

April 13, 2014 of Combined Syllabus and Schedule/Course Outline

**Summer 2014 - SYLLABUS
Law and Ethics in Health Care
32.616/041/042**

Note: Please print out a copy of this syllabus for future reference

INSTRUCTOR: Marc Guillemette, MS, M.Div.

CONTACT INFORMATION:

Marc's Cell: 603-361-4980

Email: mguillemette@att.net

DATES FOR CLASSES:

Thursday In-Person Classes: 5:30 PM – 8:30 PM, Health and Social Service Building (South Campus)
5/22, 6/5, 6/19, 6/26, 7/10, 7/24

Thursday Blackboard Classes: 7:00 PM to 10:00 PM: 5/29, 6/12, 7/3, 7/17

COURSE DESCRIPTION

This course presents an overview of legal and ethical issues facing managers and providers in health care. It provides students with a foundation of health law and ethics and reviews a wide variety of health care legal and ethical situations and dilemmas. The goals are to provide students with practical knowledge of health laws and ethics and their application in the real world of health care. By the end of the course, students will have been exposed to many management ideas, theories and applications of health care law and ethics. Students will have a working knowledge of pertinent law and ethical procedures and how to apply them in health care arena.

COURSE OBJECTIVE

Law and Ethics in Health Care (32.616) provides an overview of the laws governing health care institutions and the ethical dilemmas facing managers, and providers in these institutions. The roles of management, staff, physicians, nurses and other clinical and support staff are examined in addressing legal and ethical issues within these organizations.

My style of teaching attempts to encourage a good deal of dialogue and learning from each other. It will be very important to view and analyze legal and ethical issues from multiple perspectives. Therefore, in addition to the textbook, assigned readings and cases, and the instructor's experiences, we will build on students' prior learning and experience in these areas.

Also, I believe that students will come to see during the semester that most legal and ethical issues in health care have multiple causes with multiple effects, and that there is usually no “one best way” to resolve them. However, there are better and worse ways to handle these situations and we will explore these together.

GENERAL INFORMATION

In order for a “Blended” course to be successful, engagement, participation and communication by students is essential and are the foundations of this course. The more you’re involved and participate in all aspects of the course, the more you are likely to profit from it.

REQUIRED TEXT:

Pozgar, George D. “Legal and Ethical Issues for Health Professionals” 3rd Edition;
Jones and Bartlett Learning (2013)

Gwande, Atul. “Better”; Henry Holt and Co., (2007)

In addition, there will be supplemental readings listed on the class schedule.

IN-PERSON CLASSES

The six In-Person classes will run much like a class in a traditional master’s course. The classes will meet from 5:30 PM to 8:30 PM on six Thursday evenings at the Health and Social Sciences Building (South Campus). See above for dates.

Each session will be structured in the following way: Attendance and participation at each in-person class will be worth 10 points, for a total of 60 points towards your grade and will be based upon your participation and contributions as assessed by me.

For May 22nd In-Person First Class please read Pozgar Chapter 1 “Introduction to Ethics,” as well as read the article “Medical Ethics” by Avraham Steinberg. MD found at:

<http://www.jewishvirtuallibrary.org/jsource/Judaism/MedicalEthics.pdf>

Also, please review the Dax case found in the Course Outline.

BLACKBOARD CLASSES

There will be 4 Blackboard sessions held from 7:00 PM to 10:00 PM on Thursday evenings during the weeks, when we do not meet in- person. See above for the dates.

We will hold the Blackboard classes online using your computer and UMASS Blackboard software. With Blackboard, we will be able to have “real classroom discussions” by conversing with each other over the internet.

Note: To use Blackboard you will need quality microphone and headphones for your computer.

Attendance and participation in the Blackboard classes will be worth 10 points each for a total of 40 points towards your grade, and will be based upon your participation and contributions as assessed by me.

A note on Attendance

Students are expected to attend each In-Person and Blackboard Class unless other arrangements have been made with me in advance. Send me an email if you will be missing a class.

Note: Because of the importance of attendance, more than one absence from the Blackboard on-line class and/or one In-Person Class will result in a lowering of your grade for the course.

What happens if you have to miss a class?

To help you keep up with the class and for your review, the Blackboard class will be archived on the class web site. If you miss a Blackboard class, I still expect you to make a posting on the discussion board. If you cannot participate in a given class, then I expect, at a minimum, that you'll listen to the archive and review the PowerPoint presentation.

ASSIGNMENTS

You will have assignments for each class as follows:

- i. **Core Reading Assignment** – For each class there will be reading assignments from the textbooks by Pozgar, Gawande as well as other assigned readings.
- ii. **Posting to Discussion Board for the four Blackboard classes** – For each Blackboard class, I will assign two or more cases to analyze from legal and/or ethical perspective, using the 4 Topics of Clinical Ethical Analysis, and answer several study questions based upon the week's assignments. You will need to type and post your responses

and analyses to the class Discussion Board. These postings will be available for review and comment by the entire class. You are expected to comment and cross-talk in response to the post respond to at least four of your classmates' postings. ***Please note that there are two parts to the discussion board for each of the four Blackboard classes.***

The postings will be due on Tuesday evenings of the weeks we have a Blackboard class by 7:00 PM. During our Blackboard class, we will review and discuss the classes' responses to the assigned cases. In the interest of providing ongoing feedback, I will be assessing each of your online assignments, using the following scale.

0	No Posting
10 Points	Substantially incomplete with unduly short mechanical answers not reflecting independent thought or analysis.
15-18 Points Satisfactory	Somewhat incomplete or not fully responsive to the case issues or the study questions.
20 Satisfactory	Fully Complete, comprehensive and thoughtful answers to all questions, and responded to at least two of your classmates.
0	No Posting

Late postings will have 1 point deducted from total score. "Extra credit" will be available to anyone reflecting additional research or reporting relevant personal experience or anecdotes in responding to the discussion board assignments.

The postings are worth a total of 80 points.

iii. Book Review or Literature Review (Choose one):

A. Book Review: Each student will read and make a PowerPoint presentation of the book to the class. You are free to select a book for review that deals with an aspect of health care Law and/or Ethics, but you must submit a short description to me for approval by Sunday, June 8th. The book must be factual. The presentation can be no more than 15 minutes. (Students will be informed when they are at the 10 minute mark of the presentation, and when they reach 15 minutes.) The review

should be no more than 11 PowerPoint pages. *Students will be penalized for presentations longer than 11 pages and/or 15 minutes.* I suggest you make the slides simple with as few words as possible. **Students will sign-up to review their PowerPoint presentation with the class.** The PowerPoint presentation should be sent to me no later than two days prior to your presentation. Also, you will need to provide me with one hardcopy of the PowerPoint presentation.

- B. Literature Review: If you find that your topic is not adequately covered by a book, you may choose to do a review of your topic based on at least five articles from peer reviewed journals or official government publications. Peer reviewed journals are those that have a panel of professional editors from healthcare that review the article before it is published to determine if it is up to professional standards. The same requirements for the PowerPoint book review presentation apply for the Literature Review.

More information regarding the Book Review/Literature Review, including examples of books reviewed and literature review topics from past classes, can be found in Blackboard Book Review/Literature Review r folder.

The assignment is worth 50 points.

- iv. **Term Paper:** This is the major writing assignment for the course. You will self-select a contemporary topic or issue on a topic of either Law or Ethics and prepare and write a paper of 8 - 12 pages. You may use your book review or literature review as a starting point for your term paper, but not the sole source for your term paper.

The assignment is worth 70 points.

