EDITED BY

HENRI COLT, SILVIA QUADRELLI, AND LESTER FRIEDMAN

THE PICTURE OF HEALTH

the picture of health

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the picture of health

medical ethics and the movies

edited by
henri colt, silvia quadrelli,
and
lester d. friedman

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preface

In the Wachowski Brothers' science fiction epic, *The Matrix* (1999), Morpheus (Laurence Fishburn) offers Neo (Keanu Reeves) a critical choice: take the blue pill "the story ends. You wake up in your bed and you believe whatever you want to believe," or the red pill "you stay in Wonderland, and I show you how deep the rabbit hole goes." Using film to teach medical ethics is like swallowing the red pill. Abstract concepts and ideas can be extracted from film, debated, and discussed. Viewers can relate with or alienate themselves from the actors, the plot, or the context. They can address the issues portrayed in the film and identify others that may not be fully developed. Regardless of their level of expertise and experience, viewers can voice opinions, argue contradictory positions, display their emotions, and justify their perspectives based on external evidence, their personal experiences, and what actually happens in the fictional narrative of the cinematographic experience.

From an educator's standpoint, film provides a multilayered nucleus from which significant learning can take place: it also makes available a myriad of scenes and scenarios that can be dissected, critiqued, and used as examples to highlight moral dilemmas. Not only can films teach us *how* to restrain ourselves from doing what we know,[1] or think we know, is wrong, but they can portray situations that might confuse us and thus prompt reflection on the *why* we do what we do (or don't do). Movies can thus be used to help health care providers develop skills in the human dimensions of medical practice. They promote enthusiasm for learning, highlight themes, enhance discussion and reflection, and sometimes, help illustrate specific teaching points on clinical topics, social and health care policy issues, cultural differences, and science.[2–4]

This is cinemeducation, and, as stated in the preface of Alexander, Lenahan, and Pavlov's book on the subject,[5] if you are not already using film in your curriculum, we are confident that you will be after reading this book. Films with a solid plot and coherent story often work more dramatically and engagingly than a printed case description.[6] Visual images impart important information that simply cannot be duplicated in the written case history, which usually presents the facts and often ignores the broader context of an ethical situation; equally important, film narratives put a human face on an abstract ethical issue, taking it from the realm of the theoretical and placing it firmly within the realm of the personal. Thus, film can be effectively used as an experiential exercise, as part of problem-solving sessions, or as a metaphor to clarify or dramatically magnify perspectives about a disease process or health care–related issue. Even a discussion of how

cinematographic techniques reinforce the emotional, psychological, and intellectual impact of film—the use of flashbacks, special sequencing, framing, lighting, or animation, can dramatically illustrate social behaviors, values, and ethical principles that contribute to learning and knowledge retention. While using film enhances the intrinsic value of the educational process, and both learning and teaching should be inherently fun and satisfying, it would be incorrect to presume that simply showing a film suffices to teach medical ethics, or that the integration of film could replace thoughtful reading and analysis of essential texts. Unless educators want to entice their students to reflect de novo about a subject, reading pertinent course material prior to viewing a film is a prerequisite for a more enlightening and enriching discussion.

We designed this book to give readers specific tools to use in the classroom or the auditorium. Short scenes, with their specific DVD time sequences, are described and serve as a springboard for discussions of a particular ethics issue. Authors return to the scene and integrate their analysis into a brief commentary about the film itself. While it may not be necessary for readers, or their students, to view the entire film prior to integrating the scene into a teaching session or lecture, it is certainly preferable to do so before using the short clip in the classroom. That way, the teacher obtains a firmer grasp of how the scene fits into the overall narrative flow, as well as its place within the various characters' situation at that particular moment in the movie. Much like a particular section you might take out of a novel to illustrate a specific ethical dilemma, it remains important for instructors to know what comes before and after that scene to fully appreciate its significance.

We choose to use short scenes because our electronic age differs dramatically from any era that preceded it. Today, media saturates every level of our daily environment. Young people, in particular, dwell in a world dominated by an onslaught of visual images; they inhabit a dynamic, high-speed, rapidly changing, and sensitive environment stuffed with information acquisition and powerful emotional impact. They customarily receive, process, interpret, and react to visual images, be they on movie, television, or computer screens, Blackberries, and cell phones. As such, short scenes, often characterized by powerful emotions, can effectively help illustrate or intensify a particular point. Additionally, the use of short scenes allows a broader use of film in the context of conventional courses without altering traditional class schedules. Scenes can be carefully chosen based on the educator's learning objectives and tailored to the educator's style and personality.

The analysis of a selected scene usually constitutes the central, strategic component of any film-based educational approach.[7,8] Some educators, however, may choose to play an entire movie, advising students to view the film with an eye for reflecting on larger concepts.[9] Quite exceptionally, full-length film has been used solely to provide the audience with an artistic and aesthetic experience that they would otherwise have missed, with no specific intent to afford talking points or to illustrate ethical or clinical dilemmas.[10,11] In contrast, in a manner similar to discussions that follow the reading of a complete short story or novel, the viewing

of a film in its entirety provides a group with the opportunity to respond affectively, cognitively, comprehensively, and collectively to the narratives viewed on screen,[12] resulting, at times, in a deeper understanding of the issues being portrayed.

This book aims to supplement core texts and other readings in medical ethics. A large number of scenes, therefore, have been selected based on their value to illustrate ethical dilemmas or motivate discussions. Films were selected on the basis of their power for evocative, visually based, cinematic imagination, and a particular author's desire or experience using that film in a teaching setting. We preferred using easily accessible feature films rather than documentaries or animated films produced specifically as teaching tools with explicit didactic foci. In addition, often times, in popular, as well as in lesser known or even commercially unsuccessful films, authors may actually address what the viewer might first think is a side issue of the film itself but discover to be an important component of the overall narrative.

Our goal throughout this book was to harness the powerfully seductive, emotional, and attention-driving intensity of film to provide educators, and any viewer interested in health care professions and ethics, with a collection of films that illustrate some of the more common issues appearing in medical practice and under discussion in ethics courses. Sometimes, the entire context of a film is relevant to one's interpretation of the scene. Other times, the scene has an intrinsic value that is quite independent from the rest of the film. While we provide time sequences for scenes in order to facilitate their retrieval and bookmarking on modern DVD formats, they will not always be absolutely accurate depending on the DVD and DVD player being used. We leave to the discretion of the viewer how much or how little of each scene needs to be shown in order to succinctly comment on the ethics issue they wish to address.

As a springboard for discussion, a short essay accompanies each selected scene. These essays stress many of the more relevant theoretical and practical issues pertaining to the situation or dilemma illustrated in the scene. They are not intended to replace the rich existing literature about ethics theory; nor do we presume that the scene can be used only to address that particular teaching point. We did our best to assure that both the scene and the essay are engaging, and that the information provided will help viewers enhance their knowledge and understanding of ethics, as well as link ethical principles, theories, and abstract concepts to the concrete situations illustrated in the film. Our goal was to provide both professionals and a general readership with a collection of precise, accessible examples of how film can be applied to help illustrate, learn, and teach medical ethics. Chapters are constructed so that the reader can choose a film or an ethics issue. While educators can use the essays to help stimulate classroom discussions about a film or a medical ethics issue, interested readers can easily move from essay to essay based on their intellectual curiosity. Material from this book can be thus accessed by a general readership interested in the use and understanding of film, as well as for illustrating various aspects of

situational ethics in hospitals and universities, and for lectures or classroom teaching of humanities in medicine, film and cinematography, clinical medicine, philosophy, psychology, and ethics.

This anthology of essays encompasses a broad range of relationships between medical practice, health care and social policy, professionalism, illness, medical ethics, and film. The abundance of topics and possible perspectives, therefore, warranted that this book bring together an eclectic group of internationally recognized scholars and practitioners from diverse disciplines including medical ethics, clinical medicine, philosophy, psychology, media and communication studies, medical humanities, public health, business, theology, law, cultural studies, political science, women's studies, English, psychology, and health care education. Each author has experience using film in his or her teaching of medical ethics or other course materials. Each essay in *The Picture of Health: Medical Ethics and the Movies* is based on a scene extracted from a specific film in order to define, illustrate, and discuss a specific medical ethics issue. While each essay contains enough material to make it valuable as a resource and guide, essays are not so technically overloaded as to overwhelm readers, either in how they utilize film, or in the intellectualization of medical ethics. Although we provided creative license to authors in regards to the manner with which they presented their perspectives, we maintained a similar structure so that readers may easily understand the issues being addressed in their clinical, philosophical, scientific, and cinematographic context.

The book is divided into three parts. Part I includes a series of personal reflections whereby authors discuss specifically how they have incorporated film into their respective teaching careers. In the first essay, renowned ethicist and philosopher Al Jonsen reflects on how *Frankenstein* gave rise to medical ethics. In the second essay, medical ethicist and physician Peter Dans reflects on more than 40 years teaching ethics in the hospital and classroom setting. Johanna Shapiro, professor of humanities addresses the educational use of film in the third essay, while in the fourth, Professors Stephen Crawford and Henri Colt reflect on how a scene from *City of Angels* (1998) prompted exploration of "the dark room of their souls" while they address guilt, compassion, and the power of forgiveness in the health care professions.

