HCB 521 Clinical Ethics Practicum

Instructors: Stephen G. Post, Michael Roess, Kelly McGovern, Linda Bily, Robyn McKeefrey
Semester: Fall 2016
Schedule: Thursday, 6-9:00 pm
Room 066, Preventive Medicine 3rd Floor

While a theoretical understanding of ethical issues is essential, the details of actual clinical practice are often more complex than the abstracted principles would have one believe. This course will serve as an introduction into the practice of clinical ethics as it occurs ‘on the ground.’ Time constraints, heightened emotions, different backgrounds, communication barriers, and a host of other issues make clinical ethics a matter of getting to “good” outcomes rather than “the right” outcome.

After a three week introduction to the healthcare setting and clinical case analysis, the course will be composed of five two-week segments focusing on a particular clinical area and a particular clinical skill. Each segment will begin with several article introducing the domain and its ethically relevant features to students. The second week of each segment will involve case analysis with a guest clinician who works in the field.

Grading

For each of the five segments students will be asked to turn in a 3-page case report. Case reports will be due to the instructor in charge of the segment prior to the second meeting. Each case report will be worth 15% of the total grade.

Students will also turn in a 7 page research paper on any topic covered in the course at the end, which will account for the remaining 25% of their grade.

Readings
All readings will be made available to students electronically. Segment will typically involve 3-5 articles and 2-3 cases to analyze.

Schedule

Weeks 1-3 9/1; 9/8; 9/15
Introduction to Clinical Ethics Consultation
Kelly McGovern, Stephen Post, Michael Roess

In the opening sessions of the course we will provide an introduction to clinical ethical reasoning (touching on the principles, casuistry, and the difference between ‘good outcomes’ and ‘principled purity’), an introduction to the clinical facility and all of the moving parts, and an introduction to clinical case write-ups.
Weeks 4-5 9/22; 9/29  
Section 1: Transplantation  
Michael Roess & Brian Papszycki  

In this segment we will discuss the manner in which donation occurs, including the separation between the procurement team and the treating team, the dead donor rule, how the family is approached, and frequently encountered situations including divided families, differences between donor and family wishes.

Weeks 5-6 10/6; 10/13  
Section 2: PEGs  
Stephen Post & Maria Basile  

One of the complications of later-stage Alzheimer's Disease (AD) and other advanced dementias is the difficulty associated with adequate feeding and nutrition. Early in the course of the disease, this may manifest simply as irregular feeding patterns. As neurologic function becomes increasingly compromised, patients eventually suffer a lack of control over swallowing both solids and liquids. Family and friends are often faced with the unfortunate reality of watching a loved one suffer not only the drawn-out cognitive decline associated with these diseases, but also a terminal stage whereby achieving basic nutrition and hydration becomes an everyday challenge. Through the 1980's and mid-1990's, application of the PEG (percutaneous endoscopic gastrostomy) tube (invented in 1979) procedure toward patients with advanced dementia became commonplace, and replaced the older practice of assisted oral feeding. The relatively simple procedure, which passes a feeding tube directly through the nearby skin and then directly into the stomach itself, was thought to present a humane method for keeping these patients adequately fed and hydrated by bypassing the compromised swallowing mechanism. It was also hoped that PEG tube placement would reduce associated complications such as bed sores from malnutrition and aspiration pneumonia from poor swallowing. However, by 2000 a number of key articles were published seriously questioning the value and the ethics of PEG use in individuals with end-stage AD. Since then debate has raged over the PEG and its uses among deeply forgetful people.

Our first session will focus on the clinical ethical literature around this topic, which we will discuss in detail. Our second session will examine a number of clinical cases where PEG use is considered. We will be assigning a set of 8 articles (in italics in the readings section below) in pdf form from the following larger list, which we supply for you in the event that you decide to explore the topic further (below).

Weeks 7-8 10/20; 10/27  
Section 3: Extubation  
Kelly McGovern, Carolyn Santora, Nancy Wichtendahl
In this segment we will discuss withdrawal of mechanical ventilation from patients who are not expected to sustain independent respirations without it. We will discuss withdrawal of life sustaining treatment and the ethical issues surrounding it, including ethical justification, legal issues, conflicts which may arise between medical teams and families.

**Weeks 9-10 11/3; 11/10**  
**Section 4: Oncology**  
**Linda Bily & Darlene Kenny**

In these sessions, we will examine the ramifications of ethics in the clinical setting. Our readings and discussions will realistically demonstrate the interrelationship between compassionate care, empathy, professional obligations, and the ethical struggles encountered while addressing the desires of patients, families and the requirements of the hospital and government regulations.

**Weeks 11-12 11/17; 12/1**  
**Section 5: Reproductive Ethics**  
**Robyn McKeefrey & Richard Bronson**

Reproductive ethics assures that the basic rights of all people to decide freely concerning whether or not to reproduce is independent of discrimination, coercion or violence. In making those choices, the framework of human rights and basic medical ethics principles of autonomy, self-determination, justice, liberty, individual freedom and equitable access to services all apply. In this section we will explore within the field of reproductive ethics the topics of forced cesarean section and assisted reproductive technology with applicable case studies sure to result in an interesting paradigm of discussion.

**Week 13 12/8**  
**Section 6: Provider Wellbeing, how staff cope with patients making the “wrong” choice**  
**Michael Roess, Stephen Post, Linda Bily.**

Bad outcomes happen to the patients of even the most careful and prepared clinicians. Without proper attention to self-care, these outcomes can have initiate a negative feedback loop that leads to clinician burnout. In this section we will discuss techniques employed by flourishing clinicians to cope with the difficulties of working in an imperfect healthcare environment and bad outcomes.

**Readings**

**Pegs**

**Background**


From Official Stony Brook University Policy: Statements required to appear in all syllabi on the Stony Brook campus: Americans with Disabilities Act: If you have a physical, psychological, medical or learning disability that may impact your course work, please contact Disability Support Services, ECC (Educational Communications Center) Building, room 128, (631) 632-6748. They will determine with you what accommodations, if any, are necessary and appropriate. All information and documentation is confidential. Academic Integrity: Each student must pursue his or her academic goals honestly and be personally accountable for all submitted work. Representing another person's work as your own is always wrong. Faculty are required to report and suspected instances of academic dishonesty to the Academic Judiciary. Faculty in the Health Sciences Center (Schools of Health Technology & Management, Nursing, Social Welfare, Dental Medicine) and School of Medicine are required to follow their school-specific procedures. For more comprehensive information on academic integrity, including categories of academic dishonesty, please refer to the academic judiciary website at http://www.stonybrook.edu/uaa/academicjudiciary/ Critical Incident Management: Stony Brook University expects students to respect the rights, privileges, and property of other people. Faculty are required to report to the Office of Judicial Affairs any disruptive behavior that interrupts their ability to teach, compromises the safety of the learning environment, or inhibits students’ ability to learn. Faculty in the HSC Schools and School of Medicine are required to follow their school-specific procedures