Topics written about by previous students included:

- The Effects of Over Diagnosis
- Is Assisted Suicide ethical?
- Unionization and its effects on patients and workers
- Artificial Reproductive Technology
- Ethical and Legal Considerations in Health Care Information Technology Implementation

- Massachusetts' Changing Marijuana Laws and its impact on Health Care

These are just a few examples of the possible topics. I am also available to talk to you about possible topics.

A topical outline of your term paper should be submitted to me by email **by June 15th** so I can get an idea of where you are going for the semester.

More information regarding the format and style of the term paper, as well as examples of past topics, can be found in Blackboard Term Paper folder.

The Term Paper needs to be emailed to me by Saturday, July 12th so I can have them back to you on our final class July 24th.

Guest Lecturers

Depending on availability, guest lecturers may meet with the class and discuss pertinent topics related to health law and ethics.

EVALUATION AND GRADING

The following summarizes how points are gained:

In-Person Class Participation	60 Points
Weekly Blackboard Class Participation	40 Points
Posted Discussion of Cases and Study Question Responses	80 Points
Book or Literature Review	50 Points
Term Paper	70 Points
<hr/>	
Total Points	300 Points

Your grade will be calculated on the percentage of points you acquire throughout the semester. Letter grades will be assigned as follows:

A 93 – 100%	C 73 – 76%
A- 90 – 92%	C- 70 – 72%

B+ 87 – 89%	D+ 65 – 69%
B 83 – 86%	D 60 – 64%
B- 80 – 82%	F < 60%
C+ 77 – 79%	

Policy on Late Work. Under normal circumstances, late work will not be accepted without the prior agreement, except in the case of an emergency.

Plagiarism (whether from published sources, unpublished sources or the Internet) is not allowed in preparation of written assignments. A first offense will mean a letter reduction in your grade for the entire course; a second offense will result in your failing the course. It is incumbent on you (the student) to learn and understand what is meant by plagiarism and act accordingly. I encourage you to read <http://en.wikipedia.org/wiki/Plagiarism>. No extenuating circumstances will be allowed, and no second chance will be given.

SCHEDULE AND TOPICAL OUTLINE Summer 2014

(This Schedule is subject to change and modification so keep your eyes peeled for updates.)

Getting started in the Course before we meet:

Please review this "Schedule and Topical Outline Summer 2014" and "Syllabus." Also, when the Summer 2014 semester begins on May 19, 2014, you will be able to access this class on Blackboard; you will be able to access all the important information which will be found in the following labeled folders:

[Syllabus and Schedule/Topical Outline](#)

[Book Review/Literature Review](#)

[Term Paper](#)

[Folder for each of our classes:](#) At the present time you will find the assignment for each of our classes. From time to time I will let you know when there are reading assignments for upcoming classes. I will also place a copy of my Powerpoint presentations at the conclusion of each class.

Posting to the Discussion Board

It is important that we need to get to know each other, so please post a Personal Introduction on the Blackboard Discussion Board. (This Personal Introduction posting will not be graded.)

DATES FOR CLASSES

Thursday In-Person Classes (At Health and Social Sciences Building, (South Campus), 5:30 PM-8:30 PM):
5/22, 6/5, 6/19, 6/26, 7/10, 7/24

Thursday Blackboard Classes (7:00 PM – 10:00 PM): 5/29, 6/12, 7/3, 7/17

SCHEDULE:

May 22, 2014 – Class 1 - In-Person

Content: In this first class, we will examine the foundations of Law and Ethics in today's turbulent and changing health care system.

Before our first get together please read the article "Medical Ethics" by Avraham Steinberg, MD at:

<http://www.jewishvirtuallibrary.org/jsource/Judaism/MedicalEthics.pdf>

Although written for the Jewish Virtual Library, it presents a great summation of secular ethical and legal issues, and provides a solid foundation for the issues we will be addressing in the course.

Please also Read in the Pozgar Text: Chapter 1 "Introduction to Ethics"

Also for our first class, please be prepared to discuss the Dax's Case printed below.

Dax's Case

Here is a brief summary of a classic case healthcare ethics, namely, the case of Donald "Dax" Cowart, a burn patient who related his experience in the videotape Please Let Me Die and the documentary, Dax's Case.

"Dax" Cowart, age 25, was severely burned in a propane gas explosion. He asked the farmer who was the first person on the scene to shoot him since he was in such excruciating pain. Instead, he was rushed to the Burn Treatment Unit of Parkland Hospital in Dallas where he was found to have severe burns over 65 percent of his body; his face and hands suffered third degree burns and his eyes were severely damaged. In spite of his objections and his desire to be allowed to die, full burn therapy was instituted. After an initial period during which his survival was in doubt, he stabilized and underwent amputation of several fingers and removal of his right eye. During much of his 232 day hospitalization at Parkland, his few weeks at Texas Institute of Rehabilitation and Research at Houston, and his subsequent six month's stay at University of Texas Medical Branch in Galveston, he repeatedly insisted that treatment be discontinued and that he be allowed to die. Despite this demand, extremely painful wound care was continued, skin grafts performed and nutritional and fluid support provided. Finally, he was discharged totally blind, with minimal use of his hands, badly scarred, and dependent on others to assist in personal functions.

May 29, 2014 – Class 2 - Blackboard

Part I Content:

In part one of this evening's Blackboard class, we will review how law comes into being in the US and its influence on healthcare ethics, policy and practice and the consequences of the interactions between them.

Also, we will examine the variety of legal and ethical pressures facing health care managers and organizations and how these pressures permeate throughout the entire health care system.

In addition, we will scrutinize the elements of legal and ethical professionalism that a health care manager must have and use to be effective in his or her role as a leader within an organization.

Please Read

Chap. 5 "Development of Law"

Chap. 6 "Introduction to Law" Pages 193-220 ***(No need to read Trial and Procedures section, which we will cover at the end of the semester)***

Discussion Board Posting – Part I:

Prior to posting on the Blackboard Discussion Board please review the Chapter reprinted below from *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* which has a greater discussion of Dax's Case and the method of case analysis we discussed in class. Although written for physicians, the excerpt has relevance for other clinicians, healthcare managers and administrators. This method of case analysis should be used for your discussion board analysis throughout the semester.

ETHICS IN MEDICINE University of Washington School of Medicine

- Introduction to *Clinical Ethics*, 4th edition

The following is an excerpt from the book *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, by Albert R. Jonsen, Mark Siegler, and William J. Winslade, 4th edition. New York: McGraw-Hill, Inc., 1998. Copyright permission to reproduce this excerpt has been generously granted by McGraw-Hill.

INTRODUCTION: Case Analysis in Clinical Ethics

Clinical ethics is a practical discipline that provides a structured approach to assist physicians in identifying, analyzing and resolving ethical issues in clinical medicine. The practice of good clinical medicine requires some working knowledge about ethical issues such as informed consent, truth-telling, confidentiality, end-of-life care, pain relief, and patient rights. Medicine, even at its most technical and scientific, is an encounter between human beings, and the physician's work of diagnosing disease, offering advice, and providing treatment is embedded in a moral context. Usually, moral values such as mutual respect, honesty, trustworthiness, compassion, and a commitment to pursue shared goals, make a clinical encounter between physician and patient morally unproblematic. Occasionally, physicians and patients may disagree about values or face choices that challenge their values. It is then that ethical problems arise. Clinical ethics is both about the ethical features that are present in every clinical encounter and about the ethical problems that occasionally arise in those encounters. Clinical ethics relies upon the conviction that, even when perplexity is great and emotions run high, physicians and nurses, patients and families can work constructively to identify, analyze and resolve many

of the ethical problems that arise in clinical medicine.