The second part of this book is the longest, containing 80 essays in eight sections of ten essays, each section categorized according to the type of ethics issue they illustrate: Autonomy, justice, and informed consent; professionalism; communication and provider-patient relationships; health care policy and social responsibility; rights, responsibilities and research; reproduction, genetics, and sexuality; end-of-life and right to die; other ethical issues in medical specialties.

Part III is comprised of a filmography listing the titles of 140 films not used in this volume, but that contain powerful scenes that might be integrated into ethics lectures or training curricula. This list is by no means complete, but provided only to guide readers toward possible additional resources.

With the introduction of any innovative teaching method, some part of the academic community, especially in biological sciences, requests proof of the effectiveness of that new technique before advocating or even supporting its widespread application. Educators, except for the most conservative ones, have long ago learned that the measurement of success in teaching remains an elusive, controversial, and at the least quite ambiguous goal. As stated by Fenstermacher,[13] we should not confuse quality teaching with *successful teaching*, one that produces learning as is understood exclusively in its achievement sense. Quality teaching pertains to *what* is taught and *how* it is taught. Content must be appropriate, proper, and aimed at some worthy purpose. The methods employed must be morally defensible and grounded in shared conceptions of reasonableness.

We submit that acquiring a taste for the aesthetic provides an additional dimension to medical learning, and that even when morality is at issue, reason is an ideal tool for understanding. There is a place in this context for art, including that most powerful medium, film, that mobilizes all of our human resources for action: reason, intuition, instinctive responses, emotion and affectivity, and a need to find and provide answers. Scenes from films can encourage students to see various sides of an ethical dilemma. They contribute to classroom activities by providing an accessible point of reference that personalizes the more arcane philosophical commentaries that often characterize health care ethics debates. By introducing such provocative narrative experiences into the educational setting, the ethics teacher stimulates students to integrate abstract principles with concrete situations, a methodology that encourages students to combine theory and practice into an organic whole.[14] If we add to this a careful selection of insightful readings, and a vivid, professional, interactive, student-centered, and objectives-guided discussion of the contents of a film potentially guided by the essays in this book, we are certain that the enhanced quality of our teaching of ethics will benefit colleagues, students, and other professionals interested in this fascinating field of human behavior and psychology.

In closing, we would like to thank the diligent and always helpful contributors to this volume. Not only have they enlightened us with their knowledge and expertise, but they engendered among us fresh interests and a desire to explore new horizons. They have unselfishly shared their perspectives, trials, and tribulations using film to teach medical ethics to health care professionals, medical students, attorneys, communication and media professionals, and students of humanities studies in both the classroom and the workplace. Reading, and occasionally revising their essays, has been, for the editors, an extraordinarily enriching experience. We trust that it will be so for you as well.

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caveats

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about the editors

Henri Colt, MD, is professor of pulmonary and critical care medicine at the University of California, Irvine. He is an internationally recognized expert and opinion leader in the development and dissemination of novel technologies for lung cancer diagnosis and interventional palliative procedures. During his career, he has lectured widely on ethics and humanities issues in the context of medical practice, social injustice, humanitarian aid, and education, including the use of simulation and role playing. He has held numerous leadership positions in international and national societies, has more than 130 original research publications in various fields, and has authored or coauthored many books, book chapters, review articles, and commentaries. The recipient of several honorary society memberships, as well as national and international awards from Japan, South America, Australia, and the United States, Dr. Colt has a long experience incorporating film and other media into lectures pertaining to pulmonary medicine, cultural diversity, medical ethics, religion, and end-of-life care.

Silvia Quadrelli MD, MEd, PhD, is director of the pulmonary and critical care section of the British Hospital in Buenos Aires, Argentina. She is an internationally recognized authority in the area of humanitarian assistance, and has devoted more than 30 years of her life to the global combat against poverty and injustice. In 2010, Dr. Quadrelli received the prestigious Medal of the Bicentennial from the City of Buenos Aires, as a "woman who has helped shape modern society." In addition to her background in medicine and teaching, she holds degrees in bioethics and university political sciences. She has designed several medicine and movies programs for the University of Buenos Aires, and lectures widely in South America and abroad on medical ethics, philosophy, and medicine.

Lester D. Friedman, PhD, is currently professor and chair of the media and society program at Hobart and William Smith Colleges. Prior to this appointment, he was a member of the medical humanities program in the Feingold School of Medicine (Northwestern University) and the medical humanities and bioethics program at Upstate Medical Center (Syracuse), as well as the radio, TV, and film department at Northwestern University and the art media studies department at Syracuse University. A internationally recognized expert in cinema and medical humanities, with a particular emphasis on health care and media studies, he has authored or coauthored more than 15 books, two screenplays, and numerous peer-reviewed manuscripts. In particular, he is the editor of *Cultural Sutures* (Duke University Press), the first comprehensive book to explore the intimate connections between the cultures of medicine and media.

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contributors

Dan Aalbers, Doctor of Philosophy (ABD). York University, Toronto, Ontario, Canada

Armand H. Matheny Antommaria, MD, PhD. Assistant Professor, Division of Pediatric Inpatient Medicine, University of Utah School of Medicine, Salt Lake City, Utah

Robert M. Arnold, MD. Associate Director for Education, Center for Bioethics and Health Law, University of Pittsburgh, Pennsylvania

Cristiane Avancini Alves, PhD in Legal Science. Scuola Superiore Sant'Anna, Pisa, Italy

Paul D. Banick, MD, PhD, MBA, FACP, FCCP. Clinical Adjunct Professor, DeBusk College of Osteopathic Medicine, Lincoln Memorial University, Harrogate, Tennessee

John D. Banja, PhD. Professor, Department of Rehabilitation Medicine, Medical Ethicist, Center for Ethics, Emory University, Atlanta, Georgia

Jennifer S. Bard, JD, MPH. Professor, Alvin R. Allison Professor of Law and Director, Health Law Program, Texas Tech University School of Law, Lubbock, Texas

Donald A. Barr, PhD. Associate Professor (Teaching), Department of Pediatrics, Stanford University School of Medicine, Stanford, California

Jay M. Baruch, MD. Assistant Professor, Department of Emergency Medicine, Warren Alpert School of Medicine at Brown University, Providence, Rhode Island

Catherine Belling, PhD. Assistant Professor, Medical Humanities and Bioethics Program, Feinberg School of Medicine, Northwestern University, Chicago, Illinois

Nancy Berlinger, PhD. Deputy Director and Research Associate, The Hastings Center, Garrison, New York

Marina Boykova, MSc, RN. University of Oklahoma, College of Nursing, Oklahoma City, Oklahoma

Sherry L. Braheny, MD. Neurologist, Past Member of the California Medical Association, Council on Ethical Affairs, Grossmont Hospital, La Mesa, California

Alister Browne, PhD. Clinical Professor and Ethics Theme Director, Faculty of Medicine, University of British Columbia, Vancouver, Canada

Alexander M. Capron, LLD. University Professor, Scott H. Bice Chair in Healthcare Law, Policy and Ethics, Professor of Law and Medicine, Co-Director, Pacific Center for Health Policy and Ethics, University of Southern California, Los Angeles, California

Gretchen A. Case, PhD. Lecturing Fellow, Thompson Writing Program, Duke University, Durham, North Carolina, Adjunct Lecturer, Medical Humanities & Bioethics Program, Feinberg School of Medicine, Northwestern University, Chicago, Illinois

Lynette Cederquist, MD. Clinical Professor of, Internal Medicine, University of California, San Diego, California

René Claxton, MD. Clinical Instructor, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Diana Cohen Agrest, PhD. Associate Professor of Modern Philosophy, School of Philosophy, University of Buenos Aires, Buenos Aires, Argentina

Felicia Cohn, PhD. Director of Medical Ethics, Department of Medicine, University of California Irvine, Orange, California

Henri G. Colt, MD. Professor of Medicine, Division of Pulmonary and Critical Care Medicine, University of California Irvine, Orange, California

Stephen Crawford, MD. Medical Senior Director, Cigna Health Care

Michael D. Dahnke, PhD. Assistant Teaching Professor, Health Sciences and Health Administration Department, College of Nursing & Health Professions, Drexel University, Philadelphia, Pennsylvania

Peter E. Dans, MD. Associate Professor of Medicine, Johns Hopkins University, School of Medicine, Baltimore, Maryland

Mohsen Davoudi, MD. Assistant Professor, Division of Pulmonary and Critical Care Medicine, University of California Irvine, Orange, California

Richard A. Demme, MD. Associate Professor of Medicine and Medical Humanities, Center for Ethics, Humanities, and Palliative Care, University of Rochester Medical Center, Rochester, New York

Arthur R. Derse, MD, JD. Director for Medical and Legal Affairs, Center for the Study of Bioethics, Director, Medical Humanities Program, Professor of Bioethics and Emergency Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin

Douglas S. Diekema, MD, MPH. Professor, Department of Pediatrics, Department of Bioethics and Humanities, University of Washington School of Medicine, Seattle, Washington

Patricia Digilio, PhD. Professor of Philosophy, University of Buenos Aires, Argentina

Annette Dula, EdD. Advisory Board Member and Consultant, Tuskegee University National Center for Bioethics in Research and Health Care And Senior Associate, Womens Studies, University of Colorado, Boulder

