well,” he said. “The news seems to have jolted you into taking some responsibility for your own health.”

Commentary

Health care cannot be delivered free of values and cultural opinions about patients who belong to certain groups. Try as we might to steer clear of cultural biases that influence the way we provide care, each health care professional holds social attitudes that affect all patients. These attitudes may lead to decisions by individual clinicians or by systems such as Medicare, managed-care organizations, and insurance companies that have consequences in the real world of individual patients. Because cultural norms and values affect clinical decision making, treatment for many conditions varies depending on who has the condition and who is treating it. It has long been known that a significant number of women receive different care than men with the same clinical diagnosis; the poor are known to be treated unlike the affluent for the same disorder; people stigmatized by conditions such as AIDS and alcoholism often receive different care for unrelated health problems than those without AIDS or alcoholism who seek care for the same problems. Clinicians like Dr Kowey in this case, are only human, so we must ask whether the care Travis receives is compromised by his stigmatized condition.

Despite clearly documented biological and environmental influences on the etiology of obesity [1], many members of society—including many physicians—believe that weight is entirely under personal control, that failure at weight loss represents personal failing, and that obese people “get what they deserve and deserve what they get.” This bias has been shown to influence employment decisions, how obese individuals fare in the education system, the treatment obese children receive at the hands of their peers, and opinions that health care professionals have about obese patients [2]. Research shows a very strong anti-fat bias in general society, even among health care professionals who specialize in the treatment of obesity (although the bias among this group is somewhat lower than the norm) [3]. If society believes that obese people deserve their condition and are responsible for changing it, it follows that empathy will be low and decisions such as making medical care contingent on weight loss, perhaps in the absence of a medical justification, will be inevitable.

It is often the case that the values and priorities of patients (eg, whether to stop smoking or change lifestyle to reduce stress) differ from those of their physicians. Such is the case with Dr Kowey and Travis, where the former sees the benefit from restricted eating and the latter sees only deprivation. These differences get negotiated between patient and practitioner, and in some cases patients make the major changes physicians ask of them. What is most interesting about the Koweys and Trivises of the world is whether the quality of care is the same no matter who has the condition. In the case of obesity, research suggests this might not be true [4].

Think for a moment about gastric bypass surgery. It is only recently that insurance has paid for this procedure at all, and coverage is still spotty. There is evidence of impressive health gains from the surgery, and no alternative medical intervention

provides anywhere near the benefit [5]. If one were to create a list of all surgeries, rank their benefit by improvements in health status and quality of life, and then cross that metric with cost, we suspect (but have not investigated) that obesity surgery is covered far less often than the cost-benefit numbers would justify.

Orthopedic surgeons sometimes tell obese patients they must lose weight prior to surgery. This seems reasonable at first glance—weight loss might improve recovery, but has this been proven, and does a condition that inhibits (but does not prevent) recovery justify withholding the otherwise needed medical care? Smoking, heavy drinking, and physical inactivity are risk factors for countless diseases, but do physicians demand that people stop smoking or drinking and begin exercising before providing care? Something is unique in the way modern medicine deals with obesity, creating conditions in which patients are sometimes required to “earn” the right to health care services that others receive routinely.

The alarming fact is that obese people may avoid and delay important health care services due to bias by their providers [6]. Whether bias causes embarrassment or humiliation at being overweight or whether it takes the form of disrespectful treatment and negative attitudes, it creates barriers to health care. It is possible that a person like Travis would delay care and seek treatment only when his symptoms were more advanced; then he would be perceived as a person who had “let himself go.” This assumption could result in a physician’s feeling justified in offering qualified care or making care contingent upon patient behavior.

Persons told to lose weight as a condition for care receive a clear and decisive message—something is wrong with them, medical problems are their fault, and, in order to earn the care others receive, they must do something that seems impossible for them to do (lose weight and keep it off). Obese people are aware of these messages, at some level, which may help explain why they are reluctant to get preventive care. One can envision a maladaptive cycle in which obese people avoid care, become sicker as a consequence, are told to lose weight to receive care, cannot do so, avoid care further, and end up with illness rates beyond what might be caused by their weight.

The most serious problems arise when people or institutions conclude that weight is a simple matter of personal control and make medical decisions grounded in bias. The poor success rates of weight loss programs are well known, so making care conditional on weight loss might be likened to asking a poor person to get rich before receiving care (because poverty brings risk for many diseases and is a barrier to response to treatment). A physician who tells a client to lose weight, and then has a rare person like Travis successfully do so (at least in the short term), receives reinforcement for this unfair practice and may demand this low-probability event as a condition of care for other patients.

Dr Kowey can implement a range of strategies to help minimize weight bias while still emphasizing the importance of lifestyle changes among his overweight and obese patients. An important first step is to develop self-awareness of biased attitudes that could unintentionally affect the health care decisions he makes. Asking the following

questions may be useful in this process: (1) Do I make assumptions about a person's character, health status, or lifestyle behaviors based only on his or her weight? (2) Am I comfortable working with people of all shapes and sizes? (3) Do I give appropriate feedback to encourage healthy behavior changes? (4) Do I treat the individual or the condition?

There are also bias-reduction strategies that can be integrated into treatment approaches for obesity. An important goal for physicians is to reinforce healthy behaviors rather than focusing on the amount of weight loss needed. This allows patients to feel empowered to take charge of their health through modifiable lifestyle changes. Other strategies include:

- Acknowledge the difficulty of achieving sustainable, significant weight loss.
- Recognize the complex etiology of obesity and its multiple contributors.
- Approach patients with sensitivity and empathy, recognizing that they may have had previous experiences of weight bias in health care settings.
- Explore all causes of presenting problems, in addition to body weight.
- Recognize that many obese patients have tried to lose weight repeatedly.
- Emphasize the importance of behavior changes rather than weight.
- Recognize that small weight losses can result in meaningful health gains.

The honorable goal of modern medicine—to provide care for all who need it—should prevail over nonmedically relevant characteristics. Eliminating bias entirely may be impossible, but it is important to try. Specific health care practices, and what is covered by third parties, should be free of bias based on weight. Some progress is being made on this front. With millions of people burdened by excess weight, we hope progress can be accelerated.

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Kelly D. Brownell, PhD, is chair and professor in the Department of Psychology at Yale University, professor of epidemiology and public health, and director of Yale's Rudd Center for Food Policy and Obesity.

Rebecca M. Puhl, PhD, is coordinator of Community and Weight Stigma Initiatives at the Rudd Center for Food Policy and Obesity at Yale University.

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Clinical Case

Physician Values and Clinical Decision Making

Commentaries by Jack Drescher, MD, and Andrew Fergusson, MB, MRCP

Karl Harris is a relatively new patient in Dr Breck's practice. Dr Breck knows that Karl, who is 20 years old, moved to the city from his rural hometown just over a year ago. Karl has been waiting tables and has talked about pursuing a college degree. He comes to Dr Breck's office complaining of a burning sensation when he urinates, but seems uncomfortable speaking about his chief symptoms.

During the course of the history, Dr Breck asks Karl about his sexual interactions. Karl is very hesitant to speak about this, but eventually admits that he has had several unprotected homosexual encounters in the past year. Dr Breck also asks Karl about his obvious anxiety, and Karl eventually opens up about how he left home soon after telling his family that he was homosexual. Karl states that his family was not at all supportive and that he immediately felt ostracized by his friends. He admits that much of their rejection was based on religious ideology. "I just couldn't take their constant judgment anymore, so I decided to leave," he says.

The physical examination leads Dr Breck to suspect an infection, possibly a form of gonorrhea. He takes a few samples for culture to confirm his clinical suspicion and places Karl on a course of ceftriaxone and azithromycin as initial therapy. Dr Breck schedules Karl for a follow-up visit to go over the lab results and "talk about some of the issues that might be affecting your physical, emotional, and spiritual health."

When the results of the cultures return, Dr Breck finds that Karl did have a gonococcal infection with a strain that is responsive to the antibiotic therapy he prescribed. Nonetheless, Dr Breck has his office staff confirm the follow-up appointment with Karl.

At that next appointment, Karl is relieved that his symptoms are resolving. At that point, Dr Breck brings up his concerns about Karl's sexual behavior and speaks about blood testing for HIV and hepatitis C. Karl seems hesitant to have any blood tests, stating that "no one I have been with would have any of those diseases."

Dr Breck then brings up the issue of Karl's family and their response to his sexuality. "I understand that your experimentation with homosexuality has caused a major rift between you and your family," Dr Breck says, suggesting that his parents' reaction was most likely "one of shock at seeing a child lose his way." Dr Breck then recommends

that Karl see Dr Talbert, a local psychotherapist and personal friend of Dr Breck's, well known for his work in "conversion therapy"—counseling interventions focused on eliminating homosexual thoughts and behaviors.

Commentary 1

by Jack Drescher, MD

During his visit with Dr Breck, Karl revealed a fact related to his medical problem: he is a sexually active gay man. But being gay is a secret so volatile that its revelation to his family and friends (colloquially referred to as "coming out of the closet") led to strong judgmental responses and Karl's ultimate decision to leave home.

Given the "religious ideology" of Karl's background, it is reasonable to presume that his understanding of sexuality is limited. For example, it is likely that he does not know how to use a condom, has had little sex education, and was advised to remain abstinent until marriage. Frank conversations about same-sex behaviors were probably out of the question, with such activities strongly discouraged by quotes from Leviticus and threats of punishment in the afterlife.

But now, estranged from his lifelong support system and with limited tools or knowledge of the wider world—for example, he thinks he can spot someone with hepatitis or HIV—20-year-old Karl contracts an STI and he seeks a physician's help. Dr Breck conscientiously takes a sexual history, makes a diagnosis, and prescribes appropriate antibiotic treatment. He also encourages Karl to undergo further testing for other STIs. In a follow-up visit, Dr Breck expresses concern about Karl's "major rift" with his family and their "shock at seeing a child lose his way." He refers Karl to a "conversion" therapist who claims to change sexual orientations.

Is it ethical for Dr Breck to interject his own values (strong identification with his adult patient's parents antihomosexual beliefs) into this clinical encounter?

No physician can claim to practice value-free medicine. Undoubtedly, physicians are raised with values, religious or otherwise, that shape their decisions to become professional caretakers. Their training is further influenced by professional values, embodied in the Hippocratic Oath, the Oath of Maimonides, and the AMA's Principles of Medical Ethics. In addition, mainstream practitioners choose evidence-based, as opposed to faith-based interventions—another medical decision that cannot be viewed as value neutral. Consequently, I think it unreasonable, if not impossible, to ask physicians to practice "value-free" medicine.