We suggest that every clinical case, when seen as an ethical problem, should be analyzed by means of four topics. These four topics are

1. [Medical Indications](#);
2. [Patient Preferences](#);
3. [Quality of Life](#),
4. [Contextual Features](#),

that is, the social, economic, legal, and administrative context in which the case occurs. Every case can be viewed in terms of these four topics; no case can be adequately discussed without reference to them. Although the facts of each case differ, these four topics are always relevant. The topics organize the varying facts of the particular case and, at the same time, the topics call attention to the moral principles appropriate to the case. It is our intent to show readers how the topics provide a systematic way to identify, analyze and resolve the ethical problems arising in clinical medicine.

We illustrate our method by a brief summary of a case familiar to many who have studied medical ethics, namely, the case of Donald "Dax" Cowart, the burn patient who related his experience in the videotape [Please Let Me Die](#) and the documentary, [Dax's Case](#). [1]

In 1973, "Dax" Cowart, age 25, was severely burned in a propane gas explosion. Rushed to the Burn Treatment Unit of Parkland Hospital in Dallas, he was found to have severe burns over 65 percent of his body; his face and hands suffered third degree burns and his eyes were severely damaged. Full burn therapy was instituted. After an initial period during which his survival was in doubt, he stabilized and underwent amputation of several fingers and removal of his right eye. During much of his 232 day hospitalization at Parkland, his few weeks at Texas Institute of Rehabilitation and Research at Houston, and his subsequent six month's stay at University of Texas Medical Branch in Galveston, he repeatedly insisted that treatment be discontinued and that he be allowed to die. Despite this demand, wound care was continued, skin grafts performed and nutritional and fluid support provided. He was discharged totally blind, with minimal use of his hands, badly scarred, and dependent on others to assist in personal functions.

Discussion of a case like this can begin by raising any number of questions. Did Dax have the moral or the legal right to refuse care? Was Dax competent to make a decision? Were the physicians paternalistic? What was Dax's prognosis? All these questions, and many others, are relevant and can give rise to vigorous debate. However, we suggest that an ethical analysis should begin by an orderly review of the four topics. We

recommend that the same order be followed in all cases: (1) Medical Indications, (2) Patient Preferences, (3) Quality of Life, (4) Contextual Features. This procedure will lay out the ethically relevant facts of the case (or show where further information is needed) before debate begins. It should be noted that this order of review does not constitute an order of ethical priority. The determination of relative importance of these topics will be explained in the four chapters.

Medical Indications. This topic comprises the usual content of a clinical discussion: the diagnosis and treatment of the patient's pathological condition. "Indications" refers to the relation between the pathophysiology presented by the patient and the diagnostic and therapeutic interventions that are "indicated," that is, appropriate to evaluate and treat the problem. Although this is the usual material covered in the presentation of any patient's clinical problems, the ethical discussion will not only review the medical facts, but also attend to the purposes and goals of any indicated interventions.

In Dax's case, the medical indications include the clinical facts necessary to diagnose the extent and seriousness of burns, to make a prognosis for survival or restoration of function, and the options for treatment, including the risks, benefits and probable outcomes of each treatment modality. For example, certain prognoses are associated with burns of given severity and extent. Various forms of treatment, such as fluid replacement, skin grafting and antibiotics are associated with certain probabilities of outcome and risk. After initial emergency treatment, Dax's prognosis for survival was approximately 20%. After six months of intensive care, his prognosis for survival improved to almost 100%. If his request to stop wound care and grafting during that hospitalization had been respected, he would almost certainly have died. A clear view of the possible benefits of intervention is the first step in assessing the ethical aspects of a case.

Patient Preferences. In all medical treatment, the preferences of the patient, based on the patient's own values and personal assessment of benefits and burdens are ethically relevant. In every clinical case, the questions must be raised: "What are the patient's goals? What does the patient want?" The systematic review of this topic requires further questions. Has the patient been provided sufficient information? Does the patient comprehend? Does the patient understand the uncertainty inherent in any medical recommendation and the range of reasonable options that exist? Is the patient consenting voluntarily? Is the patient coerced? In some cases, an answer to these questions might be "We don't know because the patient is incapable of formulating a preference or expressing one." If the patient is mentally incapacitated at the time a decision must be made, we must ask "Who has the

authority to decide on behalf of this patient? What are the ethical and legal limits of that authority? What is to be done if no one can be identified as surrogate?

In Dax's case, a question about his mental capacity arose in the early days of his refusal of care. Had the physical and emotional shock of the accident undermined his ability to decide for himself? Initially it was assumed that he lacked the capacity to make his own decisions, at least about refusing life-saving therapy. The doctors accepted the consent of Dax's mother in favor of treatment, over his refusal of treatment. Later, when Dax was hospitalized in Galveston, psychiatric consultation was requested which affirmed his capacity to make decisions. Once capacity was established, the ethical implications of his desire to refuse care became central. Should his preference be respected? If not, on what grounds? Did Dax appreciate sufficiently the prospects for his rehabilitation? Are physicians obliged to pursue therapies they believe have promise over the objections of a patient? Would they be cooperating in a suicide if they assented to Dax's wishes? Any case involving the ethics of patient preferences relies on clarification of these questions.

Quality of Life. Any injury or illness threatens persons with actual or potential reduced quality of life, manifested in the signs and symptoms of their disease. The object of all medical intervention is to restore, maintain or improve quality of life. Thus, in all medical situations, the topic of quality of life must be raised. Many questions surround this topic: What does this phrase, "quality of life" mean in general? How should it be understood in particular cases? How do persons other than the patient perceive the patient's quality of life and of what ethical relevance are their perceptions? Above all, what is the relevance of quality of life to ethical judgment? This topic, which is less well worked out in the literature of medical ethics than the two previous ones, is perilous because it opens the door for bias and prejudice. Still, it must be confronted in the analysis of clinical ethical problems.

In Dax's case, we note the quality of his life prior to the accident. He was a popular, athletic young man, just discharged from the Air Force, after serving as a fighter pilot in Viet Nam. He worked in a real estate business with his father (who was also injured in the explosion and died on the way to the hospital). Before his accident, Dax's quality of life was excellent. During the course of medical care, he endured excruciating pain and profound depression. After the accident, even with the best of care, he was confronted with significant physical deficits, including notable disfigurement, blindness and limitation of activity. At some stage in his illness, Dax had the capacity to determine

what quality of life he wished for himself. However, in the early weeks of his hospitalization, he was probably mentally incapacitated at the time critical decisions had to be made. When he was, others would have had to make certain "quality of life" decisions on his behalf. Was the prospect for return to a normal or even acceptable life so poor that no reasonable person would choose to live? Who should make such decisions? What values should guide them? The meaning and import of such considerations must be clarified in any clinical ethical analysis.

Contextual Features. Patients come to physicians because they have a problem that they hope the physician can help to correct. Physicians undertake the care of patients with the intent and the duty to make all reasonable efforts to help them. The topics of medical indications, patient preferences and quality of life bring out these essential features of the case. Yet every medical case is embedded in a larger context of persons, institutions, financial and social arrangements. Patient care is influenced, positively or negatively, by the possibilities and the constraints of that context. At the same time, the context itself is affected by the decisions made by or about the patient: these decisions have psychological, emotional, financial, legal, scientific, educational, religious impact on others. In every case, the relevance of the contextual features must be determined and assessed. These contextual features may be crucially important to the understanding and resolution of the case.

