A NOD DOESN’T ALWAYS MEAN YES

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ABSTRACT

This thesis explores the role of formal bioethics instruction in preparing medical students to face ethical issues pertinent to diverse populations in clinical practice. The importance of bioethics education has been widely recognized and as a result, it is formally required in all medical schools. However, with little standardization on the actual logistics, ethics education in medical schools is extremely variable, producing students who are naïve and/or inconsistently capable of managing ethically complex situations. During medical school I pursued a Masters of Arts in Urban Bioethics (MAUB), which heavily focused on the social determinants of health and how they manifest in health care settings. I acquired new skills that gave me perspective and awareness into ethical issues that urban populations face, and during my clerkships I found I was better equipped and more comfortable navigating my patients’ non-medical complexities than my non-MAUB peers. Using three personal patient encounters as examples, I illustrate how a comprehensive urban bioethics education can positively impact patient care. Finally, I suggest improvements to medical schools’ bioethics curricula that will likely influence and mold each student’s thought processes to be more ethically-aware and culturally-sensitive. The goal of reforming bioethics education is to give students a set of real-world skills rather than a theoretical book of knowledge. Without a comprehensive and multifaceted approach to bioethics, students will likely lack the cultural sensitivity, awareness, and perspective necessary to treat a diverse patient population.
This thesis is dedicated to Mom, Dad, Rach, and Hoolies.
They’re not kidding when they say it takes a village to raise a medical (and masters) student, thank you for being the most unbelievable village.

I love you so much!
I would like to thank Dr. Nora Jones for all of her help, support, patience, and encouragement over these last four years. The MAUB is an amazing addition to Temple and I am so happy I had the opportunity to be a part of it!
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The term “bioethics” is frequently used yet commonly misunderstood. Medical students reference their bioethics lectures, residents consult social workers to help navigate patients’ non-medical complexities, and attending physicians weigh the pros and cons of their medical decisions, trying to examine the ethical considerations pertinent to each case. Despite this pervasive invocation of bioethics, many are unable to articulate specifically what “ethics” or “bioethics” entails beyond a surface-level definition. Health care providers can identify the complicated cases, and their moral compasses are attuned to ethically-challenging situations; but it isn’t enough to simply recognize these cases – a deeper understanding of bioethics is necessary to actually impact patient care.

Basic Bioethics and Its Role in Medical Education

At its most basic, bioethics is the study of ethical issues in health care settings. Some examples of general bioethics topics include the rights of the mother versus fetus in abortion discussions, whether physicians should be involved in the voluntary ending of life, and truth telling. How to navigate these complex and sensitive subjects is guided by the four principles of bioethics: autonomy, beneficence, non-maleficence, and justice.¹

Autonomy refers to a patient’s ability to exert control over their medical care. Their wishes should be paramount and respected by the medical team (assuming they have the capacity to make their own medical decisions), regardless of how strongly a physician may disagree. This tension stems from the fact that a patient’s goals or definition of “best outcome” may be very different from their physician’s. For example,
the patient may value quality of life, while the physician may privilege duration of life. Making this distinction is important because the treatment plan would differ based on whose definition is guiding the medical care. Valuing patient autonomy and increasing patient involvement in the decision-making process reflects a societal shift away from the paternalistic practice of medicine. The “doctor knows best” attitude is now merely a relic. Although in practice this contemporary doctor-patient relationship manifests as a discussion involving both parties, on the basis of patient autonomy, a patient’s wish is what should guide medical care.

Beneficence denotes the physician’s responsibility to act in the best interest of the patient. Respecting this principle may at times conflict with autonomy. For example, a physician recommends chemotherapy (non-invasive) and surgery (invasive) to treat a patient’s cancer, but the patient is only interested in non-surgical treatment (chemotherapy). Although the physician feels he/she is serving the best interest of the patient by suggesting a comprehensive treatment plan, the patient is not interested in the treatment suggested. This is where finding a balance between these potentially competing four bioethics pillars becomes relevant, knowing which should reign and when is a skill only gained with a deeper knowledge and understanding of bioethics.

Non-maleficence translates to “do no harm.” This principle highlights the importance of not doing anything that will harm the patient, rather than just doing what’s in the patient’s best interest. Surprisingly, beneficence and non-maleficence frequently contradict each other. If a patient is terminally ill and in pain, giving them morphine will improve their pain (beneficence) but may also cause respiratory depression, thereby
hastening their death (not abiding by non-maleficence). Again, balancing the four principles is challenging and requires more than a basic understanding of bioethics.

Justice’s definition is not quite as straightforward compared to its fellow pillars. In general terms, it refers to fair allocation of resources and the equal treatment of patients. Some resources may be in short supply (for example, transplant organs) and this pillar explores how to fairly distribute those more limited resources. Is it based on age? Need? Health insurance provider? Socioeconomic standing? Disease prognosis? Justice takes into account the practicality of medicine, recognizing that not everything is in abundance and then considering how to fairly distribute the available resources.