Nevertheless, while being aware of our own values, we must also respect those of our patients, even those with which we might disagree. Otherwise, there is a risk that our personal values may interfere with medical judgment. How this happened in Dr Breck's case requires a brief, sociocultural analysis of contemporary debates about homosexuality.

Attitudes toward Homosexuality

Today's moral and legal debates about homosexuality are embedded in the "culture wars" whose opposing sides argue either that (1) homosexuality is normal and acceptable or that (2) homosexuality is neither normal nor acceptable.

The first position I call a *normal/identity* model [1]. It regards homosexuality as a normal variation of human expression, analogous with left-handedness, and views a homosexual orientation as a distinguishing feature of a gay or lesbian identity. Acceptance of this position is an outgrowth of the 1973 American Psychiatric Association (APA) decision to remove homosexuality from its diagnostic manual (DSM) [2]. Following the APA decision, shifting cultural perspectives had medical support: if homosexuality is not an illness, and if one does not literally accept biblical prohibitions against homosexuality, and if gay people are able and prepared to function as productive citizens, then what is wrong with being gay? The normal/identity view is accepted by the American Medical Association, national, state, and local governments that provide civil rights protections for gay people, and religious denominations that sanctify same-sex relationships.

Some segments of society strongly oppose homosexuality's removal from the DSM. They advocate an *illness/behavior model* that regards any open expressions of homosexuality as either (1) behavioral symptoms pathognomonic of psychiatric illness; (2) a moral failing; or (3) some combination of the 2. This position, that illness or immorality cannot provide a foundation for creating a normal identity, is held by "conversion" therapists and religious and political groups opposed to the normalization of homosexuality. While the mental health mainstream has depathologized homosexuality, sexual conversion therapists criticize the mental health and medical fields and believe individuals can modify their behavior to reflect a more acceptable heterosexual norm. Their arguments often dismiss scientific facts that disagree with religious dogma, focus on gaps in scientific knowledge to discredit the entire scientific enterprise, and confuse the general public about the current state of accepted scientific knowledge. Furthermore, the religious and social conservatives who market conversion therapies as a viable alternative to being gay seem to be unaware of, uninterested in, or dismissive of warnings of the possible harms such "therapy" can do [3-6].

Subscribing to the illness/behavior model, Dr Breck refuses to perceive Karl as gay—an identity. Instead, he refers to Karl's "experimentation with homosexuality"—a behavior. Dr Breck's advice is an attempt to convince Karl to change his sexual orientation. (The question of whether such treatments are either effective or ethical is not the focus of this discussion.) From the illness/behavior perspective, Karl can reduce his risk of contracting STIs, and perhaps be reunited with his family and religious community by changing his homosexual "behavior." A physician who believes homosexuality is a sin, an illness, or both, might reasonably believe he has discharged his professional duties by challenging the patient's sexual identity. However, in choosing Karl's homosexuality rather than unsafe sexual practices as the object of the therapeutic intervention, Dr Breck provides 2 examples of poor practice.

The majority of HIV cases worldwide are heterosexually transmitted, yet we do not advise heterosexual patients to change their orientation to avoid AIDS (or other STIs). Counseling gay patients to change their sexual orientation to avoid disease is both a form of medical excess and poor public health policy. The more prudent, medically conservative, and nonjudgmental alternative would have been to counsel Karl about safer sexual practices, including sexual restraint—just as one does with a heterosexual patient.

A second example of poor practice stems from Dr Breck's imposing his own antihomosexual beliefs on the patient. Karl has already left family and friends who do not accept him as gay. Why would a physician who barely knows the patient use his medical authority in this way? One possible outcome of this intervention is losing Karl to follow-up and, perhaps, Karl's avoidance of future medical treatment. There may be other consequences as well. In February 2006, a lesbian patient sued her Florida doctor's practice for giving her unsolicited religious, antigay literature [7].

Physicians, like everyone else, are entitled to their personal and religious beliefs. But physicians are constrained in the exercise of those beliefs by state laws and professional, ethical guidelines. In other words, our medical authority derives from secular, not religious sources. In this case, Dr Breck confused the 2 sources of his authority. Acting on personal beliefs led to an error in medical judgment and possible alienation of his patient.

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Jack Drescher, MD, is a training and supervising analyst at the William Alanson White Institute in New York City. He is adjunct clinical assistant professor at the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis and clinical assistant professor of psychiatry at State University of New York—Downstate (Brooklyn).

Commentary 2

by Andrew Fergusson, MB, MRCP

How frustrating it can be to have to comment when the material in the case history is sometimes so tantalizingly brief at key points. Those of us asked to respond will inevitably read into the gaps from our own presuppositions, and that of course is what this discussion on physician values in clinical decision making is all about.

When I was taking the membership examination for the UK Royal College of General Practitioners some 25 years ago, I was required to make in every primary care consultation a diagnosis with 3 elements: the physical, the psychological, and the social. As a committed Christian who often had to struggle with situations where patients' value systems conflicted with mine (though I would have faced other conflicts had I been a committed atheist) I wanted to add a fourth element: the spiritual. Since 1998 the World Health Organization has been encouraging physicians to do so.

Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith—in healing, in the physician and in the doctor-patient relationship. This reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope, and compassion in the healing process [1].

This rediscovery reminds us of the historic concept of the doctor-patient relationship, that it is a covenantal one which goes far beyond the merely contractual [2]. On the (regrettably) ever more dominant contract basis, the physician is reduced to being the garage mechanic of the human body, offering a menu of options with their prices and their penalties. The patient is the customer who selects the physical fix they most feel they want at that time. But the recent WHO guidance reinforces the traditional covenantal model, and there is now a renewed recognition that it is ethical to approach our patients' needs holistically.

The fictitious Dr Breck handled the initial physical diagnosis and treatment correctly, and I commend him for conscientiously taking a sexual history. Sadly some physicians are still too embarrassed to broach the topic. Unfortunately he did it in the wrong way. Beyond counseling Karl about “safer sexual practices, including sexual restraint” he should have explored the wider aspects of Karl's sexuality far more holistically. In the catchphrase of the famous British sociologist, Professor Margaret Stacey, who devoted much of her life to patient-physician relationships, Dr Breck is an example of those many doctors who “mean well, but do badly.”

As a profession we continually need to acknowledge that our corporate and individual assumptions, presuppositions, and biases need to be remembered and reviewed. After all, we might be wrong. And that is perhaps particularly true in the highly politicized field of sexual ethics. It should be obvious (though it often is not) that secular biases are as value-laden as the religious biases we attribute to Dr Breck. The imperative to review

and acknowledge the effects of our beliefs and values on patients binds all physicians—Dr Breck and those whose biases differ from his.

Let me end with Karl, because I think so far we have not really considered him adequately. He is the patient who came for help. He is the one who should be receiving compassion in the healing process. What approach best respects his autonomy? What approach most recognizes and increases his sense of dignity? It strikes me that, after the initial treatment of his infection, what this young man most needed was a good listening-to.

So far, it sounds like he's only had good talkings-to—from his family who were “not at all supportive,” his friends who “ostracized” him, from Dr Breck who uses the language of “major rift” and “shock” and possibly recommends “conversion therapy,” and, perhaps, from a gay community interested in recruiting members and molding their individual identity in order to maintain the community's corporate identity.

Letting Karl tell his story, and listening to him in a nonjudgmental way, would in itself have helped him to understand himself more and explore his options. If he then chose, in the way of fully informed consent, to continue living according to a value system that conflicted with the physician's, then the physician has to accept that. But at least their relationship would have some of that holism the WHO encourages, and would probably continue healthier for both of them.

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Andrew Fergusson, MB MRCP, is president of the Center for Bioethics and Human Dignity in Bannockburn, Illinois. He was a family physician in practice in a deprived area of London for 10 years. Human sexual ethics are beyond the scope of the Center's work, and these views, based around the concept of human dignity, are his own. He takes sole responsibility for them.

Related Article

[Patient Counseling and Matters of Conscience](#), May 2005

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Clinical Case

Disagreement over Resuscitation

Commentary by John M. Lorenz, MD

After trying for 4 years to have a child, Jane Craft and her husband, George, were thrilled when Jane became pregnant. The couple considered Jasmine a “miracle baby.” Just after her first birthday, Jasmine fell down the stairs of the family’s third-floor apartment and suffered serious head trauma. The injury, coupled with prolonged hypoxemia following the fall, left Jasmine with severe mental and physical handicaps—she was unable to walk or speak coherently, suffered from seizures, and lost her vision. Jane and George coped with this sudden, devastating situation as best they could, but caring for Jasmine was a hardship. George, a bank teller, began to work extra shifts to help pay for the medical bills. Jane left gainful employment so she could provide 24-hour care for Jasmine.

A year after Jasmine’s accident, Jane found that she was pregnant again. This time the pregnancy was not a uniformly joyous event; both Jane and George worried about how they would manage, financially and emotionally, having another child. With the help of George’s health insurance coverage, Jane was able to have routine visits with her obstetrician-gynecologist, Dr. Hearsh. Melanie Hearsh, who had overseen Jane’s first pregnancy and had become quite close to the Craft family, understood Jane’s concerns and had been thorough in monitoring this pregnancy.

Twenty-four weeks into her pregnancy, Jane felt a dull, aching pain in her stomach and lower back that quickly progressed to contractions. She called George at work and together they went by ambulance to the hospital. Terbutaline therapy was started immediately in an attempt to stop the contractions, but Jane soon developed severe hypotension, and therapy was discontinued. When Dr. Hearsh arrived at the hospital she had a chance to speak with the couple. She stated that, since Jane’s membranes had ruptured, it would be dangerous to continue trying to stall labor. She spoke at length with the Crafts about the prognosis for children born at 24 weeks; many of the possible outcomes reminded the Crafts of the limitations that Jasmine faced on a daily basis. The couple told Dr. Hearsh that unless the baby was born “alive and vigorous,” they did not want him to be resuscitated.

Jane was given oxytocin to induce labor, and Dr. Hearsh oversaw the birth of a 652-gram, cyanotic boy with a weak, slow heartbeat and an extremely slow respiratory rate. His Apgar score at 1 minute was 4. Dr. Hearsh was mindful of the Crafts’ wishes, but, as she stood there over the infant, she believed that it would be morally wrong to let him

die. She quickly intubated the baby and sent him to NICU, while informing George about the baby's status. He became both distraught and enraged. Half-crying, he demanded to know why the child had been resuscitated and requested that the breathing tube be removed immediately. When Dr. Heath went to check on Baby Craft, his Apgar scores had improved to a 6. Though he had moderately diminished reflexes, he seemed to Dr. Heath to be doing as well as other infants she had delivered at 24 weeks.