In Dax's case, several of these contextual features were significant.. Dax's mother was opposed to termination of medical care for religious reasons. The legal implications of honoring Dax's demand were unclear at the time (they are clearer today). The costs of sixteen months of intensive burn therapy are not insignificant (although this was not emphasized in the various discussions of the case). The distress caused to medical and nursing personnel by Dax's refusal to cooperate with treatment might have influenced their attitudes toward him. These and other contextual factors must be made explicit and assessed for their relevance.

These four topics are relevant to any clinical case, whatever the actual circumstances. They serve as a useful organizing device for teaching and discussion. More important, however, is the way in which a review of these topics can help to move a discussion of an ethical problem toward a resolution. Any serious discussion of an ethical problem must go beyond merely talking about it in an orderly way: it must push through to a reasonable and practical resolution. Ethical problems, no less than medical problems, cannot be left hanging. Thus, after presenting a case, the task of seeking a resolution must begin.

The discussion of each topic raises, or presupposes, certain common ethical notions. These notions propose certain standards of behavior or attitudes that are morally appropriate to the topic. They can be called moral principles or rules: rules tend to be quite specific to particular topics, while principles are stated in broader, more general terms. For example, one version of the principle of beneficence states, "There is an obligation to assist others in the furthering of their legitimate interests." The moral rule, "physicians have a duty to treat patients, even at risk to themselves," is a specific expression of that broad principle, suited to a particular sphere of professional activity, namely, medical care. The topic of medical indications, in addition to the clinical data that must be discussed, raises the further questions, "How much can we do to help this patient?" "What risks of adverse effects can be tolerated in the attempt to treat the patient?" Answers to these questions, arising so naturally in the discussion of medical indications, can be guided by familiar moral rules applied to medical ethics such as, "Be of benefit and do no harm" or "Risks should be balanced by benefits." Rules such as these reflect in a specific way the broad principle that the philosophers have named beneficence. Similarly, the topic of patient preferences contains rules that instruct clinicians to tell patients the truth, to respect their deliberate preferences, to honor their values, etc. Rules such as these fall under the general scope of the principles of autonomy and respect for persons.

Our method of analysis begins, not with the principles and rules, as do many other ethics treatises, but with the factual features of the case. We refer to relevant principles and rules as they arise in the discussion of the topics. In this way, abstract discussions of principles is avoided as is the tendency to think of only one principle, such as autonomy or beneficence, as the sole guide in the case. Moral rules and principles are best appreciated in the specific context of the actual circumstances of a case. For example, a key issue in Dax's case is the autonomy of the patient. However, the significance of autonomy in Dax's case is derived, not simply from the principle that requires we respect it, but from the confluence of considerations about preferences, medical indications for treatment, quality of life, decisional capacity, and the role of his mother, the doctors, the lawyers and the hospitals. Only when all these are seen and evaluated in relation to each other, will the meaning of the principle of autonomy be appreciated in this case.

Competence in clinical ethics depends not only on being able to use a sound method for analysis, but also on familiarity with the literature of medical ethics. Some readers will seek further elaboration of the issues dealt with so briefly in this introductory book. We direct these readers to a few sources where they will find, not only that

elaboration, but references to the major literature. Thus, we place in brackets after our discussion of an issue references to The Encyclopedia of Bioethics (2), Principles of Biomedical Ethics (3), and Medical Ethics (4).

REFERENCES

1. Kliever LD, ed. *Dax's Case. Essays in Medical Ethics and Human Meaning*. Dallas: Southern Methodist University Press, 1989.
2. Reich W, ed. *Encyclopedia of Bioethics*. 2nd edition. 5 vols. New York: Simon & Schuster/ Macmillan, 1995.
3. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. New York: Oxford University Press, 4th edition, 1994.
4. Veatch RM, ed. *Medical Ethics*. 2nd edition. New York: Bartlett and Jones, 1994.
5. Walters L, Kahn TJ, eds. *Bibliography of Bioethics*. Washington, DC: Georgetown University. Published annually. On line as BIOETHICSLINE, National Library of Medicine MEDLARS.

Discussion Board Posting – Part I

Please read and post your responses on the Discussion Board to the following case:

A woman enters the emergency room with stomach pain. She undergoes a CT scan and is diagnosed with an abdominal aortic aneurysm, a weakening in the wall of the aorta which causes it to stretch and bulge. The physicians inform her that the only way to fix the problem is surgically, and that the chances of survival are about 50/50. They also inform her that time is of the essence, and that should the aneurysm burst, she would be dead in a few short minutes. The woman is an erotic dancer; she worries that the surgery will leave a scar that will negatively affect her work; therefore, she refuses any surgical treatment. Even after much pressuring from the physicians, she adamantly refuses surgery. Feeling that the woman is not in her correct state of mind and knowing that time is of the essence, the surgeons decide to perform the procedure without consent. They anesthetize her and surgically repair the aneurysm. She survives, and sues the hospital for millions of dollars.

- What are the medical indication, patient preferences, quality of life, and contextual features of this case?

- Do you believe that the physician's actions can be justified in any way?
 - Is there anything else that they could have done?
 - Is it ever right to take away someone's autonomy? (Would a court order make the physicians' decisions ethical?)
 - What would you do if you were one of the health care workers?
 - Does this case raise issues similar to Dax's case or are they very different?
-

Part II Content:

In Part II of tonight's Blackboard class, we will discuss patient consent. Patient consent is one of the most important principles in healthcare law and ethics today. Throughout the semester patient consent will be a key pillar to our case analysis. How we handle informed consent says much about our role as professionals, our organizations, and the very society in which we live.

Please Read: Pozgar Chap. 12 "Patient Consent".

Read the Following Report on the Tuskegee Study which was originally broadcast on July 25, 2002. This incident had a major impact on the idea of Patient Consent in the U.S.

July 25, 2002 --Thirty years ago today, the *Washington Evening Star* newspaper ran this headline on its front page: "Syphilis Patients Died Untreated." With those words, one of America's most notorious medical studies, the Tuskegee Syphilis Study, became public.

"For 40 years, the U.S. Public Health Service has conducted a study in which human guinea pigs, not given proper treatment, have died of syphilis and its side effects," Associated Press reporter Jean Heller wrote on July 25, 1972. "The study was conducted to determine from autopsies what the disease does to the human body."

The next morning, every major U.S. newspaper was running Heller's story. For *Morning Edition*, NPR's [Alex Chadwick](#) reports on how the Tuskegee experiment was discovered after 40 years of silence.

The Public Health Service, working with the Tuskegee Institute, began the study in 1932. Nearly 400 poor black men with syphilis from Macon County, Ala., were enrolled in the study. They were never told they had syphilis, nor were they ever treated for it. According to the Centers for Disease Control, the men were told they were being treated for "bad blood," a local term used

to describe several illnesses, including syphilis, anemia and fatigue.

For participating in the study, the men were given free medical exams, free meals and free burial insurance.

At the start of the study, there was no proven treatment for syphilis. But even after penicillin became a standard cure for the disease in 1947, the medicine was withheld from the men. The Tuskegee scientists wanted to continue to study how the disease spreads and kills. The experiment lasted four decades, until public health workers leaked the story to the media.

By then, dozens of the men had died, and many wives and children had been infected. In 1973, the National Association for the Advancement of Colored People (NAACP) filed a class-action lawsuit. A \$9 million settlement was divided among the study's participants. Free health care was given to the men who were still living, and to infected wives, widows and children.

But it wasn't until 1997 that the government formally apologized for the unethical study. President Clinton delivered the apology, saying what the government had done was deeply, profoundly and morally wrong:

"To the survivors, to the wives and family members, the children and the grandchildren, I say what you know: No power on Earth can give you back the lives lost, the pain suffered, the years of internal torment and anguish.

