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Ethical Times

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Waiting in Anticipation by Alexis Lopez

Throughout my years at UC Berkeley as an integrative biology major, I learned many technical things about medicine and the biological sciences, which laid a foundation for my desire to become a physician. Sitting through endless lectures in Pimentel Hall and the Valley Life Science Building, I had the privilege of learning from world class professors at the best public university in the nation. I can remember spending countless nights rehashing nomenclature of nitrogen-containing compounds, the endocrine system, and details of the glycolytic pathway in the liver. Through these classes, medical school admissions panels and pre-medical conferences, I gathered my ideas of what medicine is and what it takes to become a physician. With these experiences, medical school and becoming a physician seemed more of a distant idea, rather than a possibility. It was my experiences outside of the classroom that painted an illustrative picture of what medicine really is and that cemented my desire to become a physician.

I have had various and diverse research experiences, including work with a Spanish-speaking population in Peru, experimenting with anti-microbial plant compounds in Costa Rica, and program management at Asian Health Services in Oakland. But my experience as the research assistant for the Program in Medicine and Human Values at California Pacific provided the opportunity

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Ethical Times Circulation exceeds 1000

This issue of Ethical Times passes a milestone. Our newsletter, started in 2004, is now being received by over 1000 readers in five countries. ET, as we call it, was launched in order to keep our donors and supporters informed of the activities of the Program in Medicine and Human Values, but its scope has grown. We also focus on some of the ethical issues that arise in a large metropolitan community hospital such as CPMC. The reader response has been tremendous. Our lead articles, and regular feature, "The Ethicist is In," have been recognized by our ethics colleagues around the country as superior works that rival the more established ethics journals. Published quarterly, the newsletter remains free and can be received by contacting our administrative offices. Or even better, contact us to receive an electronic copy and help avoid mailing and printing costs. *Coming soon to a Kindle near you.*



Beyond Medicine.

The Ethicist Is In:

Today's Ethicist is Albert R. Jonsen, PhD

Do Not Resuscitate

Dear Dr. Jonsen, My wife, Sara is a 67- year-old woman who has suffered from multiple sclerosis for many years. At this point, she is bedbound and requires assistance for everything she does. In addition, she is becoming confused and is frequently disoriented. She has had several severe episodes of breathing difficulty which have twice led to admissions to the intensive care unit. Yesterday, she was readmitted to the hospital for treatment of pneumonia and respiratory failure. Now she is in a coma and her doctors think she may need to be placed on a respirator if she is to survive. In the past, she has emphasized to all of us that she did not wish to be placed on a respirator if it was felt that she could not recover her ability to breath independently. The neurologists have told me that her breathing trouble is due to progressive muscle weakness due to her MS and that her current pneumonia has worsened her condition.

Dr. Smith, her internist for many years, has suggested that it is appropriate, at this point, to place a Do Not Resuscitate order (Which he calls "DNR") in her chart. Since I am not sure exactly what that entails, Dr. Smith has suggested that I seek an ethics consultation from you.

Dr. Jonsen responds:

I am saddened to hear of your wife's condition. These are troubling times for you and hope that I can help as you face these difficult decisions. A Do Not Resuscitate (DNR) order (also frequently called a No Code order) means that Cardiopulmonary Resuscitation (CPR) will not be performed if the heart or lungs suddenly stop working. CPR is a set of techniques designed to restore circulation and respiration. Not restoring a patient's heartbeat and breathing will result in their death in a matter of minutes. Thus, a decision to make a patient DNR is a very serious one.

CPR, in its simplest form, consists of mouth-to-mouth breathing and pressing on the ribs over the heart to maintain blood circulation. It is taught to lay persons for use in emergency situations. In hospitals, CPR is usually done by a trained team who respond to an urgent call. They rapidly begin to press on the chest and insert a tube down the throat to assist breathing. The medical team may also apply electric shock to the chest to restore the heartbeat and inject drugs to stimulate the heart and support blood pressure.

Although few hospitals actually have a policy requiring CPR, it is traditionally performed in patients unless specifically precluded by a DNR order. The decision to write a DNR order should be based on two crucial considerations. The first is the physician's judgment that CPR would be very unlikely to succeed in restoring normal heart and lung function. A second reason for writing a DNR order is based on the preferences of

the patient, as expressed either by the patient themselves or by a surrogate such as yourself. This second reason often reflects a patient's own assessment of their quality of life.

CPR should not be done when cardiopulmonary arrest occurs as the anticipated end of a terminal illness or after vigorous efforts to save the patient have failed. Therefore, DNR orders are usually first considered when the patient is in a terminal condition and death appears to likely in a short time. These patients are highly unlikely to benefit from CPR. In such cases, the DNR order allows the patient to die without burdensome resuscitative efforts, achieving the medical goal of a peaceful death.

