FASPE

FELLOWSHIPS AT AUSCHWITZ FOR THE STUDY OF PROFESSIONAL ETHICS

2016 JOURNAL

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INTRODUCTION & OVERVIEW

Welcome to the 2016 FASPE Journal

BY DAVID GOLDMAN

CHAIRMAN, FASPE

The world has survived 2016. Yes, we live in interesting and challenging times. Artificial Intelligence, post-facts (the Oxford English Dictionary's word of the year!), questions about freedoms of press and religion. FASPE's mission, with its focus on ethical behavior, becomes ever more important.

You will see in the following pages a representative sample of work produced by the 2016 Fellows during the course of their fellowships. The FASPE fellowships, and the connections that the Fellows make with each other and with FASPE, do not end with the Fellows' return to their schools and to their places of work. In recognition of this continuity, we have also included in the Journal pieces written by two of our more distant alumni.

FASPE challenges its fellows and alumni to reflect and to think — about themselves, about their professions, about their responsibilities as leaders. The one common thematic thread shared by all of the papers published here is that they confront *ethical* issues within the professions.

Ethical challenges are not linear, they are not predictable and they are not fundamentally political. Issues can arise in an operating room, in a C-Suite, in a partner's office in a law firm, in the mind of a blogger or in a clergyperson's office. They can also arise because of the actions of a legislature, decisions made in a courthouse or as a result of the policy proposals of a mayor, governor, president or prime minister.

Our fellows and alumni are tasked with identifying ethical failures and ethical risks within the professions, however and wherever they may arise. We also seek to offer tactical suggestions as to how to act after having identified an issue. For instance, we have a session in the Law program on how to handle a situation in which a senior partner asks a young associate to act in a manner that appears inappropriate (the answer is *not* to lecture the senior partner). Moreover, FASPE intends to speak out on these matters where they have broader implications.

The issues that we face today are, of course, different from those that existed in Germany during the Nazi era. However, the influence, and therefore the responsibilities, of professionals are no less impactful.

We hope that the following pages pique your interest and demonstrate the ethical foundations that FASPE Fellows are building. On behalf of FASPE, I congratulate the 2016 class of FASPE Fellows. We look forward to their leadership in their communities — small and large.

FASPE Overview

FASPE operates fellowship programs for graduate students in professional schools — business, journalism, law, medical, and seminary — and early stage practitioners in those professions. The fellowships are comprised of intense two-week study trips in Germany and Poland where fellows study the actions and choices of their professional counterparts in Germany between 1933 and 1945.

Through this examination of the ethical failures of the professions in what was a progressive, modern society, fellows learn about the critical role that professionals play in society and the consequences of their actions — positive or negative — on the world around them. FASPE challenges its fellows to become acutely aware of their responsibilities as respected professionals in their communities and to act in an ethical fashion.

FASPE offers a contemporary approach to the study of the Holocaust by focusing on the actions of perpetrators rather than on victims. Drawing on the powers of place, the study of history, and a rich contextual education, FASPE creates a uniquely effective means for studying professional ethics — well beyond what is achieved by the rules-based approach often seen in the traditional university classroom.

Originally piloted in 2009 and launched in 2010, FASPE marked its seventh year of operation in 2016 and now has nearly 400 alumni. As a highly competitive program, FASPE accepts only 65 fellows (12 - 14 in each of the five professions) from nearly 1,000 applications per year. Its faculty is drawn from international Holocaust historians, practicing professionals, and leading academics. Fellowships are granted to students and recent graduates from professional schools throughout the United States and internationally.

FASPE seminars engage fellows in thinking across several themes that span the five disciplines, including: defining professionalism; considering a professional's responsibility to the larger society; and the tactics of enacting an ethical decision. Seminars also focus on topics that are discipline specific, such as:

- **Business:** Are there products that simply should not be sold to particular consumers? What are the responsibilities of the C-Suite, or of the corporation, beyond formalistic legal compliance? What are appropriate penalties for corporate wrongdoing?

- **Journalism:** How do journalists balance the costs and benefits of access? What ethical issues arise in political reporting? What challenges arise in fact-checking a victim's story? Does advocacy fit into journalism?

- **Law:** How do attorneys manage duties of candor and confidentiality? What control do lawyers have over decisions that impact a client? Does the duty to a client supersede all other responsibilities?

- **Medical:** What are the ethical issues involved in medical research on human subjects? Should physicians participate in assisted suicide? How should doctors deal with resource limitations in making healthcare decisions?

- **Seminary:** What is the role of religious leaders as ethical, and not just religious, educators? When and how should they address political issues with a congregation? What are the challenges of pastoral care during times of crisis?

FASPE has far-reaching goals. On an individual basis, it seeks to instill participants with a sense of personal responsibility for the ethical and moral choices they make. By extension, it also seeks to have an impact on these professions, improving the practices of all business executives, clergy, doctors, journalists, and lawyers.

MEDICAL PAPERS

Introduction to Selected Medical Papers

BY THORIN TRITTER

EXECUTIVE DIRECTOR, FASPE

FASPE's 2016 Medical program was co-led by Dr. Sara Goldkind, formerly the Senior Bioethicist at the Food and Drug Administration, and Dr. Jeffrey Botkin, a Professor of Pediatrics and the Chief of the Division of Medical Ethics and Humanities in the Department of Internal Medicine at the University of Utah School of Medicine. Under their leadership, a group of 14 strikingly intelligent and caring medical students from 13 different schools engaged in a series of discussions and debates about specific ethical challenges faced by individual physicians and the broader ethical dilemmas confronting the medical profession overall.

The starting point for these discussions was the frightening fact that Nazi physicians were neither evil monsters nor a crazed minority, but had been trained in a system with established ethical guidelines that marked German medicine as a leader of the civilized world. If the Nazi physicians could lose their professional moorings, how can physicians today avoid the same risk? This question was at the heart of many of the FASPE Medical discussions.

The selected essays that follow explore some of the questions raised during the trip in greater detail and from contemporary perspectives. They also represent the high caliber of students who are attracted to the experiential learning that FASPE Medical offers.

The first essay is by Jason Han, who noted the apparent ease with which Germans embraced the dehumanization policies of the Nazis, leading him to consider the potentials for dehumanization in the operating room where he is training. With this as his starting point, Han goes on to consider the dangers inherent in the tendency to focus on technical mastery in modern medicine, where surgeons run the risk of thinking solely about how they operate rather than why they are operating or who they are operating on.

The second essay is written by Priscilla Wang, who also draws from her medical training, but focuses on the duty-hour policy in medical schools. While making clear she has no desire to equate the two, Wang argues that there are concerning similarities between the enabling beliefs of the medical profession in Nazi Germany and the assertions and rationales used by the modern-day American medical profession to justify the treatment of medical trainees.

Finally, Ben Yu writes about a particular case that made him question a physician's ability to assess the quality of life for some patients contemplating suicide. For a patient who is

suffering from such a constant level of pain that he can only see relief through death, should a physician's sole goal be to save life? Yu points out the lack of objective data when it comes to many psychiatric ailments and questions whether these psychiatric patients should be treated in the same manner as other patients who can take medication to relieve their pain.

On behalf of FASPE, I am grateful for having had the privilege to interact with such an inquisitive, energetic, and deep-thinking group of medical students; and thank the faculty for having enriched this journey for us all.