"What was done cannot be undone. But we can end the silence. We can stop turning our heads away. We can look at you in the eye and finally say, on behalf of the American people: what the United States government did was shameful.

"And I am sorry."

Also copy the following URL into your browsers and review the Nuremberg Code of Medical Ethics at;

<http://www.cirp.org/library/ethics/nuremberg/>

Discussion Board – Part II

Read **"The Case of the Depressed Patient"** below and discuss the ethical and legal implications. Post your responses to the Discussion board.

The Case of the Depressed Patient

Melinda Lee, M.D. (Santa Clara University '69), is associate professor of medicine at Oregon Health Sciences University and a geriatrician with Providence ElderPlace in Portland.

When seriously ill patients ask to discontinue life-sustaining treatment, depression may be impairing their ability to make decisions. In this case study, a geriatrician discusses how a physician might work through the ethics of this situation.

At 80, R.L. lives with his wife in a retirement community. He has always valued his independence, but recently he has been having trouble caring for himself. He is having difficulty walking and managing his medications for diabetes, heart disease, and kidney problems.

His doctor diagnoses depression after noting that R.L. has lost interest in the things he used to enjoy. Lethargic and sleepless, R.L. has difficulty maintaining his weight and talks about killing himself with a loaded handgun. He agrees to try medication for the mood disorder.

Two weeks later, before the effect of the medicine can be seen, R.L. is hospitalized for a heart attack. The heart is damaged so severely it can't pump enough blood to keep the kidneys working.

Renal dialysis is necessary to keep R.L. alive, at least until it's clear whether the heart and kidneys will recover. This involves moving him three times a week to the dialysis unit, where needles are inserted into a large artery and a vein to connect him to a machine for three to four hours.

After the second treatment, R.L. demands that dialysis be stopped and asks to be allowed to die.

You are R.L.'s physician. What would you do?

R.L.'s was an actual case that presented his physicians with a common dilemma in treating patients with serious illnesses: Had depression rendered him incapable of making a legitimate life-and-death decision?

When patients agree to undergo or refuse medical treatment, they are supposed to reach the decision by a process called informed consent. The doctor discloses information about the medical condition, treatment options, possible complications, and expected outcomes with or without treatment.

To give informed consent or refusal, the patient must be acting voluntarily and must have the capacity to make the decision. That means the patient must be able to understand the information, appreciate its personal implications, weigh the options based on personal values and life goals, and communicate a decision. From an ethical point of view, informed consent is based on the philosophical principles of autonomy and beneficence. In R.L.'s case, these two principles are in conflict. First, R.L.'s prognosis is unclear, and the physician does not know if the benefits of dialysis will outweigh the burdens. Under normal circumstances, this decision would be made by R.L., but the physician suspects the patient's capacity for autonomous decision making is impaired by depression.

Depression is a mood disorder that can profoundly affect a person's ability to think positively, experience pleasure, or imagine a brighter future. Depressed people frequently have little energy, poor appetites, and disturbed sleep. They may have difficulty concentrating, or they may be troubled by feelings of guilt and hopelessness. Preoccupation with death is common and, in some cases, may include contemplating suicide.

Because R.L. was suicidal before his heart attack, no one was sure whether his refusal of dialysis represented an authentic exercise of his right to stop life-saving treatment or a convenient means to passively end his life. On the other hand, if the doctor continued dialysis, he would be denying R.L. the same right to refuse treatment that another patient who was not depressed would have.

When patients ask to have life-sustaining treatment withheld, doctors have been taught to consider whether depression is driving the request, because the condition lifts in two-thirds of those who are treated with anti-depressant medications. The presumption is that once the problem has cleared, the patient will look at treatment decisions differently.

Recent research has challenged that presumption by showing depressed patients don't necessarily choose to hasten death in the first place and they often make the same decisions after they recover from depression. Thus, depressed patients may be able to give informed consent, but doctors and loved ones must consider whether the decision to refuse medical treatment is logical, internally consistent, and conforms with past life choices and values.

In R.L.'s case, the doctor, in consultation with a psychiatrist, decided to continue the course of anti depressant medication to see if, when it began to take effect, R.L. would change his mind about treatment. In the meantime, his dialysis was continued.

After five weeks, R.L. showed no improvement, and he began to refuse medications and food. His wife was asked to give consent for a feeding tube.

On conferring with the rest of the family, R.L.'s wife denied the doctor's request. Her husband's repeated refusal of dialysis had convinced the family R.L. really did want to die. In addition, R.L.'s unchanged physical condition indicated that, if he survived to discharge, he would probably need nursing home care, a fate he had resisted even before his depression. Ultimately, the physician shared the family's assessment that R.L.'s consistent refusals indicated an authentic wish to halt treatment. He was taken off dialysis and put on comfort measures. Six days later, he died.

What are the medical indication, patient preferences, quality of life, and contextual features of this case?

How would you have sorted through the ethics and legal aspects of this situation if you were R.L.'s medical provider?

June 5, 2014 - Class 3 – In-Person

Content:

Acting ethically is more often a matter of deciding what is right or wrong rather than a question of good versus bad. Often, the decisions have to be made between two or more courses of action, all of which are right to a greater or lesser degree. In health care, defining ethical behavior is very complex due to the individual and social responsibilities that so often are attached to health care dilemmas. Much of health care law is based upon public health practice, personal health care, and also tort and common law.

Please read Chap. 7 "Government, Ethics and the Law"

Also read "Public Health Ethics" from the University of Washington posted below.

From: **ETHICS IN MEDICINE** University of Washington School of Medicine

Public Health Ethics

Public health practice concerns itself with issues of illness and disease of populations, and as such touches some unique ethical issues. In general, public health practices and policies seek to improve the overall health of the public, a position sometimes at odds with the autonomy of the individual. This conflict may be clinical, as in the case of immunization, or legal, as in the case of mandatory medical reporting and treatment of communicable diseases. Further, public health involved recognizing health and illness in the broader context of social, environmental, political, and economic factors. All health care providers share in public health practice, and have opportunities in their actions to shape public health policy.

When should diseases be reported to Public Health authorities?

Each state has specific statutes that identify specific diseases with public health implications, such as communicable diseases, which require reporting. Beyond this legal requirement lies the question of when it is justified to potentially violate confidentiality to protect the public's health. It is ethically justified to disclose a diagnosis to public health authorities if the risk to the public has the following features:

- the risk is high in probability
- the risk is serious in magnitude
- the risk relates to an identifiable individual or group

For instance, if a food handling restaurant worker with acute hepatitis asks that his diagnosis be held in confidence, the physician should nevertheless disclose this diagnosis to the dining establishment or public health authorities, since the risk to the public is high, serious, and relates to identifiable persons (e.g., patron of the eating establishment).

Can patients refuse to undergo routine preventive health measures?

There are a number of preventive health interventions which provide minimal if any benefit to the individual yet provide substantial collective benefit to the public's health. For example, immunizations provide protection but involve some risk to the individual. However, if a public health program can achieve universal vaccination, the overall public health benefits. If a patient refuses a legally required immunization (e.g., in jurisdictions where immunization is legally mandated), this becomes a legal matter. If not legally mandated, an adequately informed refusal, expressing compelling personal or religious beliefs, may be respected.

Can a physician refuse to follow public health mandates that he opposes?

Most public health law and regulations reflect a public policy process that involved tradeoffs. There is seldom certainty in the final policy recommendations, which are often the result of compromise positions of divergent advocacy groups. As a result, physicians and other health care workers may find their own positions at odds with regulations or health care laws. Professionals have an obligation to exercise judgment and not follow laws that are grossly unjust or immoral. Most situations are not this extreme, however. Thus, the health care professional should find ways other than outright disobedience to try to influence health care policy with which she disagrees. No health care provider should be forced to provide a service he morally opposes, but he should also not obstruct others who support it. The best and most constructive way to affect health policy is to participate actively in the policy making process.