These four principles are the foundation for the field of bioethics – a foundation seeped in complexity. They may contradict or challenge each other, and there are myriad nuances within each that make it is almost impossible to fully understand without adequate formal bioethics education. Understanding bioethics is not something you learn in medical school lecture halls, but rather it is a skill set. The importance of this skill set has been widely recognized, and as a result bioethics education is formally required in all medical schools. The Liaison Committee on Medical Education (LCME) states:

ED-20: The curriculum of a medical education program must prepare medical students for their role in addressing the medical consequences of common societal problems (e.g., provide instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse).

ED-21: The faculty and medical students of a medical education program must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

ED-22: Medical students in a medical education program must learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the process of health care delivery.
ED-23: A medical education program must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients’ families and to others involved in patient care.\(^2\)

Although the LCME guidelines appear comprehensive, they are merely listed objectives, abstract from a concrete implementation plan. Educators agree bioethics should be taught in medical schools, but the mechanics lack uniformity.\(^3\) There is no regulation on WHEN these issues should be taught, or WHAT specific topics need to be discussed, or HOW to address them. Consequently, ethics education in medical schools is extremely variable, producing students who are naïve and/or inconsistently capable of managing ethically complex situations.

**What Bioethics Education Actually Looks Like**

As of 2002, 79% of four-year medical colleges in the U.S. required a formal ethics course as part of their curriculum, with the remainder having ethics education incorporated into a larger course.\(^4\) 51% of all programs taught ethics during only one of four years of medical education (the majority during the first year), 30% taught ethics during two of four years, 10% taught this during three of four years, and only 8% of programs taught ethics continuously throughout medical training.\(^4\) Because learning in medical school occurs at an exponential rate, knowledge is easily lost if it is not frequently reviewed. With the majority of medical schools in the U.S. teaching ethics only during one year, usually during the first year,\(^4\) that information is likely to be relatively inaccessible when the student begins clinical clerkships.
Four methods are utilized by the majority of U.S. medical schools to teach bioethics: discussion/debates (84%), readings (83%), writing exercises (64%), and lectures (64%). Only 21% of schools include role playing/standardized patients, and a mere 19% include clinical rounds/field visits. Evidently, most medical schools are teaching ethics in a classroom environment, but few are actually giving the students an opportunity to apply the knowledge in a clinical or simulated setting. However, as previously discussed, bioethics is multidimensional and requires more than didactics for it to transcend the academic arena and translate to better patient-centered care.

Another area of discrepancy in bioethics education is the subject matter itself. A study of ethics syllabi in U.S. medical schools assessed 39 content areas, of which only 6 were taught in more than 50% of medical schools: informed consent (85%), health care delivery (75%), confidentiality and privacy (67%), quality of life/futility/provision of treatment (67%), death and dying (66%), and euthanasia and physician-assisted suicide (60%). If we refer back to the LCME guidelines, some objectives are not covered in a majority of programs. Discrepancies include: ethical reasoning and problem solving, which are taught in only 31% of schools; religious and spiritual issues are covered in only 24%; protecting vulnerable populations in 22%, and only a mere 17% of programs include substance abuse and cultural issues/diversity awareness in their course content.

Looking beyond the curriculum itself, we should consider the intended outcome – students’ perceptions of their knowledge and preparedness for addressing these issues in practice. A 2011 study at Case Western Reserve University School of Medicine found that 39% of first and second year students believed that understanding diverse patient cultural beliefs was insignificant to providing adequate care. Additionally, 34% were
“uncomfortable with and unsure about how to approach culture-related issues arising in patient care”\textsuperscript{5}. The implication of poor bioethics education during medical school extends to and pervades graduate medical education. A 2003 survey of senior residents across multiple specialties found that a significant percentage of residents felt ill-prepared confronting specific components of cross-cultural care, “including caring for patients with health beliefs at odds with Western medicine (25%), new immigrants (25%), and patients whose religious beliefs affect treatment (20%)”\textsuperscript{6}. Additionally, another 24% felt they lacked the skill set necessary to identify pertinent cultural customs that affect medical care.\textsuperscript{6}

The Social Determinants of Health and Urban Bioethics

When medical schools focus on a rather limited list of traditional bioethics topics, taught through circumscribed methods, it limits students to an outdated version of bioethics. Furthermore it inadequately prepares them for issues they will confront in their careers. A central flaw is the failure to acknowledge the social determinants of health, which affect a person’s health status more than the topics commonly covered and should be an essential component of any comprehensive contemporary bioethics training. The social determinants of health refer to innumerable non-medical aspects of a person’s life that tangibly impact their health status. Some examples include socioeconomic inequality,\textsuperscript{7} educational attainment,\textsuperscript{8} familial structure, home environment/housing, adverse early childhood events,\textsuperscript{9} exposure to violence,\textsuperscript{10} drug/substance abuse, stress, unemployment,\textsuperscript{11} availability of healthy foods/food deserts,\textsuperscript{12} and barriers to transportation.\textsuperscript{13} The unequal distribution of these social determinants of health and
health-facilitating and -damaging experiences is what underlies the urban context of
diversity and is the foundation for the field of urban bioethics. Urban bioethics is, in this
way, a subset of bioethics centered on ethical issues arising in health care settings with
particular salience to an urban population. Bioethicist Jeffrey Blustein writes:

Urban bioethics challenges traditional bioethics to examine value concerns
in a multicultural context, including issues related to equity and disparity,
and public health concerns that may highlight conflict between individual
rights and the public good…Urban bioethics also challenges bioethics to
broaden its primary focus on individual self-determination and respect for
autonomy to include examination of the interests of family, community,
and society.  