Commentary

Dr. Heath believed she was morally obligated to resuscitate Baby Boy Craft over the wishes of his parents. The Crafts, however, believed their decision to withhold resuscitation was morally acceptable. Assuming that both Dr. Heath and the Crafts employed a rational decision-making process and followed their consciences, how could they have reached such different conclusions? Was only 1 of these 2 alternatives morally acceptable or could both be? Ethical theory is a system of principles that provides a structured approach to moral reasoning and, thereby, directs and justifies decisions about what actions are morally acceptable. Was either Dr. Heath's or the Crafts' application of the relevant ethical principles flawed? Did the parties accept the same principles, but prioritize them differently? Moral dilemmas arise when ethical principles come into conflict and no decision is consistent with all the relevant principles; in such cases, the decision reached is the one that is most consistent with the principle(s) highly valued by the decision maker.

Relevant Ethical Principles

In searching for a "best" alternative, it is helpful to identify the ethical principles relevant to the decision about whether to withhold or withdraw neonatal intensive care. These are (1) beneficence/nonmaleficence, (2) the best interest standard for surrogate decision making, (3) sanctity of life, and (4) parental autonomy.

Beneficence/nonmaleficence. Health care professionals have a duty to minimize harms such as pain, suffering, disability, and death due to injury or disease and to promote well-being. The good to be promoted is health. Fulfillment of this duty requires judgments about the benefits and risks of various treatment options. In this case, the benefits and risks of intensive care must be weighed against the benefits and risks of providing comfort care.

Best interest standard. Surrogates responsible for making health care choices for patients who have never attained decision-making capacity should base those decisions on the best interests of the patient. Opinions vary about whether this principle is absolute or whether the interests of others are relevant to the decision-making process. *The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research* interpreted this principle strictly, completely excluding consideration of the interests of others in judging best interests of newborns.

As in all surrogate decision making, the surrogate is obligated to try to evaluate the benefits and burdens from the infant's own perspective....This is a very strict standard in

that it excludes consideration of the negative effects of the impaired child's life on other persons, including parents, siblings, and society [1].

This position is based on the vulnerability of the ill to potential discrimination or even exploitation, especially those who have lost or never achieved capacity for decision making.

Another widely held view, however, is that the circumstances of surrogate decision making are too complex to dismiss consideration of the interests of the family out of hand [2-5]. It is argued that to be part of the family in the fullest sense is to be morally bound to make decisions that consider the consequences for all concerned, not merely ourselves. In other words, it is irresponsible to completely exclude the interests of those to whom we are close. Following this line of reasoning, family interests should not be excluded from medical decisions made on behalf of persons who have lost or never had capacity to consider their family members. This view recognizes that the vulnerable require special protection and argues that their interests should be duly considered, but not necessarily exclusively served.

Sanctity of life. There is an almost-universal belief that human life has intrinsic value and ought to be preserved. One extreme of this principle holds that *biological* human life has intrinsic value and ought to be preserved. According to this belief, the *quality* of that biological life has no bearing on its value. Another sanctity-of-life view holds that only life of some minimum quality to the person ought to be preserved [6, 7]. In general, however, there is no consensus on what constitutes the "minimum quality of life" that ought to be preserved.

Parental autonomy. Parents are the legitimate surrogate decision makers for their minor children and are granted broad discretion in making informed decisions about the health care of those children, including the declining, continuing, limiting, or discontinuing treatment, whether life sustaining or not. The right of parents to make health decisions follows from the importance of natural love and affection in optimizing one's child's quality of life, as well as from the disproportionate responsibility for the consequences of these decisions that parents ultimately bear. It is argued that the less support the community is willing and able to provide the family in dealing with the consequences of unwelcome decisions, the broader the discretion parents should have. However, this discretion is not without bounds. Physicians caring for infants and children are charged to be advocates for their patients' best interests. Only in the unusual circumstance that a family's decision clearly conflicts with the best interests of the infant or child, however, does the physician have an obligation to override that decision. On first consideration it may seem that death always conflicts with patients' best interests. This, however, depends upon whether only the *patient's* interest is thought to be relevant to the health care decision and whether *quality* of life is of any relevance to the decision to forgo life-sustaining interventions.

Having reviewed the ethical principles most applicable to decision making for Baby Boy Craft, we can consider how differences in the Crafts' and Dr Hearth's values might account for the discrepancy in the conclusions reached by each and whether either or

both were in accord with wider community standards. In their application of the best interest standard, the Crafts have clearly considered their family as well as their son in their decision to conditionally withhold resuscitation. One possible explanation for the lack of agreement between their decision and Dr Hearth's, therefore, is that Dr Hearth believes that withholding resuscitation clearly conflicts with the best interests of the newborn, given his prognosis, and she may believe that only his interests should be considered. It is also possible that she accepts that interests of the family are relevant to the decision but believes that the Crafts have not given adequate weight to their son's interests.

It is likely that the Crafts considered their son's potential quality of life in light of their experience with their severely disabled daughter. This experience may well have permitted them to evaluate their son's prospective quality of life realistically, should he survive with major disabilities. Dr Hearth, on the other hand, may believe that quality of life has no role in this decision—that biologic life is sacred in and of itself and should be preserved whenever possible. Or she may have a different notion than the Crafts of what level of quality mandates an attempt to preserve a life and therefore may believe that Baby Craft's chance of surviving with this minimally acceptable quality of life is too great to justify withholding resuscitation.

Finally, Dr Hearth may believe that the Crafts could not possibly have the information necessary to make an informed decision prior to the birth of their son because information about his condition at birth was required to make an informed decision. Although case law in Texas would support this view [8], the Texas decision is highly controversial [7, 9-11]. Moreover, state law is applicable only in the state where it is passed.

Community Standards

So, was only 1 of these 2 alternatives morally acceptable or could both be? The larger community also has a role in this determination. Morality deals with things that ought or ought not to be done because of their deep social importance in the ways they affect the interest of other persons. Morality consists of social norms of behavior. In a pluralistic society, social norms often prescribe a *range* of behaviors that are morally acceptable in order to accommodate the range of legitimate values held by members of the community—or rather the various communities, professional, faith-based, political, and others. Thus, it is the larger community, not individuals alone, that determines the *bounds* of morally acceptable choices that are consistent with the relevant ethical principles. The fact that the parental choice may be inconsistent with the physician's values does not alone justify denying the parents an option that is among the range of values that are morally acceptable to the community.

If deciding to forgo resuscitation of newborns at 24 weeks of gestation is not within the range of choices considered morally acceptable by the community, then Dr Hearth is not only justified in intervening, she has a duty to do so. In this situation she also has an obligation to inform the parents of this duty when they express their wish to withhold resuscitation. If, on the other hand, withholding resuscitation is within the range of options morally acceptable in the community, Dr Hearth would have no right to impose

her personal values on the Crafts. Rather, her role in the decision-making process is to inform the family of the risk and benefits of all options and then use her medical knowledge, expertise, and experience to guide the family through decision making based on the family's value system [12]. (It would be prudent for Dr Hearth to involve a neonatologist in this counseling as recommended by the American College of Obstetricians and Gynecologists: "A multidisciplinary approach may be helpful in ensuring that information provided is consistent and represents a range of concerns and areas of clinical care" [13].)

This systematic approach requires that parental values be attained and that direct decisions about what choice is in the best interests of their infant be made. It is important to note, however, that Dr Hearth cannot be compelled to act against her own conscience. If she cannot, in good conscience, comply with the decision made by the Crafts based on their values, then she may choose not to participate further in the care of Mrs Craft. In that case, Dr Hearth has a duty to transfer care to an obstetrician who can, in good conscience, comply with parental wishes. If a pediatrician or neonatologist were expected to be involved in Baby Boy Craft's care in the delivery room, it would also be important to know whether he or she would be willing to comply with the Crafts' wishes. Delaying the induction of labor may have allowed time to acquire the relevant information and, if necessary, transfer of care to have been accomplished.

Whether Dr Hearth's action was justified, then, depends on whether a parental decision to forgo resuscitation of a 24-week newborn based on the best information available prenatally is among the range of morally acceptable options in the community or not. As a member of a moral community, do you think Dr Hearth's action was justified? Do you think the Crafts' decision was morally acceptable?

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John M. Lorenz, MD, is professor of clinical pediatrics in the College of Physicians and Surgeons of Columbia University in New York, NY. He is director of clinical research in the Division of Neonatology, chair of the Pediatric Ethics Committee, and attending neonatologist at Morgan Stanley Children’s Hospital of New York-Presbyterian.

Related Article

[Balancing Parental Wishes with Medical Judgment](#), January 2003

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Medical Education

How to Catch the Story but Not Fall Down: Reading Our Way to More Culturally Appropriate Care

by Sayantani DasGupta, MD, MPH

Central to the work of doctoring is the ability to elicit, interpret, and act upon the stories of patients. Yet these tasks of effective communication and care often fail with patients whose ethnic, socioeconomic, linguistic, gender, or sexual identities differ from those of the physician and the traditional medical establishment. Although efforts to broaden medical curricula often include teaching endeavors that fall under the heading of “cultural competency,” few such programs incorporate the lessons of narrative medicine, which employs the reading and writing of narratives to train clinicians to engage more effectively with their patients’ stories [1].

Cultural competency programs often rely on didactics, small group discussion sessions, or even simplistic lists of cultural characteristics to be memorized about various patient populations. Yet teaching understanding and empathy for patients from dissimilar backgrounds is an entirely different sort of activity than teaching pharmacology or physiology and demands a different pedagogy. Few exercises in either cultural competency or narrative medicine place students in direct contact with the communities about which they are learning, the communities outside of the medical institution. Even fewer challenge patient-physician hierarchy in any meaningful way. This article describes a unique educational activity at the intersection of cultural competency and narrative medicine, an activity that seeks to engender greater understanding across ethnic and institutional cultures while addressing issues of story, voice, and power.

At the Columbia University Community Pediatrics Program, which is located within the University’s Division of General Pediatrics in New York City, our cultural competency training program incorporates a service learning component that integrates community service with explicit learning objectives. Our residents participate in educational endeavors with a northern Manhattan (Washington Heights) Dominican American community organization, Alianza Dominicana. Service learning bridges the artificial distance between medical center and community by locating the educational classroom in the community and placing community partners at the level of teachers [2].