When can a patient be held for medical treatment against her will?

This is a controversial area in law, and the law varies by state. The ethical justification for treatment of a patient against his will is based on balancing of the risk to the public versus respecting the patient's personal freedom. If the magnitude of risk to the public is great, many states allow for involuntary treatment. For example, a patient with active pulmonary tuberculosis that is resistant to multiple anti-tuberculosis medications presents a grave risk to the public if her condition is untreated. This arises in part because of the high infectivity of active pulmonary tuberculosis and the relatively small risk to the patient from oral medications for TB treatment. Other conditions for which non-treatment pose little or no threat to the public, such as untreated acute leukemia, can rarely have involuntary treatment justified.

Please read in Gawande: "The Mop-up" p. 29.

Please read the December 2012 Center for Strategic International Studies (CSIS) report "The U.S. Role in Global Polio Eradications" and see how the situation has changed over time.

http://csis.org/files/publication/121217_Bristol_USRolePolio_Web.pdf

During natural disasters and periods where some medical resources are scarce, how those resources are distributed is a key public health decision facing health care leaders. The decisions made can impact the lives of several to hundreds of patients and citizens. Please read the following: *Disaster Triage and Allocation of Scarce Resources*, by Michael Christian, MD; J. Christopher Farmer, MD; Brian P. Young, MD, that can be found in the Class 3 Blackboard folder.

June 12, 2014 – Class 4 - Blackboard

Part I Content:

In part one of our class we will explore physicians' ethical and legal issues. Health care is supposed to be a team effort. But despite what many individuals may believe, it is often a sequence of disjointed events where patients are passed from one specialist to another without much real teamwork. In this class we review the various ethical and legal issues facing physicians and their interactions with other clinical specialists, managers, and of course, patients. However, will examine them from the managerial perspective.

Please read: Pozgar Chap. 10 "Physicians' Ethical and Legal Issues"

Please read: The following two versions of the Hippocratic Oath.

The Hippocratic Oath: Classical Version

I swear by Apollo Physician and Asclepius and Hygeia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding

such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Translation from the Greek by Ludwig Edelstein. From *The Hippocratic Oath: Text, Translation, and Interpretation*, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.

The Hippocratic Oath: Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death? If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.

Please read in Gawande: "Piecework" P. 112.

Discussion Board Posting-Part I:

Please read the Newspaper Clippings: "Concern Is Growing That The Elderly Get Too Many Medical Tests" on page 352-354 and post your responses to the discussion questions on the discussion board. Also, while this Newspaper Clipping, does not involved one particular patient, please use the 4 topic approach (Medical Indication, Patient Preferences, Quality of Life, and Contextual Features) in analyzing the issues presented.

Also, discuss the issue of payments and fees and how health care is paid for as raised in Gawande's "Piece Work". Should doctors and health care providers be paid for each service they provide? In this time of corporate health care and sky-rocketing health care costs, should we find another way to reimburse for health care? Do you believe that getting away from the fee-for-service payment model where providers are paid for each service they perform to the bundling of services where hospitals and providers are paid a single payment will be ethical? What effects might this approach have on the quality of health care?

Part II Content:

In the second part of this evening's Blackboard class we will discuss that we are all professionals in one sense or another, but clinicians have a special set of legal issues because of their direct contact with patients. We will explore these issues from a management perspective.

Please read: Pozgar Chap. 9 "Health Care Professionals' Ethical and Legal Issues"

Please read in Gawande: "The Score" p. 169.

Discussion Board Posting-Part II:

Please read the following case study, and please respond to the questions on Discussion Board. Make certain to discuss the Medical Indications, Patient Preferences, Quality of Life, and Contextual Features of the case.

SHHHHHHHH, DON'T TELL

Case prepared by Pat Wolfe, Paula Smith, [Margaret McLean](#), and Thomas Shanks.

From: <http://www.scu.edu/ethics/dialogue/candc/cases/tell.html>

After suffering a back injury at work, Lowell Baxter has completed three weeks of physical therapy. While unable to work, Lowell has been going three times per week to see therapist Eve Nye who has been working for three months at a new clinic and is still learning the ropes.

After Mr. Baxter's ninth treatment, his physician, Dr. Felton Cranz, explained that he had made good progress. Lowell no longer needed PT but was unable to return to his physically demanding job. He continued the home exercise regimen that Ms. Nye had given him. Dr. Cranz, who was not adverse to ordering additional physical therapy if necessary, told Lowell to call him if he had any further problems.

One month later, Mr. Baxter called Dr. Cranz's office and told the nurse that there had been "a flare up" in his lower back. After talking with the doctor, the nurse called Lowell and told him that Dr. Cranz ordered another round of PT - 3 times per week for 3 weeks - that he should begin right away.

During his third session, while telling Eve about his recent activities, Lowell mentioned that he slipped and fell on a rainy night while coaching his daughter's soccer team. He said that this happened "a couple of days" before the "flare up". Eve asked if he told his doctor about this latest fall. Surprised at the question, Lowell replied, "Well, no. Why would I? Anyway, I was having some painful twinges in my back before I slipped. Besides I fell on the soft grass. I'm sure I didn't hurt myself when I slipped. Dr. Cranz is always so busy and I don't need to waste his time with this. He told me after I finished my sessions a month ago that I might need another round of PT anyway. I feel better after our therapy sessionsSo, how about those Sharks - the men in teal?"

When Ms. Nye saw Mr. Baxter on his fifth visit, he complained of increased pain with radiation down his left leg. During her evaluation, Eve concluded that his pain was different from the pain he experienced after the first fall and was almost certainly related to the second fall. She explained this to Lowell and suggested to him that he talk to his doctor to ensure that he received the appropriate treatment. Lowell insisted that he did want to bother his doctor with this.

Now, on his seventh visit, Mr. Baxter is visibly fatigued and short-tempered. He complains of weakness and numbness in the left leg. Eve strongly encourages him to talk with Dr. Cranz. He adamantly refuses.

"Well, perhaps I should talk with Dr. Cranz for you. I could tell him about your fall at the soccer game and this onset of numbness and weakness in your leg. You know, Dr. Cranz looks at the notes I write."

"No," blurts Mr. Baxter. "I don't want you to say anything. It's none of your business! This is my injury, and I don't want to bother him with this. You have to respect my wishes. Your job is to do therapy; not to interfere. Now, let's get on with it!"

Questions

1. What are the medical indications, patient preferences, quality of life and contextual features of this case?
2. What should Eve Nye do now? Why?
3. What might Eve Nye have done earlier?
4. How would you have dealt with Lowell Baxter?

Also respond to the ethical and legal issues raised for you by the Gawande in "The Score", and respond to the following questions:

- What controls, if any, should be placed on the diffusion of innovation (e.g. such technologies such as MRI's, CTs, drugs or obstetrical or surgical procedures) and other knowledge in health care.
- Should we judge the past using current ethical and legal standards?

Post your responses to the Discussion Board.

Term Project Progress:

We will discuss the term projects that students have self-selected and answer any questions you might have about the project. **The term project outlines are due on June 15th.**

June 19, 2014 - Class 5 – In-Person

Content: In this class, we will address a Potpourri of Ethical and Legal Dilemmas by discussing a series of current ethical-legal problem with respect to the topics addressed by Pozgar

Please Read: Pozgar Chapter 2 "Contemporary Ethical Dilemmas"
Pozgar Chapter 3 "End-of-Life Dilemmas"

Also, please go to the following website and **view the November 13, 2012 Frontline Report "The Suicide Plan."** The video is one hour and 20 minutes long, so please plan accordingly.

