

Your Doctor Needs to Know

Ana M. Tyler, J.D., M.A., and William S. Andereck, M.D., FACP

“Mr. Strong is a 68-year-old man who went to the emergency room in November because of a headache. It was the most severe he has suffered since childhood, but it had actually gone away the day before. Due to the concerns of family and friends, he went to the emergency room to get “checked out.” The doctors evaluated him for a stroke and performed a detailed blood flow study of his brain. They told Mr. Strong that all the tests were normal, and he most likely was suffering from a recurrence of his childhood migraines. They were 97 percent confident in their diagnosis. However, to be 100 percent sure, they would need to do a spinal tap. Reluctantly, Mr. Strong agreed to the procedure and spent the next eight hours lying on a cart in the emergency room while the test was arranged, conducted and monitored. Following this event, he has been fine and has had no further headaches (except when the emergency room bill arrived). He still wonders why he let the doctors talk him into the spinal tap and why the doctors were so insistent on more testing.”

Continued on Page 3



► In this issue

| | |
|---------------------|---|
| Ethicist Is In | 2 |
| Bioethics Education | 5 |

The Beecher Award:

Dr. Albert R. Jonsen

“Dr. Beecher would be astonished to see that modern bioethics has permeated contemporary medicine and science. It has been a privilege to be a part of this growth.”

– Albert R. Jonsen, Ph.D.

Albert R. Jonsen, Ph.D., co-founder and emeritus scholar of Sutter Health’s Program in Medicine and Human Values, will receive one of the most coveted honors in the field of bioethics, the Hasting Center’s Henry Knowles Beecher Award. The award recognizes a lifetime of distinguished achievement and excellence in scholarship, research, and ethical inquiry.

The award will be presented at the annual meeting of the American Society for Bioethics and Humanities in Kansas City, Oct. 19. After the presentation, Dr. Jonsen will deliver a public lecture. The Program in Medicine and Human Values has been fortunate to have Dr. Jonsen with us since 2003 as a guiding light in the development of our clinical ethics program.

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The Ethicist Is In: The Ethics of Public Psychiatric Diagnosis



“Mental health experts sometimes publish opinions in popular media about prominent politicians they haven’t personally examined. Sometimes they even propose psychiatric diagnoses. Is this ethically appropriate?”

- Steven P. Reidbord, M.D.

Ethicist: A little history may be helpful here. Just prior to the 1964 presidential election, magazine publisher and provocateur Ralph Ginzburg mailed a survey to over 12,000 U.S. psychiatrists asking whether Republican candidate Senator Barry Goldwater was psychologically fit to serve as president. Although only 20 percent responded, and only half of those said anything negative, Ginzburg published an entire 60-page issue of *Fact* magazine devoted to Goldwater’s purported mental instability. In large type, the front cover declared: “1,189 Psychiatrists Say Goldwater Is Psychologically Unfit To Be President!” But it said nothing about the many thousands of psychiatrists who did not share this view. The issue contained a lengthy, scathing psychological hit piece written by Ginzburg (who had no mental health training), then dozens of pages of mostly negative commentary, including various alleged diagnoses, offered by some of the surveyed psychiatrists.

Senator Goldwater lost the election and later successfully sued Ginzburg and his magazine for defamation. In 1973, the American Psychiatric Association (APA) published its first ethical code. The code included a section nicknamed the Goldwater Rule, which remains unchanged to the present day. It prohibits APA members from offering professional opinions about public figures they have not personally examined and demands the patient’s consent before offering such opinions to the public.

For the past four decades this rule has been largely uncontroversial. The APA argues that diagnosis and

other professional opinions about an individual are only valid when derived from clinical interviews and other personal data. Media impressions are insufficient. The APA also believes that informal published opinions erode public confidence in psychiatry and stigmatize psychiatric language by equating having a diagnosis with unworthiness or unfitness. In fact, many individuals seem unsuited for leadership positions even without a formal diagnosis. Conversely, a number of revered leaders, such as Abraham Lincoln and Winston Churchill, likely did suffer from emotional disorders.

However, for the past year or two the Goldwater Rule has been called into question. Some mental health professionals argue it is indeed possible to diagnose a politician based on public statements and behavior. They say doing so serves the higher purpose of public safety and claim a “duty to warn” the public about a mentally unstable or dangerous leader. They hold that since the politician is not a patient and has not divulged anything in confidence, there is no requirement to obtain consent. Last but not least, they correctly note that the Goldwater Rule applies only to members of the APA, not to those psychiatrists who are not members, nor to the majority of mental health professionals who are not psychiatrists. However, other mental health experts, e.g., psychologists, are also prohibited from diagnosing someone they have not thoroughly examined.

Mental health professionals enjoy the same right as other Americans to freely express opinions. However the ethics

of a profession are often more restrictive than those of the general public. A banker is ethically obliged not to talk with others about your money. An attorney must maintain confidences. A doctor must not exploit the vulnerability of the sick. The question here is not one of free speech. It is whether the professional ethics of mental health experts should restrict public diagnosis.

