

Bioethics at the Ballpark

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In a matter of weeks, we will have reached the end of the baseball season. Many Americans follow these athletic events, from the avid fans glued to their TVs to the occasional inquirer glancing at the sports page. Whether fan or distant follower, most of us know what the game of baseball is. Over my many years as a bioethics consultant, I have tried to find ways to explain what an “ethics consultation” was. While watching my beloved Giants lose again, a new way of framing this explanation occurred to me: a bioethical consultation is somewhat like a baseball game and a consultant is something like an umpire.

I won't let this simile carry me away: baseball has structured, rule-bound procedures; umpires have defined authority; consultations and consultants lack both. But the similarities justify the simile as an educational device.

When I am asked to consult in a case of clinical ethics, I know that certain persons are likely to be present—one or more members of the medical team treating a patient, the patient or the patient's family or legal representative, possibly a representative of the hospital. The consultation should not proceed if key stakeholders are absent, e.g. someone from the treating team. I also know that some should not be there, e.g. a journalist or a curious visitor. My first duty as a consultant is to assure that the right people are “on the field” for the consultation. The umpire's first official act, once he sees that nine defensive players are in position and a batter stands ready, is to shout “play ball!” Baseball players follow that call in a routine way: balls and strikes, home runs, singles and doubles, or “three strikes and you're out.”

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The Ethicist Is In

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The Case:

Tom, an 85-year-old man, was admitted to the hospital for worsening dementia, weakness, fever and dark urine. Initial evaluation revealed a severe infection in his blood due to an enlarged prostate and obstructed bladder. To provide relief to the patient, a catheter was placed. However, the patient started getting agitated and pulled the catheter out multiple times. The patient is now requiring restraints. The medical team is recommending prostate surgery. The patient had previously stated to his family that he did not want prostate surgery since his friend became incontinent after undergoing a prostate procedure. The patient's treating physician calls for an ethics consultation asking: "What is the ethically appropriate course of action when the best medical treatment at this time is against the patient's previously expressed wishes?"

The Ethicist:

Tom's doctors are feeling stuck and so is his family. Before we address the question Tom's physician has posed to the ethics service, it is important to consider several other questions that this case presents. The first issue to review is the patient's current mental status and his ability to make decisions. While the patient's physician has noted that Tom has a history of dementia, it does not mean that the patient necessarily lacks the capacity to participate in decisions regarding his healthcare. We know that he is agitated and it may be challenging to communicate with him. However, having his family around and involving them may help calm down the patient and allow for a conversation. Depending on his level of dementia, the patient may be able to answer some simple questions about how he is currently feeling, what is bothering him, and respond to suggestions by family or treating team members about how to proceed with treatments. So while the patient may not be able to process complex information like the purpose of a catheter or how his bladder issues could get resolved through a surgical procedure, he may be able to acknowledge pain, endorse discomfort with the catheter, understand that the doctors can help him so that the catheter can be removed and it does not bother him. Having the family around to witness a conversation with the patient around current problems affecting him would be a step in the right direction to support them in their role as a surrogate decision maker.

The second element to examine here is the patient's previously expressed wishes. Exploring the context in which the patient stated that he would not want prostate surgery is key to current decision making. It may be worth discussing with the family if they knew what kind of surgery the patient's friend underwent and what medical condition it was for. If the patient's fear had been that he would become incontinent due to the surgery, it may be argued that the patient valued his independence and did not want to lose control over his bodily functions. His current condition may be a worse quality of life for him given that urine is not able to flow out of his bladder and he has an external device attached to him now allowing for urine to pass. On top of that, the inability to urinate can be extremely uncomfortable.

The key question to consider is what the patient would want if he were able to appreciate his current condition where his prostate enlargement and the resulting symptoms from it could be treated in a fairly uncomplicated manner through surgical intervention. Prostate enlargement is a fairly common condition in aging adult men and the standard of care is surgery. The surgery would allow the patient to return to his previous functional ability and quality of life where he could return home. Unfortunately, this is a situation where there are no good alternatives to surgery. The catheter is only a temporary solution to allow for urination so that the patient's condition does not deteriorate from urinary retention, which can be fatal if left untreated.

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My favorite part of this limping simile is the role of the consultant as umpire. Umpires are boringly omnipresent in their dusty black suits, behind the plate and on the baselines, making almost invisible hand signals. But that quiet function assures the essence of the game: “fair play.” Once the ethics consultation process begins, the consultant (umpire) must make sure that all parties involved in the patient’s case have their voice heard. A consultation is in danger of being dominated by an “authority,” a physician who knows “best,” or by a weeping relative or one threatening to sue. The consultant must catch these tactics before they divert the discussion away from “fair play.”

