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Medical Ethics Brought to Focus

Advances heighten interest in issues of care vs. cost, sustaining life and creating it

By Neill S. Rosenfeld

Cancer gnawed at the elderly man's body as he lay in a hospital bed, dulled with pain-killers. Electrodes led to flickering monitors; intravenous tubes dripped fluids into his body; catheters drained his wastes; drugs were administered. For the last 44 days of his life, he longed for the night visits of relatives as he confronted death alone in sterile surroundings. His physician had told him there was no other choice, and after his death his family was presented with a $47,000 bill.

"Ethically, it might have been better to say to the man, 'You may not live as long, you may be in more misery, but you have the chance to die at home,'" said Donald Rubin, director of the Consumer Commission for the Accreditation of Health Services, Manhattan, who recounted the case recently. "But the doctor never gave him the choice."

For much of history, advances in medicine came slowly. Physicians used to have decades to debate the merits of new procedures and to determine how, ethically, to cope with them.

But since the discovery of sulfa drugs in 1935, medical technology has exploded. It is forcing physicians to face new ethical questions and has led Congress to create a commission to probe the ethics of medical research on humans. If its life is extended past next July 1, the commission will issue opinions on the ethical behavior of physicians.

"For a long time, medicine *was* ethics," Carleton Dallery, a social worker and assistant professor of philosophy at the State University of New York at Stony Brook, said. "Doctors couldn't do a heck of a lot except offer trust and be honest with patients. But now, we are faced with determining just what the ethics of health care are." Among the current issues facing doctors:

- How to keep down soaring medical costs while still providing proper treatment and how to balance the hugely expensive needs of a few—such as kidney dialysis—against the less costly needs of many.
- How to guarantee the patient's right to know what is being done to his body, to know the full extent of his condition and to know the options open to him.
- How to use life-sustaining respirators. As in the Karen Anne Quinlan case, their use raises the issues of when death occurs and whether disconnecting the device is murder or merely a cessation of treatment. An underlying question: Under what circumstances should someone be connected to such equipment?
- How to handle screening for genetic disease. After medical researchers discovered the genetic cause of sickle cell anemia, Massachusetts lawmakers in the early 1970s determined that it would improve public health to require screening for the disease—which occurs mainly in blacks—before admission to school. But the law was repealed after an outcry from the physicians and philosophers at the Institute of Society, Ethics and the Life Sciences in Hastings-on-Hudson, N.Y., who warned that screening could needlessly stigmatize individuals and violate their human rights.
- How can physicians keep up with all the advances in drugs and medical devices which fill medical journals every week. Experts on medical ethics agree that the sheer quantity of new technology opened the door to a salesman of artificial hips who claims to have performed surgery in Smithtown. Two orthopedic surgeons, an anesthesiologist, an operating room supervising nurse and Smithtown General Hospital have been indicted on felony charges stemming from an operation in which the salesman claims to have implanted such a device.

Explorers of medical ethics generally agree the two most important issues are how to contain the soaring costs of Medicare and Medicaid and how to guarantee the patient's right to know what is being done to his body, known in law as "informed consent."

The debate on cost containment revolves around two points: keeping medical costs down at a time when the price of treatment is rising and deciding how to balance the expensive needs of a few against the less costly, general needs of many. As consideration of national health insurance continues, decisions will have to be made about how much is too much to spend and which medical treatments will not be paid for.

LeRoy Walters, director of the Center for Bioethics of the Kennedy Institute in Washington, cited one example of how the federal government's good intentions toward a relatively few patients with kidney failure has already imposed a growing financial burden on society. He said Washington's commitment to provide treatment on kidney dialysis machines for all

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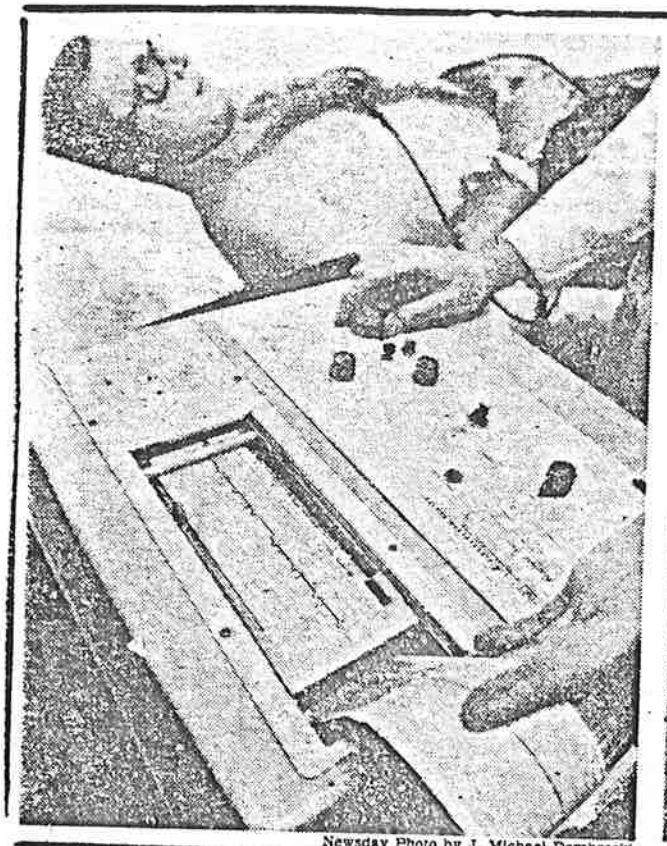