A Procedure Resides in Its Ethics
Behavior in the Operating Room

BY JASON HAN

UNIVERSITY OF PENNSYLVANIA PERELMAN SCHOOL OF MEDICINE, CLASS OF 2017

The field of surgery is rich with bioethical considerations because surgery is a universally dramatic and intrusive experience. Even the most thick-skinned person is rendered vulnerable as everything from personal belongings to consciousness is stripped away on the way to the operating table. In the ensuing hours, while the patient is under anesthesia, there is the potential for both miracles and tragedies. The diseased tissue is carefully resected, after which sutures are sewn to bring the bleeding edges of the healthy tissue back together, and this cycle of destruction and reconstruction repeats itself until finally the blade is removed, the skin is sealed, and the patient awakens into a body that has been irreversibly altered, for better or worse. It literally is a life-altering experience.

In this light, the operating room (OR) is far from sterile and has a tremendous potential to become the frontier for novel and creative ethical developments — as well as the scene of ethical failings. Aware of the ethical dangers, the American College of Surgeons issued its *Statement of Principles Underlying Perioperative Responsibility* in 1996 and issued an updated version in 2016. This document outlines topics such as informed consent, disclosure of therapeutic options and errors, conflicts of interest, and follow-up care.[1] While the document also explicitly states, "Be sensitive and respectful of patients, understanding their vulnerability during the *perioperative* period," there is a paucity of other literature that deals with matters taking place *inside* the OR. Partly this is due to the macabre subject matter. Although people readily discuss clinical issues, such as informed consent and admitting error, they are generally more squeamish about discussing surgical concepts. The public perception of the OR is also limited and skewed by the media — the surgeon with his (or her) imperturbable gaze, constantly performing heroic, brilliant maneuvers as blood pools from invisible or unreachable sources. This simplified portrayal often stands in the way of understanding just how behaviorally complex and dynamic the OR can be.

[1] American College of Surgeons, "Statement on Principles Underlying Perioperative Responsibility," *Bulletin of the American College of Surgeons* 81 (1996): 39-40.

Moreover, the OR is an autonomous and private space. It requires strict access privileges to enter. The only non-staff person in the room, the patient, is under anesthesia for the most part. No photo, video, or narration of the case is allowed to leave the room to protect the patient's rights to health privacy. And even if these were to be released, the layperson lacks the specialized knowledge to understand them. Lastly, and perhaps most important, the rituals and routines of surgery are often taught and accepted at face value without scrutiny or reformulation. Even some of the more invasive or distasteful aspects of surgery may be justified as being necessary for success.

Why do we need a strong perioperative code-of-ethics? Of course, as with any field in medicine, it is in the interest of improving patient care. But what is unique about surgery is that it is procedure-driven, and no procedure is inherently ethical or unethical. Rather, the true value of a procedure relies entirely on what meaning or purpose caregivers ascribe to it. It can be elevated into a healing art, or transformed into a tool of humiliation or harm. One need not look far back in history to find examples. In the weeks prior to starting my rotations in cardiac surgery as a fourth year medical student, I had stood at the entrance of the Auschwitz memorial retracing the steps of the Nazi apparatus as a Fellow with the Fellowship at Auschwitz for the Study of Professional Ethics. We learned about the mechanism and autonomy of Auschwitz, shielded from outside interference. We walked along the train tracks where over a million Jews, Sinti, homosexuals, the handicapped, and prisoners of war had arrived. Here, they were subjected to countless dehumanizing procedures, some of which originated outside the camps for use in medical treatments, but used by the Nazis as a tool for genocide.

Of course there are significant differences between the actions in Auschwitz and those that take place in an operating room. I do not mean to suggest an equivalency between the two. Most clearly, the goal of surgery is to cure, not kill. Still, the historical example of the Holocaust spurs us to think about how procedures without an ethical framework are capable of harm just as much as good. Modern surgery relies on the ethical ideal that surgeons "do no harm," but that is a slim reed to rely on. Using this historical example, this paper aims to describe how procedures that are not guided by an ethical framework are capable of harm just as much as good, and offers perioperative considerations that ought to supplement the ACS *Statement of Principles* in surgery. Specifically, it addresses three fundamental components of modern surgery that have the potential to cause unintended harm: 1) the sterile positioning and preparation methods; 2) the development of and reliance on muscle memory; and 3) the use of anesthesia during procedures.

Preparation and Positioning

Most people believe that an operation begins at first incision. For the surgeon, this may be true. For the patient, however, the automatic and unvaried sequence of events that comprise the operation begins immediately after entering the OR. The patient is first

asked to identify himself and the operation that he will be having. Then he is asked to lie down on the operating table, which marks his final conscious act before being anesthetized, paralyzed, and intubated. Even after having observed this process numerous times, I am still struck by the diverging interpretations of these events by the patient and the OR staff. The patient always perceives this experience as special or unique, because for the patient it is. But for the OR staff, it is as routine as sitting down at a desk and turning on the computer screen first thing in the morning.

As a medical student on my cardiac surgery rotation, I began my tasks as soon as the patient was anesthetized. I removed the blankets and the hospital gown from the patient's body. I peeled off the socks. I placed and secured a Foley tube catheter in the urethra to drain the bladder. Then, I used an electric razor to shave the chest, armpits, groins, and legs, occasionally stopping to lift up the clumps of free hair with a thick roll of silk tape. Once this was done, I scrubbed the body with sponges soaked in cold, soapy water. I dried off the patient with sterile towels and then placed sterile drapes across him or her from head to toe. At this point, the surgeon would step in to feel for the relevant bony anatomical landmarks and use a marker to outline the points of incision. The process of transforming an awake and talking patient into a ventilator-dependent, sterile body with ink markings on it, takes about an hour, on average. All of this happens prior to first incision. For most of that hour, the patient is unconscious and uncovered.

In the OR, the sterile field is sacred. The acts of removing clothes, shaving, scrubbing, and draping the patient are contextualized in an ethical, life-saving purpose. In surgery these are necessary steps to prevent infection, but the actions are not always benign and this noble context is not something that we can take for granted. Similar acts, although with a completely different purpose, were used as a series of initiatory humiliations for newly arrived prisoners at Auschwitz and other concentration camps by the *Schutzstaffel* (SS), the Nazi paramilitary staff. In their scheme, the act of cleansing the prisoners' bodies connoted a much darker concept. One of the victims, Marianne F., described the experience of undressing completely in front of the SS prior to entering the shower or "sauna," having all of her bodily hair shaved, and lastly being tattooed with a number.[2] Everyone underwent the same process regardless of their age, sex or degree of modesty, rendered equal in the process of becoming nothing. In his book, *Auschwitz: A Doctor's Eyewitness Account,* Miklos Nyiszli, a prisoner at Auschwitz and himself a doctor who was eventually forced to work with the infamous Dr. Josef Mengele, recalls entering a room labeled, "Baths & Disinfection" where he was undressed, washed, rubbed with noxious chemicals, and tattooed. In a moment of solemn awareness, he writes that "Dr. Miklos Nyiszli had ceased to exist, [and had now become] merely KZ prisoner Number A 8450."[3]

[2] Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 2000), 165.
[3] Miklos Nyiszli, *Auschwitz: A Doctor's Eyewitness Account* (New York: Arcade Publishing, 2011), 23.

