ANALYSIS
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Ethical Crossroads along the Way: Short Stories about Medical Training

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WHY TELL STORIES?

"Insofar as ethics occurs in the context of human relationships, our ability to discern right from wrong and good from bad depends to a significant extent on how open we allow ourselves to be to others. By sharing and comparing stories we learn to better appreciate where our lives and experiences intersect with the lives and experiences of others. Ethics takes place at this intersection. In a very real and important sense, the ethical landscape of each clinical encounter is subtly negotiated through shared understanding. Through sharing we cultivate empathy, and from empathy we internalize the motivation to behave toward others as we ought. Empathy is the impetus to respect, and respect is the core of ethics. Narrative is the mechanism that brings it all together."

(Workman 2006)

Introduction

The stories below were shared as part of the presentation I made at the 2006 JEMH Conference on Ethics in Mental Health. The intent of the presentation was to highlight some of the ethical flashpoints that I encountered in medical school and early on in my psychiatry career.

My hope is that these stories might foster some discussion amongst clinicians or students who are reflecting on power relationships and the evolution of medical sub-culture norms.

Ethical crossroads may be marked by a sense of malaise or discomfort that bubbles up and is not easily diffused, assuaged, or rationalized away through all of our usual strategies. Of course, we also often know we are at an ethical crossroad because the unfairness of a situation slaps us hard in the face.

What I knew before medical school...

My ethical radar was shaped by substantial formal training and experience in philosophy, medical ethics, health services, and health policy before going to medical school. My medical training and early clinical experiences were thus processed primarily through an ethicist's eye.

A culture unto itself

By and large I was taught and inspired by noble and selfless role models; these residents, physicians, and allied health workers were passionately committed to their vocations and honourable traditions. However, some of what I encountered along the way was so egregiously unethical that not only was I shocked by what actually transpired, but I was stunned by colleagues so stressed, vulnerable, fearful, or acclimatized within the hierarchical world of medicine that they were silenced or blind to the transgressions.

A remarkable thing about the culture surrounding medical training was how much behaviour is driven by fear. Fear of judgment by colleagues, fear of complaints by patients, fear of a bad evaluation by a supervisor, fear of being found out as incompetent, fear of being held to unrealistic standards, fear of administration or bosses who arbitrarily or unpredictably reprimand, fear due to the lack of effective recourse to address systemic unfairness, fear of co-workers too burnt out or angry to care about me or anyone, fear of narcissistic over-controlling bullies who run roughshod over the kind people, fear of oversight by a professional college dedicated to protecting the public's interest but not mine, fear of a hospital that will hang you out in the wind if anything goes wrong, fear of speaking up when something isn't right, fear of being labeled as a trouble maker or whistle blower if you try to challenge the status quo however perverse it is…

Against that backdrop…

1994-95 - Clerkship

Clerkship is the last year of medical school; it is an intensely busy time during which you rotate through the many areas of medicine (surgery, internal medicine, ob/gyn, psychiatry, emergency, family medicine, etc) for a couple of weeks or a month at a time. The hours are long and it represents the start of your exhausting life of being "on-call" (staying up all night every few days and working 24-36 hour shifts). You operate under the supervision of residents (recent MD graduates doing specialized training) and staff physicians.

1) "Stat to surgery"

I was paged at 3:00 in the morning stat to surgery in the large teaching hospital where I was on-call. As I ran through the family waiting area toward the operating rooms I noticed a man with two young children sitting there. He looked scared. It was his wife in the operating room. She had a disease that made her blood vessels spring leaks from time to time. I scrubbed and gowned and joined the emergency surgery that was already in progress. The surgeon needed more hands to hold instruments and push organs out of the way; that was my job. He was furiously looking for a source of bleeding and he finally found it in a large vessel deep in the liver. His efforts to stem the blood loss were hampered by the fact that the blood vessel was so fragile that it couldn't easily be repaired; the vessel wall was like paper falling apart. He worked with a focused intensity and finally looked up at me and said that there was nothing more he could do. He started packing the open abdominal cavity with towels.

I asked him what happens next as I was uncertain about her status. With frustration in his voice the surgeon said that she was going to die because her vessels were beyond repair. I asked what that meant…will she die within minutes or slowly bleed out? It was the anesthetist who answered; he said that the packing will slow the bleeding and that it would take a few days for her to die. He added that blood transfusions could keep her alive for an even longer period but that that was a waste of a precious resource given that she was going to die anyway. I then asked the surgeon whether I was to accompany him as he broke the news to her when she was awakened from the anesthetic. He looked surprised by the question and stated that it would be "cruel" to wake her up just to tell her she is going to die soon. The anesthetist then added that he would use medications to keep her unconscious until she died.

