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Editor's Forum

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This issue of *Health Ethics Today* (HET) takes a new direction in that it contains papers exclusively from physicians in training – two pediatric residents from the University of Alberta, Lester Liao and Michelle Huie, and one medical student, Veronika Makarova, from Sechenov University. Liao also provided significant editorial input to this issue. This initiative resulted from conversations at the John Dossetor Health Ethics Centre about how to involve medical trainees actively in ethics education. By devoting an issue of HET to trainee authors we aim to present ethics from a different viewpoint and to encourage further contributions from trainees across the health ethics and humanities spectrum.

The inclusion of work by medical doctors (MDs) in training is in keeping with the recognition that ethical awareness early in medical training is important for the development of empathy and to attain the requirements to deal with ethically challenging situations as a physician. In today's "information-technology" dominated health science curricula there is relatively little time and attention to ethics and humanities. Yet this exposure is necessary to develop the humanistic qualities required to be a good physician. Diagnostic and therapeutic skill is expected as a standard of care but genuine caring with empathy and compassion is what patients recognise and value. The *Royal College of Physicians and Surgeons of Canada CanMEDS* framework highlights these elements as essential to an MD's professional development.

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The paper by Makarova illustrates how the study of literature can help physicians to achieve a deeper understanding of illness beyond skills and knowledge of diagnosis and treatment. This depth of understanding requires a willingness to go beyond disease to see the person and to suspend the negative value judgments that often spring to mind. This is especially difficult when dealing with patients with "self-induced illness". Makarova cites an example of a patient with multiple hospitalizations for opioid overdose who is asked when he first realised he was an addict. The resulting story personalizes the man previously regarded as "just another overdose". Makarova's second example of an MD who is an opioid addict, crosses into territory that is an uncomfortable truth for the medical profession – the addicted MD. The story as told goes far beyond superficial judgements about addiction usually involving a name and blame approach to this tragedy.

Liao's paper questions critically the current dominance of moral relativism in ethics discourse and in clinical practice today. He illustrates its limitations by using a paediatric case (illustration altered to preserve confidentiality) in which he was involved. The case concerned life-saving treatment (LST) for a child whose parents rejected the medical team's treatment plan. The child was considered to have decision-making capacity and agreed with his parents. The conflict was not resolved in terms of supporting LST due to respect for the values of the family, and the child died. Liao argues that this current approach to ethical decision-making, which has evolved from moral relativism, is seriously at odds with his professional duty to make a decision grounded in medical knowledge, in respect for the child's autonomy and in the necessity of protecting the patient from harm. Liao articulates clearly his frustration with the primacy of moral relativism in health ethics as a confusing influence which promotes avoidance of taking any moral stance about right or wrong actions concerning care. Despite the benefits he sees from developing tolerance and broadmindedness in MDs, he presents an analysis which casts doubt on how these play out in terms of patient benefit.

Huie questions the ethics of the age old practice of using actual patients to teach clinical skills to medical students. Traditionally all patients, no matter how sick or vulnerable, were regarded as appropriate opportunities to practice examination skills. It was commonplace to introduce medical students as doctors if any introduction was made. Huie supports the necessity of clinical learning on real patients but suggests that the practice may contravene the patient's welfare physically and emotionally. She presents these potential harms in terms of the Beauchamp and Childress principles of biomedical ethics (respect for autonomy, nonmaleficence, beneficence, and justice), which she provides clear examples of pitfalls. Similar concerns may be applied to the common practice of having inexperienced physicians learning skills without adequate supervision across a broad spectrum of clinical situations. Huie uses the *Canadian Medical Association Code of Ethics* to provide guidance as to how to protect patient interests while carrying out essential clinical teaching.

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Literature and Medicine: Overcoming Stigmatization in Patients whose Conditions are Perceived to be Self-Induced

Based on *What Doctors Feel: How Emotions Affect the Practice of Medicine* by D. Ofri and *Morphine* by M. Bulgakov

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> The real work of bioethics, more often than not, is in listening, reading, and watching carefully in order to judge what is important and what is not. (Carl Elliot)

Literature provides physicians and medical students an opportunity to understand patients' experiences through a window that explores the meaning of illness. This is accomplished not through a set of symptoms but through context and metaphor. These explorations can help medical practitioners see reality in a new light, revealing insights that were previously shrouded by medical jargon and normal routine.