This history reminds us that the acts of removing clothing, hair, washing, and labeling the human body cannot only sterilize, but dehumanize. In surgery most of these steps cannot be modified, as they are necessary to prevent infection. However, by consciously acknowledging the patient's perspective — a deeply vulnerable experience — surgeons and other OR staff can preserve their patients' dignity and modesty. Empathy can elevate these acts to a narrative of healing.

"Muscle memory"

By the second week of my cardiac surgery rotation, certain tasks had become a part of my muscle memory. Movements that were once slow and purposeful became efficient and swift, which one could argue is the general aim of surgical education. But there was also an unintended side-effect: the more I performed my tasks from muscle memory, the less mindful I became of the bigger picture, which in this case, was the patient's story. I found myself performing certain tasks without being mindful of why I was doing them or what purpose they served in the scope of the operation, as a whole. On some days, I simply walked into the OR when it was time for me to do my part and, like a technician, left once I had completed my tasks. I shaved and washed bodies without knowing the patients' names. Through these encounters, I grew increasingly competent and confident in the skills I was performing, but I could not have explained why an operation was necessary for a particular patient, or who the patient was, because I had never met him or her. A procedure had become just the carrying out of a mechanical process.

Admittedly, it is in the best interests of patients that surgeons hone their technical skills. At times, the surgeon's performance in a challenging operation may depend on his or her ability to quiet his or her own emotional, ethical, or other considerations. However, there is a critical distinction between consciously utilizing muscle memories to serve well-thought-out purposes and mindlessly applying them to any setting. The former is an important attribute of any skilled surgeon. The latter can mark a dangerous slippery slope where physicians devolve into technicians and do not consider the ethical implications of their work.

Auschwitz offers one of the more extreme examples. Many physicians who worked there developed a tendency to compulsively focus on individual topics or problem-solve *technical* aspects ("*das rein Fachliche"* or the "the purely technical"), helping them to avoid thinking about the morality of their actions. As the psychiatrist and medical historian Robert Lifton has written, technically talented people who "… believed themselves to be experts … pressed forward and engaged themselves …" with the technical aspects of how to best run the crematoria.[4] They began to question how the gas chambers could accommodate more bodies or kill them at a faster rate. One doctor wanted to figure

[4] Lifton, 178.

out how to effectively ignite piles of corpses and remarked, "You can imagine — naked — nothing burns. How does one manage to [burn] this?"[5] It seems absurd to ponder the best way to burn dead bodies instead of asking why those bodies had to die, but this is part of how these physicians coped with the overwhelming guilt and psychological torment of participating in such heinous crimes. They evaded the moral and ethical considerations by treating them as purely technical and pragmatic concerns.

A similar phenomenon occurred among Nazi doctors who were hungry for surgical experiences. In the name of mastering technical skills, they operated on prisoners suffering from their conditions of interest. Ethics aside, they felt that they had found an ideal surgical laboratory, not realizing that this was a Faustian bargain that marked their regression into automatons, ready to apply their skills to any operation regardless of its morality.

While certainly in no way equivalent to the conditions under which surgeons normally find themselves, the tendency to focus on technique alone adopted as a coping mechanism by physician prisoners in the camps forced to participate in killing their fellow inmates, can nevertheless serve as a cautionary tale.

It is a common tendency in modern surgery to focus too much on the technical aspects. Some degree of it may be inevitable for doctors in training in order that they master certain skills. But doing so can also lead to a lack of ethical awareness, which only comes into view when the surgeon or surgeon-in-training bears in mind the larger context of what he or she is involved in. Without awareness of the purpose and goals of a procedure, one cannot ascertain if a procedure is being used to heal or to harm. One runs the risk of merely being a technician on automatic pilot. As physicians we hold the responsibility of safeguarding our patients' and communities' well-being. A part of that responsibility is to always ensure a meaningful application of our skills.

Anesthesia

Patients whom I cared for in the OR were usually deeply under anesthesia. I found this surprisingly comforting. Not only did it mitigate the fear of causing pain during procedures, but it also shielded me from the unnerving prospect of making a mistake that, in the case of awake patients, would lead to increased suffering for them and shame for me. It also liberated the medical staff to discuss topics, even humorous or inappropriate ones, which were unrelated to the operation, instead of worrying about how our talk would be received by the patient. In other words, we were able to act as if the patient were not there at all.

[5] Lifton, 177.

Studies have noted how surgeons' speech, behavior, and even teaching methods can drastically change when patients are under anesthesia.[6] (In an article in the *American Journal of Surgery,* Claire Smith and fellow researchers proposed surgeon-patient communication guidelines to balance patient comfort with teaching and operative efficacy.[7]) I was not aware of how much I relied on anesthesia to shield me from the psychological stresses of being around fully conscious patients, until I interacted with awake patients during minimally invasive procedures. Even when it came to innocuous chores, such as washing a patient's body, I found I experienced a substantially greater degree of empathy with awake patients and frequently felt compelled to ask them how they were doing. In contrast to working with anaesthetized patients, for example, I always made sure to use warm water to scrub their bodies so that they would not feel cold. I shaved more cautiously in an effort to avoid razor burns. Instead of joking with my co-workers, I had conversations with the patients themselves. This led me to realize that knowing that I was dealing with a human body was not enough to arouse empathy in me. Rather, my empathy seemed to vary significantly depending on the degree of patient awareness.

Anesthesia diminishes patient sensation, but just as potent, it can reduce physician empathy. In the setting of Auschwitz, physicians found reassurance in and strongly adhered to the false belief that *Zyklon-B*, the German name for hydrogen cyanide, caused a painless death. Rudolf Höss, the commander of Auschwitz, remarked that "The *doctors explained* to me that the prussic acid [*Zyklon-B*] had a paralyzing effect on the lungs … that was so quick and strong that death came before the convulsions could set in …" and cause a terrible choking sensation.[8] The physicians rejected the alternative method of killing — extermination by shooting — because it would surely cause a greater degree of pain and suffering. It is chilling to imagine in retrospect how one method of killing could be deemed more permissible simply because it causes less pain. After all, the "painless" method resulted in perhaps the most horrendous genocide in mankind's history.

In surgery, most procedures take place when the patient is under anesthesia. Being aware of how that influences the way we practice is critical. Being aware of someone else's pain is one of the strongest forms of empathy. It holds us accountable for our actions and challenges us to be better. While anesthesia is necessary to modern surgery, we should aim to treat the anaesthetized body as if it still could perceive pain, because physical harm can occur even if the patient is not feeling pain. To take the extreme example of Nazi physician behavior, a painless death, after all, does not change the fact that a murder has occurred.

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[6] Anonymous, "Our Family Secrets," *Annals of Internal Medicine* 163 (2015): 321.
[7] Claire Smith, et al., "Surgeon-Patient Communication During Awake Procedures," *American Journal of Surgery* (July 29, 2016): 30369-5.
[8] Lifton, 162.

Conclusion

I do not mean to suggest that surgery is unethical by nature. Modern surgery is undeniably a miraculous process that offers cures and hope to patients. Nor can I pretend to summarize in such a short paper the complex psychological shift that enabled doctors to participate in genocide under the Nazi regime. But in discussing some of the ethical pitfalls of the OR and citing some of the experiences of physician prisoners in concentration camps, I do hope to point to the importance of remembering that a procedure must reside within an ethical framework, and that a simple awareness of the larger context of ones actions is at times all that separates a life-saving act from a potentially harmful one. Developing and refining an ethical framework need not be complicated in a perioperative setting — at times, consciously acknowledging that the patient is in a vulnerable position or reminding oneself why certain acts are important in the context of patient care can imbue greater meaning into our work and positively influence those around us. These considerations ought to supplement our current perioperative ethical guidelines.

