

EVERDAY ETHICS - DOING RIGHT

BY

E. M. PAPPER, M.D.

PROFESSOR OF ANESTHESIOLOGY

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

DEPARTMENT OF ANESTHESIOLOGY

MIAMI, FLORIDA

AOA LECTURE AT THE UNIVERSITY OF PENNSYLVANIA

OCTOBER, 1984

DEDICATION

THIS LECTURE IS DEDICATED TO MY LATE BROTHER, **DR. SOLOMON PAPPER**, A DISTINGUISHED INTERNIST WHO PRACTICED AND WROTE SO WELL ABOUT EVERYDAY MEDICAL ETHICS, AMONG MANY OTHER MATTERS.

HE PERSONIFIED, IN HIS OWN WORDS, "**HUMANE SCHOLARSHIP**" ABOUT WHICH HE CARED DEEPLY. IF I CAN GIVE YOU SOME SENSE OF HIS THOUGHTS IN THIS LECTURE, I WILL HAVE SERVED TO SOME EXTENT THE MISSION IN WHICH HE HAD SO MUCH FAITH AND TO WHICH HE DEDICATED SO MUCH OF HIS PURPOSE IN LIFE.

I. INTRODUCTION - WHAT WE ARE NOT GOING TO DISCUSS

A. THE IMPORTANT SOCIETAL ISSUES - VERY IMPORTANT TO SOCIETY - BUT WE ARE NOT DEALING WITH THEM DELIBERATELY IN THIS DISCUSSION. WE CAN DISCUSS SOME OF THEM LATER IF THERE IS A DESIRE TO DO AND IF TIME IS AVAILABLE

SOME EXAMPLES OF MAJOR ISSUES ARE:

- 1) ABORTION
- 2) DISCONTINUANCE OF LIFE SUPPORT SYSTEMS
- 3) GENETIC ENGINEERING, ETC.

B) NOT INTENDED TO Demean OR DEEMPHASIZE THESE. ALL PHYSICIANS AS CITIZENS AND AS PROFESSIONAL EXPERTS ARE CONCERNED WITH THEM.

THEY **ARE** CRUCIAL - THEY ARE AND SHOULD BE TAUGHT AND STUDIED, BUT WE NEED TO CONSIDER ALSO SOME PRACTICAL DAY TO DAY ISSUES IN OUR FREQUENT AND **NON** GLOBAL ACTIVITIES - AND THESE MATTERS ARE WHAT I SHALL TALK ABOUT.

II. INTRODUCTION - WHAT WE ARE GOING TO TALK ABOUT - THE

EVERYDAY COMMON-PLACE MATTERS WHICH REQUIRE **BEHAVIORAL**
ATTENTION STUDY AND CHANGE IN ALL OF US.

A. DEFINITION OF ETHICS (WEBSTER) - "THE DISCIPLINE
DEALING WITH WHAT IS GOOD AND BAD AND WITH MORAL

OBLIGATION: ETHICS HAS BEEN CALLED THE SCIENCE OF THE IDEAL
OF HUMAN CHARACTER."

B. AN INTERESTING ISSUE IS THE CONCEPT OF ARISTOTLE -
REALLY ONLY WHEN YOUR LIFE IS COMPLETE CAN YOU TELL
WHETHER YOUR LIFE HAS BEEN MORALLY GOOD. THE REST OF
THE TIME IS SPENT STRIVING TO DO GOOD.

III. THE PHYSICIANS' CHARACTER

A. DOCTORS ARE HUMAN - DIFFER FROM ONE ANOTHER AND ARE
COMPLEX - LIKE MANY OTHER EDUCATED PEOPLE

1) ANY ONE WHO IS "GOOD" CAN DO "BAD" THINGS AT TIMES
AND STILL BE A GOOD PERSON

2) ANYONE CAN DO "WRONG" AND MAY FEEL THE GUILT FOR
YEARS - A NON-CONSTRUCTIVE WAY TO LIVE. ALL
ONE CAN DO IS SET THE "WRONG" RIGHT AND

TRY NOT TO REPEAT IT.