The Masters of Arts in Urban Bioethics

The Lewis Katz School of Medicine at Temple University began offering a
Masters of Arts in Urban Bioethics (MAUB) during my first year of medical school.
After graduating college with a B.A. in Urban Studies, pursuing this Masters degree was
a natural extension of my undergraduate work. Temple’s bioethics curriculum for non-
MAUB students is more comprehensive than the statistics previously discussed may
suggest, including a few lectures on health literacy and social determinants of health, and
also a simulation activity. Despite their progressive curriculum, I still sought a more
extensive understanding of urban bioethics. In addition to covering the traditional topics,
the MAUB heavily focused on the social determinants of health and how they manifest in
health care settings, catering to the dual degree student. With a diverse group of lecturers
including lawyers, business professionals, local community workers, anthropologists,
bioethicists, and physicians, the MAUB students were exposed to a 360-degree view of
urban bioethics. We were challenged to analyze our own health status and how our
upbringing impacted our own biases. We were encouraged to view each situation from the perspective of everyone involved. Lastly, we were trained not only to recognize the social determinants of health at play in a patient’s case, but also to apply our new skill set in practice. Ultimately such an education improves communication, patient-practitioner concordance, and patient-centered care.

The majority of the classroom-based work was completed during the first two years of medical school but readings, online discussion boards, our individual thesis projects, and regular one-on-one meetings with our program director continued throughout our third and fourth year clerkships. Simultaneously working towards my MAUB and MD degrees substantially enhanced my education throughout all four years of medical school, but was particularly tangible during my third and fourth year clerkships. I acquired new skills that gave me perspective and awareness into issues that urban populations face, and during my clerkships I had the opportunity to apply them. This skill set allowed me to see beyond the hospital room and appreciate the whole patient in context, including giving attention to all of those non-medical factors at play. It gave me the tools necessary to initiate difficult conversations, ask personal and sensitive questions, keenly interpret body language, and gather the subtext of conversations patients were not comfortable stating directly. It gave me exposure to various resources both in the community and in the hospital, confidence to address the primary team about patient mismanagement, and knowledge and perspective regarding how urban bioethics can meaningfully and feasibly be integrated into health care. Lastly, this training allowed me to compartmentalize my own biases so they are less likely to be perceived by the patient and adversely impact the doctor-patient relationship.
The MAUB was the bridge that allowed a Caucasian female from an affluent suburb of Philadelphia to better communicate, relate, empathize, and care for an underserved urban patient population in North Philadelphia.
CHAPTER 2: CASE STUDIES

Throughout my third and fourth year clerkships I had the opportunity to provide care to patients whose health status was complicated by various social factors. Temple University Hospital (TUH) is located in North Philadelphia and cares for a diverse underserved urban patient population. I was challenged to exercise my urban bioethics skills in managing these patients and found I was better equipped and more comfortable navigating their non-medical complexities than my non-MAUB classmates. Using three personal patient encounters as examples (all names have been changed), I illustrate how a comprehensive urban bioethics education can positively impact patient care. I present each case and outline the pertinent social factors, explaining my thought process and reasoning in approaching each situation as I did.

Case 1: The Right Way to Ask the Right Questions

While on my third year neurology clerkship, Tim, a 27 year-old African-American male presented to TUH’s Emergency Room complaining of right-sided weakness, numbness, and tingling. He was slurring his words and unable to move the right side of his face. Tim had experienced similar symptoms a few months prior but claimed they were transitory. When he awoke from sleep with the same symptoms, he waited 24 hours to see if they would resolve spontaneously again. After the symptoms proved unremitting, Tim sought medical care.

On physical exam, Tim had grossly decreased strength on his entire right side, unable to initiate movement from his eyebrows down to his toes. His sensory exam was
significantly abnormal on the right side as well, unable to appreciate a tissue brush against his skin or feel the light touch of a finger. Additionally, certain reflexes were elicited during Tim’s neurological exam that are normally only present during infancy.

At this point, Tim’s constellation of symptoms was highly suspicious for a stroke. Asymmetric neurological deficits such as a unilateral decrease in strength and/or sensation, slurred speech, and the presence of primitive reflexes are common manifestations of a stroke. Additionally, the short-lived symptoms Tim experienced a few months prior could have been from a transient ischemic attack (TIA), or “mini-stroke.” During a TIA, a blood clot forms and blocks blood flow to part of the brain, causing stroke symptoms, but then spontaneously breaks up or dislodges and the symptoms resolve. It is not uncommon for TIAs to precede a more severe stroke where the clot does not independently dislodge, risking permanent neurological damage.