Surgeons are doers. Our hands are eager to pick up the scalpel or to mend the immediate surgical issue before our minds have fully processed why. The true act of healing is done, however, at the level of thought when we reason out why a patient needs a particular life-saving procedure well before our hands are red and our blades are wet.

Patient Care Above All Else
Reexamining Residency Duty-Hour Guidelines

BY PRISCILLA WANG

YALE SCHOOL OF MEDICINE, CLASS OF 2017

On November 19, 2015, a letter was sent to the Office for Human Research Protection (OHRP) in the United States Department of Health and Human Services urging OHRP to "immediately suspend" a "highly unethical" clinical trial.[1] Signed by Public Citizen, a U.S. consumer advocacy organization, and the American Medical Student Association, the letter specifically targeted the iCOMPARE trial (Competitive Effectiveness of Models Optimizing Patient Safety and Resident Education), a multicenter National Institutes of Health-funded randomized trial comparing patient and educational outcomes of internal medicine residency programs operating under current resident duty-hour restrictions with those following a more flexible duty-hour policy. Spearheaded by investigators from the University of Pennsylvania, Johns Hopkins University, and the Brigham and Women's Hospital, the iCOMPARE study was designed in reaction to the duty-hour restrictions implemented in 2011 by the Accreditation Council for Graduate Medical Education (ACGME), which evaluates and accredits medical residency programs.

In an interview with *Medscape Medical News,* the director of Public Citizen's Health Research Group described the iCOMPARE study and a sister study examining looser surgery residency duty-hour restrictions as "among the most unethical studies I've seen in the past couple of decades."[2] Per the November 19 letter, the two main ethical violations alleged were: (1) knowingly exposing internal medicine residents to previously documented health risks of long duty-hour shifts, and (2) a failure to obtain informed consent from resident and patient subjects. The study, the letter authors affirmed, had violated U.S. federal guidelines regarding human-subjects research, as well as key tenets of the Belmont Report, a summary of core ethical principles published in 1979 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The writers of the Belmont Report drew significantly from principles first elaborated in the groundbreaking Nuremberg Code, a set of ten ethical principles for

[1] Michael A. Carome, Deborah V. Hall, Sidney M. Wolfe, and Sammy Almashat, to Jerry Menikoff and Kristina Borror, November 19, 2015, "Re: Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education (iCOMPARE) Trial," http://www.citizen.org/documents/2283.pdf.
[2] Robert Lowes, "Two Trials Extending Resident Hours Called 'Unethical,'" *Medscape,* November 23, 2015, http://www.medscape.com/viewarticle/854845.

research elaborated in 1947 as part of the verdict in the infamous "Doctors' Trial."[3] The majority of the defendants of this trial were German physicians accused of war crimes including torture, murder, and medical experimentation on inmates in Nazi concentration camps.

The role of physicians in Nazi Germany in aiding mass murder is among one of the darkest ethical chapters in the history of the medical profession. While not absolving the aforementioned physicians of personal responsibility, historians such as Robert Jay Lifton have noted that their actions were facilitated and promoted by cultural and scientific beliefs deeply held by their professional community during their era.[4] In this essay, I focus on duty-hour restrictions to argue that there are troubling parallels between the enabling beliefs of the medical profession during Nazi Germany and the assertions and rationales used by the modern-day American medical profession to justify the treatment of medical trainees. By absolutely no means do I mean to equate the end *actions* of these two groups, but I do assert that there are concerning similarities in the following practices used to rationalize their respective actions: use of romanticized or pseudo-religious language to describe the role and goals of the medical profession, glorification of physician suffering, and a willingness to overlook the rights of particular individuals in pursuit of a "greater good" advocated for by the profession.

Resident Duty-Hour Restrictions: Historical Roots

In 1984, 18 year-old Libby Zion died in New York Hospital, possibly due to an interaction between her regularly prescribed antidepressant and a medication that she was administered during her hospital admission. At the time of her death she was under the care of two medicine residents, who were on overnight duty and covering close to 40 patients. Aided by the zealous efforts of Zion's father, a journalist and lawyer angry at the hospital's staffing situation, the so-called "Libby Zion Case" set into motion a cascade of significant changes in medical resident supervision and duty-hour guidelines.[5] These culminated in a milestone for national duty-hour restrictions in 2003, with the ACGME mandating for the first time that resident workweeks be limited to 80 hours total, with no individual period of work exceeding 30 hours. In 2008, at the request of Congress, the Institute of Medicine (IOM) released a literature-based report that concluded that the existing ACGME standards required revision to address continued patient and trainee safety issues.[6] The ACGME subsequently released updated, stricter guidelines in 2011,

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[3] Evelyne Shuster, "Fifty Years Later: The Significance of the Nuremberg Code," *New England Journal of Medicine,* 337 (1997): 1436-1440.
[4] Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books. 1986).
[5] Barron H. Lerner, "A Case That Shook Medicine: How One Man's Rage Over His Daughter's Death Sped Reform of Doctor Training," *The Washington Post,* November 28, 2006.
[6] "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety," *Institute of Medicine, National Academy of Science,* December 2008.

including restricting interns (first year residents) to a maximum of 16 hours worked consecutively.

Not all physicians and training programs welcomed these guidelines. Pointing to small studies conducted after the new 2011 restrictions, a vocal fraction of the medical community argued that the implementation of duty-hour restrictions was potentially hindering medical education while not demonstrating clear benefits to patient safety.[7] They emphasized the need for additional, more high-powered studies examining the impact of different work-hour regimens. Loosening work-hour restrictions (most notably allowing interns to work 28 or more hours in a row, as opposed to 16), the iCOMPARE study was subsequently implemented in the 2015-2016 academic year at 63 internal medicine residency programs across the United States.

Medical Theocracy: Patient Care as a "Divine Purpose"

In the wake of iCOMPARE, the most recent round of debates surrounding resident duty-hour restrictions has centered predominately on issues pertaining to patient safety, as opposed to medical trainee health and well-being. For example, the main argument immediately following Libby Zion's death was that overworked, tired medical residents would be more prone to clinical errors that could endanger patients. A frequently cited counterargument also focuses on patient outcomes, suggesting that shorter work shifts would increase the number of handoffs between teams and therefore potentially increase opportunities for medical error.[8] The design of the iCOMPARE study further reinforces a patient-centered focus, with its primary measured outcome being 30-day mortality rates of patient populations at study institutions.[9] Similarly, in its letter responding to the concerns raised by Public Citizen about iCOMPARE, the ACGME first cites the need for additional studies to "evaluate the effects of duty hours on patient safety."[10]

Arguments in the duty-hours debate pertaining to the resident experience primarily focus on "educational quality," with the implication also being that a quality education is the means to the end of achieving high-quality patient care. For example, the primary goal listed on the clinicaltrials.gov webpage for the iCOMPARE study is to "examine patient

