A special, landlocked cruise is scheduled for October 10—A voyage through Bioethics! The Program in Medicine and Human Values has gathered a splendid crew of bioethical explorers for this unique event honoring one of its own explorers, Dr. Albert Jonsen. It will sail, metaphorically, from the City Club at 2 o’clock. Roy Eisenhardt will initiate a discussion between Al, Dan Callahan, founder of the Hastings Center, Ruth Faden of Johns Hopkins University, and Bill Winslade, University of Texas. Each of these prominent people played a major role in building and launching the activities of bioethics. They will present their views about why this field began and where it traveled over the last forty years as scholars from philosophy, law and social science, as well as scientists and medical practitioners attempted to grasp how an increasingly sophisticated technological medicine impacted human life. All of our PMHV friends are invited to attend the Symposium conversation and reception to follow.

You will hear some fascinating stories. Dr. Faden may tell you how you or your San Francisco relatives were bombarded by bacteria in a 1950s experiment. Dr. Callahan may relate how difficult it was for leading scientists to recognize the moral consequences of dramatic advances in genetics and reproductive science. Dr. Winslade may join with Dr. Jonsen to describe how the large ideas of bioethics had to be trimmed to fit the crucial decisions at the bedside. Our own Dr. William Andereck will step into this discussion.

He was not among the early adventurers but was among the first of young physicians to see that his care of patients required an integral understanding and application of ethics.

This voyage of bioethics which set forth in the 1960s is well underway. Today, it is, as Continued on page 5
The call on the ethics hotline was not unusual. “We have a 72 year old man who has developed a (blood) clot in his right leg. He has gangrene in that foot, and without an amputation of his lower leg, he will not survive another few weeks. The patient is refusing the amputation. What should we do?”

The case sounded familiar. Over 27 years ago, we had a similar case. That case involved an elderly diabetic woman who had lived with the ravages of her disease for quite some time. The ulcer on her foot was not healing, and the surgeon told her that an amputation was her only hope of survival. That patient was very clear about what she wanted. She had lived as long as she wanted to and did not want to go through an operation. She realized she would die soon and did not see the point of prolonging the inevitable by removing her foot. The patient’s wishes were made clear to the surgeon and the medical team. Surgery was canceled, and she was sent home to spend her last days with her family. The recommendation seemed clear. Surely this new case would be the same.

However, this case was very different. In addition to the clot in his leg, this patient had developed another in his brain, resulting in a stroke. The stroke left him with a condition called “aphasia”, the inability to speak. His condition was particularly severe, in that he could neither speak nor communicate consistently using his hands, arms or legs. His brain injury was so severe that he could not even recognize the right side of his body, where the gangrenous leg was.

The first question to ask was: How did the medical team come to the conclusion that the patient was refusing a much needed operation? Although the patient was impaired, he was also alert, with a clear and penetrating gaze that reacted emphatically to spoken words. His eye movements were accompanied by facial grimacing and head shaking, but his responses were not always appropriate to questions asked to determine decision making capacity. He showed sadness when informed about his current condition, incredulity and agitation when informed about the recommendation for amputation.

The medical team was in conflict over the patient’s capacity to make his own decisions. His older brother who visited him from a different city also felt that the patient had the ability to refuse the amputation even if it would result in his death. However, the patient’s elderly brother did not wish to serve in the role of decision maker. A neuropsychological evaluation concluded that the patient did not have the capacity to make medical decisions and could therefore not refuse the surgery.

The standard approach under California law, when a patient does not have decision making capacity and no designated surrogate, is to petition the court to appoint a conservator to make medical decisions for the patient. Unfortunately, this usually takes months and the patient would never survive the legal process.

A real time decision needed to be made and there was no one else to make it other than the doctors who were relying on the ethics team for advice regarding the right thing to do.
From a clinical ethics perspective, a patient without decision making capacity should be treated “in their best interest”. Since he was not actively dying of anything beyond the fixable condition of his infected leg, and prolonging life is considered to be in a person’s best interest, a reasonable person might say that surgery should be done. In fact it could be held that most people would accept surgery in the generic condition of an infected gangrenous leg.

However, this situation was more complex. Surgery on his leg would do nothing to alleviate the devastating injury to his brain. The probable underlying cause of the patient’s embolism, atrial fibrillation, a heart irregularity, can be managed quite easily with medication for many years. It was clear however that he would never walk again and remain confined to some type of an institutional setting for the rest of his life. It was unlikely that he would ever speak normally again, and it was still not clear that he will ever regain the ability to communicate beyond his frightened glances and facial expressions. Some of us might see this as an existence not worth enduring. It is possible to assume that a reasonable person, reflecting on the enormity of his illness and the potential for years in a nursing home with no significant recovery, might choose to forego surgery and let his life end at this point.