An MRI study was used to confirm Tim’s stroke, also showing evidence of multiple prior small strokes as suspected. After initiating the appropriate therapy for an acute stroke, Tim’s case beckoned the question of why an otherwise healthy 27 year-old man would experience a stroke? More than 75% of all strokes afflict patients aged 65 years and older,\textsuperscript{15} and the common causes in that population did not apply to Tim; he simply hadn’t been alive long enough for those issues to advance where they would invoke a stroke. Scores of blood tests and imaging studies effectively ruled out a blood clotting disorder, autoimmune disease, abnormal heart rhythm, or congenital heart defect as possible etiologies. Tim’s initial workup was only notable for a reactive syphilis titer.

Syphilis is a sexually transmitted infection that, if untreated, can spread from the bloodstream to the cerebrospinal fluid (CSF) surrounding the brain. Syphilis in the brain
is called neurosyphilis and it can cause numerous neurologic problems, including a stroke. Furthermore, if a person is co-infected with HIV, syphilis can translocate to the CSF significantly faster and cause neurological problems much earlier in the disease course.\textsuperscript{16} Interestingly, between 2007-2014 the number of reported syphilis cases have been stable amongst women and men who have sex with women, yet have nearly doubled amongst men who have sex with men.\textsuperscript{17}

Because syphilis is a reportable disease, per the CDC, Tim’s positive syphilis test prompted phone calls to Philadelphia’s Department of Health (DOH). When asked about his past medical history, Tim denied any sexually transmitted infections but it was discovered that he had been diagnosed with syphilis five years prior and treated through the DOH. I became deeply involved in Tim’s care, visiting him multiple times daily, functioning as his primary contact for the DOH and Infectious Disease consult team, and supporting him throughout the diagnostic process. Initially Tim did not discuss his sexual practices, but later when we were alone he confided that he’d had unprotected sex with men, something unbeknownst to most of his family and friends. When further testing confirmed the diagnosis of HIV and neurosyphilis, I was the one who told him. Not only had I developed a strong rapport with Tim and thought he would value if I disclosed his results, but I also felt better prepared to navigate such a sensitive and difficult conversation by virtue of my urban bioethics training. I appreciated the interplay between the medical, psychosocial, and cultural issues facing Tim at this point and directed our conversation towards both the medical and non-medical issues he’d need to confront.

Two months later while on an Infections Disease elective, the fellow informed me that Tim had missed two clinic appointments and had not yet started his HIV treatment. I
had spent considerable time counseling Tim about how manageable HIV is if compliant with treatment, so naturally I was upset to discover he had not yet had a follow-up visit. With the fellow’s permission, I personally reached out to Tim to remind him of his rescheduled appointment and asked if he anticipated any difficulties making it this time. He told me he had yet to share his diagnosis with most of his family and friends and therefore did not have a ride to attend his appointments. Additionally, he was still having trouble ambulating after his stroke so public transportation was not feasible. Tim ultimately arranged for a ride through a hospital transportation resource and reassured me I would see him in clinic later that week. Tim did show up for his appointment that day, and HIV treatment was finally initiated.

Case 1: Analysis

Tim’s case presented many challenges for the primary medical team, each requiring consideration when developing his treatment plan and discussing these delicate topics. Arguably the most significant lesson learned was the importance of having the sensitivity, awareness, and perspective necessary to ask the right questions and guide potentially difficult conversations. I was able to anticipate the challenges in Tim’s life outside the hospital because I recognized the pertinent social determinants of health: atypical support structure, uncomfortable home environment, homosexuality, social stigmas towards HIV and homosexuality, and transportation issues. I confronted Tim with these questions and scenarios in a sensitive and safe environment, hoping he’d feel more confident and prepared to tackle these obstacles outside the hospital. Considering Tim lived with a person who did not know of his HIV status, I asked him if he had a safe place to store his medication. What if a family member or friend discovered his
medication? Would he still continue taking and refilling his medication? After our conversation, Tim left the hospital knowing exactly where he would keep his medication so it would not be accidentally found.

When I learned Tim had missed his first two Infectious Disease appointments, I was both frustrated and confused. I was sure he fully understood the importance of follow-up care and the consequences of non-compliance after multiple conversations detailing both circumstances. Would Tim have attended his third scheduled Infectious Disease appointment had I not called and asked about his transportation arrangements? Similar to storing his medication, prompting Tim with these transportation challenges allowed him to plan accordingly, preventing him from missing another doctor’s appointment.

