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Teaching Medical Students How to Reconcile Law and Ethics in Practice: A Faculty Development Model[+]

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I. INTRODUCTION

Throughout the course of their medical education, future physicians are frequently exposed to comments from their physician faculty mentors about the legal risks they are likely to encounter in their professional lives. These comments may engender legal apprehensions and anxieties among medical students and may be accompanied by advice from faculty that tends to encourage future clinical behavior that is inconsistent with the best humanistic care of patients. For example, physicians may feel compelled as a matter of legally defensive medicine to: overtreat patients with inappropriately aggressive diagnostic and treatment interventions, including in end-of-life situations; undertreat patients by, for instance, refusing to prescribe adequate pain medications or declining to treat certain categories of perceived legally high-risk patients altogether; constrain the exercise of patient autonomy by not offering certain choices such as vaginal delivery following a prior Caesarian birth; be reluctant to disclose—and take advantage of opportunities to correct—medical errors; and practice ethically suboptimal medicine in other ways.

The frequently destructive relationship between physicians' negative perceptions of their legal climate, on one hand, and the humanistic character of the patient care that ought to be provided by physicians, on the other, has been acknowledged for a long time.[1] Attention to the tension between legal apprehensions and optimal humanistic medicine continues to permeate the

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1. *See* MARSHALL B. KAPP, OUR HANDS ARE TIED: LEGAL PERCEPTIONS AND MEDICAL ETHICS (Praeger Pub.1998).

professional literature in medicine,[2] law,[3] and bioethics,[4] both in the United States and internationally.[5]

However, it appears that little – if any – attention has been devoted in the medical education arena to the tension between physicians' perceptions about their risk management needs and the humanistic quality of the patient care they provide, let alone attention to the role that medical education may exert on the creation or exacerbation of that tension. This is a serious and unfortunate oversight; indeed, the ability to effectuate a positive, therapeutic alignment of legal risk management and humanistic patient care ought to be considered a core competency embedded throughout the medical education process.[6] The goal of the project outlined briefly in this article is to create and disseminate experience and knowledge that will move medical education in that humanistic direction.

II. DESCRIPTION OF PROJECT

This fifteen-month (October 1, 2010 through December 31, 2011) project seeks to develop, demonstrate, and evaluate one strategy for improving the education of medical students regarding the relationship between legal risk management, on one side, and humanistic patient care, on the other. The centerpiece of this strategy, described in this article, consists of a series of educational interventions with the Florida State University College of Medicine's ("FSU COM's") clinical faculty members who are the primary source of medical student perceptions about the legal environment within

2. *See* Allen Kachalia et al., *Physician Responses to the Malpractice Crisis: From Defense to Offense*, 33 J.L. MED., & ETHICS 416 (2005); James W. Jones et al., *A Helping Hand Bitten: An Ethical Response to Medical Malpractice Suits*, 43 J. VASCULAR SURG. 422 (2006); Robert C. Solomon, *Ethical Issues in Medical Malpractice*, 24 EMERGENCY MED. CLINICS N. AM. 733 (2006); Arthur R. Derse, *Ethics and the Law in Emergency* Medicine, 24 EMERGENCY MED. CLINICS N. AM. 547 (2006); E.A. Rybak, *Hippocratic Ideal, Faustian Bargain, and Damocles' Sword: Erosion of Patient Autonomy in Obstetrics*, 29 J. PERINATOLOGY 721 (2009); Adrian Sondheimer, *Ethics and Risk Management in Administrative Child and Adolescent Psychiatry*, 19 CHILD & ADOLESCENT PSYCHIATRY CLINICS N. AM. 115 (2010).

3. *See* Robert A. Burt, *Doctors vs. Lawyers: The Perils of Perfectionism*, 53 ST. LOUIS U. L.J. 1177 (2009); Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973 (2009); William M. Sage, *Over Under or Through: Physicians, Law, and Health Care Reform*, 53 ST. LOUIS U. L.J. 1033 (2009); Robert Schwartz, *End-of-Life Care: Doctors' Complaints and Legal Restraints*, 53 ST. LOUIS U. L.J. 1155 (2009).

4. *See* Christy A. Rentmeester & Constance George, *Legalism, Countertransference, and Clinical Moral Perception*, AM. J. BIOETHICS, Oct. 2009, at 20.

5. *See* Rob Heywood, *Excessive Risk Disclosure: The Effects of the Law on Medical Practice*, 7 MED. LAW INT'L 93 (2005).