Although the service learning component of our curriculum was designed to teach culturally responsive care for patients, it also brought to light cultural misunderstandings between residents and community workers. To address these issues, a monthly reading

group using a literary case study was formed as an educational module for pediatric residents and the predominantly Dominican American community-based workers.

Catching the Story but Not Falling Down

Anne Fadiman's 1997 book, *The Spirit Catches You and You Fall Down*, is a familiar text in many medical schools, often offered as a cautionary tale of the perils of culturally ineffective care [3]. The story, an account of a Hmong girl's epilepsy and her community's interactions with their local medical facility, illustrates the dire consequences of such a "cultural collision."

Of course, the danger of a narrative such as Fadiman's lies in its being used as a textbook of sorts—a way to learn about a specific community or a specific cultural situation. The gripping text has been critiqued as presenting a simplistic, unidimensional view of culture that has the potential to "catch" the reader and make the reader "fall down" [4], unable to critique the narrative or get beyond its extreme and obvious lessons to recognize that most instances of cultural clashes in care are far more subtle than those depicted. But the methodology by which the Columbia University Community Pediatrics Project used Fadiman's story and the context in which her story was read allowed participants to "catch the story" and not "fall down." Importantly, residents were neither given the text to read on their own, nor expected to discuss the book solely with other medical practitioners. Rather, the text was a starting point for extensive, self-revelatory and self-reflective discussions with representatives of the community from which most of the residents' patient population emerges.

The reading group between residents and community workers lasted approximately 1½ hours, and attendance averaged 15 community workers, 2 or 3 residents, and 1 or 2 community pediatrics faculty members. In our particular community context, the text represented a "neutral" culture; no one felt a sense of personal or professional ownership over the Hmong experience. Both community workers and pediatric residents were placed in the position of learners vis-a-vis this unfamiliar culture. Pediatrics faculty and the community-based organization director acted as facilitators. They began the discussion with questions from the text and subsequently allowed the conversation to develop organically, encouraging participants to draw upon personal and professional experiences that illustrated the topics, including birthing practices, cultural miscommunication, use of complementary therapies, and experiences with chronically ill or dying patients.

Qualitative evaluation of the residents and community workers found that all participants believed the activity helped them learn about the importance of recognizing cultural differences. Moreover, community-based workers suggested that the discussions afforded them a good opportunity to understand the medical point of view, including the day-to-day physician realities of long work hours and limited visit times with individual patients. Similarly, the exercise enabled the medical residents to better understand the community's expectations and their perspectives on hospitals, the practice of medicine, and physicians' day-to-day activities. Finally, community workers believed that residents would change their attitudes and behaviors in practice after the activity. Consistent with this perception, the medical residents reported a variety of

intentions to change their attitudes and behaviors including an intention to be more sensitive to cultural differences and more patient and to recognize their biases and the effect of those biases on caregiving [5].

Reading into Texts, Reading into Culture

Narrative activities such as this reading exercise can help bridge professional and personal cultural gaps. The exercise allowed participants to do what medical sociologist Arthur Frank calls “thinking with stories.” In his words, “To think about a story is to reduce it to its content and then analyze that content. . . . To think with a story is to experience it affecting one’s own life and to find in that effect a certain truth of one’s own life” [6]. Indeed, this program used the reading of a narrative to engender a real sense of community among diverse members of the literary “classroom.”

The creation of community within the classroom may not be an automatic occurrence. This activity was designed and conducted with particular awareness of the power discrepancy between physicians and community workers. Discussion leaders paid attention not only to ethnic cultural differences but also to differences in organizational cultures, with the goal of creating a safe space in which the voices of all participants were honored equally. The theoretical foundation of this sort of facilitation draws from Brazilian educator Paulo Freire, whose writing is particularly concerned with recentering the power of the classroom from the teacher to the students [7, 8]. It is also consistent with what activist and educator bell hooks calls “transformative pedagogy.” In her words, “I enter the classroom with the assumption that we must build ‘community’ in order to create a climate of openness and intellectual rigor. . . . one way to build community in the classroom is to recognize the value of each individual voice” [9].

Critical, self-reflective learning experiences can facilitate increased cultural sensitivity on the part of practitioners. Literature has great potential for encouraging self-reflection, particularly when narrative texts are used as a starting point for increasing mutual understanding among diverse discussants. It has been suggested that the diverse interpretations and perspectives that emerge when discussing a story with others, the very nature of interpretive ambiguity, challenges the “single, authoritative view” of physicians in medicine [10]. The Columbia University Community Pediatrics Program took just such a literary exercise outside the walls of the medical institution and allowed individuals of extremely varied personal and professional backgrounds to establish an emotional and intellectual community, voicing their individual interpretations of a text based on their varied life experiences, creating an environment within which it became possible to better recognize, understand, and appreciate one another.

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Related Article

[Cultural Impasse](#), October 2002

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Sayantani DasGupta, MD, MPH, is assistant clinical professor of pediatrics and faculty and Advisory Board member of the Program in Narrative Medicine at Columbia University. She is also on faculty at Sarah Lawrence College where she teaches courses on illness narratives.

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Journal Discussion

Coping Mechanisms and Quality of Life

by Helen Harrison

Kothari S. Clinical [mis]judgments of quality of life after disability. *J Clin Ethics*. 2004;15:300-307.

Much of the practice of law and medicine is predicated on the notion that disabilities impose real and significant harm. If a lawyer were to claim in court that the victim of an assault, rendered brain damaged and paralyzed, had the same quality of life as everyone else and, therefore, had suffered no injury, not a jury in the world would take that assertion seriously.

However, in his article “Clinical [Mis]judgments of Quality of Life After Disability” [1] Sunil Kothari notes that severely disabled individuals, including people with quadriplegia who require assisted ventilation, report a quality of life (QOL) that is nearly identical to the self-reported QOL of health care professionals [1]. Kothari also found that health care professionals and the public ascribe significantly lower QOL scores to people with severe disabilities than those with disabilities report for themselves. He fears that public and professional underestimation of the QOL enjoyed by the disabled may have significant clinical implications.

In “Making Lemonade: A Parent’s View of Quality of Life Studies,” [2] I have argued that the QOL self-reports of people coping with disability are inflated by the same mechanisms that allow them to put a brave face on adversity (in public at least). I refer to these coping mechanisms as “making lemonade” from the saying, “When life hands you a lemon, make lemonade.” Sadly, the private realities of lives lived with disability often differ substantially from the stoic facades.

My interest in quality-of-life issues began 3 decades ago when my son was born prematurely with severe disabilities. I was able to observe the emotional dynamics of altered QOL not only in my own family but also in the hundreds of parents, prematurely born children, and adults with disabilities that I met in support organizations, interviewed for books and articles [2-5], and studied as a parent advisor to researchers investigating outcomes and QOL of prematurely born children [6].

Those of us affected by disability quickly come to realize that others want to believe we are managing well, so we offer reassurances, hoping also to reassure *ourselves* that there are compensations for even the most devastating afflictions. We do not want to be

pitied or devalued, and so we assert our personal worth whenever it is questioned—for example, in QOL interviews. The more uncomfortable the questioning, the more defiantly optimistic our assertions tend to become.

My experience and observations are reinforced in a study by Saroj Saigal that evaluated QOL for a group of Canadian teenagers who had been born weighing less than 1000 grams (known in medical terms as extremely low birth weight or ELBW) [7]. Although 86 percent of these teens had functional limitations [8], 61 percent gave themselves perfect QOL scores compared to the 49 percent perfect QOL scores from normal birth weight control group [7]. In a personal communication, Saigal stated that perfect QOL scores were reported by ELBW adolescents who were blind, nonambulatory, and otherwise severely impaired. Were these teens honestly and fully describing their lives or were they “making lemonade”?

To examine this question, it helps to look at other responses from the teens with ELBW that could be objectively verified. For example, although 58 percent of them were experiencing severe educational difficulties (they were either in special education or had failed a grade in the previous 2 years) only 6 percent self-reported “below average academic performance” [9, 10]. By comparison, 9 percent of the control group admitted academic difficulties, a figure close to the objectively determined percentage (10 percent) [9, 10].

In virtually every area of functioning, the teens born at extremely low weights underreported medically diagnosed disabling conditions [2, 11]. According to these adolescents, more of them were free of impairment than the physicians who treated them or the general population of Canada [7, 12].

A recent study by Allin et al, “Personality in Young Adults Born Preterm,” confirms the tendency of prematurely born individuals to deny disability and answer questions in ways they think will make them appear more socially acceptable [13]. Adult stroke victims have also been found to rate their functional levels significantly higher than more objective medical assessments [14].

QOL is a subjective concept, much like “happiness” and “self-esteem,” and it may thus be considered immune to objective investigation. But the results of recent studies seem to defy common sense to a degree that calls into question the meaning of the concepts and the methodologies by which they are rated [15, 16].

Flaws in methodology may help explain the counterintuitive results of QOL studies. Researchers have described the “Hawthorne effect” in which “compliant patients have a remarkably intuitive ability to sense what is wanted of them—and they provide it” [17]. This may be especially true when the researchers also provide the subjects with medical care. One study found that subjects who were unable or unwilling to make positive QOL statements often declined to be interviewed, another fact that would contribute to biased results [18]; others have shown that the presence of an interviewer inhibits subjects from disclosing pain that they admit to in more private settings [19]. Physicians investigating QOL after treatment for complex congenital heart disease noted that

optimism during structured interviews differed from anecdotal information exchanged in less formal situations [20]. Formal characterization of QOL has also been shown to diminish over time in the same subject without any change in function [21].

QOL studies provide fascinating insights into the human psyche, but they must be supplemented by data on actual functioning, observations from others close to the patient, and in-depth, free-form interviews administered over time. Saigal et al in their 1996 QOL study urged that “a great deal of caution be exercised” regarding possible clinical application of the high QOL scores reported by teens born at extremely low weight [7]. I agree.

As a parent and a patient, I want to hear the facts about conditions and proposed treatments, not QOL reports that may be drenched in lemonade. To quote Carolyn Daniels, social worker to the teens with ELBW described above, “it is a mistake to confuse coping mechanisms with quality of life” [2].

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Helen Harrison, co-author of The Premature Baby Book and author of "The Principles for Family-Centered Neonatal Care," is the mother of a 30-year-old prematurely born son.