My immediate reaction was one of confusion. I asked a few more questions. No, she was not being kept unconscious because her pain would be unmanageable if she were awakened. No, her husband would not be told that she could simply be awakened at any time; he would be led to believe that her physical condition rendered her unconscious.

I followed along over the next couple of days and everything unfolded as the surgical team planned. She slowly bled to death and her husband and children never saw her conscious again.

I felt tremendous anguish over these circumstances. While I understood the rationale, my firm beliefs about autonomy and choice for her and her husband made acceptance of the events profoundly emotionally difficult for me.

I believed that the choice to keep her unconscious was about the surgeon's discomfort and had little to do with her best interests. I did not believe it was right to deny her a couple of days in which to do whatever she might have wished (Make her peace with God? Say goodbye to her children…). I did not believe that her husband and children should be denied the opportunity to speak with her…

In the days that followed I discussed the events with several other surgeons and anesthetists and they uniformly endorsed what had happened as the right thing to do, and explained to me that this is the norm in these types of cases. It couldn't have been clearer to me that the "norm" was wrong. And yet, I never did reveal the true state of affairs to the husband after the surgery. I was certain that to have done so would have lead to my being failed on the surgery rotation and possibly being kicked out of medical school. You simply don't defy a staff surgeon's directions.

As far as I know, this practice remains the "norm" on many surgical services.

2) "Jump on him!"

I was doing my psychiatry rotation on a general adult psychiatry service at a large provincial psychiatric hospital. While I had done my reading, I was really completely naïve about psychiatric care in a real clinical setting like this.

One day, early on in my rotation the staff psychiatrist who supervised me told me that we were going into a patient's room to give him an injection. I did not know that the patient did not want the injection, or that he was in a "bubble room" (a locked room with only a mattress on the floor) because he was so agitated. As we approached the room we were joined by about 5 of the nurses from the floor, including one burley male nurse. The door was opened, and when we went in we were immediately confronted by a large, clearly furious man. Without advance discussion or preparation the psychiatrist directed me to "Jump on him". I hesitated, confused by the direction I was being given. The male nurse, on the other hand, immediately leapt upon the man and a wild skirmish ensued. When the male nurse got the patient to the floor, the other female nurses quickly converged to secure his limbs. I too joined in at that juncture and helped to hold down a leg. The injection was given and we all ran out of the room with the enraged patient screaming after us.

The whole spectacle was simply shocking to me. I felt that this was traumatic for the patient and that I had no right to hold someone down. At that initial stage in my medical training I had not thought through issues related to isolation rooms, the merits of physical versus chemical restraints, or the legitimate use of force with patients. I also had no appreciation for how relatively humane our modern Canadian psychiatric care was relative to some of the abuses extant around the world (e.g. patients kept in small cages or tied down for weeks at a time).

I wish I had been better prepared for what we were going to do and what was expected of me. However, I offer this story not by way of claiming that what happened was unethical but rather as an illustration of an initial moment of transformational learning that informed my subsequent clinical experiences and practice. The injunction to "do no harm" should actually be, "do as little harm as possible".

Over the years since I have had many patients tell me that these institutional episodes of aggressive restraint were profoundly traumatic for them, and it is the possibility of it happening again that makes them most fearful of future readmission. The thought of being tied down for days on end is unbearable.

I have also had patients thank me for treating them using all appropriate means when they were too ill to exercise their own judgment. Even knowing this, I cannot be unaffected by a human being suffering so much, or at such great risk of harm, that the only humane response is the counter-intuitive action of aggressive restraint. Doing what is right can sometimes feel very wrong.

What has particularly disturbed me in the years since are those occasions that I have witnessed restraints seemingly used punitively or to coerce treatment compliance. And as we are numbed to our "code whites" (aggressive patient code) and it becomes easier or common to use restraints because of short staffing or because a facility is ill equipped to handle too many aggressive patients at once, we can forget that even one minute of unnecessary restraint is a gross violation of human rights and dignity.