In addition to terminally ill and dying patients, competent patients who are not close to death may initiate discussion of DNR orders with their physicians. For these patients, a DNR order is an important component of advance care planning, allowing them to express preferences about treatment at the end of life. Many of these patients are in the earlier phases of serious diseases, such as metastatic cancer, or, as in Sara's case, Multiple sclerosis. The patients are prepared to forgo resuscitation attempts due to concerns that even if they are "successfully" resuscitated, they may experience brain damage or some other functional impairment. They also may not wish to live through a painful terminal phase of their illness. Physicians should carefully discuss these requests with the patient and honor them. Surrogates, who must make decisions on behalf of inca-



Summer Workshop

A. Jonsen

"See one, do one, teach one." These are the words of an old joke (we hope it is a joke) explaining how medical students learned procedures like drawing blood or doing spinal taps. In reality, of course, it takes lots of observation and a lot of doing to reach the point where the learner becomes a teacher. Here, in the Program of Medicine and Human Values, we have done a lot of ethics consultation. Drs. Jonsen, Andereck and Bramstedt have about 50 years of ethics consultations between them. CPMC now has approximately 90 ethics consultations a year. So now we teach. For each of the last three years, we have offered a Workshop to members of hospital ethics committees. We have the teachers (ourselves and an occasional experienced guest) and the experience to inform persons who see many fewer consultations and have less background. Ethics consultations attempt to help doctors and patients answer very perplexing questions, often about who should live and who should die. This is not an unusual question in a medical world where so much can be done technically: is the technical solution always the right solution for this patient, in these circumstances? We draw on a large scholarly literature in ethics and law to formulate responses but, in the last analysis, we have to look to the patient's situation and listen to their opinions, and those of their family and their doctors. This June our Workshop is devoted to the problem of "non-beneficial or futile treatment"— what to do when a treatment seems unavailing to doctors or to family and yet someone insists that it be continued? Wait and see: we will tell you the answer in a forthcoming *Ethical Times*.

Summer Workshop takes place Saturday, June 6. For more information, please call 415-600-1647 or visit our website.

pacitated patients, such as Sara, may take this information into account in their efforts to appreciate what the patient might wish.

Even when CPR is attempted it is often not successful. Among patients who experience in-hospital cardiac arrest, only 10-17% survive to leave the hospital. Of these, many have some neurologic impairment or other disability that restricts their daily activities.

Patients and families often overestimate the success of CPR. This misapprehension may be fostered by media versions of CPR. A study of cardiac resuscitation on television dramas like ER showed that 67% of televised "patients" survived, instead of the 10-17% who actually do. Also, many patients have little

idea of the nature of resuscitation procedures and the complications caused by the chest compression (broken ribs), or intubation. When informed of these side effects, and the likelihood of success, patients often choose to forego attempts at resuscitation. It is essential that patients, their families, and physicians have accurate information on the benefits and risks of CPR so that they can make informed decisions about using CPR or choosing DNR status.

In Sara's case, it is clear that even if CPR succeeds, she will survive only a short time without permanent ventilatory support. Based on her prior wishes not to be permanently intubated, a DNR order seems reasonable. If you, as your wife's surrogate, concur with this reasoning you may allow her physicians to write an order to not attempt resuscitation.



to truly explore what it would be like to become a physician. This Program provides ethics consultation in the hospital and is currently doing research about the usefulness of ethics consultation in the Intensive Care Unit (ICU). I have served as the research assistant, enrolling patients and following their course along with interviewing them and their providers.

For these past ten months I have been in a transition period- a place neither completely here nor there. Fresh out of college, I was plunged into a culture often mystified, overdramatized, or misunderstood by the media and the general public, including myself. Daily, I can see the practical application of my biological science background as I observe clinical treatment. The knowledge that I brought to this work has expanded and now appears in another perspective. I remain eager to learn much more before embarking upon medical school.

In a country where innovation in medicine and life-sustaining technologies exists alongside millions who lack sufficient means to attain healthcare, it has been interesting to see many worlds collide within the

San Francisco. Diverse languages, ethnic and cultural backgrounds, religions, family dynamics, and life-styles have made the ICU a place of many interactions between patient and provider.

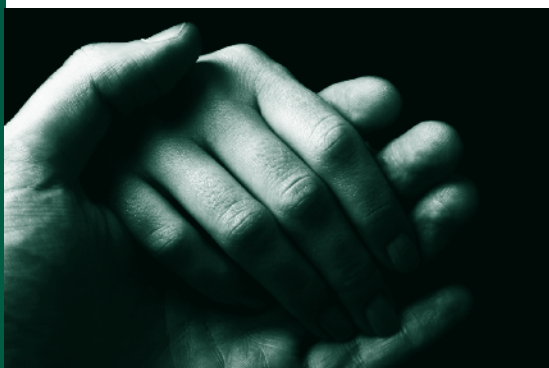
Being part of this Program, I have learned much professionally and personally. Working in the hospital I have been able to get more of an insight into what it is like to be a part of the medical culture. This ranges from how hospitals work, to how code blues are handled, to how resident and intern physicians are trained. Along with the general functioning of a hospital and ICU setting, I have also been immersed into the world of bioethics. Through consultations, rounds, committee meetings, and philosophical quips among the daily happenings here, I have garnered knowledge and an incredible interest in bioethics. Working alongside wise ethicists, including Dr.'s Albert Jonsen, William Andereck and Thomasine Kushner, I feel incredibly privileged to be in this department. Every day, in particular our especially engaging Wednesday rounds and staff meetings, is a learning experience.