The link between literature and medicine provides further guidance through a basic understanding of textual interpretation. When reading any text, we imaginatively place the words in context. This is how we should teach medical students to interpret a life event – to read both between the lines and to take them at face value to search for insight. Thus, in a therapeutic encounter, the doctor turns a trained ear to a patient's account of misfortune or malaise, places it in the company of similar accounts he or she has heard before, and then attends not only to what is said but also to what is unspoken and even unspeakable. This requires a capacity to imagine the illness experience from the patient's perspective. It is a kind of listening with a discerning ear for narrative possibility (Cole, Carlin, & Carson, 2015).

Careful reading of this nature generates a capacity for empathic insight to understand human experiences of illness. Such an approach is even more important when considering patients with "self-induced" conditions (e.g., obesity or any kind of addiction). Medical professionals are often unable to find "a perfect fit" in their bank of experiences for these kinds of patients, and this impossibility leads to a loss of empathy and even worse – contempt. Hence, medical educators should teach students and young doctors to widen their "physician's repertoire" with narratives and insights we commonly acquire from the liberal arts and especially literature.

Let us consider a few masterpieces. In her book *What Doctors Feel: How Emotions Affect the Practice of Medicine*, Ofri (2013) says:

> By unspoken rules, these patients "with self-induced conditions" are considered fair game for jokes by medical personnel at all levels. Hospital slang for such patients reflects not just disgust but also anger and resentment. It's not uncommon to hear an obese patient referred to as a beached whale, or a homeless alcoholic called a shpoz or dirtbag (p. 18).

Society has contempt for people whose conditions are perceived to be self-induced. Unfortunately, when facing an alcoholic, drug addict, or morbidly obese person, people may unconsciously consider him a squalid creature. Many will say without hesitation that all these illnesses are the direct results of human sins. As Ofri (2013) asserts:

> Despite the knowledge that addiction and obesity have at least some biological components, many doctors still unconsciously – and often consciously – view these conditions as purely a result of sloth, self-indulgence, greed, malingering, and apathy. Respect and appreciation for the ravages of these illnesses – especially when the patients themselves often appear not to – is more than some physicians can muster (p.18).

People with the aforementioned conditions are often shunned by society. In this way many alcoholics and drug addicts find themselves at the margins of society without any compassion and hope for restoration.

The problem of lack of empathy appears both in society more generally and in hospitals. It happens because "physicians are the products of an educational system that demands years of self-discipline and delayed gratification" (Ofri, 2013, p. 18). Medical students are rarely taught to look deeper into the social and psychological roots of a patient's condition. Hence, physicians are unable to see the condition ever develop in the first place. As Ofri says:

> Mostly we doctors see patients when they are already well into their illness. We also see patients at the checkups when they are perfectly healthy. But we are never present at the exact transition point (p. 21).

It is important for a physician to present him or herself not as one caught up in social stigmatizations but as a person who looks deeper into the problem and sees the serious, profound, medical and psychological issues beneath the seemingly superficial concerns.

One of the major challenges of developing deeper insight is repetition. Ofri (2013) astutely states, "The residents and students that train at Bellevue Hospital see so many alcohol (ETOH, or ethanol) withdrawal patients that these cases cease to have any individuality", so that "empathy is in short supply" (p. 19). To elucidate this concern, Ofri recounts the story of Mr. Carrillo, who was admitted to Bellevue Hospital fifty-seven times: "Every admission was for either overdose or withdrawal from opiates – heroin or oxycodone" (p. 19). On his latest admission, he was asked by the author about the "exact moment he knew he was addicted." After his answer, "the room was pin-drop silent" and she "was riveted by the specificity of the memory, of the tangible scene he created" (Ofri, p. 21).

Ofri (2013) continues:

> After our interview, we filed out of Mr. Carello's room and regrouped at the end of the hallway. The change in the team was palpable. For the first time, we had some insight – even if slight – into what Mr. Carello's life was like. It was the genesis of true empathy (p. 22).