3) ALL DOCTORS (EXCEPT A SMALL MINORITY)

PROBABLY TRY TO DO GOOD; WE WILL LOOK AT

THOSE ASPECTS OF BEHAVIOR THAT ARE NEEDED IN

DOING THE RIGHT THING AT THE RIGHT TIME.

IV. RESPONSIBILITIES OF A PHYSICIAN

A. RESPONSIBILITY TO THE PATIENT - ALWAYS HAS THE
HIGHEST PRIORITY - WHAT IS OUR OBLIGATION TO THE
PATIENT?

1) KNOWLEDGE - AS MUCH AS IS POSSIBLE TO KNOW
ABOUT THE SCIENCES WHICH CAST LIGHT ON THE
PATIENT'S PROBLEM.

IN HELPING THE PATIENT - AN EXAMPLE IN MY FIELD
OF ANESTHESIOLOGY. ANESTHESIOLOGISTS MUST KNOW
THE DISEASE, THE OPERATIONS, THE DRUGS, THE
PHYSIOLOGY, THE PHARMACOLOGY, AND THE CLINICAL
KNOWLEDGE THAT PERTAINS TO THESE PATIENTS - IT IS
THE IMPORTANT REASON FOR US TO KEEP UP TO DATE -

TO READ, STUDY, AND OBSERVE - AND, INCIDENTALLY,
IT IS A MAJOR WAY FOR US TO FEEL GOOD ABOUT OUR
WORK.

- 2) KNOWING THE PATIENT AS A PERSON - HIS SPECIFIC
NEEDS - VERY HARD FOR OUR SPECIALTY, EASIER FOR
OTHERS BUT WE MUST DO BETTER THAN WE NOW DO -
WE MUST LEARN TO DEAL WITH PATIENTS' PROBLEMS,
STRENGTHS AND CONFLICTS - THEY MAKE A DIFFERENCE
AND IT REQUIRES INTEREST AND INTUITION TO STUDY THE
PROBLEMS OF EACH PATIENT.
- 3) THERE IS NOT ONLY NO CONFLICT BETWEEN HAVING
SCIENTIFIC KNOWLEDGE AND COMPASSION FOR PATIENTS,
BUT THEY REINFORCE EACH OTHER - SINCE EACH MAKES IT
POSSIBLE FOR US TO TAKE BETTER CARE OF PATIENTS.
- 4) KNOW **OUR** OWN LIMITATIONS AND SEEK HELP WHEN THE
PROBLEMS EXCEED OUR SKILLS - NO ONE CAN KNOW
EVERYTHING. IT IS A SERVICE TO PATIENTS TO GET
HELP WHEN WE NEED IT - AND IT IMPROVES US AS

PHYSICIANS TO LEARN MORE IN THE PROCESS

5) WE MUST NOT PASS JUDGEMENT ON THE WORTH OF A
PATIENT - ALL ARE EQUALLY PRECIOUS - THERE
ARE NO UNDESIRABLE PATIENTS - EVEN THOUGH WE
WILL ALWAYS LIKE SOME BETTER THAN OTHERS - WE
ARE HUMAN - AND SOME PEOPLE ARE LOVABLE AND
OTHERS DOWNRIGHT UNPLEASANT. WE RESPOND TO THEIR
TRAITS - BUT IT MUST NOT INFLUENCE OUR CARE

A) CITE CASTLE STORY OF THE ALCOHOLIC PATIENT
DIGNITY OF PATIENTS

B) WE MUST LEARN NOT TO DISLIKE PATIENTS BECAUSE
THEY ARE "**UNCOOPERATIVE**" I.E., WHEN THEY DON'T
RESPOND THE WAY WE WISH TO OUR THERAPIES

C) WE SHOULD ALWAYS SPEAK THE TRUTH TO PATIENTS
AND THEIR FAMILIES - AS GENTLY AS THE FACTS
PERMIT - IT HELPS THEM GET WELL OR ADJUST TO
THEIR ILLNESSES BETTER - BUT THERE ARE PROBLEMS
IN TRUTH TELLING - TO DISCUSS A BIT LATER.