When I first began in my position, it was difficult to complete my responsibilities to the research task, realizing I had two different roles. At first I felt a need to separate my professional role from my personal role. My professional role as a researcher and data collector, the other a more personal role as a compassionate and emotional human being eventually blended together. Realizing the two do not have to be separate has been interesting and helpful in maintaining my role as a researcher. In the ICU, hints of morbidity and mortality are always in the air and it is often difficult to know where patients are

going to end up. From obtaining the consent of patients, to making follow-up phone calls to surviving family members, it is often a challenge to remain emotionally reserved. It is joyful to hear a patient's satisfaction with a hospital after a successful brain surgery, just as much as it is hard to listen to a surrogate unload their concerns regarding a loved one's death.

Much of this experience has come from direct contact with patients. Mrs. D was a patient in our study who suffered from end-stage liver disease and was in desperate need of a liver transplant. Because she was often jaundiced, encephalopathic, and critically ill, I communicated mostly with her husband. It was often tough to speak to him and to be surrounded by the family, knowing the patient's dire situation. Even though I had a script of questions to ask, I still felt speechless, fearing that I would say something that would further upset the family. After nearly two months in the hospital, without prospect of getting a liver transplant, Mrs. D passed away. In an emotional follow-up phone call with Mr. D, I found out that even though his experience was emotionally difficult, he was glad and appreciative of our involvement in his wife's case. While I am still continually working on it, I have gotten better at being compassionate and sympathetic with patients and families during times of need, while also considering my own feelings toward death and dying.

Witnessing patients and families in the ICU during a very vulnerable and trying time has allowed me to set an example for myself. As an observer of patients and families, I have noted many fears and motivations at play during the trying time of serious illness. Knowing what I know, I feel better equipped to deal with these issues, especially as they have faced *me* this



ICU. While I have witnessed one of the first clinical trials of an Extracorporeal Liver Assist Device, I have also witnessed much loss, mourning and illness. Many backgrounds come into contact here, especially in a place like

year. My own grandfather Juan Frias died last summer due to an unfortunate anoxic brain injury. I was now personally in the same position I had observed daily in the ICU. Filling the ICU waiting room at San Francisco General Hospital with endless family members and acquaintances, it was impossible to detach myself from my role as a health care professional. I found myself thinking about decision-making capacity, advanced directive, and other end-of-life care considerations. Many of the emotions I encountered in the ICU flooded back as the tables were turned. What was empowering for me was that, even though I was placed in this situation, I was armed with the skills necessary to help me through this time of need. As an advocate for my family I felt emotionally prepared, especially after having followed similar cases of many other patients. With my prior knowledge and experience I could both inform others and acknowledge the facts and realities of the situation.

Even more recently, I was involved in a hospital case in my hometown of Hayward. The mother of my closest friend was admitted into the ICU shortly after being taken into the emergency department. I immediately rushed to my friend's side and began probing for information regarding their hospital experience thus far. After several accounts, I realized something was askew. I began comparing this situation with many I had seen in the ICU and in ethics Program consultations. I sensed several potential ethical problems afoot and decided to take some action, given my resources in San Francisco. After relaying my questions and concerns with Dr. Jonsen, a cascade of action began. He communicated with colleagues of his in the East Bay, who then came into contact with the attending physician caring for this

specific patient. It was unapparent to the attending physician that there were concerns of miscommunication and mistrust with the family. After this unforeseen involvement from local ethicists and increased communication with the attending physician, my friends and their family felt understood and relieved that some positive change had occurred with more involvement from the attending physician. My prior history and rapport with this patient and family along with a new sense for ethics, is what allowed me to be proactive. I was close enough to this family and yet still distant enough to examine the situation with an ethics perspective.

My personal experiences with my grandfather along with my

experiences in and out of the ICU, have taught me a lot about the profession I plan on entering and even more of myself. Along with my prior experience in and out of the classroom, I feel ready to become a medical student, waiting in anticipation. There is still plenty to learn which is exciting, especially since I find myself walking around with a new-found pair of bioethical eye glasses. Along with my prior background in other disciplines including public health and ethnic studies, I hope to bring my experiences together with my forthcoming medical education. As I navigate through this complex system that is medicine I hope to find a place where I can take my experiences, make an impact on my community, and mature into the physician I dream of one day becoming.



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The Program in Medicine & Human Values depends on contributions from people like you

Since receiving its initial startup grant of \$750,000 in 2004, the Program has raised nearly two million dollars from the readers of this newsletter with gifts from over two hundred individuals and foundations ranging from \$25 to \$200,000. Despite appreciation of the goals and activities of the program, institutional support for the specific activities of the hospital ethics committee covers only 6% of our budget. 94% of our projects are supported by philanthropy, including our research project on the effect of ethics intervention in ICU patients and this newsletter. We thank all of you for your past support and encourage you to remember us in your continued charitable giving.

If you would like to donate, please contact us directly: 415.600.1647.