Virtual Mentor

OP-ED
A Toolkit for Practical Medical Ethics
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"The aspect of the bull changes when you move into the arena."—Old Spanish proverb

Autumn Fiester has argued that the principlist paradigm typically taught to medical students and residents leaves them poorly equipped to navigate the ethical complexities associated with patient care [1]. Based on 2 decades of experience with medical students and residents in the hospital setting, I agree with her conclusion. Consider the following scenarios:

A confused third-year medical student, thought by the faculty to be one of the top students in her class, stated soon after her first clinical rotation,

> I am excited about finally being in the clinical setting. I want to help patients. I want to contribute to the team. I understand I need to make my upper level look good. And yes, I want to impress the residents and attendings. But now I feel very uncertain. It's demeaning to be told, "We don't have time for a third-year medical student to do the H/P," and then to be ignored. The one thing I thought I knew how to do was a history and physical. I am afraid of failing, of appearing weak.

A shaken student near the end of his third year, in response to questions about the way he selects rotations and thinks about possible residency programs, realized,

> It's all about balancing residency program status with personal convenience. I am in the rural-track program of my medical school because I began with the intent to practice in an underserved area. But my fellow rural-track students and I hardly ever talk about that goal when we discuss rotations and the residency programs we are considering.

A troubled resident, near the end of his first year, answered, "What have I learned about myself this year? I have learned how mean and selfish I can be."

A second-year ob-gyn resident, during a lunch conversation, admitted,

> By the third year of medical school, I realized that being a physician is not what I had envisioned. Being with patients and making a difference in their lives 90 percent of the time would be great. Even 70 percent. But 40 percent or less? I feel stuck. What else can I do? It is hard to quit after having invested so many years. I am frightened by the ways I have changed. Fatigue

has darkened my mood and shaken my plans. My family and friends do not understand how tired I am. Will these changes reverse after residency?

A young physician, 3 years out from residency, explained,
The audience in residency is your attending physician. You tend to adopt his or her approach. If you take your own approach, you risk getting into trouble. So you put personal responsibility on a back burner. Your career rides on the attending's interpretation and your upper level's interpretation of your performance. Residents, especially interns, implement the decisions of those above them. Addressing the chief complaint without falling further behind severely restricts attention to deeper issues in the patient's story. This cycle eats away at the joy of what you are doing. Many residents take the position, "When I get out, I won't do it that way." The danger in taking a "later" attitude is that you tend to become what you do.

Fiester argues that the principlist paradigm as a template built around the four classic principles of biomedical ethics (1) lacks the rich and expansive potential for seeing into the ethical dimensions of patient care inherent in the theory of principlism and (2) fails to detect numerous ethically worrisome factors in patient care. She calls for ethics educators to rethink the tools they give medical students and residents. The following sections illustrate how I have responded to this call at Barnes-Jewish Hospital, the teaching hospital for Washington University, St. Louis School of Medicine.

Defining Ethics amid Clinical Realities
Each individual forms a sense of what is of ultimate value and what is of lesser value. These core values serve as a filter through which information is interpreted before being applied to life's decisions. Certain relationships, experiences, circumstances, and objects are regarded as so important to an individual that he or she is prepared to suffer great loss rather than violate them. Judgments about what ought or ought not to be done can usually be acted upon safely without much conflict. Some situations, however, require a collective judgment from a number of individuals with competing goals or divergent viewpoints. Here, a broader approach to decision-making—i.e., ethics—is necessary. Ethics then has to do with the determination of what ought to be done in a given situation, all things and all people considered.

The words "ethics" and "ethical" are used frequently in routine discourse about patient care. In seeking to understand how these words are being defined, I often ask caregivers what they understand to be the ethical dimensions of care in their patient care settings. If and when ethics needs to be reduced to a single concept, I point to the resolve to be respectful. By pausing to consider the etymology of respect (i.e., L., *re + specere*) and to recall the many words that share this root verb and image, we can use this common word as a prism by which to analyze our decisions.

Well-Intentioned People Can Reach Different Conclusions about What Ought to Be Done
Well-intentioned individuals may come to different judgments about what should be done in a given situation because they consider quite different aspects of the situation or they assign different weight, priority, and value to considerations they share. When I go on patient rounds in various care settings, I take copious notes as I move with the team from patient to patient. Some member of the team almost always pulls me aside at some point to ask, "What are you writing down? What are you hearing us say?" I often answer, "I am listening to how you and your colleagues are talking about the experience of caring for the patient. Not so much what you eventually write in the chart, but the discussion that includes your descriptions, emotions, narratives, whispered exchanges, humor, and editorial comments. That discourse reveals what you and your colleagues consider important enough to influence what should be done in caring for the patient."

Based on such observations during rounds, I created a two-part exercise that begins by asking participants to imagine being in the middle of a busy day with a complicated patient. The first part of the exercise introduces in routine language several theories of ethics, each one accompanied by a marginal-to-ultimate scale of weight and importance to the case at hand. The second part of the exercise introduces other considerations I routinely detect on rounds that are rarely addressed in textbooks or courses about medical ethics (e.g., educational benefit, research benefit, fatigue factor, disruption to the day's schedule, staffing limits, tasks that will be passed on to the next team, personal or social plans). These considerations deeply influence the judgments medical team members make about what should be done in caring for a patient.

It is important to encourage conflicted parties to hold as long as possible the assumption that each one is well-intentioned and only surrender the assumption after careful examination produces overwhelming evidence to the contrary.

