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Ethics in Medicine: Are We Blind? In Support of Teaching Medical Ethics at the Bedside

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The ability to recognize and respond to the ethical dimension of medicine is integral to providing health care that is comprehensive and humane. However, this aspect of medical practice is underemphasized in clinical and academic medicine, despite attempts to devise curricula in this field. This paper examines the origins and consequences of this deficiency through a case history of a Jehovah's Witness who reluctantly accepted a blood transfusion. It emphasizes the ubiquity of the ethical context in medicine and argues that blindness to this context stems from the prevailing scientific and technological paradigm in medicine. Innovations in medical education are called for to enhance health care providers' abilities to appreciate and cope with these complex situations.

Though man may seem to have gained
ascendancy over nature. . . .
he has not yet gained control over
his own nature. (1)

INTRODUCTION

The current medical school and residency training system effectively prepares physicians to cope with the technical aspects of organic illness. Unfortunately, however, the ethical and moral aspects of health, illness and

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death are underemphasized during both medical training and in the routine practice of medicine. Health care, it seems, is often provided in a kind of ethical vacuum, a place where ethical issues, if recognized, can be perceived as less relevant to the clinician who is often preoccupied with a patient's more immediate organic medical problems.

Nevertheless, the ethics of medical care is receiving increased attention from lay people and from the medical profession. The press now routinely reports on ethically and legally complex medical cases, hospitals have established ethics committees and consultation services (2) and have designated ethicists-in-residence to advise physicians, and all medical schools now include medical ethics in their curricula. Medical bookstores even sell a clinical guide to medical ethics, pocket-sized for easy bedside reference (3).

Our rapidly aging population with its chronic health problems, our increasingly technological approach to helping the ill, including the development and use of modern life support equipment and the mounting pressures of cost containment, have made ethically complex clinical situations more prevalent. As a result, the medical community has been forced to pay more attention to the ethics of medical care.

The growing dialogue in academic medicine on medical ethics has begun to illuminate the issues and provide some basic guidelines for physicians confronting particularly troublesome ethical dilemmas, even while the legal aspects of these situations often remain ambiguous. But this light has yet to penetrate the trenches of *everyday* practice where situations arise that may initially appear to be uncomplicated but can ultimately demonstrate a profound ethical dimension. Furthermore, serious doubts have been raised about the effectiveness of medical ethics curricula, which in fact has been characterized as still undergoing experimentation (4).

As a medical student, I was involved in a case which illustrates many of these issues. The following case history is told not to argue that insensitivity to the ethical side of medicine necessarily risks an adverse medical outcome, but to point out how the ethics of a case, often appearing invisible, inconsequential or irrelevant to the care-giver, may unexpectedly be of fundamental importance to the patient, his family and his doctor.

CASE HISTORY

By the time he presented to my hospital's emergency room, Mr. Lester Phillips (not his real name) was already a very sick man. He was quite short of breath and his hematocrit was low and dropping progressively lower. He appeared to be in high-output congestive heart failure:

the medical resident and I took one look at him and some preliminary lab results from the emergency room, and we knew that, in order to survive, he would need several units of blood immediately. I was aware of his religious convictions and knew that, as a Jehovah's Witness, he was likely to refuse a transfusion. My response to this dilemma was not reflective or cautious; instead, I rather quickly made what seemed at the time, a simple decision: I would change his mind and convince him of the necessity of the treatment. I made this decision *even before I had met the man or knew anything about him or the nature of his particular religious convictions.* This strategy was tacitly endorsed by the senior members of the medical team although we never discussed the ethical issues involved.

Sure enough, citing his religious convictions and with the decisive support of his family members, Mr. Phillips refused the transfusion. I, however, was not discouraged even by such unanimity and so over the next day I spoke with Lester quite often. I talked with him about the nature of his disease, and he told me about the nature of his religious beliefs. What kind of God is it, I asked, that would proscribe a life-preserving treatment? As his difficulty breathing increased and the disease process gradually strengthened, his resolve began to weaken. I assured him that a transfusion would allow him to breathe more easily and, after much uncertainty, Lester relented and accepted a transfusion of two units of packed red blood cells. I actually felt victorious and, despite all the tension and confusion of the previous two days, there was a warmth between us, a sense of shared relief. His family, however, was clearly shocked and alienated by his decision, but I was confident that their joy over his survival would eventually ameliorate their disapproval.

The next morning, I cheerfully entered his room, greeted his roommate, and stepped around the curtain separating the two beds. His bed was empty! It was freshly made, with military perfection, the sheets spotless and inviting for the next patient. This was certainly not a good sign, but maybe he was transferred to another room, or was out for a test or . . . but, where were his belongings? — the tables were ominously bare.

I later learned that the night before he had indeed received the transfusion, but apparently too quickly and without enough diuretic. The added volume of fluid in the transfusion overwhelmed his lungs. In acute respiratory failure, he was rushed to the intensive care unit. I went there and found him on a ventilator and, horribly, in a vegetative state. I later learned that he was the victim of yet another complication, having suffered a tension pneumothorax and cerebrovascular accident following the introduction of a Swan-Ganz catheter. Lester Phillips would not recover. His family came to visit only once.