Michael Farrell, MD. Assistant Professor of Internal Medicine, Pediatrics, and Population Health-Bioethics, Medical College of Wisconsin, Milwaukee, Wisconsin

Andrew Fenton, PhD. Project Manager, Situating Science Knowledge Cluster University of King's College and Member of the NTE Research Team, Novel Tech Ethics, Dalhousie University, Halifax, Nova Scotia, Canada

Marcia Santana Fernandes, PhD. Professor in Law, Faculty of Medicine–Federal University–UFRGS and Research Fellow, Laboratory of Bioethics and Science Research, Hospital de Clinicas, Porto Alegre, Brazil

David H. Flood, PhD. Professor, Medical Humanities, Medical Ethics, English Literature, Drexel University College of Nursing and Health Professions, Philadelphia, Pennsylvania

Cory Franklin, MD. Director Emeritus, Cook County Hospital, Chicago, Illinois

Lester D. Friedman, PhD. Chair and Professor, Media and Society Program, Hobart and William Smith Colleges, North Bethesda, Maryland

Thomas H. Gallagher, MD. Associate Professor, Departments of Medicine and Medical History and Ethics, University of Washington, Seattle, Washington

Christine Grady, RN, PhD, FAAN. Tenured Investigator, Department of Bioethics, National Institutes of Health Clinical Center, Bethesda, Maryland

Maren Grainger-Monsen, MD. Director, Program in Bioethics and Film, Stanford University Center for Biomedical Ethics, Palo Alto, California

James W. Green, PhD. Emeritus & Retired Faculty, Department of Anthropology, University of Washington, Seattle, Washington

Michael J. Green, MD, MS, FACP. Professor, Department of Humanities and Medicine, Penn State College of Medicine, Hershey, Pennsylvania

Joshua Hauser, MD. Assistant Professor, Buehler Center on Aging, Health and Society, Department of Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Illinois

Jennifer Hawkins, PhD. Trent Scholar in Bioethics and Associate Research Professor in Philosophy, Duke University, Durham, North Carolina

April M. Herndon, PhD. Assistant Professor, English and Women's and Gender Studies, Winona State University, Winona, Minnesota

Edmund G. Howe, MD, JD. Professor of Psychiatry, Director, Programs in Ethics at Uniformed Services, University of the Health Sciences, Bethesda, Maryland

Jay A. Jacobson, MD, MACP. Emeritus, Professor of Internal Medicine, Infectious Disease and Medical Ethics, University of Utah School of Medicine, Salt Lake City, Utah

Bruce Jennings, MA. Director, Center for Humans and Nature, New York, New York

Anne H. Jones, PhD. Harris L. Kempner Chair in the Humanities in Medicine, Professor and Graduate Program Director, Institute for the Medical Humanities, The University of Texas Medical Branch, Galveston, Texas

Therese Jones, PhD. Director, Arts and Humanities in Healthcare Program, Center for Bioethics and Humanities, University of Colorado, Denver, Colorado

Albert R. Jonsen, PhD. Professor Emeritus, Department of Medical History and Ethics, School of Medicine, University of Washington, Seattle, Washington, Senior Ethics Scholar in Residence, California Pacific Medical Center, San Francisco, California

Timothy Krahn, BA (Hons). Research Associate, Novel Tech Ethics, Department of Bioethics, Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada

Nicholas M. Lampros, BA. Creative Writing, University of California, Los Angeles, California

Stephen R. Latham, PhD, JD. Senior Lecturer in Political Science, Deputy Director, Bioethics Center, Yale University, New Haven, Connecticut

Solomon Liao, MD. Associate Professor, Department of Medicine, University of California Irvine, Orange, California

Sarah R. Lieber, BA. Pre-Doctoral Fellow, Department of Bioethics, National Institutes of Health, Bethesda, Maryland

David J. Loren, MD. Assistant Professor, Department of Pediatrics, University of Washington, Seattle, Washington

Carl Lundstrom, MD. Consultant, Division of General Internal Medicine, Department of Medicine, Mayo Clinic, Rochester, Minnesota

Robert C. Macauley, MD. Clinical Associate Professor, Department of Pediatrics, University of Vermont College of Medicine, Burlington, Vermont

Ignacio Maglio, PhD. Attorney at Law, University of Buenos Aires, Director, Legal Medical Risk Section, Hospital Fco. Javier Muñiz, Buenos Aires, Argentina

Irene Martinez, MD. Clinical Medical Ethics Fellow at MacLean Center at University of Chicago, Attending Physician, Internal Medicine, Primary Care, John Stroger Jr. Cook County Hospital, Chicago, Illinois

Marianne Matzo, PhD, GNP-BC, FAAN. Professor and Frances E. and A. Earl Ziegler Chair in Palliative Care Nursing, Sooner Palliative Care Institute, University of Oklahoma College of Nursing, Adjunct Professor, Department of Geriatric Medicine, Oklahoma City, Oklahoma

Thomas Wm. Mayo, JD. Director, Cary M. Maguire Center for Ethics and Public Responsibility & Associate Professor, Dedman School of Law, Southern Methodist University, Dallas, Texas

Keith G. Meador, MD, ThM, MPH. Professor of Psychiatry and Behavioral ciences, Center for Spirituality, Theology and Health, Duke University Medical Center, Durham, North Carolina

Lawrence Mohr, MD. Professor of Medicine, Environmental Biosciences Program, Medical University of South Carolina, Charleston, South Carolina

Letícia Ludwig Möller, LLM. Researcher at Bioethics Research Laboratory, Hospital de Clínicas de Porto Alegre, Brazil

Kristen R. Monroe, PhD. Professor of Political Science and Philosophy, Director of the UCI Interdisciplinary Center for the Scientific Study of Ethics and Morality University of California, Irvine, Orange, California

Stephen Murphy-Shigematsu, EdD. Center for Comparative Studies in Race and Ethnicity, Stanford University, Stanford, California

Deirdre Neilen, PhD. Associate Professor of Bioethics and Humanities, Center for Bioethics and Humanities, SUNY/Upstate Medical University, Syracuse, New York

Lawrence J. Nelson, PhD, JD. Senior Lecturer, Department of Philosophy, Santa Clara University, Santa Clara, California

Lois L. Nixon, PhD, MPH. Professor, Division of Ethics and Medical Humanities, Internal Medicine, College of Medicine, University of South Florida, Tampa, Florida

Bradley Olson, PhD. Assistant Research Professor, Foley Center for the Study of Lives, Human Development and Social Policy, Northwestern University, Evanston, Illinois

Kirsten Ostherr, PhD. Associate Professor of English, English Department, Rice University, Houston, Texas

Kayhan P. Parsi, JD, PhD. Associate Professor, Neiswanger Institute for Bioethics and Health Policy, Loyola University Chicago Stritch School of Medicine, Maywood, Illinois

Maria Luisa Pfeiffer, PhD. Doctor of Philosophy, Lecturer at the Faculty of Medicine of the University of Buenos Aires, Researcher, National Research Council (CONICET) of Argentina

Mark S. Pian, MD. Clinical Professor, Department of Pediatrics, University of California / Rady Children's Hospital, San Diego, California

Silvia Quadrelli, MD, PhD, MEd. Assistant Professor in Internal Medicine, University of Buenos Aires, Buenos Aires, Argentina

Elizabeth Reis, PhD. Associate Professor, Women's and Gender Studies Department, University of Oregon, Eugene, Oregon

Annette Rid, MD. Post-doctoral Fellow, Department of Bioethics, NIH Clinical Center, Bethesda, Maryland, Assistant Professor, Institute of Biomedical Ethics, University of Zurich, Switzerland

Jeffrey M. Ring, PhD. Director of Behavioral Sciences, Family Medicine Residency Program, White Memorial Medical Center, Los Angeles, California

David I. Rosenthal, MD. Medical Program Manager, Brigham & Women's Hospital, Harvard Medical School, Boston, Massachusetts

Alan Roth, MS, MBA, FAARC, FAAMA. Director, Respiratory Care and Rehabilitation Services, Memorial Medical Center, Modesto, California

Sadath A. Sayeed, MD, JD. Instructor, Division of Medical Ethics, Department of Global Health and Social Medicine, Harvard Medical School, Boston, Massachusetts

Carol Schilling, PhD. Visiting Scholar, Center for Bioethics, University of Pennsylvania, Philadelphia, Pennsylvania

Toby L. Schonfeld, PhD. Director, Center for Humanities, Ethics and Society, Associate Professor and Vice-Chair, Health Promotion, Social and Behavioral Health, College of Public Health, University of Nebraska Medical Center, Omaha, Nebraska

Judith Kennedy Schwarz, PhD, RN. Clinical Coordinator, Compassion & Choices of New York, New York, New York

Seema K. Shah, JD. Bioethicist, Clinical Center Department of Bioethics & Division of AIDS, National Institutes of Health, Bethesda, Maryland

Johanna Shapiro, PhD. Professor, Department of Family Medicine, Director, Program in Medical Humanities and Arts, University of California, School of Medicine, Irvine, Orange, California

Jerome Singh, PhD. Adjunct Professor, Program on Ethics and Commercialization, McLaughlin-Rotman Centre for Global Health, University of Toronto, Ontario, Canada

Rhonda L. Soricelli, MBBS (Sydney). Adjunct Assistant Professor, Department of Family, Community and Preventive Medicine, Drexel University College of Medicine, Philadelphia, Pennsylvania