<http://video.pbs.org/video/2304058290>

In preparation for this class give thought to the some of the many issues associated with end of life care and the implications of assisted suicide. Should assisted suicide be legal in this country? Should health care professionals be prosecuted as was Dr. Jack Kevorkian, also known as Dr. Death, for assisting individuals taking their own life? What are some ethical and legal reasons that assisted suicide should be or not be legal? How does the idea of Informed Consent affect this issue?

June 26, 2014 – Class 6 - In-Person

In this session, we will begin to review the moral and legal ecology of a health care organization. Which raises the question, can organizations have ethical or legal responsibilities, or just individuals? What is the context for thinking about organizational ethics; who are the stakeholders, what are the generic problems found in each organizational department or unit, what methods can we use to think about the complexity of health care organizational ethics and legal responsibilities, and what policies need to be in place to resolve and perhaps even prevent them? These issues are, perhaps, the ones that most healthcare managers and administrators face, rather than the moral responsibilities of individuals.

As it relates to Organization ethics and Law, we will examine the role that a healthcare organization's Ethics Committee serves in dealing with ethical and legal dilemmas.

Please read: Pozgar Chap. 8 "Organizational Ethics and Law"

Pozgar Chap. 4 "Health Care Ethics Committee"

Please Read: the American Medical Association's Institute for Ethics National Working Group Report "Organizational Ethics in Healthcare: Toward a Model for Ethical Decision-making by Provider Organizations", which can be found in Class 6 Blackboard folder. While published in 2000, this report is still pertinent today since it provides a solid overview of the sources of organizational ethics, and a model of standards for healthcare organizational ethics.

Please read in Gawande: "On Washing Hands" p. 13.

As part of class today we will conduct a mock Ethics Committee Consult. On Wednesday, June 25th the case will be posted in the Class 6 folder, to make our discussion more realistic, since often the Committee receives information about the consult a day before.

July 3, 2014 – Class 7 - Blackboard

Part I Content:

By this week you should have a deeper appreciation of how our personal values, and the culture of the society we live in, influences what we believe to be right and wrong, our moral compasses, and the legal responsibilities we have to our patients, our organizations and our communities.

Medical records are an essential way of communicating with healthcare professionals, and thus they contain vital patient information. As healthcare professionals, we have access to this information about individuals' personal health, detailed medical record, insurance information, provider's notes and impressions. The Health Insurance Portability and Accountability Act of 1996 regulates how this information is to be handled and disseminated.

Please read:

Chapter 18 Medical Records from Legal and Ethical Essentials of Health Care Administration – Second Edition by George D. Pozgar. Jones and Bartlett Learning. Burlington, MA. 2014. (Found in Blackboard Class 7 folder)

Summary of the HIPAA Privacy Rule by the United States Department of Health and Human Services, OCR Privacy Brief. There is a great deal more to learn about HIPAA than in this summary. We are just skimming the surface of a very complex law.

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>

Discussion Board Posting – Part I:

Read below: A very short HIPAA Case Study and post your responses to the Discussion Board.

Evan Lee went to the emergency room at Mercy Hospital after he badly cut his hand on the job as a stock associate in a retail store. Evan's manager went to the hospital to check on Evan, but he had already been released. Evan's manager approached the nurse's station, identified herself, and asked for information on Evan's case.

The nurse on duty was a new graduate and had only been on the job for one week. The supervising nurse had been called away from the station to deal with a critical patient. Unsure of what to do, the nurse on duty asked Evan's manager to wait until the supervising nurse returned. Evan's manager became emotional and explained that she was worried Evan would sue the store if he was badly hurt, and that she would lose her job. To help calm down Evan's manager, the nurse pulled Evan's file up on her computer screen and showed her the attending physician's comments on his case.

When Evan returned to work after a few days, he was beset with questions from his manager, who asked about his injury. After discussing it for a short period of time, the manager changed the topic. She said she was having some trouble with her son's moods and was curious about which medications were most effective for depression. She asked Evan what he knew about these medications. When he confronted his manager, Evan discovered that his manager had seen his electronic file and read that he was taking anti-depressants. In response, Evan was outraged and embarrassed and contacted the Office for Civil Rights in the U.S. Health and Human Service Department to file a claim against Mercy Hospital for violating his privacy.

After investigating Evan's claim, the Office for Civil Rights determined that Mercy Hospital violated privacy rules and standards established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by unlawfully sharing his private medical information. These violations extended past Evan's case to hundreds of other patients. Mercy Hospital was fined \$10,000 for non-compliance. In response to its HIPAA violation, Mercy Hospital took several steps to ensure its future compliance. These steps included notifying patients of privacy practices, training staff on proper procedure, appointing a privacy officer, and establishing safeguards against distributing patient information to unauthorized parties.

The following are questions to stimulate your responses.

1. What are the medical indications, patient preferences, quality of life, and contextual features of this case?
 2. How does HIPAA serve to protect patient rights?
 3. What areas of the organization does HIPAA compliance impact?
 4. Do you agree with the fine levied against Mercy Hospital? Why, or why not?
 5. Wasn't this just an over-reaction on the part of Evan and particularly the Office of Civil Rights?
 6. What should have been done in this case?
 7. What training should the hospital undertake?
-
-

Part II Content

In the second part of tonight's class we will discuss how we often focus on the rights of patients and the responsibilities of providers and other workers, and rightfully so. But what rights do the employees of a health care facility have? What is the priority and importance that we put on those rights? Moreover, what legal duties do healthcare facilities have to their employees? We will discuss and examine healthcare employee issues in this session.

Please read: Pozgar Chap. 11 "Employee Rights and Responsibilities".

Please just get familiar with the US Department of Labor Website at:

www.dol.gov/compliance

There is a wealth of information at this site that you should be aware of.

Also, please review the Website of SEIU, the Service Employees International Union, at: <http://www.seiu.org/seiuhealthcare/> and review their materials. This will give you an idea of unionization efforts in health care.

Please read in Gawande: "Casualties of War" p. 51.

Part II Discussion Board Posting:

Post your analysis of "Case: Paving Her Way to Heaven" on p. 381 to the discussion board. Also, what are the medical indications in this case as well as contextual features.

Also respond to Gawande's chapter and reflect on the following. Is health care a team effort in the US? If not, why not? If yes, how is it?

July 8, 2014 – Class 8 - In-Person

Content:

Health care is a multi-billion dollar industry, thus whenever this kind of money is at play, ethical and legal issues abound. For example the cost of health care continues to rise each year. What makes the issue perplexing is that the cost of health care varies from region to region. We will discuss the ethical issues related to this issue in tonight's class.

One way for individuals to deal with the high cost of health care is to have health insurance, but the challenge for many is how they access health care insurance. The Patient Protection and Affordable Care Act signed by President Obama on March 23, 2010 attempts to address this very issues. We will discuss the Act in class.

Marketing and Sales are a major activity carried out into health care system. Very large delivery organizations advertise extensively in print, on radio and television. Pharmaceutical companies advertise as well and have major sales forces made-up of "detailers" who visit physicians and other providers with information about their drugs. We might ask ourselves are these practices legal and/or ethical?

Please read: For our discussion on the ethics of differences in regional health care costs, please read the following New York Times article entitled *The \$2.7 Trillion Medical Bill*.

http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?_r=0&adxnnl=1&adxnnlx=1388354525-eHxF3UK/nYrsc3w9nTifOQ

Please read: Chapter 19 National Health Insurance and Managed Care, Section entitled National Health Insurance (pages 281 – 285), which can be found in Blackboard Class 8.