How can we know which course of action is appropriate in this particular man’s case?

In speaking with the patient about a range of topics, some serious, some silly, we watched his eyes, mouth and face. Consistently, when we talked about his stroke he seemed to express sadness. When asked about his desires to continue living, despite the stroke, he seemed to brighten up and nod affirmation, even if his response was difficult to interpret. With a sense that this patient was not eager to die, we narrowed the questions to his gangrenous leg and surgery. He continued to express agitation and horror when asked if the team could perform surgery to remove his leg. This was the reaction that had been interpreted as equivalent to a refusal. But when the question was rephrased to acknowledge that a few moments ago he had told us he was not ready to die, and that without surgery that was what would happen, we got a totally new and different response. A shrug of the shoulders, a rolling of the eyes. To all of us in the room, everything about his behavior suggested, “Then what can I do? It looks like I will have surgery even if I don’t want it.” The questions were repeated to make sure we had it right, and each time we asked about the needed leg surgery we again received a look of resigned acceptance. In the context of the responses the patient had been providing regarding his current condition and wishes to live or die, and using these responses within the wider framework of the best interest standard approach, it seemed that amputation was not only in this patient’s best interest, but consistent with his values as could be best determined.

These kinds of complex decisions are not the type that can be made in the board room, or without close personal contact. Assisting in this type of decision making is the stuff of clinical ethics. He was either going to be on the surgical table the next day, or he would not. The surgeons were advised that it seemed ethically appropriate to proceed with the amputation.

The patient had surgery and left the hospital a few days later. Still curious to know if we had done the right thing for the patient, we visited him in his rehabilitation facility 6 weeks later.

For an account of what we found, visit our website, www.cpmc.org/ethics and, click on ‘Publications’.
Titled “Practice Makes Perfect: Best Practices for Ethics Consultations,” the stated goal of the seventh annual Summer Workshop in Clinical Ethics was to share the best practices for clinical ethics consultation. “Best practices” means the most effective ways to initiate and carry on a consultation, leading to a recommendation helpful to clinicians, to patients and their families. In particular, it aims to bring general considerations, such as “Be of benefit to the patient and do no harm” down to the actual realities of particular cases. As an example, workshop faculty and participants explored the circumstances that justify writing a POLST (Physician Order about Life-Sustaining Treatment). Our faculty, together with guest faculty Dr. Margaret McLean, described two methods for thinking through this problem that consultants and ethics committees can use.

Building on the success of prior years, twenty-six different medical centers and hospitals were represented, including all Sutter West Bay institutions. Forty-five attendees, including twelve ethics committee chairpersons, made up the collective group. The Summer Workshop aims to connect the yearly themes in a way that allows returning attendees to apply the continuing education to their discipline. Following up on last year’s training that assessed the specific shared work of Clinical Ethics and Palliative Medicine, this workshop took a more broad view of improving the quality of end-of-life decision making between various specialties that care for dying patients. This is of paramount importance when patients are transferred between institutions. After presenting and practicing these methods, each participant departed with an improved – dare we say, perfected – skill set.

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**Albert R. Jonsen Bioethics Symposium**

**A Roundtable with Prominent Figures in Bioethics**

**October 10, 2012 – 2:00 to 5:00 pm**

The City Club, 155 Sansome Street, San Francisco

This Symposium is a tribute to Dr. Albert Jonsen, a pioneer and founding scholar in Bioethics.

The Roundtable will discuss the beginnings of Bioethics and the growing influence of scientific and technological advances on Bioethics. The birth of Clinical Ethics will be examined for its impact on contemporary medical practice, followed by a discussion on the integration of Bioethics into health care research and public policy.

**CEU Information**

3.8 Contact Hours Available, RN/LVN

Provider approved by the California Board of Registered Nursing, Provider #CEP 1956

$25 registration fee

Register at: cpmc.org/services/ethics/

For information: 415.600.1647

Daniel Callahan, PhD, Senior Research Scholar and President Emeritus of The Hastings Center

William J. Winslade, PhD, JD, Professor of Philosophy of Medicine, Institute for the Medical Humanities, University of Texas Medical Branch at Galveston

Ruth Faden, PhD, Director, John Hopkins Berman Institute of Bioethics

Albert R. Jonsen, PhD, Senior Ethics Scholar-in-Residence, Program in Medicine and Human Values

William S. Andereck, MD, Co-Director, Program in Medicine and Human Values

Roy Eisenhardt, JD, CPMC Board of Trustees will serve as moderator
Dan Callahan says, an “accepted sub
discipline” in the academic world.
Bioethics courses and programs exist
in every medical school and in many
universities. Doctoral and Masters
degrees are offered. Hundreds of
books, dozens of journal and thou-
sands of articles are produced. A series
of federal government commissions
have tackled major issues. Ethics
consultants are employed in major
hospitals, such as CPMC. Yet even
today, confusion exists about what
bioethics actually is and what impact
it has on patients and providers in
American health care.