Tim’s hospital visitors included only his mother, with whom he lived alone, and his cousin, whom he trusted and considered a close friend. Prior to his stroke, Tim confided in his cousin about his sexuality, but did not tell his mother. When Tim received his new HIV diagnosis he shared it with his cousin while hospitalized, but did not feel comfortable sharing with his mother just yet. Upon discharge, I realized Tim was headed home into the care of a person who was unaware of his diagnosis, so I intentionally brought this to his attention. It was clear his hospital course was so overwhelming he hadn’t considered how his life would change once he left. How would he explain his stroke to his mother and friends without sharing his HIV status? If he decided to share his new diagnosis, would they then know, or assume, he was homosexual? Although it may have appeared productive to include Tim’s mother in his treatment plans, given she is his sole cohabitant, that would have violated patient autonomy. Sharing any medical
information, especially your HIV status, is intense and extremely difficult, and so it is of the utmost importance to let the patient adjudicate what time is best, if ever. Tim expressed he wasn’t prepared to confront his mother, and as his medical team we had to support him in that decision. By better understanding the complexities of Tim’s support network, bringing it to his attention, and together brainstorming ways to better navigate his social life following his new diagnosis, Tim felt less anxious and better equipped to approach his family and friends.

It is also important to consider the social stigma still attached to HIV. As a medical student, I am well aware of how treatable and manageable HIV is – sometimes treatment consists of only one pill per day! Some may be surprised to learn that managing diabetes is more difficult day-to-day, and diabetic patients are more likely to experience long-term consequences compared to a well-managed HIV patient. Unfortunately, many people outside the health care realm are unaware of how drastically HIV treatment has improved over the last twenty years. In educating Tim on HIV management, I helped him see past his own biases, a necessary obstacle in order for Tim to believe in his recovery and own his treatment.

Addressing the non-medical factors impacting Tim’s health status was equally as important as treating the actual HIV virus, and perhaps his outcome would have been different if his doctors overlooked these issues. After almost one year of treatment, Tim is doing very well. He is improving with his stroke rehabilitation and ambulating better each day, his syphilis infection has been adequately treated, and the HIV virus is so well controlled that it is undetectable in his blood.
Case 2: A Nod Doesn’t Always Mean Yes

During my fourth year Internal Medicine sub-internship, my senior resident instructed me to go down to the Emergency Room and evaluate our new admission, Jim, a 51 year-old Caucasian man with shortness of breath. Jim had no significant past medical history and no relevant family history. Over the last few weeks, Jim experienced progressive shortness of breath and realized he was getting winded after walking shorter and shorter distances. He was unable to lie flat in bed because he felt significantly more winded than if he supported himself with pillows. He ultimately came to the hospital on his daughter’s request. She claimed he had never had any health problems and was concerned with how fast his shortness of breath had worsened.

On the general medicine floors at TUH, the primary team is responsible for the diagnostic work up, initiating treatment, and consulting any specialists if deemed necessary. Our initial workup showed Jim had pulmonary edema (fluid in the lungs), which impaired oxygen flow into his blood and thus explained his shortness of breath. This finding prompted further studies to evaluate why he developed pulmonary edema. We discovered Jim was in congestive heart failure (CHF), meaning his heart was overly stretched and incapable of pumping blood effectively. As a result, blood backed up into his lungs and caused fluid to leak into the airspaces. Additionally, while listening to Jim’s heart on physical exam, the team noticed he had an irregular heartbeat. After putting Jim on a continuous heart monitor, we noticed he also had atrial fibrillation, a disorder of the heart’s electrical wiring that causes it to beat fast and irregularly. Similar to CHF, when Jim’s heart beat abnormally it was unable to adequately fill and pump blood, causing
congestion in his lungs. Because CHF can cause atrial fibrillation and vice versa, it was especially important to discern which was the primary insult in order to guide treatment.

After identifying that Jim’s shortness of breath was of cardiac etiology, we consulted the general cardiology team. Using various pictures and diagrams, I explained to Jim how his heart problems could cause pulmonary edema. I knew the cardiologists would verbally explain the pathophysiology, but I wanted to ensure he was at least familiar with the terminology and had a visual reference, if necessary. The general cardiology team felt Jim needed to be seen by both the heart failure specialists and the electrophysiologists (two subspecialties of cardiology that focus on CHF and abnormal heart rhythms, respectively) – so now there were three different cardiology teams seeing Jim on a daily basis and suggesting management adjustments. As a member of the primary team, it’s our job to synthesize all the consults and implement their recommendations. When each specialist suggested an intervention that contradicted what another specialist recommended, it complicated our management. I made an effort to be present when each specialist saw Jim so there was some continuity of care and with every conversation, I felt more unsettled regarding Jim’s behavior. He never sat up in bed, only spoke one-word answers, and just smiled and nodded for the duration of the conversation. Jim’s responses were static and largely uncorrelated with the content of each update, which raised concern about whether or not Jim was fully understanding and processing the new information presented. The doctors would ask if he had any questions and he’d politely say no and thank them for their time. As soon as the specialists left the room, I would pull the drawings out of my pocket and walk Jim through the procedure or treatment mechanism for a second time. He never told me he had trouble following their
dialogue but I inferred from his intense concentration on my secondary explanations, and his comfort in raising questions in the specialists’ absence, that he truly did not grasp the information the first time it was presented.

I continued drawing diagrams and providing Jim alternative explanations for the duration of his hospital course. We had an unspoken understanding; he knew to expect a secondary explanation after each consult, during which he would ask questions and receive clarification. After one week in the hospital, Jim’s CHF resolved upon management of his atrial fibrillation, and his shortness of breath improved as well.