Karma Lekshe Tsomo, PhD. Associate Professor, Department of Theology & Religious Studies, University of San Diego, California

Joseph Turow, PhD. Robert Lewis Shayon Professor of Communication, Annenberg School for Communication, University of Pennsylvania, Philadelphia, Pennsylvania

Delese Wear, PhD. Professor of Behavioral and Community Health Sciences, Northeastern Ohio Universities College of Medicine, Rootstown, Ohio

Alan Wertheimer, PhD. Professor Emeritus of Political Science, University of Vermont, Senior Research Scholar, Department of Bioethics, Clinical Center, National Institutes of Health, Bethesda, Maryland

September Williams, MD. Senior Physician Specialist (Geriatrics, Palliative Care, Bioethics), Laguna, Honda Hospital, San Francisco Department of Public Health, San Francisco, California, Writer-Director Ninth Month Productions, Mill Valley, California

Rebecca E. Wolitz, BA. Bioethics Fellow, National Institutes of Health, Department of Bioethics, Bethesda, Maryland

Nazanin Z. Rohani, MD. Research Associate, Department of Pulmonary and Critical Care, University of California Irvine, Orange, California

part one

personal reflections about film and ethics

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frankenstein and the birth of medical ethics

albert r. jonsen

BIOETHICS BEGAN AT THE MOVIES. To be less dogmatic, a movie inspired one of my first bioethics classes for medical students. I joined the faculty of the Medical School, University of California, San Francisco in 1972, as professor of bioethics, one of only a few such professors in American medical schools. Until that time, I had been teaching philosophy to college students and had no experience in medical education. I quickly learned that the airy abstractions of philosophical ethics floated far over the heads of medical students concerned with bodies and diseases, not theories and conjectures. I had to find a new mode of communication.

To learn a bit more about medicine and its culture, I sat in classes with students. These classes were filled with data; the professors were devoted to summarizing it and, on rare occasions, pointing it toward some future encounter with sick persons. Above all, the classrooms were darkened, illuminated only by slides that, one after another, showed charts or cells. Aha, I thought, if I could only put bioethics on slides it might appear to be a viable topic for medical education.

Bioethics then had no data, no numbers, and no charts. I recoiled from merely marking up slides with the words I was uttering. Then, a happy coincidence solved my problem. I saw director James Whale's classic 1931 film, *Frankenstein,* on television and, a few days later, found a paperback book that contained still photos of the entire film. Starring Boris Karloff as the monster and Colin Clive as the mad doctor, *Frankenstein* is a treasure trove of bioethical images. I bought the book and had slides made of most of its episodes—the oddest slides ever produced in the medical school's Classroom Aids department. Thereafter, the Creature, Dr. Frankenstein, and his assistant Fritz introduced my medical students to the problems of medical ethics.

Informed consent, the determination of death, life support, the ethics of research, and transplantation—usual topics of those early bioethics courses—were dramatized by the creature appearing at Dr. Frankenstein's clinic with a pleading look and begging for help, by Dr. Frankenstein lopping off and sewing together pieces of the cadavers he had filched from the local cemetery, by Fritz stealing from a research lab a pickled brain marked "Dysfunctional," and, best of all, by the triumphant moment when Dr. Frankenstein focuses lightning onto his stitched creature and bringing it to life. Much to my delight, I realized that there was hardly a bioethics issue that could not be illustrated by some scene from that wonderful film. In fact, Mary Shelley's novel of Dr. Victor Frankenstein (written in 1816) was an astute commentary on the collision between the human and the scientific world and, as such, provided an accessible pathway to understand why bioethics was coming into being as a field of study.

In the late 1960s, a few insightful persons who understood that the scientific and medical advances that marked the first half of the 20th century also contained moral dilemmas created the bioethics field. Those medical innovations and scientific advances that revolutionized the treatment of disease tapped into "secrets" of physiology and psychology that showed how to "remake" humans. They opened the mysteries of reproduction and heredity, and made it possible to "make babies" outside of the body and according to design. These possibilities bestowed creative powers on scientists and, with them, the capacity to do both good and evil. Such power recalls the tale of Frankenstein, the genius scientist who imparted existence to a lifeless bundle of parts collected from cadavers. Because Frankenstein did not know how to deal with his marvelous creature, it became a monster, dangerous to all humans and to itself.

Indeed, the name itself became an easily recognizable phrase for the dangers of medical research delving into realms beyond its control. Popular writers from the 1960s onward often referred to scientific accomplishments as "Frankensteinian." In the early days of organ transplantation, commentators sometimes compared surgeons to the mad scientist and patients to the poor patched creature. In the early days of molecular genetics, Frankenstein lurked in the laboratories. A politician opposed Harvard's plan to build a genetics laboratory with the alarm, "Frankenstein's monsters will crawl out of the sewers of Cambridge." Opponents of genetically engineered crops call them "Frankenfoods," and genetically engineered organisms are named "Frankenbugs."

This literary reference is extravagant but pointed. The Frankenstein story is a fable about modern scientific power. Dr. Frankenstein imparts life to a body he has pieced together from parts snipped from cadavers. He has discovered the "secret of life," and he makes dead matter alive. He also gives that living being a physical form (he intended it to be beautiful, but his hasty surgery created something ugly) and a psychological character (he intended it to be benign but, by his own mistreatment of it, it turned malign). He created it with the best of intentions—to solve the mystery of disease and death—but his good intentions went lethally wrong. Many commentators have found this riveting novel to be emblematic of modern science: it too has powers to create life, to sustain it, to shape its qualities. At the same time, it has not conquered death, and its mastery of nature is fallible. And it can go horribly bad. The bioethical questions acknowledge these powers and their limits and, above all, interrogate the responsibility of decisions that accompany the power of creation. At the root of bioethical probing lies an even more fundamental question: What is it to be alive or more particularly, to be alive as a human being, a person? What are the moral duties and constraints that confront us as we enhance the powers over who lives, who dies?

Mary Shelley wrote the Frankenstein narrative in an era when science was on the verge of the world that makes bioethics necessary. In the early 18th century, brilliant minds examined the mysterious workings of the human body with new interest and ingenuity. Chemistry, which for a century had dissolved minerals and

fluids, began to turn to the composition of the human organism. Oxygen became a topic of avid study. In the early 19th century, the subject of "animal chemistry" encouraged scientists to study the processes of digestion and describe components even as we still do, into "oleaginous foods" (fats), "saccharinous foods" (carbohydrates), and "albuminous foods" (proteins). The field of physiological chemistry was born and, for the rest of the 19th century, unraveled the ways life originated and is sustained by respiration, nutrition, and elimination. The cellular theory and the germ theory revolutionized the understanding of disease. The structure of tissues and the hitherto hidden marvels of reproduction were observed through the microscope.

Also at the end of the 18th century, physics, which had lived in the glory of Newton's laws of motion and theory of gravity, began to investigate the physics of life. Electricity seemed to link nonliving and living matter. In 1792, Italian anatomist Luigi Galvani (or rather his wife) noted that the muscles of severed frog legs contracted and twitched when stimulated with an electric shock. "Galvanism" was coined to describe the power of electromagnetic force (imagined as a sort of fluid) to animate organic matter. In the same year, Alessandro Volta had published studies on the electrical stimulation of muscles, and several years later invented the battery to generate electrical power.

While chemists and physicists worked in their laboratories, a literary party vacationed at a lake near Geneva, Switzerland. Two of England's most famous poets, George Gordon Lord Byron and Percy Bysshe Shelley, rented adjoining villas. With Shelley was his lover and later wife, Mary, the 19-year-old daughter of philosopher William Godwin and feminist writer Mary Wollstonecraft (who died giving birth to her). Together, these literary neighbors passed balmy days sailing and stormy evenings telling ghost stories. On the evening of June 15, 1816, Byron, Shelley, and another guest, Dr. John Polidori (who later, in 1819 wrote the first vampire story in English) discussed "the principle of life." In the language of the time, "principle" meant origin, source, first cause. For example, John Hunter, a great English physician of the time, considered blood the "life-principle," distinguishing living from nonliving. Shelley and Polidori were both interested in scientific investigation and were familiar with the work of the esteemed scientist and physician, Dr. Erasmus Darwin (Charles Darwin's grandfather) who had investigated galvanism. During that evening conversation, the poets speculated that, "perhaps a corpse would be reanimated; galvanism had given token of such things; perhaps the component parts of a creature might be manufactured, brought together, and endued with vital warmth." Mary, "a devout but nearly silent listener" to that fascinating conversation, recorded those words. She could not sleep that night but saw "with acute mental vision" the shaping of a story. During that sleepless night, her imagination gave birth to her novel *Frankenstein*, the first text for bioethics.[1]

The story is well known. While still at university, Victor Frankenstein, a brilliant student of chemistry and physiology, becomes entranced by the idea of creating

a living creature by means of galvanism. His motives are noble: "wealth was an inferior object; but what glory would attend the discovery if I could banish disease from the human frame and render man invulnerable to any but a violent death." His intense studies finally shed on his mind "a light so brilliant and wondrous… the astonishing secret… the cause of generation and life, nay more, I became myself capable of bestowing animation upon lifeless matter." He decides to compose a creature "like himself… and give life to an animal as complex and wonderful as man." He collects, gathers, and composes all the needed parts from cadavers, then jolts the stitched amalgam with an electric shock from a "powerful machine." The composite cadaver comes to life. Frankenstein, however, is horrified by his creation's hideousness and cruelly repudiates it. The "Monster" or "Wretch," as Frankenstein calls it, desperately seeks to understand how he came into being and to express his feelings in language. He yearns for acceptance by humans. He masters language but wanders alone, an outcast never welcomed into the human community. Rejection turns his originally compassionate nature to bitterness and then to violence. He tells Frankenstein, "I was benevolent and good; misery made me a fiend. Make me happy and I shall again be virtuous." His creator cannot make him happy and, in the end, the Monster, now called the Fiend, kills its creator—and everyone he loves. The 1931 film vividly, though rather inaccurately, visualized the novel and remains a staple of late-night movies.