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Clinical Pearl

Prostate Cancer Screening and Treatment Recommendations for Obese Men

by Nicholas J. Fitzsimons, MD, and Stephen J. Freedland, MD

Introduction

The relationship between obesity and prostate cancer has sparked a flurry of investigation among clinicians and prostate cancer researchers alike over the past several years. Reasons for this increased interest include the rapidly growing prevalence of both obesity and prostate cancer and the need to understand the association between the 2. While some older studies suggest that obesity is positively associated with the risk of being diagnosed with prostate cancer [1-2] more recent investigations indicate that obese men may actually have a lower likelihood of being diagnosed with prostate cancer [3]. Obesity appears to be linked with more aggressive disease (eg, greater risk of progression after radical prostatectomy) and increased risk of prostate cancer death [4-5]. Related factors that have been shown to play a role in the development of prostate cancer include diet, caloric intake, and insulin resistance [6-8]. Prostate cancer incidence has been found to be much lower in countries where people eat a predominantly low-fat, plant-based diet [9]. Some suggest that dietary supplements such as selenium, vitamin E, lycopene, omega-3 fatty acids, and soy decrease cancer risk, but whether lifestyle changes after diagnosis either slow or reverse prostate cancer remains unknown [6].

Screening and Diagnosis

Current guidelines recommend that men begin to undergo yearly screening for prostate cancer at age 50. For African Americans and those with family histories of prostate cancer, screening should begin at age 45 and consist of yearly digital rectal examinations (DRE) and prostate specific antigen (PSA) tests. While these recommendations are no different for obese men, some data suggest that prostate cancer is more difficult to detect in this population.

For instance, although obese men have been shown to have larger prostates, they have also been shown to have lower overall PSAs [10-11]. Because of this, obese men may have PSA values that are elevated compared to their normal value but not yet in the statistical abnormal range for all men. Thus they are less likely to be referred for a prostate biopsy. Fewer biopsies results in fewer cancers detected. Obese men also have larger prostates at the time of biopsy than non-obese men have at the same stage. Given that performing a biopsy to find cancer in the prostate is like looking for a needle in a haystack, a larger haystack (ie, prostate) makes it more difficult to find the needle (ie,

cancer). Ultimately, the combination of lower PSA values and larger prostate size may cause a delay in diagnosis that results in more advanced disease at the time of diagnosis for obese men.

Although there are no specific screening recommendations for obese men as a population, they may warrant a greater degree of suspicion by the screening physician. As mentioned, a PSA level that would be considered normal in a man of average weight might be abnormal for an obese man and justify further investigation and biopsy. It is also more difficult to perform a thorough DRE in an obese man, which means that physicians need to be aggressive in doing so. The difficulty in performing a DRE forces many clinicians to rely more heavily on the PSA, but, as mentioned above, this only compounds the difficulty of diagnosis. In sum, urologists may need to increase the number of biopsy cores taken to compensate for these 2 inconclusive procedures.

Treatment

There are multiple treatment options available to men diagnosed with prostate cancer, including radical prostatectomy, cryosurgery, external beam radiation, brachytherapy, androgen deprivation therapy (ADT), chemotherapy, and watchful waiting. Furthermore, emerging technologies such as high-intensity focused ultrasound (HIFU) are being studied. When counseling patients who are newly diagnosed with prostate cancer about treatment options, it is often helpful to stratify them according to risk groups based on PSA, biopsy Gleason score, and clinical stage. For instance, low risk patients (PSA <10 and biopsy Gleason score ≤ 6) and intermediate risk (PSA 10-20, biopsy Gleason = 7, or both) are amenable to virtually all of the above therapies. However, patients with high-risk disease (PSA >20, biopsy Gleason ≥ 8 , or both) might be advised to undergo some form of combination therapy, such as ADT and radiation or surgery followed by radiation.

Other factors such as age, race, and family history should be included in the discussion. For example, an individual with low-risk or intermediate-risk disease who is African American or has a strong family history of prostate cancer might warrant more aggressive intervention. An elderly individual diagnosed with prostate cancer is much more likely to be offered watchful waiting than a younger man with the same clinical features.

As with screening for prostate cancer, there are no treatment recommendations specific to obese men, but there are several important treatment decision considerations. Radical prostatectomy (complete surgical removal of the prostate) is technically more challenging in obese men, resulting in a higher rate of inadvertent incision into the prostate and a higher rate of positive surgical margins, that is, presence of malignant cells in tissue surrounding the surgery site [12, 4]. Technical issues combined with overall more aggressive disease result in poorer cancer-free survival, something obese men should be aware of [4]. However, even after adjusting for surgical technique issues, obese men seem to have an increased risk of progression, strongly suggesting that they have more aggressive disease [4]. This more aggressive disease should in theory result in worse outcomes after any form of prostate cancer therapy, though to date this has been most closely studied after surgery.

Obesity can also present a technical challenge for radiation. Classically, radiation fields were designed based upon a single computed tomography scan done prior the start of the 4-8 week radiation course. But the day-to-day movement of the prostate is greater in obese men, and this variation in location can result in a lower delivered radiation dose, a condition referred to as “set-up” error [13].

ADT works by lowering serum testosterone levels. Obese men naturally have lower testosterone levels. Therefore, it is possible that obese men may be undergoing a natural chronic form of weak hormonal therapy. Thus it is plausible that lowering serum testosterone levels may not work as well on obese men, although this speculation has not yet been studied.

Conclusion

To date no specific screening or treatment recommendations exist for obese men. However, several obesity-related factors can make prostate cancer screening and treatment challenging. It is hoped that through a better understanding of these factors, we can improve outcomes among this group of men who are at increased risk for death from prostate cancer.

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Nicholas J. Fitzsimons, MD, is a third-year urology resident at Duke University Medical Center. He is working on prostate cancer outcomes research.

Stephen J. Freedland, MD, is an assistant professor of urology and pathology at the Duke Prostate Center, Duke University, and the Durham Veterans Administration Medical Centers. He has a special research interest in prostate cancer and obesity.

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Law and Medicine

Legal Protection for Conscientious Objection by Health Professionals

by Allison Grady

The emerging popularity of medical “conscience clauses” has been attracting attention most notably in the pharmaceutical field. Conscience clauses are laws that explicitly allow for health care workers to opt out of certain procedures, usually reproductive and end-of-life therapies, on moral, ethical, or religious grounds. Within medical circles, a doctor’s right to refuse to offer specific treatments in a nonemergency setting, so long as alternative treatment options are provided, is well known and reinforced by state and federal laws and the American Medical Association’s *Code of Medical Ethics* [1]. But for other health care workers, including pharmacists, there is neither legislative support nor a rich professional tradition that allows for conscientious objection. Nevertheless, in recent years larger numbers of pharmacists have been independently choosing not to participate in patient drug therapies on the grounds of moral objection. These actions have given rise to legislation that grants health care workers the same options that physicians have long had. The laws require various degrees of duties from workers, and most strive to accommodate both the conscientious objector and the vulnerable patient.

Some critics however, believe that these new laws have granted pharmacists and other workers too much latitude and that this threatens patient health. One example of this type of controversial legislation can be found in Michigan where lawmakers are attempting to pass a bill to protect conscientiously objecting health care workers from “civil liability, criminal action, administrative or licensure action” and “termination of employment or refusal of staff privileges at a health facility” [2].

The Michigan Example

The case that seemed to ignite this sudden interest in objector legislation occurred in Wisconsin when a married woman with 4 children sought the morning-after pill at a local pharmacy. Not only did the pharmacist refuse to fill the prescription, he refused to transfer it to another pharmacist or to return the original prescription to the patient [3]. After this incident others like it began gaining attention in several states. Realizing the potential for more widespread problems—for example, many people did not know until they needed it, that Wal-Mart, a pharmacy chain with more than 3600 stores, does not stock the morning-after pill—many states have decided to consider and enact laws setting the bounds of pharmacists’ and other health care workers’ professional obligations. The Michigan proposal, considered most aggressively in 2004 and currently working its way through a Senate committee, is a part of this nationwide movement. Much of the pharmaceutical debate focuses on whether a pharmacist should be required

to dispense the morning-after pill (also known as “Plan B”), contraception, the “abortion pill” RU-486, and end-of-life therapies including morphine and the drug combination approved for physician-assisted-suicide.

Under the proposed Michigan law, licensed professionals, students at a health facility, and others in health care services at more than 15 specified locations where health-related activities take place would be allowed to conscientiously object [2]. Those who choose to opt out of a particular action or procedure that may be requested of them must inform their supervisors, in writing, of the specific service or action they oppose. This notice can be filed upon offer of employment, when an ethical, moral, or religious system is adopted that would conflict with employer request, or within 24 hours of being requested to participate in a specific act [2]. This written objection is valid for the duration of employment unless the objector informs a supervisor that he or she no longer objects to these requests [2]. If an objection is filed less than 24 hours before a scheduled procedure, a supervisor must make a reasonable effort to find a replacement; if none can be found, the supervisor may require the objector to participate [2]. The right to conscientiously object does not apply in emergency situations, during a public health emergency, or if the objection is based upon civil rights-protected characteristics or a specific disease or medical condition [2]. Under this proposed law, employers may not discriminate against conscientious objectors and may not terminate employment because of a stated objection without at least 60 days notice and evidence that the refusal to perform certain actions interferes with at least “10% or more of the health care provider’s daily or weekly hours of duty” [4].

Absent in Michigan’s proposed Conscientious Objector Policy Act is the responsibility of a conscientious objector to accommodate patients or colleagues whom their moral choices have affected. Unlike traditional physician policies, there is no responsibility to transfer care, and no contingency plans need to be made to ensure that patients receive their medically indicated, lawful therapies. Indeed, it seems that adjustments made for the benefit of a patient are at the discretion of the employer and his or her employees.

The Debate

Most people seem to agree that pharmacists and other health care workers should have the right to refuse to participate in certain acts; the main disagreement centers around just how far this objection should be allowed to go.

Howard Brody, MD, former chair of Michigan State Medical Society’s Committee on Bioethics, feared that the Michigan House bill “would have opened the door to a whole new set of abuses such as medical students refusing to attend lectures on the grounds that they objected to their content” [5]. Others fear that a pharmacist who refuses to dispense medicine that has been prescribed by a physician is intruding upon the patient-physician relationship. According to a writer for *Slate*:

...your pharmacist has neither the tools nor the right to probe details about rape and abuse, incest and health risks. Which is why pharmacists who interpose themselves between decisions made by a doctor and her patient are overstepping moral and ethical boundaries—

and undermining another professional relationship that is fundamentally different from their own. You needn't believe that one relationship is more important than the other to recognize that neither relationship should be allowed to intrude upon the other [6].