[7] Andis Robeznieks, "'Shift Work': 24-hour Workdays Are Out as Residents, Hospitals Deal with Changes, Mixed Feelings on Restrictions," *Modern Healthcare,* July 25, 2011, http://www.modernhealthcare.com/article/20110725/MAGAZINE/307259963.
[8] Rob Stein, "Is It Safe For Medical Residents To Work 30-Hour Shifts?" *National Public Radio,* December 7, 2015, http://www.npr.org/sections/health-shots/2015/12/07/458049301/is-it-safe-for-medical-residents-to-work-30-hour-shifts.
[9] "Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education (iCOMPARE)," *ClinicalTrials.gov,* August 29, 2016, https://clinicaltrials.gov/ct2/show/NCT02274818.
[10] Thomas J. Nasca to Michael Carome, Sidney Wolfe, Deborah Hall, and Sammy Almashat, December 7, 2015, "RE: iCompare and FIRST Trials" http://www.citizen.org/documents/2285_ACGME_Response.pdf.

safety and costs as well as quality of education."[11] The secondary outcomes cited by iCOMPARE that are related to trainee experience include "sleep duration," "behavioral alertness," "self-perceived sleepiness," "time spent in direct patient care," and "trainee satisfaction with education."[12] In neither the iCOMPARE grant application nor the trial protocol do the investigators specifically and thoroughly discuss the previously noted risks of sleep deprivation to medical residents' well-being, as detailed in the 2008 IOM report on resident hours, such as effects on emotional and mental health (e.g. depression), needle-stick injuries, and motor vehicle accidents.[13]

The relegation of resident experience to that of a secondary concern is reinforced by the study design of the iCOMPARE trial as a non-inferiority trial. This implies that longer working shifts would be acceptable to the investigators if the experimental group with looser work-hour restrictions showed no *worsened* outcomes with regard to patient safety and "educational quality." Conversely, if resident health or sleep time was held in similar regard as an outcome, one might imagine a contrasting study designed as a superiority trial; in this case the looser work-hour restriction arm would be required to show *improved* patient outcomes and educational quality to justify allowing a move away from current work-hour restrictions.

This focus on patients over providers is not unique to the realm of duty-hours; it reflects the prevailing sentiment espoused by the majority of medical societies and organizations. In the American Medical Association Code of Ethics, it is stated that physicians have the "ethical responsibility to place patients' welfare above the physician's own self-interest."[14] The American College of Physicians ethics manual states that medicine is a profession, in which members must abide by "a code of ethics and a duty of service that puts patient care above self-interest."[15] The 2011 ACGME document on new work-hour restrictions speaks of "the establishment of a humanistic learning environment in which residents learn and demonstrate effacement of self-interest in favor of the needs of their patients."[16]

There are obvious and laudable reasons why one would want his or her physician to avoid inserting self-interest into the patient-doctor relationship. Most people would be very troubled, for instance, by a physician who deliberately orders unnecessary medical tests in

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[11] "Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education (iCOMPARE)," *ClinicalTrials.gov,* August 29, 2016, https://clinicaltrials.gov/ct2/show/NCT02274818.
[12] "Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education (iCOMPARE)," *ClinicalTrials.gov,* August 29, 2016, https://clinicaltrials.gov/ct2/show/NCT02274818..
[13] "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety," *Institute of Medicine, National Academy of Science,* December 2008.
[14] "Code of Medical Ethics," *American Medical Association,* June 2016, https://www.ama-assn.org/about-us/code-medical-ethics.
[15] "ACP Ethics Manual Sixth Edition," *American College of Physicians,* January, 2012, https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-sixth-edition.
[16] *The ACGME 2011 Duty Hour Standards: Enhancing Quality of Care, Supervision and Resident Professional Development* (ACGME: 2011), Accreditation Council for Graduate Medical Education, http://www.acgme.org/Portals/0/PDFs/jgme-monograph[1].pdf.

order to increase her profit margin, or a clinician-researcher who pressures patients to join his clinical trial to increase the trial's sample size. Taken to the extreme, however, the promotion of "effacement of self-interest in favor of the needs of … patients" could result in actual detriment to self-welfare in the process of caring for patients. Of greater concern is that vulnerable populations in the medical community — i.e. trainees with limited self-advocacy options and who are dependent on supervisor evaluations to advance their careers — may be the ones who experience these harmful effects the most, in the seemingly untouchable name of "patient care."

In *The Nazi Doctors,* his seminal treatise on the paths that led German doctors to facilitate Nazi genocide, historian Robert Jay Lifton argues that a key factor spurring on the ethically questionable participation of doctors was the romanticization and deification of the end goals of the Nazi State. He writes:

> One can speak of the Nazi state as a 'biocracy.' The model here is a theocracy, a system of rule by priests of a sacred order under the claim of divine prerogative … that of cure through purification and revitalization of the Aryan race … Just as in a theocracy, the state itself is no more than a vehicle for the divine purpose, so in the Nazi biocracy was the state no more than a means to achieve 'a mission of the German people on earth.'[17]

That end vision itself — in this case preservation and elevation of the "Aryan race" — was often described in both romanticized and religious terms. Physicians played a key role in this model by supporting the goal and providing a practical means of carrying it out. Lifton uses the term "medical fundamentalism" to describe this pseudo-religious thought system and subsequent violent defense of an exalted goal. In Lifton's words, "in all fundamentalisms … usually religious or political, there is the sense of profound threat to what are considered fundamental beliefs."[18]

In the current medical professional community in the United States, there is a similar strain of "medical fundamentalism," with "the needs of the patient above all else" as the "fundamental belief." The language used to describe patient care often uses religious and/or romantic imagery. For example, in his 2015 remarks to the American College of Cardiology, physician-writer Abraham Verghese describes the doctor's interaction with a patient as ritualistic: "I'm wearing a white ceremonial outfit with shamanistic tools in the pockets … then the patient disrobes and allows touch … tell me that this is not an important ritual."[19] The modern Hippocractic Oath, used by many medical schools,

[17] Lifton, 17.
[18] Lifton, 488.
[19] Abraham Verghese, "I Carry Your Heart," *JAMA Cardiology* 1(2016): 213-215.

describes the tenets of the oath as a "covenant."[20] Patient care is often also commonly described as a "calling," a word often used in religious contexts to describe a sense of mission or greater purpose conferred by a higher power.

In my own experience as a medical student, I have frequently heard older physicians bemoaning the younger medical generation as, in their view, falling short of this calling and posing a threat to the high standards of patient care upheld during the prior "golden days" of practice. Standing in place holding a skin retractor during a surgical procedure, I was once subjected to a 20-minute lecture by a well-known gynecologic surgeon about how my generation lacked a sense of wholehearted dedication to patient care. On another occasion, a private practice attending lamented to me in his clinic about the irreverence of modern graduates toward the medical profession, and that younger physicians "no longer see medicine as a calling but as a nine-to-five job."