Mary Shelley's novel was more than a chilling ghost story. It was a moralizing tale subtitled "The Modern Prometheus." Her readers, familiar with classic legend and literature, would have immediately understood this classical allusion: Prometheus was a rebel Titan who stole fire from the gods and brought it to mankind, a theft for which he was grievously punished by being bound to a rock while great eagles feasted daily on his liver only to have it grow back the next day to be eaten again. However, the classically trained reader would also recall Prometheus Plasticator, Prometheus the Maker, who shaped the human form from clay, readying it to receive heavenly fire, as the cause of its life and thought. Ancient literature portrays this artist as less than competent and relates the many human ills that result from his imperfect construction.

Victor Frankenstein, a modern Prometheus, hoped to create a beautiful being of great power and ingenuity but failed not in his vision but his execution of it. The Monster blames his creator for his unhappiness and for his crimes. Mary Shelley wrote a warning for those who would carry their science into the mysteries of the creation of life. To affirm that this fantastic story was not mere imagination, her husband, Percy, opened the preface that he composed for the first edition with the words, "The event on which this fiction is founded, has been supposed, by Dr. Darwin, and some of the physiological writers of German, as not of impossible occurrence." This was a moral tale about science and its future achievements.

I said that *Frankenstein* could be considered the first text of bioethics. That rather melodramatic claim needs some clarification. First, I do not mean that modern medicine and biological science is a horror story, telling how scientists

create, willy-nilly, monsters rather than miracles. Bioethics is not a rounding condemnation of medical science (though some would make it so). It is not even a detective story, trying to find evil machinations behind each miracle. For, while science can go wrong, and medicine can harm instead of heal, the general direction has been toward human benefit. Only a kind of moralistic paranoia wants to suspect evil in every good.

Still, the story of Victor Frankenstein contains some of the essential elements of modern bioethics. First, it is a story about life, making alive and reviving life. The "bio" in bioethics means "life." The word "life" is itself ambiguous. It can mean the course of a person's history from birth to death. Its major moments can be listed in a "bio," or picturesquely or poignantly described in a biography. It can also mean the processes that sustain organic life, the complex activities of cells, programmed by genes, in interaction with a nourishing environment. All of the "bio" sciences; biology, biochemistry, and biophysics, study facets of these processes.

The fictional Victor Frankenstein immersed himself in these studies (in their very immature forms) and burns to bring them from theory to practice. By creating life in a cadaver, he has found "the principle of life." He wants to "banish disease from the human frame." His scientific quest has a healing goal; it is meant to provide ultimate success to the medical task that is, in Hippocrates' words, "to alleviate pain and lessen the violence of disease" (*The Art, iii*). Medicine deals with life in the biological sense and equally with life in the biographical sense. Physicians manipulate biological process, so that the life-course of an individual can progress without pain or disability. They must know the biography of their patients, as well as the biology. In dealing with the patient as a person, physicians must observe standards of behavior that we call "ethics," the other half of the word bioethics. Even more, the power of science must be ethically employed as it is brought into contact with human life. So, the Frankenstein story, in which a scientist revives a living being and then must decide how to behave in relation to it, is an anticipation of bioethics.

The practitioners of modern bioscience have yet to restore life after death has truly taken place. However, they can initiate life, imitating sexual reproduction in a laboratory dish, and can sustain life as a merely organic process long after personal life has disappeared. They cannot yet compose a complete human being out of exhumed organs and impart life to it. However, they can lift organs from a cadaver and implant them in a person whose own organs have failed. These men and women of medicine can substitute mechanical devices for organic parts and functions. Whenever they perform one of these actions, they encounter the standards of behavior we call ethics because the action is performed, not in a chemical preparation or physical device, but with a human person. The work of bioethics is to examine the points at which the biosciences touch human life, in individuals and in societies. The purpose of the examination is to discern how the science and its products can bring benefits with as little harm as possible. Bioethics seeks to form

a picture of human persons and human society that can guide the vision and intentions of scientists.

Bioethics, however, is much more than a picture or a vision of an ideal world in which scientific discoveries and human dignity are in harmony. It is a field of practical ethics concerned with particular problems and cases of moral perplexity. *Frankenstein*, the film, contains many such moments of moral perplexity about how humans should treat the creature. The film does not linger on these perplexities, but sweeps to its dramatic ending. In real life, where scientific medicine meets the needs of particular patients, moral perplexities do—or should—bring a pause for reflection. The real moral case is a convergence of elements: the unique medical situation and possible medical responses; the desires, preferences, and choices of a particular patient; the judgments made about the worth and dignity of life, and particular life conditions and styles; the context of financial costs, laws, institutional constraints, and public welfare. All these converge into a case.

Bioethics has evolved as a form of moral philosophy that attempts to analyze these cases of moral perplexity and to render advice about how best to proceed, in the light of our understanding of moral principles. This form of bioethics is sometimes called *clinical ethics* to distinguish it from the broader vision of a humane medicine. Clinical ethics draws, consciously or unconsciously, on an ancient form of moral analysis called *casuistry*. Casuistry sorts out different kinds of moral dilemmas, governed by distinct moral values and principles.[2] It then attempts to fill out these general forms of moral dilemmas with the circumstances of the real case under consideration. It compares this case with other similar cases and with proposed solutions. This process has as its goal a decision about how to manage the medical case in a way that best meets standards of moral rightness, and also respects the very unique circumstances of real life.

Mary Shelley bestowed on Victor Frankenstein the title "The Modern Prometheus" because he sought to do what the legendary Titan did, namely, make a human being. The modern biosciences all conspire toward the same goal. The modern making of humans consists in the correction of the physical and mental faults and failures that bring disease and death. Making is an activity in which the mind forms an image of something that will come into being as the hands manipulate material to meet that image. Human purposes and motives guide the making and decide what is to be done with the product. Human purposes, however, are not only overarching goals filling a wide vision, but also many particular choices made at various juncture of human experience. These particular choices are the common, daily matter of our moral lives; the broad vision may be present, but it is often vague and unarticulated. Bioethics needs both. It must attempt to articulate the meaning, value, and dignity of human life, and it must respond to questions such as "under what conditions should this human life be saved?" The first task is a grand philosophical question; the latter task is casuistry. The Frankenstein story and the movies made from it point in both directions. It can be rightly honored as a beginning for bioethics.

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a personal journey using film to teach medical ethics

peter e. dans[i]

GROWING UP IN A COLD-WATER flat on Manhattan's Lower East Side, movies were a ticket out of the neighborhood and into other worlds.[1,2] As such, I was happy to find a way to incorporate them into my professional life. I first ventured into using films for teaching at the University of Colorado, during the 1970s, in the dark days before video recorders. Later, I used film while directing the required first year ethics and medical care course at Johns Hopkins University School of Medicine. A significant consideration in teaching medical ethics in a secular environment is that the students come from heterogeneous backgrounds and have diverse beliefs about both secular and spiritual issues. When they enter the classroom, they are strangers to one another and to their teachers. We were able to conduct a detailed, anonymous survey of incoming students at each yearly orientation from 1984 to 1990, however, in order to learn about their experiences in medical care, their understanding of ethics, their attitudes toward ethical issues, and the norms they used in making moral judgments.[3,4] We thus learned about their varying beliefs regarding contentious issues: whether life began at conception, birth, or somewhere in between; if they had cheated in college, high school, and elementary school; and when, if ever, was lying permissible.

The survey also served to help students understand that this course would not simply be a series of bull sessions or a rest-and-recreation period from "real" courses like anatomy and biochemistry. Rather, it was intended to foster their understanding that the discipline they were about to study, normative ethics, was as important to their personal and professional lives as the so-called "hard" sciences.

Normative ethics is that branch of moral philosophy that systematically and formally examines the rightness and wrongness of actions using general principles (e.g., autonomy and beneficence), theories (e.g., utilitarianism and deontology), standards (e.g., codes, virtues, and religious precepts), and nonstandardized approaches (e.g., cultural relativism, intuition, and secular humanism). Collating student responses allowed faculty members an infusion of insights, so that we could preview potential areas of discordance and concordance before students wrestled with contentious subjects in small discussion groups. We could also gauge the differing sophistication of class members depending on their background in philosophy and medicine, as well as their pluralism with regard to the norms used to resolve dilemmas.