“Fair play” consists not only of preventing domination but also of observing the “bioethical rules.” Every participant may be—and hopefully is—an ethical person but not everyone will be familiar with the framework of bioethics that has emerged over the last few decades—the centrality of principles of respect for autonomy, beneficence, non-maleficence and justice.

The consultant will know the meaning of these principles but, more importantly, will know how to apply them to the particular case. A good consultant can recognize how the specific circumstances of the case at hand give strength to one or another resolution.

The umpire has seen many pitches over the plate. Likewise, the consultant’s skill arises, in large part, from repetitive experience. The ethics consultant has probably seen hundreds of cases. Every case is a little bit different but they each must be analyzed within the unifying theme of bioethics and decision making in clinical medicine. The consultant is aware of the uniqueness of each case but also recognizes that there are cases around which broad

agreement gathers. Situations in which the way to proceed is clear, like the batter being out after three strikes, are called “paradigm” cases in bioethics. But a consultant cannot simply “apply” paradigm cases to the new case. The skilled bioethicist must discern the similarities and the differences between the new case and the paradigms previously encountered and recognize how these differences can lead to different calls. This is why the circumstances of a case are so crucial. The major ethical principles that provide the structure of the case are given their “weight” by the circumstances. Thus, the ethical principle of respect for autonomy is much less weighty when the patient no longer has the mental capacity to make medical decisions. In such a situation, beneficence and non-maleficence take on heavier roles in coming to a decision.

This way of thinking constitutes the “casuistry” of ethical consultation. “Casuistry,” a term derived from the Latin “casus,” meaning a “particular instance,” was elaborated in the 17th-18th century by moral theologians to assist those responsible for deciding whether a particular action fell within the boundaries of right or wrong, given the circumstances of the cases—for example, is it morally wrong for a starving man to steal a loaf of bread? The bioethicist, casuist or umpire must make these decisions in real time, and this method—identifying differences and similarities with well agreed upon prior decisions and the particular circumstances that surrounded them—has proven most helpful to our bioethicists as they formulate responses to ethical dilemmas most consistent with the ethical principles relevant to the case.

I hope this rough simile between baseball and clinical ethics consultation helps clarify the nature of the work that we do at the Program in Medicine and Human Values.

Spotlight: Bioethics Education

DISPATCHES FROM PARIS

The 2018 Neuroethics Network’s annual meeting, June 19–21, took place in Paris, hosted by ICM, *Institut du Cerveau et de la Moelle Épinère* (Brain & Spine Institute). The meeting focused on seminars aimed at creating a deeper understanding of newly emerging ethical issues in neuroscience. Seminar themes for 2018 included: Theory of Mind: Philosophical Considerations and Practical Implications, New Developments in Imaging along with Legal and Social Concerns, Deep Brain Stimulation and Recording, and Consciousness: Building Bridges.

This year offered participants the option to earn a Charcot Certificate in Neuroethics, awarded to professionals with terminal degrees who attended the 23 hours of agenda, seminars, and completed a summary of the themes discussed. Earning a Charcot Certificate in 2018 were: Edmundo Estevez, M.D., Medical School of the Central University of Ecuador, Silvano Franco, Ph.D., University of Cassano and Lazio Meridionale, Italy, Mako Junjako, Ph.D., University of Rijeka, Croatia, Frederica Madonna, Ph.D., University of Cassano and Lazio Meridionale, Italy, Luca Malatesti, Ph.D., University of Rijeka, Croatia, Gil Palchik, Ph.D., California Pacific Medical Center, San Francisco, USA, Marisa Russo, Ph.D., Federal University of Sao Palo, Brazil.

PARIS CONFERENCES

The *International Bioethics Retreat*, June 27–29, was held at Reid Hall, Columbia University’s Global Centers–Europe. It is an annual conference which allows international bioethicists to share their current work and receive feedback on their research. In the session entitled “In the Clinic,” PMHV’s Program Director and Senior Scholar, Dr. William Andereck, posed the question “What is our Duty to Respect Preferences in the Incapacitated Patient” to the attendees while Bioethicist, Dr. Shilpa Shashidhara, presented on “Preventing Beneficence from Becoming Maleficence: The Ethicist’s Role.” PMHV’s Neuroethicist, Dr. Gil Palchik, presented his poster “A Novel Role for Clinical Neuroethics: Assessing Neurotechnology for Patient Impact” at the conference.