Buried within these statements, and deeply entrenched in modern medical culture, is a glorification of suffering on the part of the physician and a perspective that hard work and pushing the bounds of one's natural physical and emotional limits may be necessary to achieve excellence as a doctor. In the words of Dr. Candace Sloan, chair of the Massachusetts Board of Registration of Medicine, "in medical training, we're taught we have to almost be superhuman."[21] Sample comments by registered physicians on a *Medscape* article critiquing the iCOMPARE study describe some of these sentiments:[22]

> Residents today indeed lack the vigorous training as compared to what it was thirty years ago. One of the skill [sic] indeed is [to be] able to function when one is in extreme exhaustion and make decision[s] when woken up from REM sleep. (*Urologist*)
>
> I worked well over 100 hours/week. It was torture sometimes! But … the resident who must go home early, on a clock, does all the work, all night, and then doesn't learn how the case resolved. (*Orthopedic surgeon*)
>
> Was the old paradigm abusive and less humane, absolutely. Did it create some less human workaholic physicians, most assuredly. But it also created some of the most knowledgeable and dedicated physicians … Nobody is looking at hour restrictions when they are applauding a conjoined twin separation or similar multi-hour operation. (*Orthopedic surgeon*)

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[20] "Hippocratic Oath, Modern Version," Johns Hopkins Sheridan Libraries & University Museums, Johns Hopkins University, last updated on December 14, 2016, http://guides.library.jhu.edu/c.php?g=202502&p=1335759.
[21] Elisabeth Poorman, "I Felt Alone But I Wasn't: Depression Is Rampant Among Doctors In Training," *CommonHealth,* WBUR, August 19, 2016, http://www.wbur.org/commonhealth/2016/08/19/depression-resident-doctor.
[22] Lowes, "Two Trials Extending Resident Hours Called 'Unethical.'"

> I worked 30 out of 30 straight days as a second year resident in charge of 27 patients at Charity Hospital, seeing every patient every day. Did that make me a better doctor? You better believe it. (*Emergency medicine physician*)

A similar emphasis was placed on the glorification of sacrifice on the behalf of a greater good in the medical profession during Nazi Germany. German culture, in particular, compared to British and French culture for instance, focused on the "tragic-heroic motif" and "celebration of heroic sacrifice."[23] The same applied to the medical profession. The Nazi-authored book *The Face of the Germanic Doctor over Four Centuries,* for example, features the story of Parcelsus, a Swiss-German physician-alchemist, who (in this book's interpretation) struggles through despair and suffering to promote the higher ideal of the health of the national body.[24] Lifton writes that "the doctor, like everyone in Nazi Germany, was expected to become 'hardened'" in light of the assertion that "'the life of the individual has meaning only in the light of that ultimate aim.'"[25] It became framed as a matter of professional responsibility for physicians to lay down their individual preferences and concerns on behalf of a national patient.

Reexamining Professional "Expectations" and Tradition

In contemporary American medical culture, however, should it be considered a matter of expected professionalism that physicians and medical trainees rise to a similar level of personal sacrifice? And how much sacrifice is enough? Concern should arise when a well-established professional expectation is allowed to persist without any reexamination of its ethics in light of new evidence and misgivings. For example, to the primary investigators, grant funders, and the Institutional Review Board (IRB) that approved the iCOMPARE study, it appears to be a foregone conclusion that residents should be putting in extremely long work hours. In the "Potential Risks" section, the grant application in fact states that "the greatest risk to participants is the risk to confidentiality," without further discussion of documented risks cited by previous ACGME guidelines in favor of stricter duty-hour restrictions.[26] The iCOMPARE study was then approved without requiring investigators to obtain informed consent from residents. According to one of the study's primary investigators, it would not have been practical to get consent from all the residents (and patients) participating in the study.[27] It seems questionable at best and unethical at worst, however, to forgo informed consent in the name of practicality, particularly in light of the

[23] Lifton, 481.
[24] Lifton, 31.
[25] Lifton, 31.
[26] "Research Project Cooperative Agreement for ICOMPARE-CCC Project," NIH, Grant 1U01HL125388-01A1, August 10, 2015, [Award Letter from National Institutes of Health, Dept. of Health and Human Services, Grant Submission by David Asch], http://www.citizen.org/documents/iCOMPARE-grant_1U01HL12538801A1_UPenn_Key%20Sections.pdf.
[27] Stein, "Is It Safe For Medical Residents To Work 30-Hour Shifts?"

literature describing the risks of sleep deprivation in medical residents and other study populations.

If we regard the issue in a much more extreme setting, it bears noting that sleep deprivation and "sleep management" have both been deemed unethical as torture techniques by multiple international bodies. "Sleep management" is a form of interrogation in which detainees' sleep schedules are disturbed even without depriving the detainee of sleep.[28] In fact, in the 1963 CIA manual, sleep disruption is recommended over sleep deprivation as a more effective interrogation method to "sap [the] will."[29] Sleep deprivation, the deliberate limitation of sleeping time, was central to the George W. Bush administration's "enhanced interrogation techniques" and was condemned as being unethical by the United Nations Committee Against Torture.[30] These criticized interrogation guidelines (in the infamous "Appendix M" of the Army Field Manual) include the "safety" parameter that detainees should at least get "four hours of continuous sleep every 24 hours" — a requirement that most medical residents completing a 28-hour on-call shift cannot even expect to meet, given their need to respond to urgent pages and emergency medical situations.[31] I am not attempting to suggest that long resident work-hours are equivalent to torture or interrogation techniques. There are clearly significant differences between the two settings: residents would not work more than one 28-hour shift in a row, and there are many situations in which individuals would even willingly deprive themselves of sleep. From a perspective of situational ethics, however, it is worth reexamining why we tolerate or even celebrate sleep disruption or sleep deprivation in one context but condemn it so vociferously in another, especially when in both cases those affected lack the autonomy or hierarchical standing to refuse. Certainly, the end goals of the two situations (provision of patient care versus coerced extraction of information from a detainee) vary quite significantly and the former goal would appear more acceptable to most onlookers. However, as extreme examples, such as the behavior of Nazi physicians demonstrate, simply using an "ends justify the means" rationale can lead to ethically questionable actions.

The issue of sleep deprivation experienced by residents also gains greater urgency in light of recent medical trainee suicides and a recent study suggesting that almost one in three resident physicians experiences depression or depressive symptoms.[32] In a recent September 2016 press release, Marsha Rappley, a physician and chair-elect of the

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[28] Jennifer K. Elsea, "Lawfulness of Interrogation Techniques under the Geneva Convention," *Congressional Research Service Report for Congress,* Order Code RL32567, September 8, 2004, https://fas.org/irp/crs/RL32567.pdf.
[29] "Kubark Counterintelligence Interrogation," Central Intelligence Agency, July 1963, http://nsarchive.gwu.edu/NSAEBB/NSAEBB122/CIA%20Kubark%201-60.pdf.
[30] Ed Pilkington, "UN Torture Report Condemns Sleep Deprivation Among US Detainees," *The Guardian,* November 28, 2014, https://www.theguardian.com/law/2014/nov/28/un-condemns-sleep-deprivation-among-us-detainees.
[31] Pilkington, "UN Torture Report Condemns Sleep Deprivation Among US Detainees."
[32] Douglas A. Mata, *et al.,* "Prevalence of Depression and Depressive Symptoms among Resident Physicians: A Systematic Review and Meta-analysis," *JAMA* 314 (2015): 2373-83.