Bioethics is often described as “inter-
disciplinary.” Our guests demonstrate
that: Callahan is a philosopher, Faden
a social scientist and Winslade a
lawyer, philosopher and psychoana-
lyst. Al Jonsen is a theologian. The
term “interdisciplinary” is a signal of
rough seas ahead. Which intellectual
method should lead? How do meth-
ods so different flow together?  How
can philosophy which thinks ideas,
sociology which describes social
practices and law which prescribes
behavior collaborate? And to what
purpose: to warn? To clarify? To
correct? To recommend? And, above
all, what right do these “strangers”
have to trespass on the work of physi-
cians and scientists? These are mat-
ters still debated within the field of
bioethics, as you will hear during our
discussion.

Another question asks how the ideas
that bioethicists debate can be brought
to the education of others. Those ideas
are not like calculus which we learn
in high school but never use unless
we become engineers. Every person
suffers illness and confronts death.
The costs and commercialism of health
care touches everyone, as does the
steady march of technological forms of
treatment. These are the topics of bio-
ethics and they should be understood
by the broad public, and not just by
scholars who carry a title. Your pres-
ence at this event will demonstrate
that you are among the public who
desire to learn. The bioethicists have to
learn to talk to you.

Bioethicists wonder about the future
of the field. The early explorers used to
say that bioethicists were like the old
time general practitioners. They knew
a little bit about everything, and could
quickly study up on anything new.
Today, the rapid advances in science
and medicine require specialization.
There are bioethicists who are experts
on the issues of end of life care, on
genetics, on reproductive medicine, on
transplantation, on health policy, etc.
When specialization occurs it becomes
more difficult to understand what
keeps the field together. A wide range
of philosophical theories or theological
doctrines also separates the field at its
roots. Is it possible to think of a uni-
fied bioethics in a pluralistic world?

The future of bioethics certainly will
continue the current concerns about
end of life care. Consultation about the
use of elaborate life sustaining tech-
ologies will increase as more people
are enrolled in health insurance and
as technologies become increasingly
effective. A consultation service such
as ours at CPMC will always be in
demand, and its consultants will be
more competent to deal with complex-
ity. But large questions loom. Means of
life extension and enhancement are
becoming more feasible, and most
of them challenge the accepted ideas
of quality of life. What is a good life
at any stage? Also, as health care
expands, will efficiency drown out
compassion and respect?

The Voyage of Bioethics has not ended.
Your presence at this event will make
you a co-adventurer as bioethics sails
into the future of American health
care, striving always to navigate
through its surging tides in ways that
never lose sight of the fact that vulner-
able human beings—that is, all of us—
are the passengers.
Happenings

Training: Dr. Ruchika Mishra has led ethics committee trainings for both Sutter and non-Sutter hospitals. John Muir Hospital again welcomed her, on this occasion asking that she conduct a training for their Patient Care and Education Ethics Committees. Dr. Mishra and Dr. William Andereck also had the opportunity to lead a discussion on “Cross-Cultural Pediatrics Ethics” to CPMC Pediatrics staff.

Publication: Three members of the Program in Medicine and Human Values (PMHV) staff coauthored a paper that was published in the Journal of Healthcare Management. The July/August issue features the article by Dr. William Andereck, Dr. Albert Jonsen, and J. Westly McGaughey. Titled “The Clinical Ethics Consultant: Verifying the Qualification of a New Type of Practitioner in a Community Hospital”, it makes a recommendation for standards to insure that medical centers have competent clinical ethicists.

Fellowship: The PMHV is proud to announce a new member of our team. Lucia Tanassi, PhD, has been accepted as our 2012-2013 Clinical Ethics Fellow. She has taught Medical Ethics and Medical Anthropology at Vanderbilt University, and works as a clinical social worker. We look forward to sharing aspects of her work in a future issue of Ethical Times.

Awards: The University of Central Lancashire, United Kingdom, awarded Dr. Thomasine Kushner with an Honorary Fellowship in July. Hers was one of nine bestowed by the university on to a group of distinguished academics.