The *New York Times* was less philosophical when it revealed its position on the subject in an April 2005 editorial, writing “Any pharmacist who cannot dispense medicine lawfully prescribed by a doctor should find another line of work” [7].

But some—many, in fact—steadfastly believe in a right to object *without* limitations. During the Canadian debate on the same topic, conscientious objector Nancy Metcalfe spoke at the Canadian Pharmacist Association Annual Meeting saying that she “will not direct people to a source of life-taking medicine. I cannot collaborate in the modern Holocaust” [8]. After hearing arguments on conscientious objection, the province of Manitoba decided that their pharmacists “do not have to dispense or refer if they object to a product” [8]. American Karen Brauer of Pharmacists for Life was equally fervent in her opposition to making those who conscientiously object refer patients to other pharmacies, likening it to saying, “I don't kill people myself but let me tell you about the guy down the street who does” [9].

Despite such polarizing positions, some are calling for compromise. In a 2004 *New England Journal of Medicine* article, Julie Cantor and Ken Baum advocated a middle ground for pharmacists who wish to conscientiously object.

Although we believe that the most ethical course is to treat patients compassionately—that is, to stock emergency contraception and fill prescriptions for it—the totality of the arguments make us stop short of advocating a legal duty to do so as a first resort....because emergency contraception is not an absolute emergency, because other options exist, and because, when possible, the moral beliefs of those delivering care should be considered [10].

Even though professional organizations' positions are not legally binding, they tend to have wide influence over their members. Given the controversy over this topic, many associations have weighed in, usually advocating for a middle-of-the-road approach. In June of 2005 the American Medical Association passed a resolution at its Annual Meeting to

support legislation that requires referral to other pharmacies if a pharmacist objects to filling a legal prescription, work with state medical societies to support legislation that would protect a patient's ability to fill a legal and valid prescription, and work with other associations to guarantee individual pharmacists' right to conscientious objection while ensuring referral to another pharmacy [11].

The American Association of Family Physicians (AAFP) passed a resolution in October of 2005 stating their belief “that a pharmacist’s right of conscientious objection should be reasonably accommodated,” but that “governmental policies must be in place to protect patients’ right to obtain legally prescribed and medically indicated treatments” [12]. And the American Pharmacists Association has taken the position that

pharmacists, like physicians and nurses, should not be required to engage in activity to which they object. But supporting a pharmacist’s ability to step away from objectionable situations does not require a confrontation with the patient....Pharmacists must not use their position to berate, belittle or lecture their patients...pharmacists must not obstruct patient access to therapy [13].

Also adding his voice to the debate, Joseph DiPiro, pharmacy educator and editor of the *American Journal of Pharmaceutical Education*, wrote that “the issue of the pharmacist’s right to refuse is multi-faceted and not amenable to a simple conclusion that encompasses the major variations of all possible scenarios. In short, it is an excellent issue for faculty members to encourage discussion in and outside of the classroom” [14].

Conclusion

Ten states have laws on the books regarding pharmacist conscientious objection; another 23 are currently considering legislation specifically allowing for a pharmacist refusal clause; 4 states are debating laws that *require* that pharmacists fill all prescriptions; and 3 states are contemplating general conscience clause legislation [15]. This is a subject that has clearly hit a nerve in the health care field as well as among the general public. One must not lose sight of the fact that neither a pharmacist nor any other health care worker is a machine—they are people who perform jobs while also holding moral and ethical value systems that sometimes conflict with their professions. But it seems most just that, when possible, the conscience and morals of a health care worker should be considered, so long as patients are being cared for and not overburdened by long drives through rural towns and not being shamed for what someone presumes to be an immoral lifestyle choice.

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Allison Grady is a senior research assistant and assistant editor of Virtual Mentor at the American Medical Association in Chicago, Illinois.

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Medicine and Society

Obligation To Provide Services:

A Physician-Public Defender Comparison

by June M. McKoy, MD, MPH, JD

Right to Medical Treatment in Emergencies

In 1986 Congress enacted the federal Emergency Medical Treatment and Active Labor Act (EMTALA) in response to a surge of “patient dumping” by hospitals that refused to treat individuals who were unable to pay for medical care. Under EMTALA, all hospitals that participate in Medicare and their physicians are duty bound to stabilize and provide medical screening examinations for each patient who comes to the facility for emergency care, regardless of the patient’s ability to pay. While EMTALA does not expose individual physicians to direct liability for failure to comply, repeated violations of the act may lead to exclusion from participation in Medicare and Medicaid and to civil monetary damages.

Treatment in the Absence of Emergency

Obligation to treat patients in nonemergent situations is not clear-cut. Principle VI of the American Medical Association’s (AMA) “Principles of Medical Ethics,” states that a “physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care” [1]. Hence, no common law duty or ethical imperative exists outside of EMTALA or a patient-physician relationship that requires a physician to treat every patient. While the AMA Council on Ethical and Judicial Affairs has deemed it unethical to refuse to treat patients based on certain disease states such as HIV, that ruling is not instructive of whether physicians are wrong in refusing patients without specified conditions or disabilities [2].

Right to Legal Representation

The Sixth Amendment of the United States Constitution guarantees everyone charged with a criminal offense certain rights, such as the right to be represented by an attorney. For those who are poor, this representative is a public defender whose duty it is to provide adequate legal counsel. Forty years ago, US Attorney General Robert Kennedy said: “The poor man charged with crime has no lobby. Ensuring fairness and equal treatment in criminal trials is the responsibility of us all” [3]. Additionally, in the 1963 *Gideon v Wainwright* ruling, the US Supreme Court held that every defendant facing the threat of imprisonment is entitled to an attorney, regardless of ability to pay [4]. There is no corresponding constitutional mandate for people in need of nonemergency health care.

In the context of the indigent, the public defender's mandate to preserve the legal rights of clients is heightened. On the face of it, then, justifications for advocacy within the medical arena should take on added meaning in the context of the uninsured and the underinsured; patients who are already socially displaced by their inability to pay or their alternate lifestyles are further alienated when physicians refuse them care. The physician and the public defender each plays a unique role in society; the physician heals the body, while the public defender is a healer of conflicts. Both work to advance social justice. But the representation public defenders are obligated to provide is paid in fixed salaries from either state or federal governments. Physicians do not make their choices of whom to treat in the context of fixed salaries and must factor financial constraints and emotional expenditure into the equation.

The Refusing Physician's Moral Crisis

Unlike the public defender, the physician confronts a moral dilemma: conscience urges that he or she treat all patients, no matter what, but a convergence of health system factors such as rising medical liability premiums, stagnant reimbursement from commercial insurers, escalating overhead, and personal moral beliefs can make following one's conscience costly. The patient-physician relationship is different than the client-public defender relationship. The physician must obtain a tremendous amount of information about a patient's personal life and background in order to provide effective care. Trust and honesty lie at the core of the relationship. The public defender does not ask and in all probability does not care whether his client is guilty or not. Therefore, even though fiduciary relationships exist in both medicine and law, a public defender's personal values are of far less consequence to his or her client. Confidence and trust are critical in diagnosis and treatment. If the physician harbors resentment against the patient because of lifestyle or failure to comply with treatment, the patient-physician alliance is compromised and, thus, care is ultimately compromised.

The Model of Cure: Does it Promote Refusal?

Medical care in the United States focuses increasingly on successful treatment outcomes. That is what evidence-based practice is all about. Regrettably, when a physician perceives that positive outcomes may be jeopardized in certain patient groups or that these certain groups have medical problems that are too overwhelming, that physician may refuse care to members of the group. So, in essence, the medical model that lauds cure over care may be the same model that leads physicians to refuse to treat members of certain populations.

Justice dictates that physicians provide care to all who need it, and it is illegal for a physician to refuse services based on race, ethnicity, gender, religion, or sexual orientation. But sometimes patients request services that are antithetical to the physician's personal beliefs. Abortion is the most obvious example. In such instances, the complexities of balancing the physician's personal beliefs and internal value system make it almost impossible for him or her to accept every patient. How far should the physician's ethical and social responsibility extend? Does an ethic of care demand that a physician accept every patient? There are no clear answers to these questions.

Should Society's Investment in Medical Education Dictate a Duty to Treat?

The US system of health care is a product primarily of the free market. Most of those who seek care pay for it out-of-pocket or through some form of private benefit plan reimbursement. Medical students bear the major portion of the cost of their medical education. In the postgraduate years, hospitals recoup costs for residents' salaries from Medicare, but this, after all, is salary for services that residents deliver. The development of a medical education financing system that, subject to government oversight, would cover medical students' enormous debt might provide incentive for more physicians to repay society by treating all patients. Arguably, since it does not bear the medical student's financial burden, society should remain silent on the issue of whether physicians have the right to refuse patients.

In sum, a duty to treat beyond the emergency arena may only come with publicly financed medical education, through legislation, from the courts, or in ethics guidelines promulgated by individual medical societies. Such guidelines currently call upon physicians to commit to providing care and healing to all patients who seek it from them and underscore the duty to treat. But they do so only on professional, altruistic ccwgrounds and without legal force.

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June M. McKoy, MD, MPH, JD, is an assistant professor of medicine and preventive medicine at Northwestern University's Feinberg School of Medicine and a member of the Ethics Committee at Northwestern Memorial Hospital and the Institutional Review Board at Northwestern University, in Chicago, Illinois.

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Medicine and Society

Professional Demands and Religious Observance

by Mahendr S. Kochar, MD

To a certain extent medicine and religion are inseparable; most physicians tend to be religious and view God as a higher power that helps in the healing process. Many probably say a silent prayer, particularly when undertaking a difficult and risky procedure. But should physicians allow their religious beliefs to mold the way they practice medicine and influence their decisions, particularly when the patient doesn't share their beliefs?

By taking the Hippocratic Oath, a physician pledges to always do the best he can for his patients. The physician must decide what is best, based on medical knowledge and current practice standards in conjunction with the patients' understanding of their own best interests. Religious beliefs or teachings of the organized religion to which a physician belongs should not enter into his or her clinical judgment of what is best for a patient. To let religious beliefs influence clinical judgment would be a disservice to the patient and a breach of the Oath.

If a physician's religion calls for cessation of work on certain days of the week, but the profession requires him either to work or, when on call, to be available to attend to the sick, his priority must be to patients. Caring for the sick is a calling that no religion opposes. Similarly, if praying several times during the day would jeopardize the health and care of patients, once again, the physician must attend to the sick.