The chance to slip into a patient's shoes can transform how doctors view their patients. It elicits genuine empathy because it engages deeply in appreciating a patient's suffering. While such empathy will not eradicate an addiction overnight, it's hard to imagine that the patient's illness will have a chance of remitting without it.

Another outstanding physician-penned masterpiece is *Morphine* by Mikhail Afanasievich Bulgakov. The story is a semi-autobiographical, rare depiction of physician addiction written by a physician-author himself. It illustrates many silent features of opiate addiction, such as self-loathing and loss of inner balance between spiritual and physical needs. This tale is riveting and insightful with the writer speaking

from an insider perspective, as a physician who has become a patient (Tischler, 2015).

Bulgakov's character, Sergey Polyakov, could understand the severity of morphine addiction consequences as a country doctor but was simultaneously completely consumed by it. This is obvious from his thoughts:

> My forearms and thighs are a mass of unhealed abscesses. I don't know how to prepare sterile solutions, besides which I have injected myself with an unsterilized syringe on about three occasions when I was in a great hurry to go out on my rounds. This can't be allowed to go on (Bulgakov, 2012, p. 92).

Being on the brink of despair and unable to control his own life, Polyakov could only think of someone who could show him compassion and empathy. The person that came to mind was not his doctor.

> I have decided to appeal to Bomgard. Why to him? Because he is not a psychiatrist; because he's young and we were friends at university. He is healthy and tough yet kind-hearted, if I have gauged his character right. Perhaps he will be... sympathetic (Bulgakov, 2012, p. 94).

In contrast, Polyakov thought about the doctor he was examined by:

> I swore at the feldsher. He just laughed ... It doesn't matter. He had come to report to me, and offered to sound my respiration and heartbeat. I refused to let him. Must I go on finding excuses for refusing? (Bulgakov, 2012, p. 94).

Rather than appreciate Polyakov's deepest concerns, the physician only continued about his routine business.

Sergey Polyakov, a man whose profession was to save human life, committed suicide.

> It would be shameful to prolong my life a minute more. Certainly not a life like mine. The remedy is right beside me. Why didn't I think of it before? (Bulgakov, 2012, p. 95).

The case of Bulgakov's character is a genuine example of a doctor slipping into a patient's shoes, giving both physicians and medical students a harrowing story of one's malaise

In conclusion, physician-penned literature such as Bulgakov's *Morphine* and Ofri's *What Doctors Feel: How Emotions Affect the Practice of Medicine* has great value in medical education. It offers a window into intimate topics and insider perspectives. This can foster self-reflection (Chopra, 2010), a skill which is highly valued in the development of medical professionalism (Tischler, Chopra, Nixon, & McCormack, 2011). Finally, the use of literature can be incorporated into medical education to teach medical students to be more empathetic to patients with "self-induced" conditions.

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When Relativism is not Enough

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Truth is relative. Such an idea is commonplace amongst many in North America today. More specifically called relativism, it is the belief that truth, and subsequently moral truth, is relative to either individuals or cultures. It has been present for decades and has long been identified as a trend in both learners (Bloom, 1987) and educators (Hayes & Mieschbuehler, 2016) of institutions of higher learning. Our medical trainees are cultivated in these establishments, and I am one of them. Open-mindedness and tolerance are its cardinal virtues. In this milieu, relativism and its implications are not frequently pondered. We are oblivious of it much like we hardly give the air we breathe a second thought. It has been an invisible presence, unnoticed and undisturbed. That is, until I met one particular child and family. I have altered details to preserve confidentiality.

Here I examine the case of a boy and his family and use it to elucidate the conflict between the relativism of popular culture, or colloquial relativism, and the four principles of medical ethics: respect for autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2012). This conflict is generally not addressed in medical curricula. Trainees are inundated with information about disease and management, and few have time to undertake evaluating ethics in practice or ethical theory. I will illustrate how relativism (and its subcategory moral relativism) fails us in the face of life and death realities with patients, as in the case of this boy. In the end we may say that "truth is relative," but we do not really believe it. We must rethink the foundations of our thought to set us on a path of reflection and understanding in the interests of better patient care.