When and Why Does Trust Break Down in Patient Care?
When I ask caregivers this question, they invariably respond, "Failed communication." A proactive and preventive approach to the ethical dimensions of patient care encompasses communication within its scope.

One of my first collaborations with the staff in our hospital's cardiothoracic ICU was to identify vulnerabilities in the routines of patient care communication that, when they falter in some combination, result in a deterioration of trust and respect. We eventually focused on three vulnerabilities: (1) the information upon which patient care decisions are made, (2) the decision-making process, and (3) the goals that influence patient care decisions. I then developed a tool that provides a construct for examining each vulnerability in two steps—first with a description and then with a set of assessment criteria [2].

In didactic sessions with residents and medical students, I often introduce this tool by first asking the participants to imagine the responsibility engineers have to ensure that bridges and buildings have structural integrity. Bridges and buildings can then be used as metaphors for the delivery of a patient's care from admission to discharge. Such visual aids prepare the participants to explore the link between the structural integrity of the communication infrastructure upon which patient care depends and the ethical dimensions of patient care.

And who is responsible for regularly assessing the communication infrastructure upon which patient care depends? We all are.

Involving Patients and Their Surrogates in Decision Making
Consider the following encounter:
An intern writes orders for the nurse to obtain a urine sample for a drug screen. When the nurse asks for the urine sample, he tells the patient what tests will be conducted. The patient refuses to consent to the drug screen. The nurse tells the intern the patient would not consent. The intern criticizes the nurse for mentioning the drug screen and tells him, "I don't care that he doesn't give consent, go back in there and get the urine and send it. I will deal with it later."

This scenario highlights the disagreements common in the clinical setting over when and how to involve patients and surrogates in decision making. I created a bubble gram to assist residents and medical students think through such cases. This tool identifies four questions that should be asked about shared decision making: "Does this need to be mentioned to the patient?" "Should the patient be made aware though there is no decision to discuss?" "Should the patient be informed sufficiently to be able to question or object?" "Should the patient share in the decision making?"

This tool calls attention to how few activities in the plan for a given day call for shared decision making and opens discussion of the choices other than shared decision making by (1) identifying the factors that influence a medical team's choices and (2) testing a medical team's ability to give ethical justification for whichever of the four choices it will act upon in a given case. The significance of decisional capacity in determining whether to involve patients and surrogates is emphasized.

Sensible Care at Life's End
I asked two residents who were near the end of their medicine ICU rotations, "At any given time, how many of the management plans make no sense to you?" I explained that my question did not have to do with the management plans' internal medical reasoning, but instead with the link between the management plans and feasible outcome expectations. Both residents responded, "Fifty percent."

Discussions between the patient (or surrogate) and the health care team should lead to consensus regarding the patient's expectations for the hospitalization. The patient may refer to expectations such as restoration to preadmission functional status, relief

from pain and suffering, survival regardless of quality of life, or survival long enough for desired closure. Quality of life unacceptable to the patient may include being permanently in one of the following conditions: unconscious, unable to remember or make decisions or recognize loved ones, bedridden and dependent on others for activities of daily living, or dependent on hemodialysis, artificial nutrition, or hydration. The focus of care should be restoring the patient to a level of function compatible with his or her expectations, with all medically appropriate therapies being initiated and continued. If the medical team concludes that such restoration cannot be achieved, further discussion with the patient or surrogate is needed to reconsider the expectations for the hospitalization. Based on this discussion, management may not be escalated, additional interventions may not be introduced, and current life-sustaining treatments may be discontinued, so as not to place undue burden on the patient. In some cases, the focus of care should shift to concentration on the patient's comfort during the dying process. Treatments that serve only to prolong the process of dying or place undue burden on the patient should, in these cases, not be initiated or continued.

Sustaining such communication with patients and their families is an art. I have collected the following list of discussion starters from physicians who have mastered this art:

- What makes for a good day for you? (With attention on how the patient or surrogate defines "good.")
- What are your difficult days like? (With attention on how the patient or surrogate defines "difficult.")
- Do your good days help you make it through your difficult days? (With attention on indications of how firm a "yes" is and whether the good/difficult ratio is diminishing.)
- Do you more often find yourself waking up in the morning hoping for a good day or hoping not to have a bad day? (With attention on how encouraged or discouraged the patient is.)
- What do you want me to know as the team and I consider how best to take care of you? (With attention on acceptable or unacceptable outcomes rather than on management plan details.)
- What outcomes do you want to keep fighting for? (With attention on how feasible the outcomes are.)
- Are you concerned that your illness will interfere with your participation in any activities or events in the near future that are especially important to you? (With attention on what demands these activities or events would make on the patient, how feasible it is for the patient to participate, and what condition the patient hopes to be in at the time of these activities or events.)
- Do you have any questions or worries that are difficult to talk about with your family or friends? (With reassurances that such can be discussed with you in complete confidence.)

- Patients sometimes tell me they find themselves thinking, "That would be worse than dying." Have you had this thought? (With attention on indications regarding what such conditions would be.)

Conclusion

Anxious medical students cope with their disillusionment behind an unstated code of silence, without the means to make meaningful use of ethical theory or of consensus statements in the professional literature. Weary residents wrestle with pressure to focus on priorities other than actions and experiences that would benefit patients. Insecure young physicians stumble through their first few years after residency without mentors to hold them accountable as they sort out their professional values and priorities. They need analytical tools designed specifically for use in the arena.

References
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2. Brown D. "Rethink the tools": a response. 2009. http://sites.google.com/site/rethinkthetools1. Accessed October 8, 2009.

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