**Case 2: Analysis**

The challenges in caring for a patient like Jim are multidimensional and include understanding the social factors impacting his health status (similar to Tim), attentiveness to non-verbal cues, and tactful delivery of detailed and technical medical information. Prior to this hospital admission, Jim was very healthy and his experiences seeking medical care were limited to his inconsistent primary care visits. For a person with no previous exposure to a hospital environment and no experience as a patient, hospitalization (especially in a teaching hospital with large medical teams) can understandably be very intimidating and overwhelming. Jim’s relative unfamiliarity with the role of a patient translated to surrendering all medical decision making to his doctors, giving them full autonomy. Without knowledge of a contemporary doctor-patient relationship, it is possible Jim was completely unaware he had the right to participate in the medical decision-making process. Recognizing Jim’s medical inexperience was imperative in forming a working relationship, guiding my approach to each conversation and my interpreting of his responses.
Once I realized Jim’s medical unfamiliarity was contributing to his submissiveness, I knew special attention was needed to the non-verbal cues. Despite receiving two new diagnoses, being placed on a continuous heart monitor, and starting multiple new medications, Jim seemed largely unphased. While the other team members simply saw Jim as a very pleasant patient, I found this disassociation unsettling, and I sensed an important aspect of his case was going unaddressed. I looked beyond his outward appearance and reassuring nods to investigate what other factors were at play. When I first drew a diagram to explain CHF, I sat in a chair next to Jim’s bed and he actually leaned forward to look at my drawing instead of remaining reclined. I drew simple diagrams and made analogies using common references to try translating the complicated medical information into something easier to understand. He seemed more engaged in our conversation than I had seen him previously. When I returned the following day and went over the picture again, Jim actually asked a question. At this point, I concluded his previously submissive behavior was due to a lack of understanding and discomfort in that environment. It is reasonable that someone would feel overwhelmed and intimidated as there are many doctors crowded in your small hospital room, physically standing over you while you’re lying in bed. Additionally, it is not a very inviting environment to ask questions, especially when the entire inpatient dynamic is unfamiliar. Talking with Jim alone, and sitting in a chair so we were at eye level, made him feel more relaxed as evidenced by his leaning forward and asking questions. Based on the increasing complexity of Jim’s questions, I was able to gauge his understanding as such detailed questions could only be posed with a sufficient level of comprehension.
Paying attention to Jim’s reactions led me to concentrate on his non-verbal cues, ultimately improving patient care by tailoring my approach to Jim’s needs.

Jim’s case illustrates one of the most important lessons for any health care professional: that is a nod doesn’t always mean yes. Patients may nod in agreement to indicate understanding or because they are uncomfortable saying no. Looking beyond the nod can provoke further investigation into what each patient is experiencing and thus provide a platform to alter your approach and improve patient care.

Case 3: How to Manage One Patient While Caring for an Entire Community

During my sub-internship I was also responsible for taking care of Tori, a 25 year-old Caucasian female who was complaining of toe pain. Tori was an IV drug user and had been hospitalized for four months the year prior for a very serious heart infection secondary to unsanitary needle practices. Although her new complaint was seemingly benign, given her extensive medical history and known risk factors (she was still using IV drugs), we admitted her to make sure this wasn’t a complication of a second heart infection.

As with every drug user who is admitted to the hospital, we asked Tori if she was interested in rehab. She vehemently refused and proceeded to lecture us on how rehabs have never helped in the past. A few months prior Tori was in an inpatient rehab facility but claimed they kicked her out and “left her for dead.” Although she said she had been sleeping on friends’ couches since then, we later discovered that this hospital visit coincided with her friend forcing her out, leaving her with no place to sleep.
We undertook every diagnostic test necessary to rule out another heart infection. Each test was more reassuring than the last, so we concluded that her new toe pain was not due to a more serious underlying problem. After giving her some over-the-counter medication for her pain, we deemed she no longer required inpatient-level medical care and began preparing her discharge paperwork. When we informed Tori she would be leaving, she grew very angry. Tori accused us of forcing her into homelessness because she had nowhere to go and suddenly insisted she wanted to go to rehab. Between rejecting rehab upon admission and the coincidental timing of her belated interest in sobriety, I felt very strongly this was an empty plea to ensure another night in the hospital and thus a place to sleep. Regardless, as her medical team we had to take her request seriously.

In order to qualify for inpatient rehab, you need to be evaluated by a psychiatrist. However, at 5:30pm on a Saturday night, our psychiatry consult services were no longer in house and likely wouldn’t get around to evaluating Tori until Monday. We had already determined Tori did not require inpatient-level care, so keeping her in the hospital almost two days beyond what was medically necessary seemed inappropriate. Furthermore, it was announced earlier on Saturday that the hospital was at capacity and unable to accept any new patients.