This boy has a chronic illness and requires ongoing lifesaving therapy. The health care team strongly advises and encourages standard treatment, but his parents seek non-validated alternatives. While he is partial to the idea of standard medical treatment himself, and is of an age to make an independent judgment, he agrees with the family's decision. Despite further efforts by the health care team to convince the parents otherwise, they still refuse, and because of this the child is at serious risk of death.

Up to this point in my training, disagreements have hardly been a concern. Patients often have different values from physicians, but this discrepancy has never before resulted in a decision that could devastate my patient's health. For example, I may encourage parents to nurture stronger relationships with their

children when they prefer to cultivate their careers. Our values conflict, but because this has never hospitalized a child, I have hardly thought about being more insistent. At other times, opposing values have nonetheless produced the same result. I may entreat parents to pursue treatment in hopes that their child's healthiness will enable him to pursue his desired wish to play hockey; his parents likewise covet his health but primarily for their aspirations of having a physician for a son. The practical decision remains the same despite different goals. These scenarios have spared me the uncomfortable thoughts accompanying clashing moral standards.

This is not the case with my patient. I have a strong impulse to tell him to make his own decision regarding the treatment. Surely the other family members are unduly influencing what would otherwise be an unencumbered life preserving decision. Yet he is surprisingly comfortable with the decision because it has been made collectively within his family. Now I am keenly aware of the cultural chasm between us. I struggle to say our disagreement is simply a matter of "differences" and I am tempted to use the language of right and wrong.

Now relativism is rearing its head. I want to preserve open-mindedness and tolerance. There is surely some intolerance to suggesting autonomous decisions reign over collective ones. To avoid this, I might rely on cultural norms to encourage autonomy. There are "new rules" that apply to the scenario in North America. The trouble is that I have arbitrarily determined where my culture starts and his culture ends. Similarly, my preference for autonomy over the collective is itself culturally conditioned. This means it is a standard subject to change depending on my milieu, and hence provides little authority to compel anyone toward a particular decision. Even if he makes the wrong decision in my individual or cultural eyes, this recognition by me is practically powerless because it does not lead to treatment, which is my end goal. Moral relativism is failing me.

I cannot escape the sense that there is a right or wrong course of action here which we are missing. I see this as a wrong decision to forego the treatment because it fails both to protect him (do no harm) and to provide benefit. Despite my professional and ethical opposition, his autonomy in making such a decision must be respected. I am not simply saying that I prefer one decision in the way I might prefer green over blue. In the former case I am arguing that there is something incorrect about the decision itself. In the latter case I am stating a subjective evaluation about how green is more pleasant to me than blue. One evaluation is about the object, the other is about the subject. To disagree with "I like green" and reply "No, I like blue" would be to miss the point entirely (Lewis, 2001). In contrast, the decision to treat is built on principles of ethical medicine. It is right not because I like it, but because it is the right thing to do.

When it comes to using the language of right and wrong, I must appeal to a foundation for morality. This manifests in the various principles of nonmaleficence, justice, beneficence, and respect for autonomy. Without some form of moral objectivism, or standard and reality of morality, I cannot begin to speak of ideals to pursue. Caught in the constant flux of relativity, there is no way to argue that something is right or wrong (Jecker, Jonsen, & Pearlman, 2012). I can only speak of differences and personal preferences. Similarly, with no ethical goals, I also eliminate the idea of moral progress. We know whether we progress or regress in a race because the finish line frames the activity. Such language becomes meaningless when such markers are absent. It is like a hiker who stumbles through a vast forest and passes the same tree multiple times without landmarking

it. He is lost because he has no reference point. So it is with moral relativism. It is inconsistent with the principles of medical ethics.

A further lesson can be learned from the hiker. He feels he is lost, but if he could only recognize the tree he would make progress. The tree is present whether he is aware of it or not. Likewise when I am skeptical about a moral truth, I must nonetheless use a standard to judge the thing I am skeptical about. I cannot condemn moral truth as untrue without having some idea of what is true. Whether or not I am aware of this benchmark, it is there and I cannot escape it. The proverbial tree is ever present. I am, in fact, only selectively skeptical towards morals outside of my own (Lewis, 2001).

