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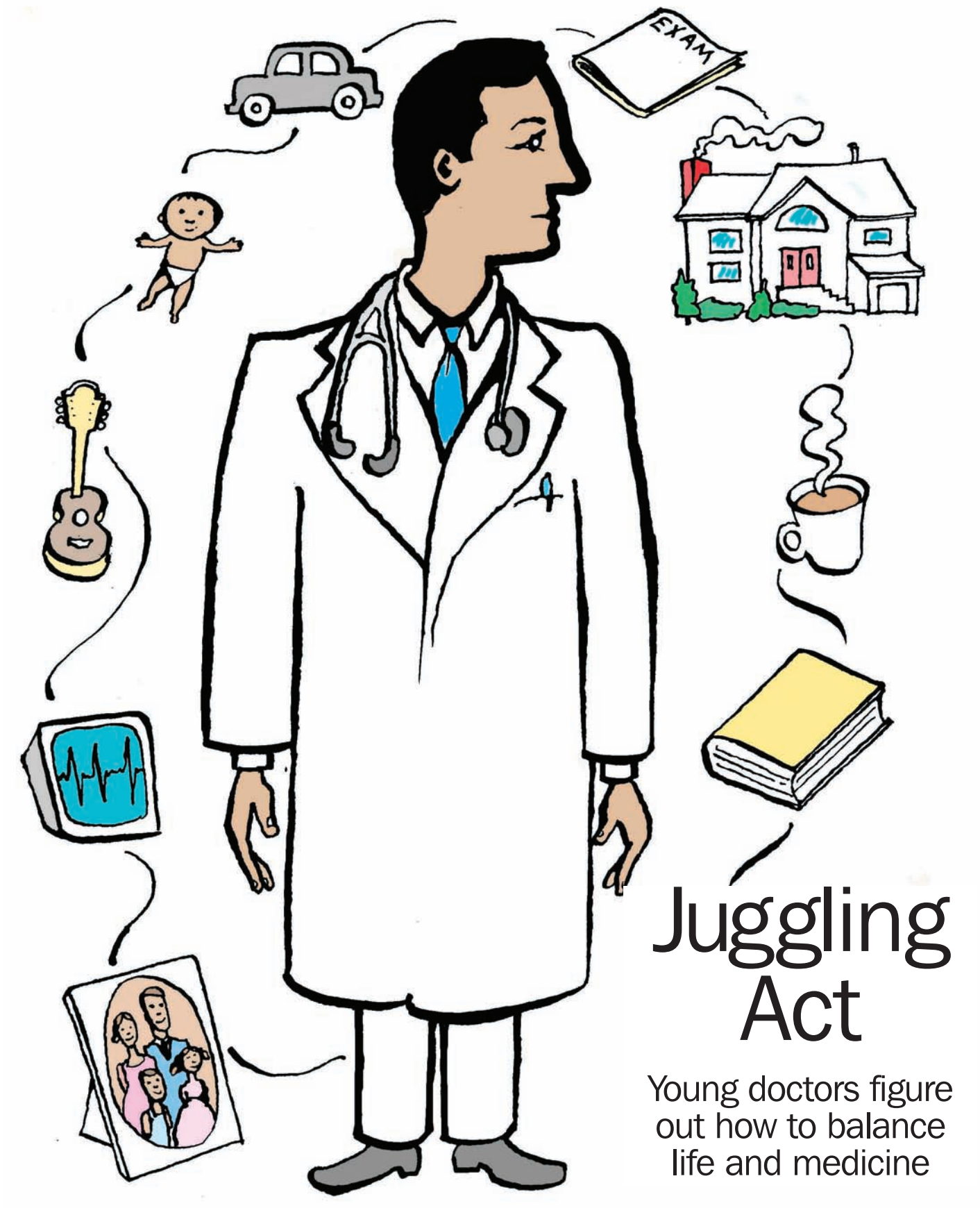

Juggling Act

Young doctors figure out how to balance life and medicine

Hard Choices

Ethics experts aid patients and families

IT'S A CASE THAT PHYSICIAN-ETHICIST Elizabeth Nilson, MD, remembers well. A man in his mid-sixties came to the emergency room with wet gangrene on his foot, a complication of diabetes. Stagnant blood and bacteria saturated the dead tissue. Without treatment it would likely lead to sepsis—and eventually death. Surgeons wanted to amputate the foot, Nilson recalls, but the patient said no. He would not speak with psychiatrists, who determined that his refusal was proof he lacked the capacity to decline treatment. Meanwhile his family gave the go-ahead. "The physicians wanted to do the surgery, the patient was saying no, the family was consenting," Nilson recalls. "It was, 'What do we do here?' So they called us."

Nilson is a member of Weill Cornell's Ethics Consultation Service, founded and directed by Joseph J. Fins, MD '86, chief of the Division of Medical Ethics at Weill Cornell. The service is a team of physician-ethicists and staff who help patients, families, and clinicians navigate the sometimes murky waters of medical decision-making. In the case of the diabetic man, Nilson arranged for a social worker to ask the patient why he was refusing the surgery. It turned out that he spent much of his retirement playing the organ—using the diseased foot to work the pedals. "Here we were trying to save his life," says Nilson, an assistant professor of public health and medicine. "But as far as he could tell, we were about to take away the one thing that gave his life meaning." Once he understood that a prosthetic would allow him to play, he agreed to the amputation. "A lot of what we do is make sure that good communication is happening," she says, "and everything else just works itself out."