I devised an alternative plan – we could discharge Tori from TUH with a cab voucher and immediately send her to Episcopal Hospital, where they have psychiatrists on staff 24/7 in their Crisis Response Center (CRC). In doing this, Tori would be seen and evaluated by a psychiatrist sooner than if she remained at TUH and also would vacate a bed needed for another sick patient. I presented this idea to the rest of the team
but our attending physician was uncomfortable having her leave without a psychiatry consult. He feared if she left TUH and overdosed, he would be responsible since he would be the last physician to have seen her. He further explained he was forewarned upon accepting a job in Philadelphia that he should expect to get sued within his first few years of practice; he did not want that to be Tori. I politely explained how, based on the principal of distributive ethics, keeping Tori hospitalized for a psychiatry consult is a misuse of hospital resources. Furthermore, it was not in the best interest of the patient – if Tori was serious about rehab, expediting the evaluation process would be best and that necessitated getting her to the Episcopal CRC.

Ultimately our attending physician gave me permission to discharge Tori with a cab voucher under the condition that I explicitly documented Tori’s verbal agreement to go to the CRC. I called the CRC ahead of time to inform them we were sending over a patient and I reassured Tori they knew to expect her. I spoke with the CRC later Saturday night, Sunday, and Monday – Tori never went. Almost one year later, Tori has not been at TUH, she has not been to the CRC, and our attending physician has yet to be sued.

**Case 3: Analysis**

Tori’s case significantly differs from the previous two cases in that its bioethics challenges are not related as much to a patient’s medical care, but rather to how patients are managed on a larger scale. It is difficult to justify spending thousands of dollars to keep a patient hospitalized who does not require inpatient care and who also would occupy a bed needed for another ill patient. However, my attending physician allowed his fears about Tori’s possible deception to guide his clinical management. With competing interests influencing management discussions, multiple bioethics principles are
jeopardized. If Tori genuinely wanted inpatient rehab, respecting beneficence would have meant initiating the evaluation process as soon as possible, not prolonging her stay at TUH so the physician feels less vulnerable. Furthermore, with the hospital at capacity, keeping a patient longer than medically necessary is an inappropriate allocation of resources.

I conceded Tori’s ulterior motives in requesting rehab and recognized my attending’s unethical use of hospital resources, taking both into account when devising an alternative management plan. By sending Tori to the CRC, she’d receive the care she presumably wanted and simultaneously generate an available bed for a patient who truly needed inpatient care. To encourage Tori’s compliance, I asked social work to provide a cab voucher instead of a subway token, anticipating she would claim her toe was too painful to walk to the subway. Lastly, by discussing with Tori how the CRC was her best option and by documenting her agreement with the plan, I sufficiently addressed my attending’s concern with liability.

Applying urban bioethics in clinical practice is not limited to direct patient care, it also encompasses understanding how the urban context of density and diversity impact overall patient management. If a physician allows their fears and biases to guide clinical decision-making, they will never have the perspective necessary to manage one patient while caring for an entire community.
CHAPTER 3: DISCUSSION

If bioethics education is not reformed, medical schools will continue producing physicians unfit to navigate modern ethical dilemmas. Traditional ethics courses do not teach the skill set necessary to tell someone of a new HIV diagnosis or to recognize and address the non-medical factors influencing how that patient interprets their new diagnosis. It falls short in teaching an appreciation for subtleties in body language and facial expressions, and it does not prepare students to address issues of drug abuse or homelessness. These concerns are not isolated to idiosyncratic patients, and the current health system is unsustainable unless it confronts the varying health care attitudes, values, and customs that define a multicultural society. In order to achieve a higher level of ethical reasoning with sustainability, the content, methods, and structure of bioethics instruction will require revision.

Simply put, the social determinants of health should be incorporated into all bioethics courses across the country. Every curriculum should address these factors through lectures, readings, discussions, and simulated patient encounters where students put theory into practice. All physicians will inevitably treat patients from a differing racial, ethnic, socioeconomic, cultural, or educational background. Even if one chooses to practice in a small community hospital, patients travel to seek medical treatment, and a comprehensive contemporary bioethics education is necessary to help navigate their non-medical complexities. Furthermore, the social determinants of health should not be taught exclusively in urban medical schools, because “cultural and racial diversity have now spread beyond the central city into suburbs, small towns, and rural areas”; issues that
were once considered “urban” are no longer restricted to the concrete jungle. Although homicide rates continue to be highest in large metro areas, other differences are narrowing. The prevalence of recreational prescription opioid use in rural and urban counties is similar; youth in rural areas have higher rates of alcohol use than their urban counterparts; rural residents smoke more and have poorer diets; and as per the U.S. Census Bureau, of the people living in poverty in 2010 51% lived in central cities, 29% in suburban areas, and 20% outside of metropolitan areas.

Additionally, Lindsey Wahowiak, a writer for Diabetes Forecast magazine, illustrates how limited access to nutritious fresh food plagues both urban and rural communities. In urban areas the nearest place to purchase food is often a corner store, and most carry a very limited supply of fresh produce, priced significantly higher than packaged goods. In rural communities, despite being surrounded by farms, the nearest grocery store may be over twenty miles away in another town. The social determinants of health are applicable to every population and community throughout this country, and therefore should be universally incorporated into bioethics curricula.

