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A Seminar With Medical Students

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For eight years a seminar has been conducted with medical students at the University of Pittsburgh School of Medicine during their third year clerkship in Anesthesiology. The groups were limited to eight students and the moderator. Although initially, the seminar stressed medical aspects of hopeless and dying patients, a void was present in the discussions. Consequently, the stress now is placed almost entirely on the moral, philosophical and religious considerations of these patients. This subject is not discussed in any other area of the student's training during the four years in Medical School. To the students who do not possess any specific religious beliefs, much of the information presented and discussed was not always acceptable to them.

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On the part of the faculty there seems to be a tendency to relegate moral and religious attitudes of patients to a lesser importance than medical considerations. Particularly in the setting of a teaching hospital, trainees frequently are unaware of the spiritual and emotional needs of critically ill patients. By contrast, the medical literature contains numberous articles alluding to these emotional needs. For example, some titles of recent articles are: "Let 'Hopeless Cases' Die, MD's Say"; "If A Man Die, Shall He Live Again?"; "Let's Retain the Dignity of Dying"; "A Person's Right to Die"; "Medical Students Puzzle Over Ethics".

Today, moral issues are the subject of considerable controversy (e.g. the abortion problem). Consequently, it is important that we inculcate into our medical students sound moral principles which will guide them in the future. This paper presents a synopsis of the subject matter discussed at our seminars and analyzes the reactions and contributions of the students.

The seminar was opened by discussing specific examples of patients with whom the author was personally familiar. The students' attention was focused on real-life situations, rather than generalities. The group then defined Death and Life. Generally, the students recognized that extensive, irreversible brain damage was a good criterion of death. However, the definition of Life was more difficult. Frequently, they were evasive and were preoccupied with a definition of biological life, or the "antitheses of death", without considering the essential human attributes of life. With assistance and prodding some students could identify such attributes as rationality, creativity, interpersonal communication and the ability to love and be loved.

Much controversy was generated during the discussion of euthanasia. Opinion was divided sharply as to whether a difference existed between positive (directly intending death) and negative (unintentional death resulting from a treatment) euthanasia. Most students believed that either the omission or removal of efforts, which might prolong a dying patient's life (e.g. discontinuing long-term artificial respiration), were equally wrong and a form of positive euthanasia. They agreed that giving large doses of analgesics for patients dying of carcinoma was humane (negative euthanasia).

The concepts of ordinary and extraordinary means of preserving life were presented as guidelines. Although most students agreed that the physician was not obligated to institute extraordinary means, they found it difficult to differentiate between them. The extraordinary means of today are often the ordinary ones of tomorrow. Possibly their (nions were influenced by the experie e at a major teaching center where t latest advances in medicine, regar ss of efficacy, are often used the treatment of patients.

Specific reasons for prolon g the life of a hopeless or dying pati were considered in detail. A conse is felt that a patient's life should pro- longed artificially for religious asons, to settle important legal and ancial matters, to visit with rela es or friends, or to participate in pecial event (graduation of a d hter). Opinion was divided over pro ging a patient's life for the advanc nt of science, especially without ormed consent.

Probably because of seeing atients in an intensive care envi ment, students often did not appre te the importance of dying with gnity. They did not realize that many instances it might be kind for a patient to die at home a ng his friends and loved ones, rathe han in the invironment of a hosp l. The spiritual concent of a "heav was a controversial subject. Most udents felt that all men wanted to li as long as possible, irregardless of the quality of life". This feeling was evalent amoung Jewish students, wh have no concrete beliefs concerning h aven. A minority appreciated that a patient might look forward to death as a reward for living a good life, or to take him out of misery.

Other frequently discussed topics were: a) "playing God", b) value judgements, and c) making decisions. Many students stated that a physician who chose not to institute a particular treatment, or to withdraw one which had been started previously, was "playing God", They would not accept an explanation that the natural course of events (God's will) was taking the life of the patient. The morality of making value judgements was discussed intensely. For example, how does one decide which of two patients should receive a kidney transplant, if only one is available? Many students tried to abrogate their responsibility for making decisions concerning medical treatment. They felt that the patient should be required to make these decisions after being presented all the facts. It was stressed that physicians should influence decisions by presenting facts in that they are in the best interests of the patient.

Frequently, students were puzzled over several ethical matters. What does one do if a patient asks to die? When and how does one tell a patient bad news concerning death or malignancy? When should one tell a patient with cancer the facts and how much should be told? Do moral and religious attitudes influence the recovery of patients? Students without religious values felt that consideration of such attitudes was inconsequential. Therefore, it was emphasized that regardless of the physician's own beliefs, he should not impose them on his patients. Only a few students agreed that a clergyman could play an important supportive role in managing critically ill patients.

Without exception, students were concerned about making the right decisions in the interests of their patient. They were told always to follow their conscience in making a decision. And because a conscience can be erroneous, they should become as informed as possible about moral and medical facts.

Much of the seminar was devoted to the topic of love and its real meaning. Although many were married, few students has thought about the true meaning of love, and how to apply it in their professional lives. It was stressed that if physicians would *love* their patients (ie., always be concerned about their health and happiness), it would be very difficult to make a wrong decision.

SUMMARY

For a complete education, medical students must be introduced not only to the medical and scientific aspects of the disease process, but also the the moral, philosophical and religious aspects. Discussions with over 800 students during this eight-year period have been beneficial to both the students and the author. Although the seminars are usually intense and controversial, the students are now reflecting on some of these matters in their daily associations with patients.

Students come from varied cultural and religious backgrounds, and their moral and philosophical attitudes are often confused or lacking. As physicians and educators, who are also Christians, we have a definite obligation to communicate to these students during their formative years the importance of morality, impathy, and love in the care of patients. If we succeed on our task, patient care and the image of the medical profession will inevitable improve.