6. Robert I. Simon & Daniel W. Shuman, *Therapeutic Risk Management of Clinical-Legal Dilemmas: Should It Be a Core Competency?*, 37 J. AM. ACAD. PSYCHIATRY & LAW 155 (2009).

which those students will later practice as physicians.

Several other components of this project will be reported in separate articles. One of those articles will describe the conduct by the authors of a student focus group for first and second year medical students on November 16, 2010, utilizing the existing Health & Law Organization ("HALO") student interest group.[7] This focus group elicited and collected student ideas about the legal risk management lessons they believe they should be taught in medical school and the optimal ways of conveying those lessons to students. Another article will summarize a comprehensive review of relevant medical, legal, health policy, and bioethics literature and report on the research portion of this project; the research component is based primarily on analysis of responses to brief pre-intervention survey instruments (1) for FSU COM students in their third and fourth years inquiring about what they learn from faculty regarding legal risks and their management and (2) for FSU physician faculty members regarding what they teach medical students regarding legal risks and their management, as well as an investigation of the impact of the faculty workshop educational intervention on the subsequent teaching behaviors of faculty participants.[8]

III. THE FACULTY WORKSHOPS—THE EDUCATIONAL INTERVENTION

The educational intervention in this project utilized the mechanism of the current FSU COM Faculty Development educational program to plan and conduct a two-hour faculty development educational session at each of the six Regional Campuses. These sessions were devoted initially to reviewing third and fourth year students' present exposure to information from clerkship faculty regarding physicians' legal risks and their management, and then explored and emphasized strategies for clerkship faculty to provide students with accurate information in this arena in a manner that encourages future physician behavior that is consistent with patient-centered, humanistic medicine. It was hypothesized that, as a result, clerkship faculty would be better able to teach students to practice humanistic risk management. In designing this project, we followed principles for conducting effective workshops as described by Steinert.[9]

Following a brief introduction (largely didactic, but eliciting some audience comments) by the Principal Investigator ("P.I.") describing the project's background, hypotheses, and anticipated outcomes, the bulk of

7. Marshall B. Kapp et al., *What Do Medical Students Think About the Law? Report of a Focus Group*, 21 LEGAL MED. PERSP. 63-65.

8. Marshall B. Kapp et al., Preparing Medical Students to Reconcile Legal Risk Management and Ethical Patient Care: What Are Faculty Teaching, What Are Students Learning? (unpublished manuscript, on file with author).

9. Yvonne Steinert, *Twelve Tips for Conducting Effective Workshops*, 14 MED. TCHR. 127 (1992).

each workshop was devoted to a whole group discussion—facilitated by the P.I.—of hypothetical cases prepared by the P.I. for this project. Attendees were eighty-eight physician clinical faculty members representing a wide range of medical specialties, although primary care physicians predominated; attendance at the six sessions ranged from nine to twenty-seven, with an average attendance of fifteen. Although four cases were available for discussion, in all but one workshop the group interaction was sufficiently robust that only Case 1 and Case 2 could be discussed during the available allotted time. The cases, which were designed specifically to highlight potential tensions between physicians' legal risk management concerns, on one hand, and the practice of good ethical clinical medicine, on the other, intentionally were not shared with participants prior to each workshop, in order to assure the spontaneity of participants' reactions and contributions to the discussion. These cases, along with a series of questions employed to facilitate the discussion in the intended direction, are presented below.

IV. DISCUSSION CASES

A. Workshop Discussion Case #1 – Ordering Tests and Procedures[10]

Mr. K was a fifty-year-old man in generally good health except for hypertension, which is well-controlled with medication. He had a good health insurance policy purchased through his employer, with standard deductible and co-insurance provisions. He has never used tobacco products and drinks alcohol very moderately.

For several days, Mr. K noticed that his right foot was swollen and had developed a "funny looking" rash unlike anything he had experienced previously. Mr. K was scheduled to board an airplane for a three-day business trip on Thursday and so, on Wednesday, he went to the office of his primary care physician ("Dr. B") to be assured that the swelling and rash were nothing to worry about. However, when Dr. B examined Mr. K's foot, his reaction was one of serious concern. "I don't know what that rash is exactly, but you have some form of unusual infection. You are not going anywhere except the hospital next door so you can be treated by an infectious disease specialist." Mr. K went directly to the hospital and was admitted on Dr. B's orders. At the hospital, Mr. K was subjected to the full battery of standard admission testing, including a routine chest X-ray. He was seen that afternoon (Wednesday) by infectious disease specialist Dr. H, who examined Mr. K's foot and said, "I won't know what specific infection

10. For a more complete discussion of this case, *see* Marshall B. Kapp, *Informed Consent to Defensive Medicine: Letting the Patient Decide*, PHAROS, Spring 1993, at 12.

you have until the culture comes back from the lab in a few days, but in the meantime I'll treat you with medicine X and we'll see if you respond." Mr. K did respond very favorably to medicine X and within twenty-four hours the swelling and discoloration of his foot had subsided almost totally; he was discharged from the hospital on Friday morning.

