Ethics Teaching on Ward Rounds

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Ethics teaching in medical settings usually takes place in the classroom or at specially designated times and places, as in "ethics grand rounds." The authors, an ethicist and an internist, have integrated ethics teaching into regular attending rounds. Three cases illustrated their approach.

. . . within the universe of things medical, the issues and dealings are so very sensitive, intimate, emotionally charged, and critical to lives. This calls for meticulous attention, fine distinctions, and careful surveillance. Hence, the intense focus and highlighting of ethics in medicine—to the point of giving it its own name, "medical ethics."

The other main reason for special attention to this realm is its sheer complication. The facts, probabilities, distinctions, risks, and benefits are so involved that it is not easy to act in accord with the moral rules even if you want to. Hence, it becomes imperative to magnify this sector to work through its microscopic webs.[1]

In a growing number of medical schools ethics is singled out and given special attention because the issues to be engaged in medical practice are often complex and the stakes in resolving those issues high. Yet, ethics in medicine differs in no essential way from ethics in life generally. What differences exist are situational.

Medical ethics teaching is done in a variety of settings, most commonly in the classroom but occasionally in such forums as the clinical case conference and ethics grand rounds. Theoretical issues are best dealt with in the classroom, and the lecture-discussion approach lends itself well to a consideration of such issues. The case conference and grand rounds, common in clinical teaching, are case oriented and encourage formal dialogue using a presentation-critical repartee format.

Ward rounds, in comparison to these other settings, are much less controlled. The pace is rapid, and the agenda is determined by patients and problems. Can the teaching of ethics be tailored to such settings? Can such teaching be effective in this fast-clip, tug-and-tumble atmosphere?

For approximately two years the authors, an internist and an ethicist, have made ward rounds in a community hospital with family practice residents on a general medical inpatient service associated with the University of Florida College of Medicine. The hospital is a 450-bed, non-profit general hospital with a medical staff of approximately 180 physicians, all in private practice. The family practice residency program is the only university based teaching service in the hospital. Three family practice residents staff the medical service to which they admit about 60 patients per month, with an average census of 20 patients. Faculty attending rounds are held six days a week, during which new patients are presented and the problems of all patients discussed. An ethicist accompanies the physicians on rounds once weekly. These Wednesday morning sessions are not what is coming to be known as "ethics rounds." Rather, they are regular ward rounds aimed at teaching family medicine by analyzing, criticizing, and reinforcing the care of sick patients as it is provided by residents under the close supervision

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of an attending physician. It should be noted, however, that one recent report identifies the purpose of "ethics rounds" at Children's Hospital Medical Center in Boston as being to help "elucidate the ethical content and moral implications of medical choices."[2] That coincides exactly with the purpose of our efforts.*

Case Reports

The following case reports illustrate our attempts to integrate ethics teaching into attending rounds.

Case 1: A Course of Treatment Decision

R.P., a 70-year-old male patient with severe chronic obstructive pulmonary disease, was hospitalized because of increasing dyspnea associated with progressive obtundation, weakness, anorexia, and inanition. Clinical evaluation demonstrated pulmonary infection and respiratory failure. Treatment was started with antibiotics, hydration, and pulmonary toilet. Pulmonary function, as judged by physical examination, vital signs, and arterial blood gases, improved slightly. R.P. remained obtunded, responsive only to painful stimuli (essentially unchanged since admission). The laboratory data excluded a metabolic cause for stupor. Although stable, he coughed only only when suctioned and deterioration appeared inevitable without intubation and ventilation. On teaching rounds the day following admission, the first year resident caring for him was undecided as to how aggressive therapy should be. He was torn between a desire to step back and "let nature take its course" and a sense of obligation to further evaluate Mr. R.P.'s stupor and to prolong his life as long as possible with more intensive respiratory therapy. In response to a question about the family's disposition, he stated that the patient's daughter had been very solicitous and was well informed about the gravity of her father's condition. She had not been asked how she felt about beginning more intensive therapy that might prolong her father's life.

A visit to the patient's bedside revealed a wasted elderly man in mild respiratory distress, unresponsive to verbal stimuli, obtunded but apparently comfortable in a fetal position. The general visual impression received on entering the room was striking. R.P.'s adult daughter, visibly grieving, was bathing her dying father. And this was no ordinary bath, but a ritual. Here was a woman in the throes of experiencing a loss, not yet complete but seemingly certain, and beginning to cope by preparing her father for death.

Caucusing in a conference room, the attending physicians and residents reviewed the options. The second year resident felt that the patient should be allowed to die on the grounds that his chances for recovery to even his previous debilitated state were virtually non-existent. The third year resident felt that the patient should be completely "worked up," intubated, and aggressive respiratory therapy initiated. The first year resident saw merit in both points of view but was faced with a decision.