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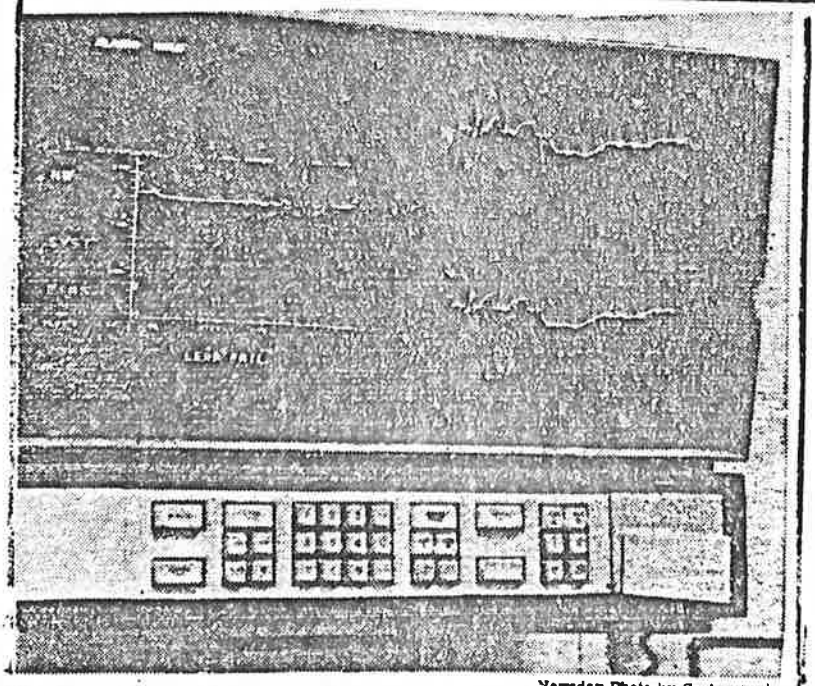

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An electrocardiogram, above left, a fetal monitoring machine, above, and a Patient Data System, left, which gives instant readout for EKG, blood pressure, temperature and other measurements and has a memory bank for storing previous test results. With an unprecedented burst of knowledge and new competence have come gnawing questions about medical ethics—the relation between man and science—and where they're leading society.

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who need it now costs $1 billion a year. The machines remove lethal impurities from the blood.

"In the future, it will cost $2- or $3-billion a year because of inflation and because the pool of people on dialysis continues to grow because they're living longer. We can't go on providing expensive services for every disease," Walters said. "Hemophiliacs would like to get the clotting factor, which is very expensive. People with heart disease will want a nuclear-powered implantable heart, costing $25,000 for installation. Legislators will have to decide that certain categories of disease will be too expensive, or we'll bankrupt ourselves."

Dallery, who lectured last year on medical ethics in a number of libraries in the area, said, "As a culture we have a belief that every life counts, which is why we put people on respirators who have slim chances of recovering. There are many lives we save that should not have been. Is society going to support a medical system that will save every life? We cannot afford it. We have to make decisions that are tragic."

Another controversy directly affecting the general public involves the patient's right to know what is happening to his body. Physicians often withhold information from patients about the seriousness of their conditions or fail to inform them they have a choice between, say, chemotherapy or surgery in treating a condition.

Dr. Marvin Belsky, a Manhattan internist who wrote the controversial patient's rights book, "How to Choose and Use Your Doctor," takes an avant-garde stance: "It is unethical for a doctor not to give a patient enough information to make a decision about his treatment . . . Many patients have a childlike approach to physicians, wanting law from on high, but they should understand that medicine deals with uncertainty . . . They have to know what the consequences of an operation are, or what the side-effects of the drugs they are taking may be, so they can watch for them."

Malpractice suits based on a lack of informed consent are far from rare. Walters said they reflect a lack of communication. "Expectations of the medical profession and the public have been raised too high. Many of the procedures are dangerous, and we somehow assume they will all turn out well."

The question of informed consent is illustrated by the controversy regarding the actions of medical device salesmen in the operating room, since patients virtually never give prior approval for them to be there. Most hospitals allow salesmen to offer advice about their products, but all contend that salesmen never touch patients—a statement several Long Island salesmen have disputed.

Daniel Callahan, a philosopher who in 1969 founded the Institute of Society, Ethics and the Life Sciences—a leading "think-tank" for medical ethics—said, "I see no problem with a technician helping if he's trained as well as a physician, as long as the patient knows that is the case."