Please read: "Pharmaceutical Marketing and the Invention of the Medical Consumer" in the Public Library of Science (PLOS) an online journal for April

2006, vol. 3, Issue 4, e189 found at
<http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030189>

Please read: For our discussion regarding advertisement in health care, please review the following New York Times article entitled Forty Year's War: Cancer Center Ads Use Emotion More Than Fact:

<http://www.nytimes.com/2009/12/19/health/19cancerads.html>

Saturday July 15th: Completed Term Projects are to be sent to me by this date so I can read them before the end of the term.

July 17, 2014 – Class 9 - Blackboard

Part I Content:

Patient Abuse is a serious issue in health care today in almost all health care facilities and even in patients' homes.

Please read: Pozgar Chap. 13 "Patient Abuse"

Please read in Gawande: "Naked" p. 71.

Discussion Board Posting-Part I:

Please review the Case: "Abusive Search" on p. 434 and post your responses to the discussion board.

Also, post your responses regarding how does Gawande's chapter "Naked" informs your understanding patients' rights, patient abuse, and the role of etiquette and respect for patients and others in health care?

Part II Content:

In part II of tonight's class we will return to once more to focusing on the rights of patients. You may recall that in the Dax case we discussed in our first class, we focused on patient autonomy. Patients have a broad scope of rights when they are under our care. These are often expressed as a Patients Bill of Rights. Health care organizations must make sure that their staff is in compliance with all policies regarding the rights of patients.

Please Read: Pozgar Chap. 14 "Patients Rights and Responsibilities."

Discussion Board Posting – Part II:

Cancer: A Failure to Communicate

By Karen Peterson-Iyer

Farhad Tabrizi, a 69-year-old immigrant from Iran, is brought to the emergency room at St. Vincent's Medical Center (a private urban hospital) after coughing up blood. He presents with severe coughing, fatigue, chest pain, shortness of breath, and headaches. After stabilizing Mr. Tabrizi, the emergency room team admits him to the hospital, where he is given (over the course of a few days) a thorough workup, including chest x-rays, CT scans, mediastinoscopy, and a PET scan.

At the start of the visit, the nurses attempt to gather a detailed health history; but this proves difficult, since Mr. Tabrizi speaks almost no English. He does speak fluent Farsi, but there are no Farsi-speaking medical personnel readily available. However, Mr. Tabrizi is accompanied on-and-off by his adult son, who is reasonably fluent in both English and Farsi. He is also accompanied intermittently by his wife, who speaks only Farsi. (The wife makes it a point of regularly offering prayers for her husband's health.) The nurses attempt to gather a health history whenever the son is present, which is not always easy, since his visits are unpredictable. Even when his son is present to help translate, Mr. Tabrizi seems extremely uncomfortable offering up any detailed information about his own or his family's health history, causing high levels of frustration among the medical staff.

Additionally, Mr. Tabrizi appears extremely reluctant to eat whatever food is offered him in the hospital. This is most pronounced when he is alone-if neither his son nor his wife is present at a mealtime. On the second day of his stay, his son explains to the flustered nurses that Mr. Tabrizi is fearful that the hospital food may contain hidden pork by-products. Since he is a devout Muslim, he feels it is safest to refuse the food altogether unless he is absolutely certain. Although the son has attempted to persuade Mr. Tabrizi

that he (as a sick person) must eat, Mr. Tabrizi apparently is determined to eat as little as possible. The chief nurse curtly replies that, while religious belief is important, Mr. Tabrizi needs to keep his strength up if he hopes ever to go home; thus he will need to nourish himself by eating more. She says that she will "see what we can do" about ensuring that there is no pork used in the hospital's food preparation. The son thanks her for her help. From then on he and his mother attempt to bring outside food to Mr. Tabrizi whenever they visit.

After almost three days in the hospital, the results of the various scans are in; and the attending physician, Dr. Looke, sits down with Mr. Tabrizi to discuss his situation. His son and wife are also present. Dr. Looke first offers a handshake to Mr. Tabrizi's son. He inquires explicitly about the extent of his English skills and asks if the son would be willing to translate what he is about to say to Mr. Tabrizi. He agrees, while Mr. Tabrizi and his wife sit by. The doctor then gazes directly into Mr. Tabrizi's eyes and tells him that he has extensive small cell lung cancer.

After a moment of stunned silence, the son turns to his father and tells him in Farsi that the doctor believes that he is very sick, with some "growths" in his body. Dr. Looke goes on to say that Mr. Tabrizi most likely does not have long to live. The doctor holds up two fingers (at which point the patient grows increasingly alarmed and agitated), describing that there are basically "two possible treatments" available for this cancer: chemotherapy and radiation; Dr. Looke strongly prefers beginning with the first (chemotherapy). In spite of Mr. Tabrizi's alarm and confused expression, the doctor presses on that, given the apparently advanced stage of the disease, even chemotherapy would be very unlikely to provide a complete cure, but it could provide some relief and lengthen the remainder of his life. The son, again silent for several moments, then turns to his father and also holds up two fingers. He tells him that the doctor says he must do *two things* to care for himself: eat well and get more rest. He also relays that his father could take some "strong medicines" which would most likely help him to get better. Mr. Tabrizi looks extremely uncomfortable but says nothing.

After a few more moments, Mr. Tabrizi, somewhat confused, asks (via his son) what the "strong medicines" would consist of. The doctor replies by describing (in some detail) what the course of chemotherapy would look like-how often it would be administered and that the treatments would last for several weeks. He also describes that it may produce severe side effects such as nausea, vomiting, increased fatigue, and elevated risk of infection. In spite of his hesitations, the son attempts to translate the bare outlines of this information (leaving out the term "chemotherapy"), at which point Mr. Tabrizi

declares flat-out that he doesn't want any such cumbersome treatments; they would compromise his relationships with his family and friends and place too heavy a burden on his wife. Further, he doesn't really know what might be in such a strong medication that could help him get better. Instead, he will simply do the two things the doctor had recommended-improve his diet and get more rest.

What are the Medical Indications, Patient Preferences, Quality of Life and Contextual Features of this case.

Were Mr. Tabrizi's rights violated in any way? Did the providers and the hospital insure that his rights were respected?

What could/should the doctor/hospital have done differently in order to handle this case in a more helpful and culturally competent manner?

Please post your responses to the discussion board. .

Also please go to: <http://video.pbs.org/video/1639625115/> and view the video "Facing Death"

Questions regarding the Video for Discussion Board posting: What is your reaction to the video? Should people be kept alive regardless of the financial or psychological costs? Were the provider deliberations "Death Panels"? What are the ethical and legal issues that come up in the video for you? How does the video inform current ethical and legal practice in the delivery of healthcare at the time of death? What lessons do you take from this video and the other readings and cases we have discussed over the semester regarding how people should be treated at death?

July 24, 2014 – Class 10 - In-Person

Content: A practicing attorney with malpractice and other relevant experience is scheduled to be a guest speaker at this class. As part of class today we will have a mock malpractice jury deliberation.

Please Read in Pozgar: Chap. 6 "Introduction to Law" Pages 220 to 231

Please read in Gawande: "What Doctors Owe" p. 84.

Housekeeping:

We will conduct a class wrap-up and evaluation.

What did you learn in this class?

What did you learn from your case analyses and postings?

What did you learn from your classmates?

How useful was the Term Project? What did you learn from it?

What can you do with the new learning you have acquired in this class?

Does this class work in a Summer Semester?