In an attempt to clarify the clinical management of this patient, the ethicist differentiated between a treatment decision and course of treatment decision as described by Donegan.[3] Treatment decisions revolve around the technical aspects of therapy, such as which antibiotics to use, what tests to order, and the details of respiratory care. Much of attending rounds and residency training is directed toward this level of decision making. A *course* of treatment decision, stated or implicit, underlies the treatment decision to be made in Mr. R.P.'s case. The *course* of treatment hinges on such considerations as his quality of life, his chances for improvement, and the amount of suffering likely to be induced by the use of diagnostic and therapeutic maneuvers. The physician's twin obligations to prolong life and relieve suffering may at times be mutually exclusive, necessitating a choice of one over the other. The question regarding the patient's condition—is he very sick, or is he dying?—is a medical question best answered by a physician. The question—should R.P. be allowed to die peacefully or be subjected to further testing and therapy which may be frightening and painful?—is a personal question best answered by the patient fully appraised of the medical situation, or by a responsible family member if the patient is incompetent.

*For a slightly different approach to "teaching clinical ethics at the bedside," see Siegler MK: A legacy of Osler. JAMA 239:951-956, 1978

After discussing these concepts, the first year resident returned to the bedside where he reviewed with Mr. R.P.'s daughter the alternatives available and the choices to be made. After considerable discussion and in accordance with her wishes, he decided the *course* of treatment should be to comfort the patient and relieve his suffering. Mr. R.P. expired in respiratory failure the following day.

Case 2: A Matter of Consent

F.G., a 74-year-old man, was in good health until February 1978 at which time he was hospitalized with abdominal pain and jaundice. Laboratory and x-ray studies demonstrated obstruction of the common bile duct close to the pancreas. During exploratory surgery the pancreas was found to be enlarged and obstructing the common bile duct. Multiple biopsies were obtained and a choledochoduodenostomy was performed to bypass the obstruction. The biopsies revealed only fibrosis with no evidence of carcinoma. Consultants felt the primary cause of the pancreatic enlargement and duct obstruction was pancreatitis, although carcinoma remained a possibility. The postoperative convalescence was difficult and lengthy, but F.G. gradually improved and returned home in March feeling considerably better. He was seen frequently as an outpatient and continued to do well until August when he began losing weight and experiencing a recurrence of mild abdominal pain. He was then rehospitalized with increasing abdominal pain, fever, chills, and jaundice. Radiologic studies demonstrated obstruction of the common bile duct close to the site of the previous surgical anastomosis. A gastrointestinal consultant felt that the etiology of the obstruction was "almost certainly fibrosis and stricture of the anastomosis." Consultants from general surgery and gastroenterology both agreed that surgical decompression of the common bile duct was indicated.

Thus, it appeared that the patient had a benign stricture due to scarring and that surgery might be lifesaving and the long-term prognosis good. Without surgery the patient could expect increasing jaundice, liver failure, continued abdominal pain, sepsis, and death. The situation was explained to the patient and the family on numerous occasions by the resident physician, the attending physician, the surgical consultant, and the gastroenterologist. F.G. refused surgery. Mrs. F.G. acknowledged that surgery offered the only hope, but repeatedly stated that she would have to accept her husband's decision. His refusal apparently resulted from a feeling that he was too weak to withstand surgery, his recollection of the pain and discomfort of the previous surgical procedure and a desire to avoid that, and a sense of futility or hopelessness because he continued to feel worse in spite of receiving intensive medical therapy for more than a week. The consultants withdrew, stating that without Mr. F.G.'s permission nothing more could be done.

On hospital rounds the residents expressed concern about the patient's deteriorating condition and alarm at the practical consequences of his refusal of permission for surgery. One resident asked, should we attempt to coerce the patient to sign a consent form? Another queried, should he be discharged, as one consultant had suggested, because "nothing more could be done?" The crucial issue, the ethicist pointed out, was one of consent. In discussing this issue the residents concluded that the physician's primary responsibility was to ensure that the patient's decision be truly informed. Did Mr. F.G. understand that, although he now feels "too weak," further delay would increase both his weakness and operative risk? Had he been adequately reassured that the maximum pain relief possible would be administered and that the alternative (no surgery) would also result in increased pain and discomfort? Did he comprehend that surgery offered his only hope for resuming his normal activities? Did the patient, a reasonable man, have a clear and full understanding of his problem and its consequences? If so, all agreed the physician should abide by Mr. F.G.'s decision.

The resident returned to the bedside and raised these questions with F.G. and his wife. His approach was to ensure the patient's understanding and convey our readiness to support his decision. After openly confronting his desperate situation and the formidable decisions only he could make, F.G. consented to surgery. The subsequent operation demonstrated inoperable pancreatic carcinoma and F.G. expired several weeks later.