Redirecting skepticism towards myself requires me to revisit tolerance and open-mindedness. These are the operating guides for relativism. In many ways, relativism has been instrumental in reaffirming the crucial place of tolerance and open-mindedness in both society and medicine. But under the banner of relativism they have become skewed. Tolerance requires recognizing and enduring an alternate idea despite disagreement. It is not possible to tolerate another position that you believe is entirely valid; this is simply agreeing. True tolerance manifests as respect towards the person who holds the ideas in question, not as an affirmation of the veracity of their worldview (Inazu, 2016). I tolerate, not affirm, anti-vacciners, and I will continue to respect and care for these families (MacDonald & Finlay, 2013). Without right and wrong, relativism unintentionally eliminates tolerance. Similarly, to be open-minded to all viewpoints is to consider them all not as true but to the degree they are true and conform to reality. It is necessary to be close-minded to error, lest the very function of logic and reason be erased and all discussion be consigned not to thoughts but only to impulses and feelings. I must also remember that the existence of multiple worldviews does not logically necessitate relativism. This would be to confuse the epistemological issue (the accurate knowledge of objective values) with the ontological issue (the existence of objective values). It does not follow that because many disagree, nobody is therefore correct (Beckwith & Koukl, 1998).

I conclude with two final thoughts that compel me to reject relativism. First, when I speak of truth and morals being relative, I am really saying nothing at all. For even in making such a propositional statement I am engaging in "truth talk" and hoping to convince others that my position on relative truth is absolutely true (Bridges, 1999). It is nonsensical. Second, my patient has reminded me that all physicians engage in moral activity when they practice medicine. Every day we tell patients it is good to act in certain ways; to exercise and adhere to treatment is good because health is of value. Otherwise we might commend smoking for its pleasures over its detrimental health effects. Relativism can have no place in a profession that seeks to link health-valuing decisions to objective realities about the human body.

In the end, this boy has challenged colloquial relativism. He went away with his family, and he died. Despite assertions about relative truth that we have imbibed, we physicians are not relativists at all. In the face of life and death, we cannot be. We must recognize this in medicine lest we be swept away in the aimless current of relativism. We must not hesitate to advocate for what is good and right for the wellbeing of every patient.

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Medical Education Ethics at the Bedside

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In medical education, early hands-on experience is critical for the development of quality physical examination skills. Currently, clinical skills teaching takes place in small groups or one-on-one as early as the first year medical school. When medical students transition into clerkship (the senior years of their training), physical examination skills are integral to their everyday learning where teaching is often performed at the patient's bedside. One could wonder if the benefits of hands-on experiences received by learners outweigh the costs to patients. Returning to Beauchamp and Childress' four basic principles of medical ethics: respect for autonomy, nonmaleficence, beneficence, and justice, may provide a valuable perspective to further examine this issue.

Autonomy

The principle of autonomy is defined by Beauchamp and Childress (2009) as self-rule that is free from both controlling interference by others and from certain limitations. These limitations may include inadequate information and the cognitive capacity to make a meaningful choice. Autonomy requires that patients act intentionally and with understanding. Although participating in medical education is not a conventional medical procedure, there should be an opportunity for the patient to provide consent and permission for participating prior to bringing learners to the bedside (Sayer, Bowman, Evans, Wessier & Wood, 2002). For the majority of patients, participating in teaching is voluntary. There may be times when the consent is implied as part of the care provided at a teaching hospital or when the student provides service to the team and their learning is a parallel objective. For the principle of autonomy to be upheld, patients must be fully informed of and must understand the risks of partaking in the experience. Although the risks of participating in teaching are minimal, they are not completely absent. Risks may include discomfort with physical examination, extra time from the patient's schedule, de-personalization during teaching, and sharing of personal patient information (Coldicott, Pope, & Roberts, 2003). This information is rarely communicated to the patient. Lastly, autonomy requires that the teaching team and trainees respect the rights of the patient to refuse taking part in medical education.