B. RESPONSIBILITY OF A PHYSICIAN TO SOCIETY - WE ARE

SUPPOSED TO BE EDUCATED PEOPLE, WE MUST HELP SOCIETY, ESPECIALLY IN OUR AREAS OF COMPETENCE AND INTERESTS - WE SHOULD PARTICIPATE IN SOME COMMUNITY, CHARITABLE OR RELIGIOUS ACTIVITIES ACCORDING TO OUR SKILLS AND INTERESTS. WE MUST NOT FEEL THAT WE ARE GOD'S GIFT TO A COMMUNITY ACTIVITY - BUT ARE ONLY DOING OUR FAIR SHARE.

C. **RESPONSIBILITY TO OUR COLLEAGUES** - WE OWE EACH OTHER EDUCATION, FRIENDSHIP, HELP, BUT NOT COVER-UP FOR INCOMPETENCE.

D. **RESPONSIBILITY TO OUR FAMILIES** - THEY DESERVE DIGNIFIED FULSOME LOVING AND TIME OF HIGH QUALITY - WE OWE THEM MUCH AND SHOULD APPRECIATE THEM MORE THAN WE DO. WE CAN WORK HARD AND SHOULD - BUT WE CAN ALSO GIVE OF OURSELVES TO OUR SPOUSES AND CHILDREN. THE OPPORTUNITY TO DO THIS KIND OF GOOD IS UNFORTUNATELY ALL TOO SHORT IN DURATION - BEFORE YOU KNOW IT - YEARS MAY PASS IF YOU DON'T APPRECIATE YOUR

OPPORTUNITIES TO ACT - AND THEN THE OPPORTUNITY IS GONE, OFTEN FOREVER.

E. RESPONSIBILITY TO OURSELVES - WE MUST INCREASE OUR LIVES WITH FRIENDS, WE NEED TO HAVE FUN. WE MUST NOT BE VICTIMIZED AS MARGARET MILLER PUT IT BY LIVING BADLY: SHE SAID "LIFE IS SOMETHING THAT HAPPENS TO YOU WHILE YOU ARE MAKING OTHER PLANS." WE MUST ALWAYS CONTINUE TO LEARN AND BE CURIOUS. THE STORY TOLD OF A GREAT PHYSICIAN-TEACHER, KNOWN TO MOST OF YOU, DR. ROBERT LOEB, WHO ENDED A LECTURE "LADIES AND GENTLEMEN, I HAVE TOLD YOU MORE THAN I KNOW. 50% OF MY LECTURE WILL BE PROVED WRONG OR INADEQUATE WITH TIME. MY PROBLEM IS THAT I CANNOT IDENTIFY WHICH 50%."

V. PATIENT MANAGEMENT

A. THE PREOPERATIVE INTERVIEW - YOU MUST COMMUNICATE CLEARLY WITH SURGEON AND INTERNIST AND WITH THE PATIENT.

1) SIT DOWN TO TALK WITH PATIENTS - WHEN YOU SEE

PATIENTS - IDENTIFY YOURSELF AND CITE DR.

RAVDIN'S ROUNDS - AND THE APPRECIATION OF PATIENTS

FOR THE INTEREST OF PHYSICIANS

- 2) LISTEN CLOSELY AND DON'T INTERRUPT
- 3) TALK ONLY AFTER YOU HAVE LISTENED ADEQUATELY - BUT
PRONOUNCE YOUR NAME CLEARLY IN THE INTRODUCTION
- 4) EXPLAIN IN CLEAR NON-FANCY LANGUAGE WHAT WILL BE
EXPERIENCED BY THE PATIENT - NOT ALL YOUR VAST
KNOWLEDGE - USE NO TECHNICAL JARGON UNLESS YOUR
PATIENT CAN BE EXPECTED TO UNDERSTAND IT.
- 5) ANSWER ALL QUESTIONS HONESTLY - EVEN TO SAY "I
DON'T KNOW"
- 6) DO NOT USE INAPPROPRIATE LANGUAGE - E.G. DO NOT
USE FIRST NAMES WITH PATIENTS UNLESS INVITED TO
DO SO. CITE MY MOTHER AND FIRST NAME USAGE BY A
SOCIAL WORKER.
- 7) DO NOT USE LOOSE TALK ABOUT PATIENTS OR PRO-
FESSIONAL STAFF ANYWHERE IN PUBLIC PLACES -
ESPECIALLY ELEVATORS, LOUNGES, ETC. - THIS IS