Medical sociologist Renee Fox suggests that it isn’t sufficient to just raise consciousness about cultural differences, but one must gain “in-depth knowledge and understanding of at least one society other than one’s own. This sort of learning experience…is essential to opening up cultural perspectives and overcoming provincialism.” Each teaching hospital has at least one identifiable patient population (some may have more depending on its location) and during students’ third and fourth year clerkships, they are immersed in the hospital setting and are exposed to the intricacies of their hospital’s patients. Without a deeper understanding of the social
determinants of health, students will be unable to internalize their patient experiences in a significant way. The current structure of third and fourth year clerkships, coupled with an updated curriculum that meaningfully integrates the social determinants of health, would produce a more well-rounded, culturally-sensitive, and empathetic physician.

After addressing curricular contents, we need to reevaluate the methods used to actually teach the information. In my own experience, I was able to appreciate how a multidimensional education was superior to the primarily classroom-based education of my non-MAUB peers. Rather than focusing on didactics and lectures, scheduled bioethics time should incorporate more discussions, dialogues, and debates. By giving the students an opportunity to exercise their analytical skills and compare their viewpoints and biases to those of other students, it challenges them to understand how and why they formed the opinions they did. “Deliberation promotes the value of mutual respect…[it] discourages moral rigidity and helps remedy the limitations of knowledge and understanding that often hamper unilateral decision making”[26]. Interactive sessions should be equally as featured a teaching method as readings and lectures in order to facilitate self-reflection regarding one’s own biases and comfort discussing differing viewpoints.

After a student is comfortable with the bioethics content and has exercised their understanding through deliberation,[26] the next step is learning how to apply the knowledge in a clinical scenario. One study showed that there was no correlation between a medical students’ ability to recognize an ethically challenging situation and their ability to effectively communicate with patients in those scenarios.[27] It is impractical to simply discuss bioethical topics in a vacuum; rather the content needs to be applied to real
clinical encounters for it to foster more ethical practice and improve patient outcomes. Standardized Patients (SPs), actors who play the role of a patient in a simulated environment, are currently incorporated in medical school curricula to teach the physical exam and to practice communication skills. Recently SPs’ utility has extended to include evaluating medical students’ ability to handle ethical dilemmas. A study at Icahn School of Medicine at Mount Sinai formally incorporated SPs into their bioethics curriculum and found that SPs “[bridged] the gap between knowledge and practice…Practicing in a controlled learning environment with timely faculty feedback prepares students to face the challenges of clinical ethics”28. SP encounters are an extremely effective way for students to appreciate how ethical issues manifest in a clinical setting, while also having the opportunity to practice handling these situations without fear of mismanaging a real patient.

Lastly, bioethics education should be incorporated continuously throughout all four years of medical school. The didactic and discussion portions of the new curriculum should be concentrated during the first two years, along with the bulk of the students’ other classroom-based studies. Establishing a solid bioethics foundation prior to third and fourth year clerkships will provide students with the knowledge necessary to begin contemplating the relationship between ethics and clinical medicine. Once the student begins working in the hospital, the bioethics course would shift to focus on the SP encounters. Prior to their third year, students do not have the experience or context to accurately envision how ethical dilemmas will play out in the clinical setting, and “ethics education cannot be properly conceptualized in isolation from the broader social contexts in which they arise”29. By paralleling the SP activities with the clinical clerkships,
students can realistically practice managing ethically complex situations and ideally reinforce and sharpen those skills while on their rotations.

The goal of reforming bioethics education is to give students a set of real-world skills rather than a theoretical book of knowledge. Without a comprehensive and multifaceted approach to bioethics, students will lack cultural sensitivity, awareness, and perspective. The Associate Director of the Mayo Clinic’s Professionalism and Ethics Program, Frederic Hafferty, says:

…At minimum, institutions of medical education have a responsibility to facilitate students’ development not just of critical thinking skills but of an ability…to be self-reflecting…and to be sensitive to how structural factors, social situations, and cultural contexts influence the work of medicine. More important, medicine has the obligation to identify these skills as traits of a good physician and thus as entities to be internalized and made part of one’s character.30

A person’s character is not an inherited trait fixed from birth; it is malleable and teachable, but until now the typical approach we’ve used to try to teach bioethics isn’t sufficient. With the curricular reforms set forth, bioethics education in medical schools will likely influence and mold each student’s thought processes to be more ethically-aware and culturally-sensitive. Health care providers are privy to some of the most intimate and complicated aspects of patients’ lives, and it takes a solid understanding of bioethics to develop the skill set necessary to provide them thoughtful and effective care. When a patient feels understood and respected by their physician, I doubt they’re walking away thinking their physician really understood bioethics. Instead they’re probably thinking that they had a great doctor. What is the key to being a great doctor? As Dr. Hafferty said, the key is internalization of that skill set to the point where it becomes part
of your character,\textsuperscript{30} and a comprehensive contemporary bioethics education provides a path towards achieving this goal.
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