DISCUSSION

Iatrogenesis is an obvious and disturbing element of these tragic events. But, other issues are also highlighted including my (and colleagues') unfortunate failure to recognize and adequately address the ethical dimensions of so complex a case. I have yet to decide if it is unethical to convince a patient to accept a transfusion that was initially refused on religious grounds, but which is needed to survive. Most people writing on this topic argue that a Jehovah's Witness' decision to refuse a transfusion should be respected. (These authorities, however, may not be sensitive to the subtleties and emotion of the actual situation, and I can't help but speculate that they too might be tempted to act paternalistically if they had in their care a dying patient whose clinical stability and potential subsequent successful treatment depended on the transfusion of blood products). The doctor-patient relationship in which the physician is asked to acquiesce to a patient's desires and needs is unfortunately unfamiliar and disquieting to physicians who, in general, are more accustomed to dictate therapy than act in partnership with patients. Dixon recognizes this conflict and goes on to note that: *"With the Witness patient, physicians are being asked to manage the medical or surgical problem in harmony with the patient's choice and conscience, his moral/religious decision to abstain from blood" (5).*

But to return to the question of why these issues were not addressed at the outset. It seems most likely that I failed to respect the patient's right to refuse the treatment by virtue of blindness to the ethical ramifications of my decisions. Or, I may have sensed that my actions were unethical but nevertheless tolerated an inconsistency between my beliefs and how I actually behaved towards the patient. In doing so it seems that I did not understand the conflict between my ethical responsibility to not let a person die versus a responsibility to respect that person's autonomy. In either case, the issues were never adequately identified, discussed or resolved to the satisfaction of patient, family or care-giver. And why not?

We could rephrase this question and ask which factors influence what we are sensitive to and what we perceive in our world. To find the answer we will have to look beyond the relatively narrow scope of medical science. Edmund Husserl, the early twentieth century philosopher who originated Phenomenology, believed that we perceive and interpret the world and all that happens in it as a function of our own particular, highly individual viewpoint or frame of reference which he defines as a perceptual stance (6). The nature of our stance or perceptual viewpoint is related to and reflects our individual concerns, or to put it simply, to what is important in our lives. It follows, then, that if our perceptual stance does not reflect

a grounding in ethics, then moral and ethical dilemmas, when they arise, are less likely to be recognized and dealt with.

Siegler has essentially endorsed this phenomenological interpretation in his statement that physicians are often ignorant of the way in which their own value systems influence their ethical and medical beliefs (4). The case of Mr. Phillips is evidence that ethical sensitivity may not automatically be a constituent of our relationship with patients, and may in fact be lacking despite educational programs in medical ethics. In this case, therefore, when I and my colleagues began to act in ways which in retrospect may seem unethical, we were quite unenlightened because such issues were not relevant to the predominately technological and scientific perceptual stance with which we understood the patient and his experience. The ethical dimension remained an abstract notion, discrete from the reassuringly concrete world of clinical medicine.

How can we stimulate our own perception of the ethical dimension of medicine? Husserl believed that *with practice* it is possible to shift our perceptual frame of reference, thereby providing our consciousness with access to an unfamiliar reality. R. D. Laing endorsed a similar concept in more practical terms when he wrote that: *"we are taught what to experience and what not to experience as we are taught what movements to make and what sounds to emit"* (7). The recognition and appreciation of the ethical aspect of our relationships with patients, like any unfamiliar activity, must be learned and, therefore, must somehow be taught.

A *new* curriculum for this endeavor is indicated. The case of Mr. Phillips reveals serious limitations of the popular case-history approach to teaching medical ethics. This experience taught me, a product of such a curriculum, that medical ethics case studies capture little of the emotion and pressure that make one's actual involvement so difficult and confusing. I certainly agree with the assertion that academic ethical discourse *"remains one step removed from the realities of actual decision making"* (8). In learning about organic disease processes, medical students and residents base much of their education on interacting with actual patients, the so-called Oslerian approach to medical education. This concept has been proposed for the study of medical ethics as well (4) and could provide physicians in training with an appreciation of how ubiquitous these situations are, how significant they are to patients and how relevant they are to the doctor-patient relationship. Teaching ethics at the bedside, where the student is exposed to the human and immediate nature of an ethical issue, can provide a powerful and lasting educational experience. An appropriate beginning to this effort would be in the area of informed consent which, it has been argued, must be regarded as an integral element of quality health care(9).

CONCLUSION

This case history is both an example and a painful lesson. It is an example of the preoccupation physicians have with the technological and scientific aspects of patient care. And it is a lesson in the consequences of neglecting the human and ethical experience of medicine: pain, uncertainty, confusion and alienation for patients, family and care-givers. These unfortunate outcomes can result, we have seen, from our inability to recognize or respond to the ethical and moral dimension of caring for our patients. This failure has been articulated in terms of a perceptual or phenomenological model which is consistent with the objectives of educational interventions that may be designed to enhance health providers' ethical consciousness. The argument here in support of structuring the educational programs at the bedside comes from a physician who has experienced the traditional case-history medical ethics curricula. In comparison, my lesson in ethics at the bedside of Mr. Phillips was incomparably more profound.

Before any attempt is made to improve education on medical ethics, however, we need to think how to create an environment in clinical medicine which encourages an open dialogue on ethical issues.

The alternative to such a reform of clinical ethics is the practice and teaching of medicine with a limited scope, to the detriment of both physician and patient. In such an atmosphere, controversy over physician behavior and patient rights may not be recognized at all, or perhaps only in the most dramatic cases or by observers outside of the medical field whose perception is sharpened by their distance and perspective.

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