IMMORAL FOR A PHYSICIAN TO DO AND HENCE
"UNETHICAL" AND WRONG. I THINK ALL OF YOU HAVE
HEARD AND PERHAPS PARTICIPATED IN **"ROOM 516 IS A
CROCK AND IS ALL SCREWED UP."** WE SHOULD NOT
VIEW PATIENTS AS PORCELAIN OR CARPENTRY. THEY
ARE PEOPLE!

B. THE TELLING OF TRUTH TO PATIENTS

- 1) WE ARE ALWAYS IN A DILEMMA - IT SHOULD BE
AGREED UPON **IN ADVANCE** WHAT TO TELL PATIENTS
BUT TO STRIVE TO HAVE THE POLICY ONE OF
"TELLING THE TRUTH GENTLY SPOKEN" - PATIENTS HAVE
A RIGHT TO DECIDE ABOUT PROCEDURES - BUT YOU MUST
ADVISE AND NEVER DO WHAT YOU THINK IS WRONG. YOU
HAVE NO RIGHT TO ASSUME RISKS FOR OTHERS. YOU
HAVE THE OBLIGATION TO GIVE YOUR OPINIONS. THERE
IS ALSO A WAY OF TELLING THE TRUTH AND THE RIGHT
TIME TO DO SO. CITE SOME **"GOOD"** AND **"BAD"** WAYS OF
TRUTH TELLING.

2) ANOTHER PROBLEM IS WHAT IS THE TRUTH AND CAN THE PATIENT UNDERSTAND IT. ALSO THE **"TRUTH"** CHANGES WITH NEW KNOWLEDGE - IT CANNOT BE ACCEPTED AS MORE THAN RELATIVE TRUTH AT A GIVEN TIME.

3) SUPPORT PERSONNEL - NOW THAT WE HAVE PAIN CLINICS AND PRE-OP PREPARATION ROOMS PATIENTS SHOULD NOT BE LEFT WAITING - SHOULD BE CONTINUOUSLY AND SELECTIVELY CARED FOR BY SUPPORT PEOPLE - YOU HAVE TO TELL YOUR PEOPLE TO BE THOUGHTFUL AND CONSIDERATE AND COMFORTING TO THE WAITING PATIENT. MOSTLY YOU HAVE TO SET THE RIGHT EXAMPLE YOURSELF AND ACCEPT NOTHING LESS.

C. THE SETTING - THE HOSPITAL - "A HOSPITAL IS OKAY IF YOU ARE HEALTHY AND CAN PROTECT YOURSELF" - OUR PATIENTS ARE NOT HEALTHY AND THEY **NEED** PROTECTION

1) PATIENTS NEED TO HAVE THINGS EXPLAINED -THERE ARE NO ROUTINES TO THE PATIENT - ONLY TO THE STAFF

2) PATIENTS HAVE TO WAIT TOO LONG FOR X-RAYS AND OTHER

TESTS - ALL THIS SHOULD BE PROMPT AND CARING -
E.G., X-RAY TABLES SHOULD BE WARM. HAVE YOU EVER
PUT YOUR BOTTOM ON A COLD X-RAY TABLE?

3) THERE IS AN EXCESSIVE OBSESSION WITH FORMS AND
NUMBERS BY STAFF - YOU SHOULD WORK TO CHANGE IT.
ALMOST ALWAYS THE FIRST CONTACT WITH THE HOSPITAL
FOR A PATIENT IS TO TELL THE HOSPITAL HOW THE
PATIENT INTENDS TO PAY. MUCH MORE EFFORT,
UNDERSTANDABLE THOUGH IT IS, IS FOR PAYMENT THAN
FOR CARE IN THE ADMISSION OFFICE - AND NEEDS
CHANGE.