The course was taught in three-hour sessions twice a week for nine weeks. Like many courses in moral judgment, topics consisted of what might be called mega-ethics, featuring true dilemmas in which opposing views cannot be easily

reconciled, and in which the use of differing norms to resolve dilemmas often leads to disparate outcomes. For example, we studied abortion, a topic that had been excluded from the curriculum by the previous course director because it was considered to be too emotionally charged to be discussed with equanimity, especially in such a pluralistic setting. The session began by debating issues such as a woman's right to privacy over her body, where a fetus becomes a person on the continuum from conception to birth, whether it has rights and, if it does, when and to what degree they are commensurate with those of the mother. We insisted that all students participate in the lectures and discussion groups because, as caregivers, they would not be able to opt out of contentious issues when facing their patients.

The students' beliefs about personhood and attitudes toward abortion were thus displayed.[3] The concept of negative and positive rights, especially with regard to payment for abortion, was addressed.[5] Students were then shown the Public Broadcasting System film *Abortion Clinic*,[6] from the Emmy award–winning *Frontline* television program hosted by Jessica Savitch (initially aired on April 18, 1983). To prepare for this remarkably well-balanced program, Savitch had interviewed numerous women at the Reproductive Health and Counseling Center in Chester, Pennsylvania, and focused on two who chose abortion and two who did not. She interviewed doctors and nurses who worked in the clinic, as well as those protesting outside, including a pro-life physician. Students were thus able to put human faces on the women, the protestors, and the clinic personnel.

Heated arguments were avoided by encouraging students to use the technique of "active listening,"[7] which I had found particularly helpful while conducting pediatric oncology rounds, where nurses, social workers, and doctors held strong and sometimes-conflicting opinions about treatment choices. The technique consists of asking speakers, before they voice a forceful and contrary opinion, to restate what the previous speaker said, thus forcing him or her to listen and not simply rehearse their opinion while awaiting their turn to speak. Furthermore, rather than injecting their opinions, faculty moderated these sessions, thus allowing the discussion to flow among the students. The response to the sessions was very positive, with students gaining a better understanding of the arguments on both sides of the issue, while not necessarily changing their own opinions.

In the case of euthanasia, we prefaced the viewing of the film *Dax's Case*[8] by first discussing the distinction between active and passive euthanasia, as well as by discussing related issues of autonomy, competence, beneficence, and sanctity of life. This was followed by the half-hour film *Please Let Me Die*,[9] originally produced for a bioethics seminar at Southern Methodist University by Dr. Robert B. White, a psychiatrist at the University of Texas Medical Branch at Galveston, who had been one of the consulting physicians in Dax's case.

The film recounts how Donald "Dax" Cowart, a handsome Air Force Reserve pilot, was severely burned when his car's ignition set off a raging fire of propane gas that had leaked onto property he and his father were inspecting. He was

massively disfigured, left blind and in considerable pain. Students were asked to focus on the various participants in the case and the various decision points. First, there was a farmer who had rescued Dax and had refused to give him a gun to shoot himself. Instead of walking away, which would have assured Dax's death, the farmer called 911, thus engaging the medical care system, beginning with emergency response of an ambulance and medics. Dax's father died in the ambulance, and Dax refused treatment en route; however, once he arrived at the emergency department of the rural hospital, physicians decided to stabilize him and then to refer him to the tertiary care center at Parkland Hospital in Dallas, all the while providing treatment against his wishes.

His mother had just lost her husband and did not want to lose her only son. She and her lawyer insisted that he be treated, even though it involved considerable pain, and they ignored his pleas to be allowed to die. Much of the debate centered on whether and when Dax was considered competent to make decisions about his care. Students discussed other factors affecting the reluctance of the staff to accede to his wish to be allowed to die: his favorable prognosis, the fact that he was not imminently and irreversibly dying, and that complying with his wishes would have meant essentially walking away from him and withholding food, water, and medicines unless direct active euthanasia was performed.

Believing that it was important for students to commit themselves before hearing the rest of the story, we asked them to vote on whether Dax should have been allowed to die, as they would have had to do if they had been in charge of the case. They were then shown a follow-up documentary produced by Keith Burton entitled *Dax's Case,*[10] which consists of interviews with the surviving participants. The students learned that Dax was discharged and, at one point was so adamant about dying that he escaped from his mother's house and made an unsuccessful attempt to reach a nearby road to get run over. Resigned to his fate, he married and pursued a law career devoted to championing patient autonomy.[ii] The students then discussed how what they learned about his subsequent life affected their beliefs as to whether he should have been allowed to die, and when and how that would have been accomplished had they acquiesced.

I also use film to teach "doctoring" from a historical perspective. We don't often have the luxury today of canvassing lecture attendees beforehand and feeding back their attitudes, nor is time allotted to show a complete film. So, except for rare occasions, I use scenes that focus on the portrayal of doctors in films dating from 1931 to the present, ranging from positive in early films to decidedly negative beginning in the 1980s.[2] By focusing on doctors collectively or as particular subsets (e.g., women doctors, medical students, specialists, etc.), these presentations aim at showing what patients value, or by contrast, are concerned about with regard to medical care, as well as medical ethics. It's important, therefore, to know the film well, in order to select the most instructive scenes. By viewing the film on multiple occasions, I am able to see things missed on first viewing and sometimes, even reevaluate a film once liked (*M*A*S*H*) or disliked (*The Interns*). What you get out

of a film often depends upon what you bring to it, such as your stage in life, attitudes, and the cultural climate at the time you viewed it.

In large part, films provide snapshots of the conventional wisdom of the day. Filtered through the studio, screenwriter, and director, they illustrate the evolution of societal perceptions of a topic over time. In this way, films represent an intersection of medical ethics and history. For example, I began a presentation on abortion in film[11]—as part of a University of Michigan Medical School elective entitled "Contemporary Issues in Women's Health" (November 2007)—with a scene from *Men in White* (1934), in which a student nurse becomes pregnant, obtains an abortion, and dies of a pulmonary embolus. Tracing the trend line from there, the portrayal of abortion follows the evolution of its societal acceptance: from once being illegal and unethical according to the Hippocratic Oath and the American Medical Association (AMA) Code of Ethics, and considered generally immoral except when the life of the mother was at stake, to the present, where it is both legal and generally considered ethical except in Catholic hospitals, while remaining a highly contentious issue with respect to its morality.

Other films that show this progression include *The Interns* (1962), which also wrestles with the issue of euthanasia, in which an intern (Cliff Robertson) who tries to steal Pitocin to give to his pregnant girl friend (Suzy Parker) in order to induce an abortion is dismissed from the hospital; *Love with a Proper Stranger* (1964), in which the woman (Natalie Wood) walks out on the abortionist and ultimately marries the father (Steve McQueen) of her child; and the original *Alfie* (1966), in which a notorious womanizer (Michael Caine) arranges an abortion for the married woman involved in a one-night stand. In all three films, those performing abortions or wishing to do so are portrayed unsympathetically.

In several later films, however, those performing abortions were portrayed sympathetically and, as in *Cider House Rules* (1999) or *Vera Drake* (2004), in a laudatory manner. In turn, these portrayals have given way to movies in which abortion is rejected. This includes the remake of *Alfie* (2004), in which the woman (Nia Long), instead of having an abortion as in the original, leaves the abortion clinic and decides to have the baby. In *Waitress* (2007), a mother (Keri Russell), who despises her abusive husband, decides to go through with her pregnancy saying, "the child has a right to thrive." In *Knocked Up* (2007), a female television anchor (Katherine Heigl) decides to keep a child resulting from a one-night stand, and improbably marries the creepy father (Seth Rogen). In *Juno* (2007), an unwed adolescent mother (Ellen Page) leaves the abortion clinic and decides to put her child up for adoption. In *Bella* (2006), essentially the same thing occurs.

The reason for this attitude change in Hollywood films may relate to the ubiquity of ultrasound beginning early in pregnancy. In *Knocked Up*, this connection is fairly explicit when the parents see the beating heart at eight weeks and, during subsequent ultrasounds, recognize how early the fetus has a human appearance. From a historical perspective, issues such as personhood, rights of the unborn, whether the wishes of the father play a role in the decision to abort the pregnancy,

and what, if any, lasting medical and psychological aftermaths occur after an abortion have come even more to the fore than when we were discussing this issue years ago.

Studying feature films from a historical perspective has also shown the virtual disappearance of references to codes of medical ethics that had been enshrined for over two millennia. If one asks physicians and even patients what comes to mind when they hear the term *medical ethics*, most would respond the Hippocratic Oath (although many might not be able to say what's in it, and its wording often differs from version to version[12]). Other codes, like that of Maimonides and later of Percival,[13] augmented rather than superseded the Oath.[iii] Scenes that feature the Hippocratic Oath are useful in discussing how it came to represent medicine and then how it was modified, beginning with the elimination of the proscription of both abortion and the administration of a deadly draught to the dying, into the many different versions in use today.[iv]

Exploring film from a historical perspective also provides insight into the evolution of the ethics of medical research. A number of older films treat this subject quite seriously. In *Arrowsmith* (1931), two scenes are particularly on point. The first is that showing Arrowsmith recite a researcher's prayer when he is given a laboratory in the McGurk Institute (representing the Rockefeller Institute in New York). The second is when Arrowsmith is shown testing plague vaccine in a randomized trial on a Caribbean island. The importance of a randomized trial in the development of an anthrax vaccine in sheep is shown in *The Story of Louis Pasteur* (1936), and in *Dr. Ehrlich's Magic Bullet* (1940), testing the efficacy of Salvarsan for the treatment of syphilis in humans. When one considers these films, along with the impassioned plea for research shown in *Madame Curie* (1943) and *The Citadel* (1938), one is impressed with how, unlike today, filmmakers did not feel the need to talk down to their audience or dumb down scientific concepts.