The following Monday, Dr. B called Mr. K and asked how he was doing. He then said, "When you were admitted to the hospital, you had a chest X-ray done. The report the hospital sent me today indicated that the radiologist who read the X-ray said that the picture of one of your lungs appeared a little suspicious. You have had several other chest X-rays done in the past with no remarkable findings, but I will need you to go to the hospital outpatient department ASAP to have another chest X-ray done." It was not until Thursday that Mr. K was able to schedule an outpatient chest X-ray at the hospital. The following Monday, Dr. B called Mr. K with the news that his new chest X-ray was normal.

- Did Dr. B behave properly? Why or why not?
- What relevant legal considerations apply to this case?
- What relevant ethical considerations apply to this case?
- Do the legal and ethical considerations in this case conflict or reinforce each other?
- What should Mr. K have been told in this case?
- What alternative courses of action were open to Dr. B?

B. Workshop Discussion Case #2 – Informed Consent/Pain Management

Mr. K was a thirty-five-year-old man in generally good health except for being overweight. One early summer evening, while mowing his home lawn he pulled the mower back toward himself; his left foot got stuck on an obstruction in the high grass and he accidentally ran over the left big toe with the mower. He was in great pain and bleeding profusely. He cried out for his wife, who was outside nearby talking to a neighbor. They wrapped a towel around the injured foot, Mr. K got in the passenger side of the car, and his wife drove him to the nearest hospital emergency department ("ED") about ten minutes away.

At the ED, Mr. K was taken back into the patient examination area quickly, where he was given an injection of sedative for his pain and the foot was temporarily bandaged to stop the bleeding. A few minutes later, the ED physician ("Dr. R") examined Mr. K, asked him questions about how the accident had occurred and about Mr. K's medical history, and–in response to Mr. K's questions–indicated that Mr. K's foot would "need some work" once the orthopedic surgeon on call arrived. The conversation between Dr. R and Mr. K took approximately ten minutes. Mr. K and his

wife were then left in the examining room for approximately an hour until the orthopedic surgeon arrived; during that time, Mr. K was awake and asking questions each time the nurses or Dr. R periodically stopped in to check on him. When the orthopedic surgeon ("Dr. Q") arrived, she spoke with Dr. R for several minutes, read Mr. K's medical chart, and then spoke with Mr. K for about 10 minutes. Dr. Q then said, "Well, Mr. K, I see you were given a sedative when you arrived here. We will need to obtain consent for your surgery from your wife." Mr. K had never named his wife (or anyone else) to act as his medical agent in a durable power of attorney instrument, nor had he ever been declared incompetent by a court.

- Did Dr. Q act appropriately?
- What are the legal considerations in this case?
- What are the ethical considerations in this case?
- Do the legal and ethical considerations in this case conflict or reinforce each other?
- What is the proper role for Dr. R to play at this stage of the case?
- What should Dr. Q and Dr. R do if Mr. K's wife refuses to consent to the surgery for Mr. K?
- Would it have been appropriate to have handled this scenario from the outset by not giving Mr. K a sedative in the ED?[11]

C. *Workshop Discussion Case #3 – Medical Decision Making for the Questionably Capable Patient*

Mrs. B is an eighty-year-old widow who suffers from chronic obstructive pulmonary disease, peripheral vascular disease, and mild dementia. During her two-year nursing home stay, she has remained relatively stable physically but has slowly but noticeably declined in terms of cognitive status. She has a fair amount of regular interaction with her family, the facility staff, and other residents. When she first entered the nursing home, Mrs. B executed a health care proxy appointing her daughter as her agent and her son as alternate agent. Simultaneously, Mrs. B. executed a living will that stated, among other things, that Mrs. B would not want dialysis if she became terminally ill or permanently unconscious.

Based on complaints of chest pain and shortness of breath, Mrs. B has just been admitted to the hospital. She was found to have undergone a mild heart attack, to be in acute renal failure, and to be acting confused and agitated. Her primary care physician and nephrology consultant want to order a few dialysis treatments to improve her kidney function and possibly improve her mental status while the extent of her heart damage is studied.