In thinking about this, it may be useful to consider several questions. Is there a legitimate duty to warn the public about a mentally unstable leader, and what are the likely consequences of such a warning? Does it still feel okay when one's favored politician, and not a disliked figure, is diagnosed in this way? Does public diagnosis improve the tone of political debate or degrade it? Does it unfairly exploit professional status or power? Are patients or the mental health profession itself harmed by this practice?

And finally, can the same results be achieved in other ways, without fueling this ethical controversy?

This is a difficult area, and thoughtful people can and do disagree. It is worth remembering that political positions are often strongly held, and those with contrary views often sound unreasonable or even “crazy.” The public has long used the language of craziness and foolishness to describe disliked political figures and viewpoints. If mental health experts use similar language in public, they should be clear about whether these opinions should be treated the same, i.e., as belonging simply to an individual. Conversely, if the voice of authority is claimed—and particularly if one claims to speak “for the profession”—the basis of that authority should be made clear. Merely being a psychiatrist or psychologist is insufficient when many colleagues hold the opposite view.

Your Doctor Needs to Know Continued from Page 1

The answers to Mr. Strong's questions may lie in how physicians' unique personality characteristics—specifically their intolerance for ambiguity and their affinity for risk taking—affect how they treat patients and practice medicine. Everyone has, to a greater or lesser degree, personality traits such as intolerance for ambiguity. However, high degrees of particular personality traits seem to significantly affect an individual's career choice.

The role of uncertainty in the culture of medicine has been discussed for years. Since the 1950s, researchers have tried to link variables, such as physician subspecialty, to individual personality traits. A few more recent efforts have been made to illustrate a connection between individuals who choose to become physicians and their inability to tolerate what is unknown or uncertain. We define intolerance for ambiguity as “perceiving situations that are complex or insoluble as threatening situations.”

The ability to tolerate ambiguity is spread unevenly throughout the medical profession and can vary greatly by specialty. For example, one study found that tolerance for ambiguity was much higher among future psychiatrists than future surgeons. It also found no change in students' *intolerance for ambiguity* throughout their educations, but did find that female students and students who were older when they first began medical school had a higher tolerance for clinical and situational ambiguity than their peers. Later studies have repeated these results and found surgeons to be particularly less tolerant of uncertainty than other types of physicians (usually family physicians or general practitioners).

Intolerance for ambiguity may be so ingrained in students' personalities that self-selection for medical sub-specialty begins long before the MCAT. It appears that by their undergraduate years, students have already drifted into definitive groups within the

spectrum of ambiguity intolerance. A recent study found that students who choose majors in the social sciences, arts, and architecture reported higher “cognitive risk tolerance” than students who majored in the health sciences or engineering. Risk tolerance examines the willingness to take calculated risks, and the propensity to take and tolerate risks is positively related to tolerance for ambiguity.

It may well be that the American healthcare system self-selects for physicians with low tolerance for risk and ambiguity. Beginning in undergraduate education, pre-medical and “hard” science training does not allow for “maybes.” There is early exposure to, and rigorous repetition of, the tenets of the scientific method: the only knowable truth lies in the results of repeated experimentation coupled with observation of quantifiable data. Like accountants, who also show a high level of intolerance for ambiguity, accuracy and precision are paramount. For years, students who succeed at this have been the ones selected for medical school. These absolute-centric patterns of thinking and reasoning are reinforced by what has been called the “hidden curriculum” of medical training, as young physicians face the clinical realities of medical practice guided by teachers who share the same biases. The most successful often go on to become teachers themselves and perpetuate the standards.

Patients, too, have learned to expect answers in black and white from their physicians. For most patients, there is comfort in “knowing” but their expectations can reinforce the cycle of intolerance for ambiguity by holding their medical professionals to an impossible standard of absolute certainty.

So now let us turn back to Mr. Strong. His doctors had definitively excluded the diagnoses they were most concerned about: a stroke or intracranial bleed. Clearly, there was no brain tumor. The diagnosis under consideration, migraine headache, has no definitive test for confirmation. In such situations, doctors resort to what is called the “rule-out.” The idea is that if you cannot prove what is, you can at least show what is not. For Mr. Strong, the brain scan did not rule out all possible causes of his headache, and the spinal tap was proposed to investigate

the more obscure and unlikely diagnoses. How far doctors pursue increasingly remote possibilities depends on their ability to be comfortable with—or tolerant of—the remaining uncertainty in any clinical situation.

Of course, individual physicians will differ. In a recent study, researchers found that with respect to healthcare costs, such spending varies more across individual physicians than it does across hospitals. Another study examining regional variations in healthcare spending grouped physicians into “cowboys” and “comforters” based on their inclination to recommend treatments that are either more aggressive or invasive than those recommended by guidelines or treatment schemes that are lower in cost. These studies seem to support our idea that some physicians are naturally inclined to test and spend more in response to their personal intolerance for ambiguity.