4) THE OPERATION AND THE ANESTHETIC MUST BE TAKEN
SERIOUSLY BUT APPROPRIATELY - THERE ARE NO MINOR
OPERATIONS NOR ANESTHETICS TO PATIENTS. THEY
MAY BE MINOR SURGEONS AND ANESTHESIOLOGISTS -
BUT WHAT THEY DO IS MAJOR TO A PATIENT

5) THE INTENSIVE CARE UNIT (ICU) - IS A TOUGH PLACE
TO BE IN. A PHYSICIAN-PATIENT SAID: "A CRITICAL

ILLNESS IS A DEVASTATING EMOTIONAL AND PHYSICAL EXPERIENCE WHICH THE PATIENT IS ASKED TO BEAR WHEN HE IS LEAST ABLE." "OUR PATIENTS ARE HELPLESS, DEPENDENT, FRUSTRATED AND UNABLE TO FIGHT BACK." THESE EMOTIONAL NEEDS HAVE TO BE BETTER MANAGED THAN THEY ARE.

6) TESTS-

A) NEVER OMIT USEFUL ONES

B) TRY NEVER TO DO INVASIVE ONES IF THE INFORMATION WON'T BE USEFUL - JUST TO BE FANCY - ALWAYS DO WHAT IS REQUIRED FOR BETTER CARE - NOT MORE AND NOT LESS

VI. THE UNDESIRABLE PATIENT

A. GENERAL - ALL OF US HAVE BIAS - IT MAY BE REFLECTED

IN MANY WAYS INCLUDING OUR VIEWING CERTAIN PATIENTS AS UNDESIRABLE. IN GENERAL, THEY ARE PATIENTS WHO DO NOT GIVE US GRATIFICATION PROFESSIONAL OR PERSONAL -

AND WE SHOULD LOOK AT THE CLASSIC "**UNDESIRABLES**" TO
BE ABLE TO OVERCOME OUR PREJUDICES

B. **TYPES**

- 1) THE POOR
- 2) THE ALCOHOLIC
- 3) THE UNGRATEFUL PATIENT
- 4) PHYSICAL CONDITION OF COMPLEX ORGANIC DISEASE -
WHO RESPONDS POORLY OR NOT AT ALL TO TREATMENT. A
PATIENT IS A "NUT," A "CROCK," OR A SENILE OLD
GOAT - ALL ARE BAD AND EACH OF YOU WILL PROBABLY
AT THE LEAST BECOME ONE OF THEM UNLESS YOUR
SUCCESSORS LEARN TO CHANGE THEIR VOCABULARY!
- 5) FAILURE TO RESPOND TO THERAPY CAN MAKE A
PATIENT UNDESIRABLE - OFFENDS DOCTOR'S EGO
- 6) A FAILED EPIDURAL MAY BE VIEWED AS THE PATIENT'S
FAULT - SO CAN A DIFFICULT INTUBATION - WE NEED
TO DO BETTER AND BE LESS CRITICAL OF THE PATIENT'S
COOPERATION OR LACK THEREOF.

VII. THE STUDENT, RESIDENT AND PHYSICIAN

A. THERE ARE DEHUMANIZING INFLUENCES TO OVERCOME TO DO RIGHT

- 1) USE OF LANGUAGE - PATIENTS ARE PEOPLE, NOT CASES
- 2) COMPUTERS - GREAT, BUT THEY HAVE NO HUMAN QUALITIES YET - MUST BE USED TO FURTHER HUMAN PURPOSES NOT REPLACE THEM.
- 3) LAB DATA HAVE ASSUMED DISPROPORTIONAL VALUES TO PHYSICIANS
- 4) THE TECHNOLOGISTS - WHO ARE INTERESTED IN PROCESS, NOT PEOPLE