When one decides to become a physician, knowing full well that patients can fall ill at any time, one makes an implicit commitment to provide care 24/7—even if doing so conflicts with religious practices. Most physicians work in groups where religious observances and practices can be accommodated without compromising patient care. When accommodation cannot be made, however, professionalism and the physician's duty to care must take precedence.

In a similar vein, when one chooses to become a physician, one commits to take care of the sick regardless of their habits and shortcomings. Physicians must refrain from denying care to patients whether or not their behavior is morally wrong, unnatural, or even illegal. A physician should offer the best evidence-based advice, be available to the patient, and work to restore health, even if the patient ignores medical advice and neglects his or her own health. This duty is not always easy to accept, but it is required

of a professional committed to taking care of all people regardless of their lifestyles, habits, and beliefs.

As a designated institutional official (DIO), I'm often asked whether there should be hospital policy that honors religious practices and holidays in the scheduling of resident work hours. Graduate medical education lasts 3-7 years out of a professional life of 30-40 years. My preference, therefore, is not to create hospital policy, but to allow house staff to work out scheduling among themselves, so that, when they enter practice, they are used to doing so. As professionals, physicians should be able to accommodate one another's needs—and work when necessary—to ensure that patient care is not jeopardized.

In summary, physicians must act reasonably, responsibly, and professionally and use common sense and good judgment. A physician must not allow his or her religious beliefs to interfere with providing the best possible evidence-based care to patients.

Mahendr S. Kochar, MD, is senior associate dean of Graduate Medical Education and professor of medicine and of pharmacology/toxicology at Medical College of Wisconsin in Milwaukee. He is also executive director of the Medical College of Wisconsin Affiliated Hospitals, Inc in Milwaukee.

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Op-Ed

The Growing Abuse of Conscientious Objection

by Rebecca J. Cook, JD, JSD, and Bernard M. Dickens, LLB, LLM, PhD, LLD

Physicians' rights to refuse to participate in medical procedures that offend their conscience may be incompatible with patients' rights to receive lawful, medically indicated treatment. Historically, the goal of medicine has been to provide care to the sick. The World Medical Association's modern variant of the Hippocratic Oath, The Declaration of Geneva, inspires the graduating physician to pledge that, "The health of my patient will be my first consideration" [1]. For many who enter medicine, the commitment to assist their fellow human beings and pursue a path of personal salvation through this professional calling is religiously inspired. A conflict of interest can arise if the physician's religious or other conscientious convictions are in tension with medically indicated procedures. The obvious case is therapeutic abortion, but analogous cases include contraceptive sterilization and withdrawal of life support from otherwise viable patients. Physicians who give priority to their own moral and spiritual convictions over their patients' need and desire for medically indicated care face a conflict that needs resolution [2].

The ethical conflict can be avoided through mutual accommodation; physicians have the right to decide whom to treat, and patients have the right to decide from whom they will receive care. Physicians do not have the same ethical duties to nonpatients as to patients except in emergency circumstances [3]. In all other circumstances, physicians are at liberty to choose those for whom they will accept the responsibility of care. If there are services they will not perform, physicians should make that fact known to patients for whom they have accepted responsibility. Doing so not only saves patients the distress of seeking those services and being turned down, it also saves physicians from the dilemma of unfulfilled responsibilities to those whose care they have agreed to undertake. This arrangement is well understood in medicine; physicians who notify prospective patients that they are, for instance, pediatricians, will not be asked to treat those requiring geriatric care, and geriatricians do not have to accept patients seeking pediatric services. More explicit disclosure is required, of course, when prospective patients may reasonably expect that care will be available from the specialists they approach. Obstetrician-gynecologists who will not participate in abortion procedures must make that fact clear before forming patient-physician relationships.

Clinicians who have already established professional relationships with their patients have an obligation to refer them to alternative sources of care if they do not intend to offer particular services [4]. Referrals of this sort do not constitute participation in any

procedures agreed upon between the referred patient and the physician to whom the patient is referred. If, for instance, the second physician were to counsel or treat the referred patient negligently or unlawfully, the referring physician would not be a participant in the negligence or illegality. Similarly, the referring physician does not participate in the treating physicians' fee. The ethical duty of referral, which reflects legal duties that arise in the patient-physician relationship, is made clear in the World Medical Association's 1970 Declaration on Therapeutic Abortion, which provides in article 6 that:

If the physician considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of medical care by a qualified colleague [5].

Fulfilling duties owed to others is also a central religious value. In his 1991 Message for the 24th World Day of Peace, entitled "If You Want Peace, Respect the Conscience of Every Person," Pope John Paul II stated:

Freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses [6].

In the same address the Pope warned against political, religious, or other forms of extremism that deliberately deny or violate human rights. He warned against authoritarian intolerance of conscientious convictions and "the recurring temptation to fundamentalism, which easily leads to serious abuses" [6].

The late Pope's primary experience was of *political* fundamentalism's or totalitarianism's intolerance of religion, but *religious* sectarianism can itself be the cause of intolerance.

Conscience Clauses in Legislation

Legislation currently being passed in some states and considered in others protects the right of conscientious objectors not only to practice their own religious faith but also to impose their objections on those of different conscience [7]. The effect of conscientious objection when exercised by physicians is to frustrate or negate patients' legal rights of access to abortions and other services including emergency (or postcoital) contraception. Medication-induced emergency contraception and termination of pregnancy have (like the prevention of pregnancy) become possible through use of prescription drugs. Opposition has therefore come from physicians' objection to writing prescriptions for either medication-induced abortion or emergency contraception and also from pharmacists' objections to filling them. Medical evidence suggests that once an embryo has become implanted in utero emergency contraceptives will not affect gestation. The conscience-based objection is predicated on the possibility of delayed or impaired implantation of an embryo, in which case, the emergency contraception drug could act as an abortifacient. On this reasoning, use of emergency contraception conflicts with the religious and moral beliefs of some physicians and pharmacists.

Legislation, typified by a law enacted in Mississippi in 2004, protects a wide range of health care and health-related professionals and institutions against criminal law and civil (ie, non-criminal law) liability for withholding their services on grounds of “the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer” [7]. This law grants immunity to a physician for refusing to undertake a life-saving procedure on a patient and to refer her to a nonobjecting colleague; to a nurse for refusing to undertake hygienic care of an abortion patient; to a hospital staff member for refusing to prepare or serve meals for such a patient; and, for example, to an ambulance driver or paraprofessional for refusing to carry a patient believed to be suffering incomplete induced abortion. Paradoxically, a physician’s or pharmacist’s refusal to supply emergency contraception to a rape victim could lead to her resorting to abortion.

In short, such legislation, enacted or proposed in several states, entitles physicians and many other health care professionals to violate the most basic ethic of medicine by disregarding patient care. It also allows hospitals and other health facilities to neglect the medical needs of their patients, prospective patients, and dependent communities. Religiously affiliated hospitals, the first established facilities for administering health needs, are now absorbing nondenominational hospitals, thereby reducing lawful health service levels in those communities [8]. The American Medical Association, American Bar Association, and many other professional associations have condemned the violations of professional standards and ethics exemplified by such legislation [9, 10]. Religious initiatives to propose, legislate, and enforce laws that protect denial of care or assistance to patients, (almost invariably women in need), and bar their right of access to lawful health services, are abuses of conscientious objection clauses that aggravate public divisiveness and bring unjustified criticism toward more mainstream religious beliefs. Physicians who abuse the right to conscientious objection and fail to refer patients to nonobjecting colleagues are not fulfilling their profession’s covenant with society [11].

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Rebecca J. Cook JD, JSD, is the faculty chair in International Human Rights, the Faculty of Law, and is cross-appointed to the Faculty of Medicine at the University of Toronto. She is also the codirector of the International Programme on Reproductive and Sexual Health Law at the University of Toronto.

Bernard M. Dickens, LLB, LLM, PhD, LLD, is the Dr William M. Scholl Professor Emeritus of Health Law and Policy in the Faculty of Law, the Faculty of Medicine, the Joint Centre for Bioethics, and is the codirector of the International Programme on Reproductive and Sexual Health Law at the University of Toronto.

Related Articles

[Reproductive Rights](#), September 2004

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Op-Ed

The Myth of Value Neutrality

by Paul J. Hoehner, MD, MA

The patient-physician encounter is, by its nature, a value-laden encounter, a fact that provokes a number of ethical questions, especially when differing values conflict within the clinical setting. Can the moral values that lead many students into the field of medicine be set aside when they conflict with those of patients? Are a physician's values always secondary to those of the patient? Whose values should guide clinical decisions? These are complicated questions. The loss of a moral consensus in the medical profession (and society as a whole) and the embrace of philosophical pluralism are evident in the medical profession's acceptance of the seductive but ill-defined concept of "physician value neutrality" [1].

The image of the physician as "natural scientist" has had a significant role in fostering this concept. Rosenberg and Towers write that, "The natural scientist has traditionally sought to suspend all feelings, attitudes, and other presumed sources of potential bias in the observations of external phenomena" [2]. Accepting the natural science approach to medicine presupposes that physicians should be value neutral, ie, completely objective, in order to prevent their therapeutic plans, diagnoses, and relationships with patients from being influenced by values, beliefs, feelings, and other "unscientific" biases. The value-neutral concept shows up early in medical school, where, sociologist Theodore Dorpat writes, there is a "misapplication of a natural science model of neutrality to the student's patient-physician relationships" [3]. But John Peppin notes in an essay entitled "Physician Values and Value Neutrality" that there is more than a misapplication of the natural science model going on here. The criticism of certain disciplines for their nonscientific bases, Peppin says, "ignores the reality that the foundations of science, those basic presuppositions that must be assumed to do science, are also without 'scientific' basis" [4]. Why then, should this critique apply to the art of medicine when our subjects are real people, with emotional, psychological, and spiritual natures?

Expectations that physicians will act objectively are well grounded. Beauchamp and Childress, in their seminal work *Principles of Biomedical Ethics*, believe that information provided to patients must be free from the "entrenched values and goals of medical professionals" [5]. Physician and health law scholar, David Orentlicher, states that physicians should "examine their practices in order to ensure that they are not imposing their values, wittingly or unwittingly, on patients' end of life decisions" [6]. And Bruce Miller concurs: "Physicians and other health professionals are to respect the values of patients and not to let their own values influence decisions about treatment"

[7]. Even television doctor Dean Edell suggests that physicians, “particularly when suggesting life-style changes...must act non-judgmentally—often despite their own feelings of anger or indignation” [8].