1995-96 - Year 1: Rotating Internship

Like clerkship, during the rotating internship year you move from one area of medicine to another every month. Unlike clerkship you are now a doctor with an extraordinary amount of responsibility and a paucity of clinical experience to guide you. My internship year was without doubt the most stressful and exhausting year of my life.

3) The abortion clinic

During my obstetrics & gynecology rotation I was assigned to work in the abortion clinic at a general university hospital. I was told I would not be doing the abortions directly ("the ob/gyn residents do them"), but that I would be doing the same day pre-op physical examinations required before the abortion procedures could be performed. No one asked me whether this represented a moral conflict for me, and there was no indication that I could refuse and request another placement. This lack of discussion astonished me given the civic, religious, and moral divides that make abortion the ongoing minefield that it is. It seemed clear to me that there was an assumption that no one would object to being part of the process if they didn't actually have to do the abortions themselves. A questionable moral assumption akin to assuming someone won't mind building bombs as long as they don't have to drop the bombs themselves.

Interestingly, the Royal College of Canada specialty certification process for Obstetrics & Gynecology does not require that residents in this field have actually done abortions as part of their residency training but that they simply know how to do them.

4) "You'll be fine"

One early morning during my surgery rotation I was on hospital rounds going from room to room with the staff surgeon to whose team I had been assigned. Other team members in the gaggle trailing along were the senior surgical resident, the junior surgical resident, some clerks, and medical students. Before entering one room the surgeon told us that the woman we were about to see had been found, during exploratory surgery the day before, to have widespread abdominal cancer. We were also told the cancer was well advanced and beyond treatment and that she would likely die within a few weeks. We then entered the patient's room and the surgeon cheerily told her that the surgery had gone well, that nothing significant had been discovered and that she would go home soon and be fine.

I was shocked. When we returned to the hall I asked the surgeon what his plan or strategy was for disclosure of the terminal cancer diagnosis. He told me he had no intention of telling her the truth as this would be harmful. I asked about what happens as she gets sicker and wants an explanation for her lack of improvement. He responded that by then it wouldn't matter what she knows and that she will have had a nice period without worry.

Given my thorough knowledge of the literature and ethics of truth telling I cautiously challenged his position. The days of withholding information under the guise of 'therapeutic privilege' and 'best interests' were long past in Canada. The conversation, however, was dismissively shut down by him. The senior resident quickly gave me a clear message that she and I could discuss it further later.

When I spoke with the senior resident alone after rounds she made it clear that the surgeon lied to patients regularly, and she told me that when she herself had challenged him on this early in her assignment to his team, he simply revoked her operating privileges for a month. For a surgical resident to be denied operating time is a dire consequence, so she remained silent on this matter from that point on. She also told me that other staff in the surgery department were fully aware of this surgeon's communication patterns but that he was free to practice as he wished as a self regulated independent practitioner.

His exercise of power was remarkable and his certainty about his actions was stunning. Short of patients complaining themselves, there seemed truly to be little systemic recourse. And he was modeling his behaviour for clerks and medical students who took at face value that what he was doing was morally acceptable.

1996- 2000 Years 2 to 5: Psychiatric Residency

There are so many stories to be told. Some represent violations that are nuanced, subtle, innocent, of little real consequence, and sometimes occur in plain sight of colleagues. Others, interestingly, are really not about ethical issues in the sense that those involved in a situation struggled with uncertainty over the best moral course; rather they are simply stories about blunt abuses of power, authority, and privilege that go unanswered.

The years in residency produce a remarkable transformation wrought through intense clinical exposure. If you took the number of hours you work in the five years of residency and divide that number into a more typical 40 hour work week, it turns out that in five years you have worked what would be an equivalent of nine years at a regular job.

In residency you develop clinical competence, hone communication skills, sift through the biases, learn about your own huge blind spots and prejudices, feel a growing sense of professional autonomy, and you work to find the balance as you behave more and more authoritatively and paternalistically in moments of crisis. You struggle with certifying someone ("civil commitment") against their will. You deal with your vulnerability and the high probability (over 70%) of being assaulted by a patient sometime during your training. And you experience the recurrent and vicarious micro-traumas that accompany such emotionally demanding work.

5) "In my country"

During my psychiatry residency I had the privilege of working with a number of Saudi Arabian residents who were training in Canada. I enjoyed the discussions with them that challenged my world views, and forced me to think about culture bound symptoms and disease interpretations in a much broader and richer light.