What should we expect? The American healthcare system selects physicians based on their detailed knowledge and ability to perform to exacting standards. When people who are naturally intolerant of ambiguity are confronted with ambiguous information, their instincts are to seek additional information to clarify the situation. Individuals’ intolerance for ambiguity is a factor in test-ordering behavior, a tendency that is nearly always costly but may not always be necessary. Mr. Strong’s doctors, like most of their colleagues, were not comfortable enough with the 3 percent probability to let it go unexplored, despite an asymptomatic patient with a history compatible with migraine.

This “personality trait” that doctors share has significant implications for efforts to control healthcare costs. Currently, we have placed the cost/benefit analysis for medical diagnosis and treatment predominantly in the hands of the physician. Who better to know the individual needs of the patient and the specific potential benefits? But physicians need to learn to balance their “need to know” with the relative benefits their diagnostic workups will provide. Otherwise the healthcare system, as the American people desire it to be, will not be sustainable. Navigating the fine line between “careful” and “compulsive” is one of the arts of medicine that warrants continued attention.

Spotlight: Bioethics Education

DISPATCHES FROM PARIS

The fourth *Neuroethics Network*, coordinated by the Program in Medicine and Human Values (PMHV) and hosted by ICM (*Institut du Cerveau et de la Moelle Épinière*), was held in Paris, June 19-21, on the campus of the historic Hôpital de la Pitié-Salpêtrière. The purpose of these annual meetings is to bring together neuroscientists and ethicists to discuss issues emerging from advancing technologies.

This year's meeting included sessions on charting unknown territory in brain mapping, dealing with the puzzle of consciousness. The topic of Alzheimer's disease was addressed by Dr. Catherine Madison, director of the Dolby Brain Health Center, who presented the paper "Assisting Physicians to Recognize Subclinical Impairment." Sutter Health was also represented by "The Clinical Neuroethics Initiative" poster, submitted by Drs. Guillermo A. Palchik, Thomasine K. Kushner and Alan H. Yee.

While visiting one of the leading neurological research institutes in Europe, Neuroethics Network participants were invited to visit a lab and observe a procedure described as "thought scribing," where a subject would "type" words using just his thoughts.

Plans are already underway for next year's Neuroethics Network conference, scheduled for June 20-22, 2018, at ICM. For more information, contact Gil Palchik (palchiga@sutterhealth.org).

The International Bioethics Retreat, June 26-28, was held at Reid Hall, Columbia University's Global Centers – Europe. Bioethicists from around the world gathered in Paris to share their works in progress and receive feedback on their research. PMHV's Program Director, Dr. William Andereck, chaired the session on "Looking Ahead in Bioethics," while Senior Bioethicist, Dr. Ruchika Mishra, presented her work on "Implementing the California End of Life Option Act in a Community Hospital" as part of a panel discussion on "Aid In Dying."

The seventh *Cambridge Consortium for Bioethics Education*, July 3-5, brought together leaders in bioethics

education to share pedagogical tools and methodologies to teach ethics to medical students, residents, and other healthcare providers. Dr. Andereck discussed the role of ambiguity and physicians' tolerance for uncertainty in his presentation. Dr. Mishra revealed the innovative web series launched by PMHV, "What To Do When," to teach ethics in a community hospital.

COMMUNICATING IN ETHICALLY CHALLENGING SITUATIONS – (SUMMER WORKSHOP 2017)

PMHV held its 12th annual Summer Workshop on Saturday, June 10, which was attended by over 65 Ethics Committee members and other healthcare professionals from various disciplines. Participants included bioethicists, physicians, nurses, legal counsel, risk managers, chaplains, social workers, administrators, ethics committee members, patient advocates, attorneys and others. These attendees represented Sutter Health, Dignity Health and Kaiser Permanente, to name just a few.

This year's workshop "Say It Right the First Time: A Blueprint for Communication in Ethically Challenging Situations" focused on communication skills in clinical care. The morning discussion was led by Dr. Lael Duncan who addressed skills required for conducting effective goals-of-care conversations with patients from diverse backgrounds. CPMC Ethics Committee member Rev. Julie Hanada highlighted a patient-centered approach to cultural competence helped providers understand how culture impacts a patient's ability to communicate about their illness and care options. The afternoon session, led by PMHV staff, Drs. Mishra, Shashidhara, Palchik and Ms. Tyler, focused on practical skills in clinical communication and provided strategies for improved communication in the clinical setting. The information was well-received by attendees who stated the workshop "provided excellent, real-world communication tips," "will help me communicate more intentionally in difficult situations in my work," "will impact my work directly" and helped them feel "more equipped now" to handle complex clinical patient situations.

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