I believe that these expressions, said to be essential, even axiomatic, to the patient-physician relationship, have undermined our profession to a staggering degree. Any relationship between 2 people involves values, and these are especially significant in the advice and treatment physicians offer their patients. There have been scores of articles decrying the loss of empathy, sympathy, and compassion in the modern health care system—emotions that are at the core of what is envisioned as good health “care.” But one wonders how these sentiments could ever be expressed in a value-neutral system.

Furthermore, physicians are consistently called upon to exhibit a whole range of ethical traits all of which are expressions of their underlying beliefs and are defined in value-laden language. As Peppin emphasizes,

The worth of persons, the importance of helping those in need, caring for the sick, and role of the physicians are all important aspects of the ability to express these traits in action. Religious beliefs, world views, and political beliefs all form the foundations upon which our values stand. We cannot separate our actions from these foundations without having actions which lack substance [9].

Moreover, to suggest that physicians should act “non-judgmentally” is to misunderstand how medicine works. Physicians constantly judge behavior, whether it is smoking, sedentary lifestyles, stress management, or interpersonal relations. Eric Cassell states that, “[o]nly the physician as a person can empathically experience the experience of a sick person,” and

the information on which the process of recreating the past is based is value laden and cannot be separated from the aesthetics of parts of wholes—the whole patient, the whole of patient and doctor, and the whole of patient, doctor and setting [10].

In other words, physicians’ values affect how they interpret their patients’ histories, their relationships with patients, and their therapies.

Proponents of neutrality claim there is a “2-tiered” system of values—with a distinction made between the “personal” and “professional.” Professional values are those agreed upon by the majority of the profession that inform the set of “appropriate” principles for a physician to act upon within the context of the patient-physician relationship. Personal values, such as those derived from religious belief, neutrality proponents argue, should not enter into interactions with patients. But, as John Peppin observes, a profession has no values apart from those professed and exhibited by individuals within that profession [11]. What is the basis for deciding which of these are “professional” and which are “personal”? Physicians must engage all the values they hold when developing their relationships with patients. A truly value-neutral doctor would have no patient-physician relationship of significance. Even with respect to religious values,

Denise McKee notes that a “physician cannot choose whether to acknowledge religious variables in practice; they exist, whether recognized or not” [12]. And Roy Couser states in *The Myth of Religious Neutrality* that “religious belief is the most influential of all beliefs, and most powerful force in the world...the most decisive influence on everyone’s understanding of the major issues of life” [13]. Clearly, physicians have the same “religious variables” (recognized or not) as non physicians, which have a profound effect on how they see and interpret the world. These beliefs help define who physicians are and, most importantly, form the foundations upon which all values rest. They also have a tremendous impact on how physicians practice medicine.

To expose the myth of value neutrality is certainly not to undermine the importance of patient values or the very real vulnerability of our patients in any clinical encounter. The power differential between physician and patient can easily be exploited, and we must be reminded of that possibility continually. There is a fine distinction between the values that guide our practices and patient interactions and how we engage our patients around those values. Not every meeting with a patient is an “evangelistic encounter,” nor should it be. And certainly there are times when we must advocate for our patient’s values, not ours, as they apply to important treatment decisions. To make these fine-line distinctions in our patient encounters takes wisdom, discernment, and judgment. But this is a far cry from being “value neutral,” since wisdom, discernment, and judgment are also value-dependent concepts.

In this era of respect for diversity, we need more than ever to bury the myth of value neutrality. Not only is value neutrality impossible, but the pretense of practicing medicine under its umbrella only undermines a competent, caring, and honest patient-physician relationship. The myth is built upon a poor foundation and is ultimately a nonsensical intellectual surrender to philosophical pluralism. Dorpat suggests that members of his profession have a choice “between an open and honest expression of their values and pursuing a ‘vain ritual’ of moral neutrality that, because it invites men to ignore the vulnerability of reason to bias, leaves it at the mercy of irrationality” [14]. Physicians have the same choice. And patients also have a choice. As Peppin acknowledges,

If patients could select physicians who shared similar values this would seem at least more honest and more in keeping with a number of current medical ethics paradigms including the principles approach of Beauchamp and Childress, the virtue approach of Pellegrino and Thomasma, and Siegler’s ‘Doctor-Patient’ encounter [15].

It seems both timely and honest, given our pluralistic society, for physicians, as a first step in appreciating medical ethics and regaining the trust and confidence of their patients, to make every possible effort to understand more clearly and evaluate more critically their own worldview, values, and faith. They may then provide some type of honest statement that would give patients an idea of where they stand on important moral issues. In such a context, sharing—not imposing—one’s faith and values is both truthful and commendable.

Notes and References

1. There is a confusion between “empirical plurality” and “philosophical pluralism” in American society today. Plural-*ity* sums up the growing diversity in our culture. It refers to the sheer diversity of race, value systems, heritage, language, culture, and religion in many Western and some other nations. Plural-*ism* is a philosophical or ideological statement which maintains that any notion that a particular ideological or religious claim is intrinsically superior to another is necessarily wrong. The practical result of philosophical pluralism is to deny any objective truth claim or deny that any objective truth can ever be obtained. It was natural for this type of thinking to spill over to the medical profession with the nebulous concept of “physician value neutrality.”
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Paul J. Hoebner, MD, MA, is a cardiovascular and thoracic anesthesiologist in private practice in Charlottesville, Virginia. He is a Harvey Doctoral Dissertation Fellow in Theology, Ethics, and Culture in the Department of Religious Studies at the University of Virginia where he is completing his PhD in theological ethics.

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Contributors

Kelly D. Brownell, PhD, is chair and professor in the Department of Psychology and professor of epidemiology and public health at Yale University and director of Yale's Rudd Center for Food Policy and Obesity.

Rebecca J. Cook JD, JSD, is the faculty chair in International Human Rights, the Faculty of Law, and is cross-appointed to the Faculty of Medicine at the University of Toronto. She is also the codirector of the International Programme on Reproductive and Sexual Health Law at the University of Toronto.

Sayantani DasGupta, MD, MPH, is assistant clinical professor of pediatrics and faculty and Advisory Board member of the Program in Narrative Medicine at Columbia University. She is also on faculty at Sarah Lawrence College where she teaches courses on illness narratives. She is co-author of *The Demon Slayers and Other Stories: Bengali Folktales* (1995), author of *Her Own Medicine: A Woman's Journey from Student to Doctor* (1999), and co-editor of a forthcoming volume of women's illness writing called *Stories of Illness and Healing: Women Write their Bodies*.

Bernard M. Dickens, LLB, LLM, PhD, LLD, is the Dr William M. Scholl Professor Emeritus of Health Law and Policy in the Faculty of Law, the Faculty of Medicine, and the Joint Centre for Bioethics and is the codirector of the International Programme on Reproductive and Sexual Health Law at the University of Toronto.

Jack Drescher, MD, is a training and supervising analyst at the William Alanson White Institute in New York City. He is adjunct clinical assistant professor at the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, clinical assistant professor of psychiatry at State University of New York-Downstate (Brooklyn), and in private practice in New York City. Dr Drescher is also completing his sixth and final year as chair of the American Psychiatric Association's Committee on Gay, Lesbian, and Bisexual Issues.

Andrew Fergusson, MB, MRCP, is president of the Center for Bioethics and Human Dignity in Bannockburn, Illinois. He was a practicing family physician in a deprived area of London for 10 years.

Nicholas J. Fitzsimons, MD, is a third-year urology resident at Duke University Medical Center in Durham, North Carolina. He is currently working on prostate cancer outcomes research.

Stephen J. Freedland, MD, is an assistant professor of urology and pathology at the Duke Prostate Center, Duke University and the Durham Veterans Administration Medical Centers all in Durham, North Carolina. His research interest is in prostate cancer and obesity.

Helen Harrison, co-author of *The Premature Baby Book* and author of “The Principles for Family-Centered Neonatal Care,” is the mother of a 30-year-old prematurely born son. Mrs Harrison lives in Berkeley, California, and moderates the Internet support group NAROF (Neonatology and the Rights of Families).

Paul J. Hoehner, MD, MA, is a cardiovascular and thoracic anesthesiologist in private practice in Charlottesville, Virginia. He is a Harvey Doctoral Dissertation Fellow in Theology, Ethics, and Culture in the Department of Religious Studies, at the University of Virginia where he is completing his PhD in theological ethics. He is a fellow of the American Heart Association, Council on Cardiovascular and Thoracic Surgery, a member of the Christian Medical & Dental Associations National Ethics Commission, and was appointed to the Commonwealth of Virginia House of Delegates Joint Subcommittee on Medical, Ethical, and Scientific Issues Relating to Stem Cell Research.

Mahendr S. Kochar, MD, is senior associate dean of Graduate Medical Education and professor of medicine and of pharmacology/toxicology at the Medical College of Wisconsin in Milwaukee. He is also executive director of the Medical College of Wisconsin Affiliated Hospitals, Inc in Milwaukee.

John M. Lorenz, MD, is professor of clinical pediatrics in the College of Physicians and Surgeons at Columbia University in New York. He is director of clinical research in the Division of Neonatology, chair of the Pediatric Ethics Committee, and attending neonatologist at Morgan Stanley Children’s Hospital of New York Presbyterian. His research interests include long-term newborn intensive care outcomes, the impact of variation in clinical practice on outcome, and decision-making in the neonatal intensive care unit.

June M. McKoy, MD, MPH, JD, is an assistant professor of medicine and preventive medicine at Northwestern University’s Feinberg School of Medicine and a member of the Ethics Committee at Northwestern Memorial Hospital and the Institutional Review Board at Northwestern University, in Chicago, Illinois.

Rebecca M. Puhl, PhD, is coordinator of Community and Weight Stigma Initiatives at the Rudd Center for Food Policy and Obesity at Yale University.

Staff Contributor

Allison Grady is a senior research assistant and editor of *Virtual Mentor* at the American Medical Association.

Theme Issue Editor

Manish Tushar Raiji is a second-year student at Michigan State University’s College of Human Medicine. He received a BS in economics and science from the University of

Michigan, Ann Arbor, with a research focus on economic disparities. He also served as an associate editorial page editor for the *Michigan Daily*. While receiving a master's degree in teaching from Johns Hopkins University, Manish taught sixth-grade mathematics in Baltimore, Maryland, for Teach for America.

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