American Association of Medical Colleges (AAMC), is quoted as saying that the medical profession has "reached a crisis point — in fact a public health crisis" with regard to burnout, depression, and suicide within the medical profession.[33] Among all professions, the medical field has one of the highest suicide rates, with rates up to twice that of the general population (among female physicians, two-and-a-half to four times greater).[34] In 2014, two New York medical interns in separate residency programs committed suicide in the span of one week; in March 2016, another medicine resident jumped to her death.[35]

We cannot know what prompted these residents to end their lives, but studies show that depression rates increase by 15-30% during the intern year (first year) of residency.[36] One study of interns in the University of Pennsylvania noted an increase of moderate depression prevalence from 4.3% to 29.8% in the span of the year, with a concomitant increase in chronic sleep deprivation from 9% to 43%.[37] Studies have linked sleep loss to disordered emotional brain responses[38] and an increased risk of developing a mood disorder such as depression or anxiety.[39] Additionally, since the 1970s and even prior to the death of Libby Zion, there has been a growing body of literature examining the results of sleep deprivation in residents specifically, which has found an inverse correlation between amount of sleep and reported mood symptoms, including sadness, clinical depression, anger, and irritability.[40] From this perspective, one could argue that a program of training that systematically disturbs sleep patterns, deprives trainees of sleep on a regular basis, and provides little time off for rest poses not only a challenging rite of passage but potentially a public health risk.

The Need to Rethink the Culture of Medical Training

The most frightening aspect of the medical profession's participation in torture and murder in Nazi Germany is not necessarily what the profession *did*, horrific as those

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[33] Rebecca Greenberg, "Leaders in Academic Medicine Address Physician Well-being and Resilience," American Association of Medical Colleges, September 2016, https://www.aamc.org/newsroom/newsreleases/469244/leadership_forum_09072016.html.
[34] Louise B. Andrew, "Physician Suicide," *Medscape,* October 2016, http://emedicine.medscape.com/article/806779-overview.
[35] Pamela Wible, "Three Young Doctors Jump to Their Deaths in NYC," *Pamela Wible MD,* March 12, 2016, https://www.idealmedicalcare.org/blog/three-young-doctors-jump-to-their-deaths-in-nyc/.
[36] Douglas A. Mata, D.A. *et al.,* "Prevalence of Depression and Depressive Symptoms among Resident Physicians: A Systematic Review and Meta-analysis."
[37] I. M. Rosen, *et al.,* "Evolution of Sleep Quantity, Sleep Deprivation, Mood Disturbances, Empathy, and Burnout among Interns," *Academic Medicine* 81 (2006): 82-85.
[38] S.S. Yoo, *et al.,* "The Human Emotional Brain Without Sleep – A Prefrontal Amygdala Disconnect," *Current Biology* 17 (2007): R877-878.
[39] N. F. Watson, *et al.,* "Sleep Duration and Depressive Symptoms: A Gene-Environment Interaction," *Sleep* 37 (2014): 351-8.
[40] I. M. Rosen, *et al.,* "Evolution of Sleep Quantity, Sleep Deprivation, Mood Disturbances, Empathy, and Burnout among Interns;" J. S. Samkoff, and C. H. Jacques, "A Review of Studies Concerning Effects of Sleep Deprivation and Fatigue on Residents' Performance," *Academic Medicine* 66 (1991); E. M. Al-Maddah, *et al.,* "Prevalence of Sleep Deprivation and Relation with Depressive Symptoms among Medical Residents in King Fahd University Hospital in Saudi Arabia," *Sultan Qaboos University Medical Journal* 15(2015): e78-84.

actions were. Rather, it is the unchecked *process* by which the profession arrived at that point—the fact that physicians' actions were facilitated by the environment in which they practiced, their cultural ideas and professional beliefs, and what was upheld as an ultimate good. Similarly, the purpose of this essay is not to argue for a particular reform, such as the abolishment of 28-hour shifts in residency training or the promotion of a particular medical resident duty-hour regimen. My purpose is to draw attention to the potentially questionable belief structures that the modern-day American medical profession currently uses to justify current work expectations for residents. Today, the ostensibly laudable goal of patient care has been elevated to an unchallengeable sacred standing, such that the means used to achieve that end may escape rigorous ethical examination. Physician suffering is framed as a rite of passage and celebrated almost to the point of masochism, such that legitimate concerns are at times framed as weakness and risks to emotional health dismissed as inconsequential.

Perhaps physician-trainees in decades past were able to survive working more than 100 hours a week and 36-hour shifts, but that does not automatically lead to the imperative to continue this practice. To truly cultivate an ethical model of medical education and physician training, the medical profession needs to continually reexamine its professional practices, in light of new evidence and a changing external environment. We need to recognize that the medical system that trainees practice in today has changed greatly over the past two decades, with a much larger body of knowledge to master and with a significantly increased documentation and reporting burden. We need to make sure that we are asking the right questions. If handoffs appear to increase clinical errors, the question should not necessarily be how to eliminate handoffs, but how to *improve* them. If a system in which residents working 16 hours a day six days a week for several years appears to be producing "less experienced" graduates, then perhaps we should question the educational *quality* of the time spent in the hospital, as opposed to increasing the quantity.

Most importantly, we need to ensure that we are using the right equations in our calculations, and giving proper — and ethically sound — weight to the variable of resident mental health and physical wellbeing. In a profession that has long sworn an oath to "do no harm," there is a strange incongruity in a model that requires damaging one's health in order to heal others. Unquestionably, any medical resident must be willing to work hard to achieve a competent level of practice, but surely we would want to limit any unnecessary suffering among trainees, just as we aim to do so for patients. Additionally, if we subscribe to a belief that the intangible components of the doctor-patient interaction — rapport, an emotional connection, a relationship of trust — are just as critically important as the biomedical care that is provided, surely we want to cultivate future generations of physicians that have the physical and emotional bandwidth to engage fully with their patients, instead of directing their internal resources toward merely "surviving." Surely the medical profession seeks to foster healers, not produce martyrs.

Assessing Quality of Life for a Suicidal Patient

BY BEN YU

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I met Joe on a muggy July morning. When I walked into the breakfast room and summoned him for his intake interview with the inpatient team, he merely blinked at me, very slowly took another bite of his pancakes, and unfolded his lanky frame from his seat to follow me out of the room. At full height, Joe was six-foot-five, but built like a very frail bird, all brittle bone, with the hospital-issued pajamas drooping off his narrow frame. His movements were jerky, as if he were a marionette controlled by a tipsy puppeteer. But what caught the eye most immediately was the stuffed toy elephant he was holding. In his huge hands, it looked like a miniature toy, and he clutched it tightly as he shuffled after me.

The team was at ease. This wasn't like other intakes we'd done, with patients screaming, cursing, being forced into the room by security, or behaving in a floridly manic or psychotic manner. Those interviews tend to be tension-filled, with everyone in the room constantly on high alert. But this was a harmless old man — probably vaguely depressed, likely just lonely, maybe with a touch of social anxiety — carrying a toy elephant.

The interview started easily enough: "What brings you in; tell me about yourself," the standard opening salvo. And he gave us … nothing. As I volleyed question after question at him, he just sat quietly with his eyes locked on the table and his hands slowly stroking the elephant. After the sixth or seventh question with no response, I stopped. I wanted to see what he would do next. Finally, he looked up from the table and said, quietly and evenly, "I am in so much pain all the time. Every day I wake up and ask myself what the whole fucking point of this is."

Joe wasn't histrionic. He wasn't combative. He wasn't agitated or delirious or recalcitrant or any of the other things we deem patients to be when they don't want to speak to us. He had said what he wanted to say. We had the note from the crisis response center that had sent him to us: "Arrested at a train station for being on the train tracks and refusing to cooperate with the police; told everyone all he wanted to do was die; brought to the

psychiatric crisis center; admitted to inpatient care for further management." He had no ID, no friends or family he would admit to, nobody for us to either inform or question.