The eighth *Cambridge Consortium for Bioethics Education*, July 4–6, was also held at Reid Hall, Columbia University’s Global Centers–Europe. It assembled university professors, medical professionals and bioethics leaders from around the world to share the practical methods and tools they utilize to teach ethics to medical



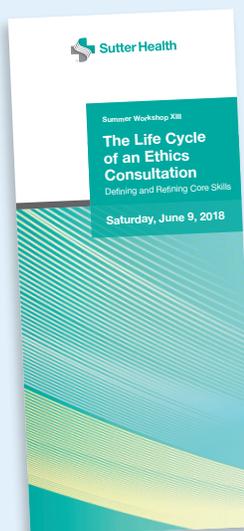
(First row left to right) Seated left: PMHV Neuroethicist, Dr. Thomasine Kushner; Seated middle to right: Sutter Health Bay Area CMO, Dr. Kelvin Lam; PMHV Director, Dr. William Andereck; PMHV Bioethicist, Dr. Shilpa Shashidhara.

students and other healthcare providers. Dr. William Andereck presented “Words We Shouldn’t Use: Rethinking the Way We Talk in the Clinical Setting.” Dr. Shilpa Shashidhara presented on “Creating a Digital Community for Ethics Education” which discussed PMHV’s “How to” web series.

The 2019 Paris conference meeting dates have been set: Neuroethics Network meeting will take place June 20–22; The International Bioethics Retreat, June 26–28; and the Cambridge Consortium for Bioethics Education will be held July 3–5. For more information, please contact Senior Neuroethicist and coordinator of all three conferences, Dr. Thomasine Kushner kushnertk@gmail.com.

SUMMER WORKSHOP 2018

On Saturday, June 9, PMHV held its 13th annual *Summer Workshop in Clinical Ethics*. This education event was attended by nearly 60 ethics committee members and other healthcare professionals from various disciplines including bioethicists, physicians, nurses, risk managers, chaplains, social workers, administrators, patient advocates, attorneys and others. These attendees were represented by 21 institutions, including California healthcare institutions such as



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“What is the ethically appropriate course of action when the best medical treatment at this time is against the patient’s previously expressed wishes?”

However, the catheter is not a long-term solution due to the high risks for infection as well as the fact that it does not treat the underlying prostate condition causing the retention. Additionally, the catheter seems to irritate the patient to the extent that he has pulled it out and is now requiring restraints. Would the patient, had he been decisional, rather be in pain, experience the discomfort of not being able to urinate, and risk having kidney failure, urinary tract infections and further bladder problems?

The role of the surrogate decision maker is to have a good understanding of the patient’s current medical

problems, weigh the risks and benefits of the procedures that are being recommended by the treating team and make a decision in the context of the patient’s values and preferences. While the patient had expressed previously that he did not want prostate surgery, it is not clear what exact type of surgery he had in mind and the purpose for which it was provided. What we do know though is that the patient did not want to become incontinent and it would be fair to therefore say that the patient valued his independence, control over his body and comfort. Additionally, during the current hospitalization, the patient has demonstrated a preference to have no external devices attached to him. Given that these are the preferences exhibited by the patient, the patient’s surrogate decision maker should be supported in making a treatment decision that is in the best interest of the patient in the current time. It would be ethically appropriate to proceed with surgery in this patient in an effort to return him to his baseline functional status and quality of life that he seemed to enjoy prior to being hospitalized.

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Sutter Health, Dignity Health, and Kaiser Permanente as well as Renown Health in Nevada. This year’s skills-based, practical workshop, “The Life Cycle of an Ethics Consultation: Defining and Refining Core Skills” gave participants an opportunity to understand the process of an ethics consultation from “start to finish.” Utilizing a real case example, the participants were provided a comprehensive overview of how each step contributes to the consultation process, including how to assess the facts, best strategies to resolve conflicts encountered, practical recommendations that the medical team can implement and finally how to write an effective ethics consult note. Each of the sessions were led by PMHV staff, Drs. Andereck, Holmes, Lescher, Mishra, Palchik and Shashidhara. Senior Bioethics Scholar-in-Residence Emeritus, Dr. Albert Jonsen, also presented a session on “Casuistry” and its relation to ethics consultations. The information was well-received by attendees who stated that the “workshop was well organized, presenters were well prepared and the information delivered was relevant and useful for my job.” Specifically, stating “very appreciative to have a quality program like this available to me and others,” “I’m so glad I came! I learned so much! Great job team! I learned new

things and will do some things differently” and “looking forward to next year’s workshop.”

BIOETHICS WEEK

In May, PMHV hosted **Bioethics Week** at CPMC’s Pacific Campus, an event that reached approximately 150 people through ethics jeopardy, daily case discussions and two grand rounds presentations. Administration, Physicians, Nursing, Spiritual Care, Social Work/Case Management, Physician Assistants, Technicians, Therapists, Patient/Family, Security, Environmental Services and Parking were all represented. Themes of moral distress, code status and non-beneficial treatments were the most common topics of discussion among the staff providing direct patient care, but it became clear that ethical issues have a breadth and depth much greater than previously thought. Some of the most pressing issues discussed were brought up by employees that do not provide direct patient care and serve as support staff at the institution. This presents a challenge and an opportunity for the future to consider the ethical dilemmas that could arise in any role requiring an interaction with patients or families.

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