Part of the Weill Cornell Division of Medical Ethics, the Ethics Consultation Service handles approximately 200 consults each year, making it one of the busiest in the country. And the volume is increasing, says Susan Mascitelli, vice president for patient services administration at NewYork-Presbyterian Hospital. "As technology grows, and as our ability to keep people alive and provide potential treatment grows," she says, "hospitals will necessarily be faced with these kinds of situations." While all hospitals are required to have a process to address ethical issues in clinical practice, NYPH/WCMC's service takes a unique approach, based on a method of moral problem-solving called clinical pragmatism. The method, developed by Fins, was inspired by the philosophy of John Dewey and emphasizes collecting information and reaching consensus. Fins and colleagues have published articles about clinical pragmatism in the peer-reviewed literature and teach the method to medical students and residents.

When an ethics consult is requested by patients, families, or

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Joseph Fins, MD '86, and Elizabeth Nilson, MD

staff, a member of Mascitelli's staff gathers clinical and narrative information about the case, including the patient's values and wishes. A physician-ethicist—one is available at any time, day or night—reviews the case with patient services staff, then with the clinicians. A hospital lawyer will participate if a potential legal issue is involved, and the patient's family may be invited to join the discussion. Ethically problematic situations, Nilson notes, typically emerge when a patient or family members "are caught between two choices that both seem reasonable. For example, stopping care can be looked at as ending someone's suffering. But some people view it as giving up."

Consultations often center on patients at the end of life. The toughest cases involve what Nilson calls family pathology: "adult children estranged from their parents who feel guilty because Mom is dying, or siblings who never got along and are trying to make decisions together." When there is a family dispute, Fins and Nilson try to move the discussion forward. "One trick is to get them to agree about something. You can say, 'It sounds like you all really love your mother,' " Nilson says. "And usually everybody will nod to that." Fins says that he will try to get the family to "let the goals drive the therapy, and the therapy drive the goals."

Fins notes that patients and families often misunderstand the clinical situation due to fragmentation of care, in which subspecialization and complex technology divide responsibility for treatment among several clinical teams—and sometimes the clinicians themselves are at odds over the appropriate course of action. "There may be multiple quarterbacks, and there may be multiple teams," he says. "One of our great privileges is convening people across specialties."

Given the end-of-life context, religious concerns often come into play. A Roman Catholic family didn't want to withdraw care for their relative because they assumed their faith forbade it. So Fins brought in a nun who explained that Catholicism does not require that a patient be given extraordinary care if the burden exceeds the benefit. Helping families understand religious practices often resolves the conflict—and diminishes grief, Fins says. "It keeps them vested in the religious traditions that will hopefully help them address their bereavement after they leave the hospital."

Cultural misunderstandings can surface as well, as when a Japanese businessman fell ill while vacationing in New York City. At NYPH/WCMC his condition progressed to brain death—his brain stem and entire cerebral cortex had ceased to function—but his family objected to that definition of death. "They didn't want to do anything that wouldn't be proper in Japan," Fins says. So he contacted a bioethicist colleague in Tokyo and discovered that Japan's Diet had just passed brain death legislation. With that information, the family accepted that the man had died. "It was a great help to them," Fins says, "because they felt that their actions were consistent with their community."

— Susan Kelley

Rubino's Revolution

A surgical cure for Type 2 diabetes?

FOR MANY PATIENTS SUFFERING from lingering illness and disease, surgery feels like a last resort. An extended course of medication, improved diet, rigorous exercise—almost any option seems more attractive. But one of Weill Cornell's newest doctors has found surgery to be the best option for treating a chronic and progressive condition that has long been controlled only through strict diet and daily injections of insulin: Type 2 diabetes. Through a study he began while at the European Institute of Telesurgery, Francesco Rubino, MD, has found that a new procedure not only aids diabetes patients but may also help reveal the molecular origins of the disease—and even point to a cure.

The procedure, called duodenal-jejunal bypass, is the first of its kind to treat Type 2 diabetes without involving weight loss. The operation, which Rubino himself designed, leaves the stomach intact—maintaining its endocrine and digestive function—and reroutes nutrients away from the duodenum and first part of the jejunum. "I was trying to avoid restricting food intake," Rubino explains, "so I decided to preserve the stomach." (The study, which Rubino and colleagues published in the *Annals of Surgery* in 2004, confirmed that the bypass ameliorates Type 2 diabetes without affecting diet.) The cutting-edge technique has not yet been performed on human subjects in the U.S.; however, Rubino's colleagues have seen great success with the procedure overseas, where less stringent approval standards for new surgeries have allowed about 100 patients to undergo the operation. Rubino, who was named head of the newly created Section of Gastrointestinal Metabolic Surgery at NewYork-Presbyterian Hospital/Weill Cornell Medical Center in November, hopes to begin clinical trials there this year.