Having proposed the advantages of using film to study an ethics issue from a historical perspective, I should also describe some hazards. First, you need to know the composition of your audience. Setting the scene is important in all cases, but becomes most critical when there are marked disparities in a class's knowledge, attitudes, backgrounds, and experience. The second relates to how much time you have and whether you can break students into small groups for discussion and, if not, the possibility of meaningful interaction in the large group setting. While scene selection is easier because of DVDs, Internet sources, books, and screenplays devoted to particular films, one should probably retain only enough frames to trigger discussion or make a point. By and large, the scenes should probably not exceed five minutes, sequenced on DVDs using menus that allow stopping and starting, as well as skipping around or truncating a presentation, if necessary.

A third consideration, especially if the subject is controversial and highly charged, is to wrap up the session by providing a substantive conclusion that encourages the attendees to continue rational discussions (since the intent is to continue to wrestle with it) rather than heated argumentation. In this respect, one

should use caution when showing politically motivated or manipulative films, as well as those filled with falsehoods, unless that's the subject of the lesson. While films by Michael Moore and Oliver Stone represent the extreme in this regard, many films conflate or distort history to sway the audience.[v] In short, in selecting a film, the watchword should be caveat emptor.

I often ask students and residents about ethical dilemmas they encounter in daily practice. The vignettes they describe are rarely true dilemmas in that, after ascertaining more facts and the patient's preferences, the choice is usually clear. However, while not being examples of dilemma ethics, they are what might be called *everyday ethics* because caregivers, who are taught to practice beneficence (to do well by the patient), make many decisions daily, often without all available data and with limited time. Beneficence is manifested when these decisions are accompanied by a kind word, smile, or the simplest of actions to help patients cope with even the most mundane condition. That is why the doctor's character is a patient's most important safeguard.[vi] In *The Fugitive* (1993), one of my all-time favorite films, Harrison Ford plays a doctor who has been falsely convicted of killing his wife. He sets about trying to find the real killer, and although on the run from the law, can't help being a doctor. While posing as a janitor, for example, he is asked by a triage nurse to wheel a young boy with a fractured sternum to the observation area. Realizing the seriousness of the condition, he enters a note in the chart, and delivers the boy to the operating room. A nurse is scolded by a detective for not detaining Ford after realizing what he had done. Tired and wanting to go home after a long night, she can only answer that "He saved the boy's life." That's what the best of beneficence is all about; self-abnegation, denying one's needs and giving priority to another's. Health care professionals do that daily and, yes, they are practicing ethics while doing so.

NOTES

i. Dr. Dans authored the "Physician at the Movies" section of the Alpha Omega Alpha Honor Medical Society's quarterly journal Pharos, and a book on Hollywood's portrayal of doctors in film from Arrowsmith (1931) to Patch Adams (1998).[2]

ii. Despite his apparent successes, Dax still maintains that he should have been allowed to die and that medical professionals violated his rights.

iii. Percival's Code of the Gentleman served as the basis for the AMA Code of Ethics until the 1970s.

iv. Films in which the Oath is prominently featured include *Mary Stevens M.D.* (1933); *Men in White* (1934); *The Girl in White* (1952), the story of real-life physician Emily Dunning Barringer; *The Interns* (1962); and, for the Oath of Maimonides, *The Symphony of Six Million* (1932).

v. One example of such distortion and manipulation is the 1960 film *Inherit the Wind*, which is used in many high schools but whose portrayal of the Scopes Trial and its principals was totally debunked in Edward Larson's Pulitzer Prize winning 1997 book *Summer for the Gods.*[14] To a much lesser degree, the same holds for the 1992 film

Lorenzo's Oil, which painted a distorted picture of the researcher vis a vis the parents with regard to the development and use of an experimental treatment in a child fated to die from adrenoleukodystrophy.[2]

vi. To illustrate this, I have found the following films to be most useful: The Kildare films, including the first one wonderfully titled *Interns Can't Take Money* (1937); *Meet Doctor Christian* (1939); *People Will Talk* (1951); *The Last Angry Man* (1959); and *Awakenings* (1990).

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3

movies help us explore relational ethics in health care

johanna shapiro

MANY MEDICAL SCHOLARS HAVE NOTED the potential of movies to address broad philosophical and ethical questions pertinent to the practice of medicine. For example, Baños argues that movies are a better way to teach about the patient–clinician relationship than are didactic presentations.[1] Yamada, Maskarinec, and Greene note that movies provide a forum for helping learners understand that illness has a moral trajectory as well as a medical course; and to help students in medicine, nursing, and related health professions to see themselves as moral actors.[2] Saab et al. point out that a good movie causes learners to ask reflective, introspective, self-critical questions about ethics in the context of relationships and emotion,[3] while Quadrelli, Colt, and Semeniuk demonstrate how it can teach students to resist social injustice.[4] Indeed, movies clearly are a valuable tool to encourage us to puzzle through questions about doing what is right, avoiding cynicism and disillusionment, and maintaining kind and compassionate hearts.[5] Movies facilitate reflection on such philosophical questions as the nature of medicine, sickness and health, life, death, and suffering.[6] Although movies can promulgate important truths about the human condition, they rarely offer entirely accurate factual scenarios. As such, they may persuade students to ponder the possibility that factual information is not the only source of learning[7]; therefore, questions about ethics and meaning, for example, may be more effectively examined through artistic media such as film than through didactic presentations.

Film is especially well positioned to help learners interested in the health professions recognize that caring for patients necessarily embodies principles of relational ethics and intrinsically contains both inherent moral value and incurs inevitable moral responsibility.[8] The theories and practices of relational ethics in health care have been developed primarily in nursing. Since one essay cannot do justice to the entirety of relational ethics as a moral philosophy, I will focus on only a few key themes often addressed in movies featuring serious illness and the patient–clinician relationship: empathetically understanding and respecting the experience and perspective of the suffering other; reflecting on the full range of personal emotions and judgments that emerge in response to the patient's situation; exploring the "proper" professional connection between clinician and patient; and considering how to translate these dimensions into meaningful relationships in "real" clinical situations. These foci reflect the essential elements of relational ethics,[9,10] that interactions with others are the location for ethical action[11] and a source of moral knowing[12]; that emotional engagement is as important as cognitive

understanding in developing empathy for the other; and that mutual respect, including acceptance of difference, must anchor all relationships.

Within this essay, I will reference easily accessible American narrative films[i] that quickly capture a viewer's attention and engage him or her emotionally.[13] Such hallmarks focus learners on essential aspects of patients' illness experiences (a submersion in the phenomenological world of the suffering other) and on the core aspects of the patient–clinician encounter. These sanitized, and at times unabashedly romantic conceptualizations can sensitize learners to practicing relational ethics.[15] Specifically, engaging narrative illness movies may ultimately help learners refocus on the supremacy of relational ethics in promoting compassionate and effective health care.

awareness of and empathy for the other: the phenomenology of illness

A deep understanding of the other is fundamental to a relational ethics, especially the suffering (and therefore potentially threatening and disturbing) other.[16] Alexander et al.[17] coined the term *cinemeducation* to encompass the use of movie clips or whole movies as a method of helping educate learners about bio-psycho-social-spiritual aspects of health care. Essentially, cinemeducation assumes that movies provide insight about the phenomenology of illness—what happens to people when they become sick.[18] Movies tend to focus on how illness affects a person's life and relationships, not on the medical details that often become the primary concern of health profession students, thus encouraging an important rebalancing for these learners. This shift in focus helps students learn to situate patients both within their subjective experience of illness and within the relationships affected by this illness.