Despite the tragic outcome, the dilemma facing

the resident was resolved by identifying the issue of consent as the key issue, discussing briefly the nature and purposes of informed consent, and increasing patient involvement in the decision making process.

Case 3: A Difference of Opinion

A.W., a 65-year-old woman, was referred from an outlying Emergency Room for hospitalization on the family practice service. Her chief complaint was shortness of breath at rest and with exertion, gradually increasing over the previous several weeks. Her past medical history was unremarkable; she had had no previous serious medical illness. Evaluation revealed the patient to be in congestive heart failure and moderately severe chronic renal failure. Intravenous pyelogram demonstrated small scarred kidneys consistent with chronic pyelonephritis, suggesting little or no reversibility of the renal disease. After the usual therapeutic maneuvers there was only minimal improvement in her congestive heart failure, and renal consultation was obtained. The nephrologist began hemodialysis which rapidly corrected her fluid and electrolyte abnormalities with resolution of the congestive heart failure. After three weeks of hospitalization she was symptomatically well, controlled on periodic hemodialysis. Chronic long-term dialysis now became a consideration in discharge planning.

The patient lived alone in a small town in a shack with no running water or flush toilet. She had no identifiable living relatives or income other than welfare assistance. In view of her socioeconomic situation the only reasonable living arrangement appeared to be a nursing home. The resident physician and social worker initiated placement procedures. A problem arose, however, when the nephrologist stated that he would not continue chronic hemodialysis on a nursing home patient. He felt that this was a misuse of facilities and monies, apparently basing this judgment on the poor quality of life of many nursing home patients. It was clear that without hemodialysis the patient's prognosis was dismal. Mrs. A.W. suffered periods of mental confusion coupled with inappropriate behavior, but at other times was lucid and well oriented. The resident physician explored treatment options with the patient. She expressed her desire to continue hemodialysis regardless of her living situation.

We were confronted on morning rounds with an intermittently competent patient who could be kept alive only by continuing hemodialysis, her physician (the family practice resident) who felt that hemodialysis was indicated on a chronic basis despite the patient's borderline cognition and her quality of life, and a nephrologist who refused to consider long-term hemodialysis with a nursing home patient.

In response to questioning, the resident identified his primary responsibility as advocating and supporting the patient's position. This was difficult for him because his consultant, the "expert," disagreed with his conclusions. The disagreement, however, provoked further analysis which focused on the essential features of the situation. Was the patient competent to make a decision? Did she understand the risks and benefits of dialysis, and the alternatives? Was dialysis financially and technically a real possibility for her? The resident concluded that the answers to these questions were all affirmative and that A.W.'s living situation, although it presented an obstacle to her care, was an irrelevant consideration in the decision regarding the course of her treatment. He presented these arguments to the nephrologist, and in the ensuing discussion convinced the consultant that hemodialysis was appropriate.*

Comment

The task of medical ethics is to prepare the ground for moral actions and to articulate the moral implications of medical decisions. The authors' approach to this task is exemplified in the three case histories presented. Case 1 required a discussion of modes of clinical decision making. Case 2 involved a clarification of informed consent, and Case 3, a restatement of physician priorities. The examples, of course, represent only

*This case raised a number of other questions related to the ethics of professional peer relations. Whose patient was Mrs. A.W.? What are the limits of the legitimate authority of a primary care physician in his dealings with consultants? These questions, too, are particularly pressing for physicians-in-training.

a small parcel of the large domain of medical ethics. The cases chosen to illustrate the authors' teaching methods might have been handled differently but correctly by others. The case histories are incidental; the emphasis has been on the method of interweaving ward rounds and ethics teaching.

Although the ethical problems confronted in the day-to-day practice of primary care medicine are many, a circumscribed number of questions came up again and again: Who should decide? Should this dying person's life be prolonged? How does one act on an uncertain prognosis? How does one conduct oneself with one's peers? The ends served by elucidating such questions on rounds are neither hortatory nor prescriptive but instructional. The ethicist functions in the clinical setting not primarily as an advisor or a consultant[4] (although, on occasion, he advises and consults) and certainly not as a decision maker, but as a teacher of physicians-in-training. He is challenged to bring his expertise to bear in such a way "that it will directly—at whatever cost to disciplinary elegance—serve those physicians . . . whose position demands that they make the practical decision."[5] He does this by challenging assumptions, clarifying issues, making distinctions, pointing out deficiencies in reasoning, asking for reasons, and then probing them to see whether they can withstand scrutiny. Our experience has been that such teaching can be effectively done on ward rounds by an ethicist—attending-physician team.

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