Over the course of the next three days, we pieced together some of the details of Joe's story. He was homeless and drifted from shelter to shelter. He had had over 40 inpatient psychiatric admissions for depression and suicidality, and consistently refused all mental health services set up for him. He had arrived recently from out of town as a cargo train stowaway.

All I ever saw him do over those first few days in the hospital was pet his toy elephant and stare at the TV in the common room. Once or twice he traced slow, shuffling laps from one end of the L-shaped unit to the other. He still wanted to die, he wanted no part of any medication or talk therapy, and he said he was going to go finish himself off as soon as he was released.

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One of the things we debated vigorously on our FASPE trip, in a conference room under the Topography of Terror Documentation Center in Berlin, was whether human life has intrinsic value. Should a physician's goal always be to save life? Should that be the end-all and be-all of what it means to be a physician? During our debate, we drew a distinction between the intrinsic sanctity of life and quality of life, which can be defined as an individual's subjective lived experience. I am unmoved by the former, but the latter — the goal of improving a person's quality of life — is what has most driven me to become a physician.

I believed Joe's pain — the chronicity of it, the impassability of his depressive abyss, the sweet anticipation of the release of death. His life was already a jagged string of almost-suicides, followed closely by some period of time suspended in the numbing, shoelace-free tombs of various inpatient psychiatric wards. As I thought about Joe, I felt a deep sense that he was right, that any further life for him was most likely only going to tighten the emotional screws, day after endless day. Regardless of the Hippocratic Oath I had sworn, and all the teachings on morality that I'd encountered and thought I had absorbed into my belief system, my strongest impulse was to release Joe from the hospital, so that he could end his life.

In the case of more objective disease states, such as kidney failure, there are blood tests one can point to in order to support the claim that a patient needs to stay in the hospital for treatment. In the case of suicidal thoughts or actions, as with many other psychiatric ailments, there is no objective data to point to. Physicians listen to their patients, examine the evidence and the sequence of events that have led up to the moment of intake, and then they decide whether or not the patient is at such a high risk of harming him or herself

that admitting the patient is necessary. Some would refer to the current method of suicide assessment as an art. Others would call it the absence of science.

Our predictive models for whether someone will commit suicide after being released from an institutional setting are no better than flipping a coin. The best we can do is identify risk factors — previous suicide attempts, suicide attempts in the family, access to guns in the home — and create a safety plan together with the patient, sometimes including a "I-won't-commit-suicide" declaration that the patient must sign prior to being released. Nevertheless, there is still little scientific data available to demonstrate the predictive value of such safety plans or whether they can influence patient behavior.

Beyond the question of whether interventions are effective in preventing suicide, the main question I had after meeting Joe was whether suicide prevention was even the right treatment for him. This question arose from a wellspring of emotion that resembled sentiments I had heard expressed by fellow medical students and healthcare providers who have worked in intensive care unit (ICU) settings. Often, when taking care of debilitated patients who are slowly wasting away on ventilators and nasogastric tubes, providers experience despair and conflicting emotions, because they feel that no amount of intervention will ameliorate the patient's condition. In such situations, additional medical intervention isn't always in the best interests of the patient, as all it really does is prolong suffering without any tangible improvements in the quality of life.

As a physician in training, it seems to me that there must come a point at which the accumulation of pain and suffering experienced by a patient due to disease and/or interventions outweighs the obligation to provide medical treatment. But is this also so in the case of a suicidal patient?

The principle behind the medical treatment of suicidality is to keep a person safe until the most acute emotional pain has passed. According to this model, depression and suicidality are just a phase. When a suicidal patient is younger, has potential he or she can still realize, and does not have a history of chronic institutionalization, holding such a person against his or her will to prevent suicide sits well with my moral intuition. But with someone in Joe's circumstances, I feel and felt conflicted. Part of me rationalized that my attitude toward Joe's case was due to the fact that I was seeing suffering in front of me and that my natural impulse is to find a cure for that suffering and to realize that cure. Another part of me wondered whether my attitude was simply the consequence of thinly disguised ageism, and that I was giving up on precisely the sort of patient who needed the most help, but who I subconsciously assumed was too far gone, because of his age.

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One could describe Birkenau today as looking beautiful. The endless rows of decaying chimneys — two for each former bunk — cast an endless symmetry over the fields. On the summer day that we visited the camp, the sky was cloudy. A cloying mist hung everywhere. I spent a long time sitting by one of the murky grey ponds where the Nazis dumped human ashes, struggling with how to square the silent expanse of today with the staggering number of lives that ended there 60 years ago.

Back in our FASPE seminars, we spent a great deal of time trying to understand how the events of the Holocaust could have transpired. In one narrative we discussed, the Holocaust represented the rock bottom of a slippery slope, the end result of a slow decay of the morals and ethics of the everyman, among which medical practitioners formed a critical subgroup.

In our discussions, we tracked the slow decline of medical ethics during the Nazi regime: the T4 euthanasia program, Mengele's train-side selections, horrific medical experiments in the concentration camps. We kept returning to the idea that many physicians who helped create and participated in the horrors of the Holocaust fundamentally believed that they were doing the right thing, that theirs was a morally ironclad mission that couldn't be questioned.

The slippery slope argument informs much of the discussion around the medical treatment of suicidal patients. If one believes it is morally defensible to allow certain patients to commit suicide, what is to stop one from extending that argument to apply to all patients, or to extend it to the point where it is acceptable for physicians to administer a lethal overdose of morphine when the physician deems it appropriate? Analogous and equally thorny ethical questions have been debated with respect to other medical fields: palliative care, end-of-life care, physician-assisted suicide, euthanasia. Each has its own unique identifiers, especially with regard to how directly physicians are involved in the course of action that ends a person's life. The fundamental belief underlying these practices is that a patient's subjective experience of suffering can and should be acknowledged, that preservation of life itself shouldn't always be the ultimate goal. Yet among physicians and in the wider society, accepting and legalizing these practices is often perceived as the gateway to a slippery slope away from "do no harm."

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Joe was still in the hospital when I rotated off that inpatient service. I've wondered many times since then what ended up happening to him. In some ways, I'm hesitant to find out the answer. Whether it's because I don't want that information about a single case — a "single data point" — to sway me toward one medical argument or another, or because I

fear how I would react emotionally to learning his fate, or because of some mix of the two that I haven't yet put my finger on, something has always held me back from checking the medical records to find out.

My intuitively-driven stance that suicide could be a reasonable and morally defensible choice for some patients is far removed from what the medical establishment and our broader society define as being ethically sound. What I'm left with, after all my ruminations over suicidality and the ethics of treating it, is that "it depends on the patient," which, to me, is simultaneously the least helpful and the most reassuring way to bring these threads — my own moral intuition, our societal norms regarding what is ethical healthcare, and the nuance of taking care of each individual patient — together.

More broadly, what do I do with my beliefs when they diverge from the standard of care or from moral norms? How do I understand the limits of incorporating my personal views into clinical practice? I don't have satisfying answers to these questions yet. At a minimum, I want to continue to engage with my impulses and intuitions, because I believe that it is vital to continue to question accepted medical practice, while also remaining vigilant as to how my views on care could harm others.

For now, I don't know what I'll say, and I'm even less sure as to what I'll do, should I meet Joe again or another patient who has a similar story and should I be the one in the position to make the final call on whether to send home a suicidal patient.