Non-maleficence

Non-maleficence is the principle to not inflict harm on others (Beauchamp & Childress, 2009). As mentioned above, the risk of participating in bedside teaching is low. However, repeated examinations by many, and sometimes inexperienced, learners may cause increased physical discomfort to the patient (Coldicott, et al., 2003). Good physical exam skills attend to patient comfort and aim to reduce discomfort and pain. In addition to potential discomfort, teaching takes time away from the patient. In the context of bedside teaching, usually the patients have been admitted and are expected to spend a majority, if not the entirety, of their day in the hospital. However, teaching can still take away

time from rest, visitation, meals and other leisurely activities. Explaining and pointing out physical findings during the teaching experience may cause loss of privacy and embarrassment to the patient (Coldicott, et al., 2003). For example, a patient may be asked to disrobe before a group of learners and the preceptor may point out abdominal girth or striae. Further, teaching may require disclosure of personal history which provides context to the physical exam.

Beneficence

Beneficence is the intention to act for the benefit of others (Beauchamp & Childress, 2009). In the context of medical education at the bedside, this includes weighing the best interests of the patient. In bedside teaching, the benefit for the patient is often indirect. Altruistic patients may receive joy and satisfaction from participating in the training of the next generation of physicians. This is in essence a community service, as it enables learners to provide better care to their future patients (Jagsi & Lehmann, 2004). Some patients report that they find teaching a positive experience as it offers them an opportunity to educate and raise awareness to neglected areas of medical care (Watts, Mcpherson, Robson, Rawling, & Burge, 2015). Further, some patients may seldom have visitors at the bedside and teaching offers an opportunity for conversation and human connection. Rarely, but from time to time, bedside teaching may provide an opportunity for the discovery of new and relevant findings which can improve care for the patient.

Justice

Beauchamp and Childress (2009) examine several approaches to justice and primarily side with egalitarian (equal access to goods in life) and utilitarian (maximizing public utility) theories. From these standpoints, every patient should have an equal opportunity for bedside teaching. In reality, clinical preceptors are selective of the patients they involve in their teachings; patients who are medically stable, pleasant, cooperative and who have relevant physical exam findings. Preceptors must also be mindful of the number of times a patient with good findings is asked to partake in medical teaching.

In addition to considering the four principles, vulnerable populations also raise particular ethical challenges. These include patients who have been anaesthetized or sedated as well as children and adolescents. The Canadian Paediatric Society has published guidelines for the ethical participation of children and youth in medical education (Hilliard, Fernandez, & Tsai, 2011). Some of their suggestions include obtaining consent from both the child patient and their families (parent or guardian), supervision by experienced clinicians for intimate exams, and being honest and truthful with families about the stage and skill levels of the trainees.

Ultimately, bedside teaching is inevitable. Despite the advancing age of robotics and patient simulation, there is still no better example than a real human model on the wards (Sayer, et al., 2002). It is difficult to imagine someone arguing for a graduating class of doctors who have had minimal patient interaction throughout their medical training. Nonetheless, there are existing codes of ethics for both preceptors and learners directing ethical practices of medical education at the bedside.

The *Canadian Medical Association* published a *Code of Ethics* that was most recently updated in 2004. There are sections for patient, professional, societal responsibilities, and a subsection on research (Canadian Medical Association). A specific section for medical education is lacking. However, a code for medical education can be implied by this Code of Ethics outlined in other sections including the following principles:

1. Consider first the well-being of the patient.

2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.

6. Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.

8. Contribute to the development of the medical profession, whether through clinical practice,

research, teaching, or administration on behalf of the profession or the public.

24. Respect the right of a competent patient to accept or reject any medical care recommended.

31. Protect the personal health information of your patient.

47. Be willing to teach and learn from medical students, residents, and other colleagues and other health professionals.

Both medical learners and preceptors must be aware of ethical practices at the patient's bedside. These principles should also extend to the use of real patients in examination and assessment purposes. In the ethics of caring and medical education, Branch (2000) states that the physician is always to be the patient's advocate. During bed-side teaching, there are simple ways that we can advocate for, respect, and acknowledge our patient's generosity (Hamilton, 2006; Sayer, et al., 2002). These include:

1. Asking for permission

2. Respecting the right to refuse teaching

3. Introducing learners and their trainee statuses

4. Ensuring that the patient is comfortable and minimizing discomfort

5. Allowing opportunities for the patient to take part in teaching

6. Being aware of and respecting the patient's time

7. Expressing gratitude

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