B. THE CURRICULUM AND THE FACULTY - EDUCATION IS OVERLOADED WITH FACTS, TURF POSSESSION AND TOO LITTLE WITH CONCEPTS AND PREPARATION FOR PATIENT CARE. A TEACHING HOSPITAL HAS THE GREATEST TEACHING RESOURCE IN THE WORLD - ITS PATIENTS - AND THEIR ROLE IS INSUFFICIENTLY APPRECIATED

C. FACULTY - MAIMONIDES - "HE WHO HAS NOT STUDIED ENOUGH AND TEACHES IMPERFECT KNOWLEDGE IS TO BE TREATED AS IF HE HAD SINNED INTENTIONALLY." TEACHERS WHO DO NOT DO THEIR BEST FOR STUDENTS ARE "UNETHICAL" IN THIS SENSE.

VIII. RESEARCH - WE WILL TODAY DEAL ONLY WITH EVERDAY PROBLEMS - NOT WITH GLOBAL ISSUES

A. BASICALLY - COMES DOWN TO MORALITY OF THE INDIVIDUAL SCIENTIST - EVEN THOUGH WE NEED SOCIETAL SYSTEMS TO PROTECT PATIENTS - AN EXAMPLE OF A KIND OF UNETHICAL BEHAVIOR IS TO PLACE A SCIENTIST, NO MATTER HOW SKILLFUL, IN A ROLE OF CLINICAL RESPONSIBILITY UNLESS HE IS EQUALLY SKILLFUL CLINICALLY - AND EVEN THEN PROBABLY SOME WHO ARE **NOT** DOING THE CLINICAL RESEARCH SHOULD BE IN CHARGE OF THE PATIENT.

IX. ADMINISTRATION AND INSTITUTIONS

- A. **THE BUREAUCRACY** - VERY DIFFICULT TO DO RIGHT - LIKE THE SAD EYED DOG, IN ONE OF DR. DRIPP'S FAVORITE CARTOONS, SAYING "I MAY NOT ALWAYS BE RIGHT, BUT I'M WILLING TO BE FORGIVEN." THE PROCESS CAN BECOME IMPERSONAL AND PEOPLE INEVITABLY BECOME UNETHICAL - TURF BATTLES, POWER BATTLES, ETC. THE "CLIPBOARD HIERARCHY" OF ADMINISTRATION
- B. RELATION TO OTHER HEALTH PROFESSIONALS - ESPECIALLY SURGEONS AND NURSES. WE HAVE MUCH TO LEARN FROM ALL ESPECIALLY NURSES AND SHOULD CHERISH THEM MORE - IN THE BEST SENSE OF THAT WORD

X. **TEN RULES FOR DOING RIGHT**

- 1) TREAT ALL PATIENTS AS YOU WISH TO BE CARED FOR
- THE APPLICATION OF THE GOLDEN RULE
- 2) TREAT COLLEAGUES OF ALL LEVELS WITH FAIRNESS AND DIGNITY
- 3) WORK TO IMPROVE COMMUNITY HEALTH SERVICES
- 4) CARE FOR THE CHRONICALLY ILL, THE DISADVANTAGED

AND THE AGED AND THE POOR

- 5) PRACTICE JUSTICE, COMPASSION AND CARE
- 6) TREAT FRIENDS AND FAMILY WITH DIGNITY AND SELF-
RESPECT
- 7) ACQUIRE THE ATTITUDES AND SELF-DISCIPLINE NEEDED
FOR YOUR OWN GROWTH
- 8) FEEL AND EXPRESS GRATITUDE FOR THE PRIVILEGE AND
JOY OF BEING A PHYSICIAN
- 9) RECOGNIZE THAT GOOD PEOPLE SOMETIMES DO BAD
THINGS
- 10) WORK ALL YOUR LIFE TO GETTING BETTER AND MORE
COMPETENT

**XI. THE STORY OF THE MAGIC RING IN ANCIENT GREECE - THE TEST
OF JUSTICE FOR ALL OF US - TELL THIS STORY AND GET REACTIONS.**