Steven Jonas, a physician and associate professor of community medicine at the State University Medical School at Stony Brook, said he might consider using technicians in the operating room. "It is no longer appropriate to think that one person should be doing all the tasks which come under the rubric of medicine. We already have physician assistants and nurse practitioners providing primary health care under a doctor's supervision.

Like all ethicians questioned, Jonas, appointed last month to the state Board for Medicine, which sets standards for medical licensing and education, favored periodic relicensing of physicians. (Several states already require evidence of continuing medical education to retain the license and New York legislators are considering such a proposal.) Jonas said he will work to have the board "develop means of testing the competency of physicians" before the license would be renewed.

Noting that "a common problem is that most doctors get most of their information about new equipment from salesmen," Jonas raised two other crucial ethical issues facing the medical profession: Where does a doctor go to learn about advances in drugs and equipment? Who is to say that a doctor has enough training to use the technology?

One solution was offered by Harold Edgar, a Columbia University law school professor. He said some consideration might be given to licensing salesmen to participate in operations involving the wares they sell in order to train the doctors in their use. But it is more important to impose tighter controls on physicians, he said. "You could require that doctors become certified in the use of new devices before they are allowed to operate with them," Edgar said.

The ethical issue that has received the most public debate is that of when death occurs. Because equipment was invented that continues respiration and circulation after a patient's body has failed, the cessation of heartbeat and breathing were no longer conclusive signs of death. A new concept, "brain death," was developed. That allowed physicians to remove organs from clinically dead persons before the heartbeat stopped, helping to preserve the viability of the organs.

In brain death, the brain is destroyed, according to a prominent Nassau neurologist and lawyer who asked that his name not be used. "Doctors are quite comfortable using this definition," he said. "The problem is more a social one, in which people fear that care will be prematurely terminated for someone who could survive. To my knowledge, this has never happened.

Related but more arcane issues arise from the Karen Anne Quinlan case, which involved a court battle about whether to disconnect the respirators her family believed were keeping her alive. Unexpectedly, she

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Skatron cell harvester in hematology laboratory

was able to breathe on her own after the devices were unhooked. But if she hadn't been able, would it have been euthanasia to remove her from the machine, or merely cessation of treatment? Miss Quinlan did not meet all the criteria for brain death, but doctors said there was no chance she could ever again be conscious, think or interact with other people. Should that be a standard for discontinuing treatment?

The Rev. Richard McCormick, a Jesuit professor of ethics at the Kennedy Institute, takes a controversial stance: "Is it our duty to preserve someone in a chronic vegetative state? We preserve it for basic human life, not to support circulation and ventilation, but for achievement." He, like other ethicians, stressed that the decision to disconnect the machinery should be made by the patient, the family and the doctor together.

As for when persons should be placed on life-support machines, all questioned said that responsible physicians should use the machines if there is the slightest chance the person may improve; an exception would be if there were massive brain tissue loss upon arrival in the hospital. As Peter Williams, a lawyer and philosophy professor at the Stony Brook medical school, said, "It's better to err in keeping someone alive because you can always remedy that mistake."

Williams is one of the growing number of people [illegible] and poorly executed.

teaching ethics in the nation's medical schools. While such courses are becoming more numerous, it is generally agreed that ethics is far from a top priority. As Williams said, "I had 11 of the 48 first-year medical students for about 14 hours [all year, whereas the students had 21 hours a week of science courses]. You can do very little."

Robert Veatch, a senior staff member at the Institute of Society, Ethics and the Life Sciences, said about 75 of the nation's 116 medical schools offer some sort of course, but only a half-dozen require ethics training. He said 14 hours is about average. In contrast, students not heading for careers in medicine have available to them more than 1,000 courses in medical ethics offered in colleges and universities, he said.

Jonas said, "Ethics should not be a separate course, but should be an integral part of medical training on the wards."

Whether practicing physicians should be required to take ethics courses as part of the requirements for any prospective periodic relicensure is now being debated. On a more immediate level, patients' rights advocates like Rubin suggest that to ensure higher ethical standards in medicine, patients should join the physicians now conducting "medical audits" in which medical records are examined to determine the quality of health care provided by hospitals and individual physicians working in them.

For example, an in-house team of physicians surveys the records of all the appendectomies done in its hospital in a six-month period and determines whether there were any trends in doctor or technician error, longer than average healing time or complaints about any particular doctor. The team is established either by the hospital or under the auspices of a federally mandated Professional Services Review Organization, which is now operating in Nassau and parts of Manhattan and Queens.

Jonas said a program in which laymen monitored the outpatient clinics and emergency rooms of a number of hospitals for the New York City Health Department for more than six years "brought significant improvements in care."

Rubin sees such public oversight as a way of "breaking down the medical club," which has silently tolerated many instances of physician misconduct. The first case mentioned by ethicians is that of the Marcus twins in Manhattan—gynecologists who operated while they were under the influence of the barbiturates to which they were addicted and from which they died. The second case mentioned was that of Moses Ashkenazy, the former Smithtown neurosurgeon obsessed with neck operations, many of which are said in numerous malpractice suits to have been unnecessary

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