As residents we regularly observed each other doing interviews and assessments, and then provided formal feedback. In the discussion following an observed interview with a homosexual patient, one of my Saudi colleagues commented that he thought the man should be put to death. He explained that in his country he had on many occasions gone to witness public executions of gay men on Sunday afternoons in the marketplace. Not surprisingly, his comments provoked a strong reaction among the discussants present. He was accused of homophobia, ignorance about the biological nature of the determination of sexual orientation, crass insensitivity, and bigotry. He, in response, clearly and simply explained his beliefs, his culture, and his values, and he wondered at the intensity of our responses.

My personal experience of this fellow resident was that he was very caring, and very kind and respectful with patients. Paradoxically, as much as I found his posture in relation to homosexual patients abhorrent, his challenge to me to try and see the world through his eyes was a remarkable lesson in cultural sensitivity.

6) Attitudes towards patients with Borderline Personality Disorder

Difficult patients can evoke intense responses. What makes them difficult? Among other things: threats of violence, suicidal threats to manipulate an outcome, intense and unpredictable emotional responses, threats of legal action, and pressured boundary violations.

On any given psychiatry service you quickly hear about some of the most difficult patients. "She is a PD" (personality disorder) is both the catchphrase and warning that a patient is difficult. Interestingly, the person "is a PD" rather than someone "living with a personality disorder illness". The implicit and explicit message is often that these patients are intentionally problematic and that their "acting out" behaviours should be responded to with autocratic redirection and rebuff rather than a nuanced clinical appreciation of what the behaviour represents in terms of an attempt to elicit help.

Make no mistake about what I am saying. The appropriate care of patients with personality disorders represents some of the hardest and most skilled work a psychiatrist can do. The therapeutic challenges related to abandonment and maintenance of boundaries are huge, as evidenced by a voluminous literature and case reports on these very topics. To say that some of these patients are a challenge is an astonishing understatement.

As you move through residency, developing a positive attitude of care towards this group of patients can mean having to swim against the affective undercurrent of resentment, frustration, and helplessness that some staff psychiatrists exude.

Hospital admission is therapeutically counterproductive in some patients with personality disorders (they get sicker or more distressed in hospital inpatient milieus). As a resident I frequently found myself in the awkward and distressing position of seeing a patient in the Emergency Room whom the staff psychiatrists at that hospital had agreed (following years of experience with the patient) should never be admitted to hospital because it makes matters worse. Obviously, good clinical judgment is still called for with each new encounter in the Emergency Room. And certainly, sometimes a brief crisis admission is warranted. Nevertheless, the history and records available to you are key guiding information as you make a decision about whether it is safe to let a suicidal patient with borderline personality disorder illness go home.

Being denied admission can be very difficult for a desperate and suicidal patient to accept, even when all the evidence is that in the past they clearly became more distressed on admission. On one occasion, I informed a patient that she would not be admitted and, unbeknownst to me, rather than leaving the ER she went into a nearby examination room and attempted to hang herself off a short, thin chain dangling under a gurney. This required that she put all her weight on her neck as she lay prone on the floor (like doing a push-up and lifting her hands up with her head through the chain). The chain cut into her neck and she was bleeding a lot. She kicked and fought off staff trying to help her. As the ER physician and I stood in the doorway and watched the mayhem, he turned to me and said, "Well, I guess you'll admit her now". And

so I did. But on team rounds the next morning where admissions from the night before are reviewed, I was grilled for 10 minutes over the folly of my decision to admit. In the end, the staff psychiatrists finally let it go with my defense that if I hadn't admitted her she would have left the ER and once again made a near lethal suicide attempt, as was commonplace with her (e.g. overdoses, swallowing razor blades), and that she would then be admitted anyway but that she would be taking up a scarce ICU bed.

So what is the ethical essence that I wish to highlight in all of this? I believe the shaping of attitudes towards difficult patients that occurs within a teaching centre has a ripple effect across the broad domain of psychiatric culture and that it is at the root of some of the paternalism and disrespect that is both tolerated and fostered in some clinical settings. Such bias and prejudice gives us mutually reinforced license to haughtily dismiss and discount the needs of "annoying" "non-compliant" and "difficult" patients.

And the stories continue...

Benjy Freedman, an old medical ethics professor of mine asked, "Where are the heroes of bioethics?" When we see something that is wrong we may pay a great price for saying so. However, if we don't speak up, we all pay a price. History has taught us the savage toll that silence takes when we abrogate our moral duty to each other…

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Endnote:

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