11. *See* Marshall B. Kapp, *Withholding Pain Medication in the ED Because of Legal Fears—Bad Practice for a Bad Reason*, 17 AM. J. EMERGENCY MED. 207 (1999).

The daughter readily consents, but the son protests that Mrs. B's living will expressly precludes this plan.

- What should the physicians do?
- To whom should the physicians look for decision making for Mrs. B?
- What are the legal considerations in this case?
- What are the ethical considerations in this case?
- How can the physicians protect themselves legally while providing good ethical care to Mrs. B?

D. Workshop Discussion Case #4—Medical Decision Making for the Critically Ill Patient

Assume the same initial facts as Case #3, *except that* Mrs. B's heart attack was a very major event, during which her brain was deprived of oxygen for several minutes and she fell into a vegetative state from which her physicians feel strongly she will not recover. She has been placed on a respirator and feeding tubes have been inserted.

The son has indicated a desire to have all medical intervention except palliative care withdrawn and withheld from Mrs. B, because he believes that "death with dignity" is what his mother would want. On the other hand, the daughter (who is an attorney and just arrived on the scene from a distant part of the country) insists that "everything" be done for her mother and that no "Dr. Kevorkians" will be tolerated.

- What should the physicians do?
- To whom should the physicians look for decision making for Mrs. B?
- What are the legal considerations in this case?
- What are the ethical considerations in this case?
- How can the physicians protect themselves legally while providing good ethical care to Mrs. B?

V. LESSONS FOR TEACHING

During the last several minutes of each workshop, participants were asked to collectively reflect upon the case discussions that had just unfolded, with an eye toward formulating specific strategies or guidelines they could implement in teaching new medical students about ways to effectively reconcile the perceived potential tensions between their apprehensions about potential litigation and legal liability (and the consequent imperative to practice defensively), on one hand, and the ethical (as well as legal) imperative to provide ethically and clinically sound

patient care, on the other. Among the most salient of the strategies and guidelines enunciated, and endorsed by consensus, through this process were the following:

- I will try to describe explicitly my thought processes involving legal and ethical considerations when students are present.
- I will teach the student that ethics, common sense, and focusing on proper care of the patient are the best guides for managing legal risks.
- I will be mindful of the signals I send to the student and will be more open and candid in discussions about taking the best ethical care of my patients.
- I will spend time elaborating to the student the need to communicate with patients and to document what we are doing and why we are doing it.
- I will explain explicitly to the student the legal and ethical implications of patient care recommendations and the resulting acceptance or refusal of that care by the patient.
- I will challenge the student to evaluate situations that might entail ethical and legal issues or ramifications.

In this project, each workshop was preceded by distribution of a pre-test assessment instrument to participants and followed by distribution of a complementary post-test assessment instrument. These instruments were designed to evaluate the success of the workshop is meeting its stated educational objectives. Aggregating the assessment instrument responses collected at the six workshops, three-quarters of the workshop participants filled out the pre-assessment instrument and 86 percent completed the post-assessment instrument. The responses indicated that, on the whole, the workshop objectives had been met. More specifically, responders to both workshop assessment instruments indicated, in a statistically significant manner,[12] that following participation in the workshop they believe that they: (1) have a clearer understanding of the ways that the legal environment influences their own medical practice; (2) are more aware of the messages they send to medical students regarding the decisions they make in response to perceived potential legal consequences; (3) can better describe how effective risk management practices can be consistent with good ethical patient care; and (4) are better prepared to implement teaching strategies to more effectively teach medical students how to reconcile positive risk management strategies with good clinical and ethical patient

12. The data derived from the pre-assessment and post-assessment instruments are on file with the authors.

care.

The project discussed here is considered a pilot attempt. In future, expanded projects building on the knowledge gained through this pilot, follow up activities would take place that attempt to evaluate the effectiveness of the faculty development workshops described above in positively changing (i.e., improving) the quality of teaching delivered by participating faculty physicians and the quality of learning reaped by their medical students. More particularly, the authors will try to assess whether, as a consequence (at least in part) of this type of educational intervention, clerkship faculty are more likely than before to signal to their students affirmative messages about the ability of physicians to successfully reconcile their ethical obligations, precepts of good evidence-based clinical care, and their own legal risk management interests – in other words, an ethos of positive rather than negative defensive medicine.

The true, ultimate objective of these faculty development workshops is to enhance the quality of medical care received ten and twenty years from now by the future patients of the students who are presently being acculturated into the medical profession by the faculty mentors who participated in these workshops. We leave to future research the challenge and opportunity of measuring the success of faculty development initiatives such as the one described here in moving medical education further toward achievement of that important objective.