Movies are not neutral occurrences. Quite the opposite, they present definite points of view (or multiple points of view), according to the filmmaker's agenda. In a way that most other art forms do not, mainstream cinema often insists on a seamless binding together of the character's and spectator's points of view. Watching a film, the audience literally sees through the eyes of the onscreen character.[19] *The Diving Bell and the Butterfly* (2007) provides a striking example of this phenomenon. The protagonist Jean-Dominique Bauby (Mathieu Amalric), who suffered from locked-in syndrome after a massive stroke, is almost inaccessible to most viewers on a physical plane. But because director Julian Schnabel decided to tell parts of his story literally from the inside, through the juxtaposition of what he sees through his one still-functioning eye and in his vivid memories, the viewer experiences him empathetically and three-dimensionally. As in *The Diving Bell and the Butterfly,* illness films almost invariably lead the audience to sympathize with the plight of the patient.[20] In fact, medical educators report such connections when they use films with medical residents.[21,22,ii] Students participating in discussions of films used in

medical education routinely pay great attention to the perspectives and viewpoints of others.[6]

Although contemporary films and television dramas often go to great lengths to achieve accuracy, medical content is always in the service of core story lines that are emotional and relational in nature.[23] Even when incorporating a diagnostic curiosity (e.g., *Mask* [1995] and Proteus syndrome; *Lorenzo's Oil* [1992] and adrenoleukodystrophy [ALD]), illness movies are primarily concerned with the relational implications that result from a specific medical condition. In the films *Stepmom* (1998) and *Terms of Endearment* (1983), for example, the central question revolves around how a mother dying of cancer can bear to part with her children, as well as prepare them to grow up without her and under the guidance of another woman with whom the protagonist has had a troubled relationship. For all the melodrama and tear jerking, the exploration and working through of this question is closer to how "ordinary people" experience their illnesses than how doctors experience their patients' illnesses.[24] Movies like *My Left Foot* (1989) or *Children of a Lesser God* (1986) are primarily about persons with physical difference (in the first case, severe cerebral palsy; in the other case, deafness) navigating in a majority nondisabled world and evolving a meaningful identity in relation to others that both incorporates and honors their physical circumstances.[iii]

Such films give learners invaluable opportunities to see medicine through the eyes of people (rather than patients). In the dark and quiet of the movie theater,[iv] viewers have a two-hour opportunity to reorient themselves, to adopt a different perspective on the meaning of illness that more closely parallels the agenda of the filmmaker rather than that of a clinician. Thus, movies offer an essential complement to the prevailing educational emphasis on the disease model and enable learners immersed in this perspective to see the patient and family situated in their lived lives.[25] A movie helps learners see wider relational dimensions and implications of illness than can be seen in a clinic visit.[26]

awareness of self: emotional education

Since relational ethics is predicated on the ability to forge an emotional connection, clinicians should be familiar with their own emotional responses, both positive and negative, toward their patients and be comfortable working with them in a way that promotes a conscious, intentional relationship that benefits the patient. Unfortunately, their education in general does a poor job of emotionally preparing students for clinical practice. Little effort is exerted to develop emotional honesty[v] in medical students or residents, for example,[27] either in terms of their own affective responses, or in terms of their awareness of others' emotions. Prosocial professional attributes of altruism, respect, compassion, and empathy are paid lip service, but are often not demonstrated by physician role models,[28] and students consequently spend little time learning how to cultivate such attitudes.[3] Conversely, while students often see displays of and personally experience negative emotions

of fear, frustration, irritation, anger, and contempt toward patients, they only know that these feelings are "unprofessional" and should be stifled. Finding emotions so confusing, unsafe, and difficult, learners sometimes decide to adopt a position of emotional detachment and distance.[29]

Successful movies about illness, on the other hand, must be emotionally evocative and, as such, engage the learners' emotions.[30,vi] In terms of health professions education, film is a highly effective method for allowing learners to explore the affective domain by stimulating reflection.[14] Although some have argued that emotions evoked by movies are unimportant because they are not in response to "real" events, these emotions have depth and resonance because they are inexorably attached to the personal narratives of our own lives.[31] Thus, narrative films can provide valuable access to viewers' affective lives by "lighting up" disruptive or disturbing parts of the self that might otherwise be ignored or neglected. Movies allow learners to explore difficult emotions in nonthreatening ways,[21] in privacy, without judgment, and without the expectation of action or alleviating suffering. Because the characters portrayed in movies are not "real" (not even those based on "real" people), learners can be more honest about their reactions than if they were discussing actual patients. This emotional honesty becomes a starting point for exploring other emotional responses.

In the movie *Motorcycle Diaries* (2004), for instance, the medical student Che Guevara spends time in a leper colony, and through his modeling of caring attitudes, viewers' initial responses of revulsion have the potential to transform into caring and concern. In most illness movies, evolution in emotion occurs primarily as a result of the sympathetic portrayal of the characters. For example, films such as *The Elephant Man* (1980) or *Dying Young* (1991) intentionally evoke strong feelings of horror or aversion (in the first case to extreme physical anomaly, in the second to the visceral aftermath of chemotherapy), only to develop empathy for and identification with the initially grotesque protagonists. In this way, movies promote an ethics of relational engagement with the suffering other, rather than an ethics based on the detached, intellectual mastery of moral principles and theories.[32]

cinematic depictions of the patient–clinician relationship

Movies also provide both concrete positive and negative role models of relational ethics in the patient–clinician relationship. Films such as *The Elephant Man, Patch Adams* (1998), or scenes in *My Life Without Me* (2003) help guide emerging health professionals on a path that incorporates emotional self-awareness, commitment to and engagement with the patient, and respect and sensitivity to the subjective experiences of the patient. The relationship that develops between John Merrick, who suffered from a highly disfiguring medical condition, and his physician Sir Frederick Treves, in *The Elephant Man* shows an evolution from patient-as-exploited (scientific) object into one of mutual caring and respect. *Patch Adams*

presents an idealistic medical student who defies his training to provide to patients health care that acknowledges their emotional needs and quality of life. In *My Life Without Me*, a young woman has advanced ovarian cancer. In the filmic depiction of breaking this bad news, the doctor clearly suffers along with his patient and mingles his helplessness and vulnerability with that of his patient.[20]

Contemporary television medical dramas also tend to represent physicians in a positive light. These doctors are not so much heroic as human, sensitive, vulnerable, fallible to be sure, but ultimately caring and committed.[23,34] While their tone is often soap-operish, the contextual seriousness (life and death are the stakes) often (although not always) retrieves these shows from pure silliness. Further, despite patently absurd situations (doctors falling in love with patients, violating all sorts of medical ethics codes to help them), they contain compelling depictions of physician–patient relationships, precisely because of these physicians' willingness to become emotionally involved with their patients.[35] Doctors who worry about and struggle with the suffering of their patients, even when they transgress appropriate professional boundaries to do so, provide fertile ground for viewers to examine the complex parameters of relational ethics.

Other portrayals of doctors in movies as greedy, egotistical, uncaring, unethical, materialistic, or caring more about science than patients create negative role models.[36,37] *Wit* (2001), for example, is replete with critical views of physicians as impersonal, emotionally distant, jargon-spouting, and insensitive.[38] In *Ikiru* (1952), the paternalistic physician lies about the patient's terminal diagnosis of stomach cancer, which protects himself, but not the patient.[20] The physician Jack McKee in *The Doctor* (1991) initially demonstrates a glib, insensitive, and indifferent attitude toward his patients.[19] Using examples from such films with learners to help build patient–doctor relational ethics entails an analysis of "anti-role modeling"; that is, encouraging learners to reflect on who they want to be as clinicians by contrasting it with what they witness on the screen.

translational applications: putting relational ethics into practice

The ultimate goal of cinemeducation is to facilitate students' ability to make links between movies they see and how they might feel and behave in actual clinical situations. Consequently, education using film must not stop with the evocation of learners' emotions—whether awareness of one's own emotions or empathy for the emotions of the suffering other—but further guide learners through discussions with peers and role models.[14] Such a group process is designed to assist learners in carrying forward their "movie learning" into their daily lives, by addressing the question of how to bridge the gap between the illusion of the movies and the reality of patient care.[4,15] Through various written and imaginative exercises, learners can practice putting themselves in the position of a particular patient's doctor and explore different ways to establish connection and caring; they can repeatedly imagine, rehearse, and play variations on their interaction.[20] Because

the film's audience is expected to respond emotionally and cognitively, but not necessarily to act, it may help learners to think about their relationships with patients in more creative ways.[31] Finally, these discussions can assist learners to develop a healthy skepticism toward the excessive simplification and idealization that characterize many narrative illness movies, while maintaining awareness that such movies attempt to reach past the difficult complexities of the real world toward the essential humanity and connection that should bind together clinician and patient.

The nature of the medium itself is particularly powerful in this regard. Film, the audiovisual version of storytelling, emphasizes emotions and images. Movies are sometimes about language,[vii] but they are indelibly about powerful visual images,[39] usually supported by a musical score that intensifies the emotions evoked by the screen images.[40] A younger generation of learners that has come of age in the milieu of powerful visual and musical cues enjoys and benefits from learning about how cinematographic techniques strengthen the message of the film.[4] For example, the movie *Wit* raises many ethical issues about doctors' treatment of patients, the nature of clinical trials, and the coming to terms with one's own death with some dignity.[37] Yet, medical students who have viewed the film most often mention the visual impact of a single scene that transpires not between the physician and the patient (a John Donne scholar, Vivian Bearing played by Emma Thompson), but between the patient and her old teacher (Eileen Atkins). In this scene, Bearing is in great pain and dying. The professor has come to visit, but quickly realizes the extent of her former student's illness. She climbs into the hospital bed and begins reading a children's story. This scene becomes fixed in learners' minds as a metaphoric touchstone, an iconic representation for how they wish to care for terminally ill patients.

Integrating movies into medical education provides a powerful way to address relational ethics by presenting learners with moving scenarios rooted in relationship dilemmas and evolution. Watching a movie enables students to understand and emotionally resonate to the life experiences of a protagonist-patient; to explore problematic, shameful emotions while reflecting on how to transform them into more positive responses through their identification with the film's protagonist; and to observe in an emotionally engaged way various options for embodying or rejecting relational ethics in the patient–clinician relationship. Finally, through facilitated discussion, medical learners can rehearse different possibilities for uniting insights and attitudes toward self and other into an ethical, respectful, and caring clinical relationship.

NOTES

i. In the tactful words of a Brazilian family physician and medical educator who regularly incorporates film in his teaching, "American movies are particularly useful, since they tend to tell stories in a straightforward and uncomplicated manner."[14]