CRITICAL CARE

PRACTICING PHYSICIAN AND INSIGHTFUL ETHICIST—IT'S A RARE COMBINATION THAT DR. JOSEPH J. FINS '82 EMBODIES AS CHIEF OF MEDICAL ETHICS AT NEW YORK-PRESBYTERIAN WEILL CORNELL MEDICAL CENTER. FROM THE BEDSIDE OF DYING PATIENTS, HE HAS A MESSAGE FOR THE EVER-MORE HURRIED WORLD OF MODERN MEDICINE. **BY WILLIAM L. HOLDER '75**

Dr. Joseph J. Fins '82 was a first-year fellow in general internal medicine in New York when Eunice Thomas*, a black woman from Guyana with a problem-plagued medical history, was wheeled in by her daughter, Jennifer. Stroke, chronic lung disease, congestive heart failure, and rheumatoid arthritis had left her sound in mind but slow in speech.

Fins recounts that Jennifer, a fierce defender of her mother, "looked me up and down, pausing for an eternity at the ID that hung off the lapel of my starched white lab coat. When she completed her assessment, she simply shook her head. I had come up short."

Emboldened by a smile from Mrs. Thomas, he dropped the standard doctor-patient script, turned to Jennifer and said, "You're probably thinking that your mom has gotten another young white doctor and that won't do. Well, I am a new fellow in medicine, and I'm not all that experienced. But I'll do the best I can do to take care of your mother. If I don't know the answer to a question, I will make sure that I get help."

Encouraged by that offer of genuine caring, Jennifer offered her hand. Fins had begun a relationship that would extend for years through Mrs. Thomas's frequent hospitalizations and outpatient visits.

Life ebbed slowly from this spirited and friendly woman. Fins talked with mother and daughter about end-of-life issues. They drew up an advance directive that designated Jennifer as the decision-maker should Mrs. Thomas lose the ability to speak for herself. Fins led Jennifer to an understanding that more care, such as resuscitation, is not always better care.

Fortunately for the two women, they were in the hands of a doctor who would become an authority on end-of-life care and attendant ethical issues. As director of medical ethics at New York-Presbyterian Weill Cornell Medical Center, one of the country's leading academic medical centers, he has consulted on 800 ethics cases since 1994. Most of them pertained to end-of-life issues. A frequent contributor to medical journals, he has written about topics ranging from managed care to brain death to physician-assisted suicide.

"He is one of the leading bioethicists of his era," says Dr. Sherwin Nuland, author of the 1994 book *How We Die*. "His writings about death and dying have in them a perspective that very few ethicists have: that of an experienced and mature bedside physician."

Fins has contributed to sweeping changes in medical care over the past decade that have led to greatly increased awareness on the part of physicians regarding appropriate care at the end of life. Medical schools have introduced courses on the topic, hospices are much more common, and there has been a proliferation of literature about death and dying for lay persons and specialists.

"When I wrote the book, the real problem was getting doctors to stop—to cease their efforts to keep people alive," Nuland adds. "My friends who work in intensive care units now tell me that more often the problem now is getting families to understand that we must stop. That's a big change."

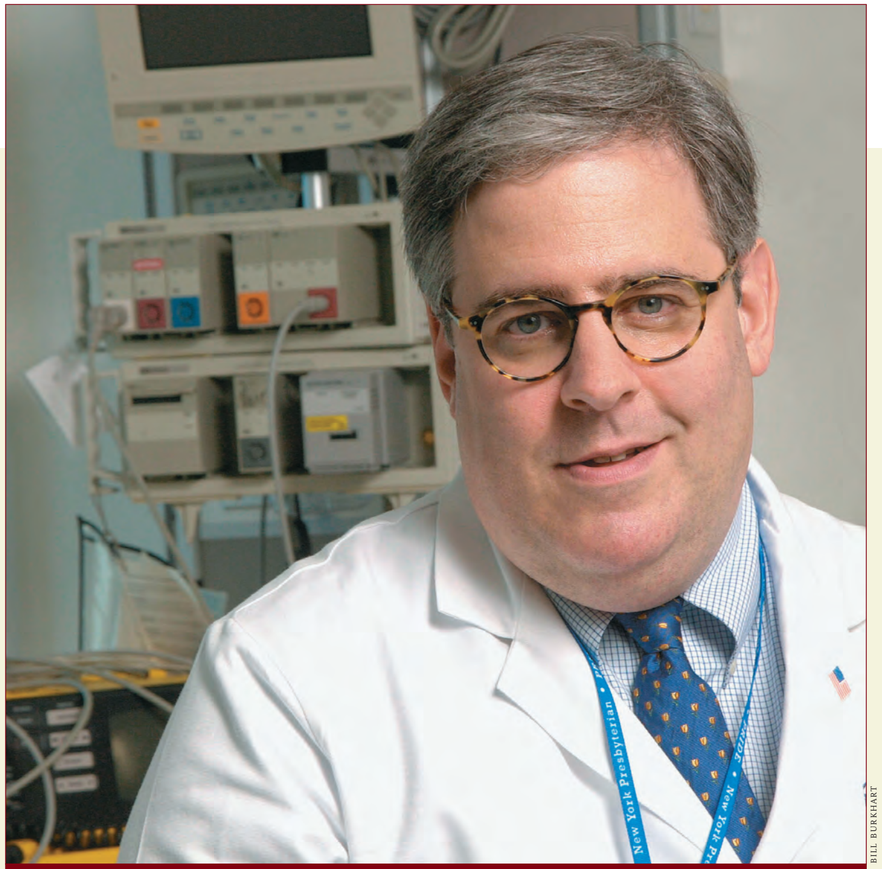
Fins argues that in order for physicians to attend to the needs of the dying, they must be sensitive to the moral dimensions of clinical practice. Too often physicians are neither trained nor encouraged to do so, and the result may be a serious breakdown in communication with the patient.

Fins was gaining a national reputation in medical circles for his articulation of ethical issues when in 1995 he returned to the College of Letters, where he had majored, to deliver the annual Philip Hallie Lecture. He had flourished in the COL's interdisciplinary environment, reveling in the intellectual give and take. Professor of Letters Paul Schwaber says that as an undergraduate, he had already displayed a talent for marrying philosophical expression with narrative style. Hinting at his future career, he also had displayed a keen interest in rendering the complexity of a situation for moral purposes.

"From the first, Joe Fins seemed to have an old, wise soul in a youthful body and spirit," Schwaber recalled.

In the Philip Hallie Lecture, Fins asserted that he and his colleagues were attempting to guide the reform of medical practice through an approach called clinical pragmatism, drawing on the work of the American philosopher and pragmatist, John Dewey.

Dewey died in 1952 and his work was largely ignored during the 1960s, when medical ethics gained



BILL BURKHART

DR. JOSEPH J. FINS
resolves ethical dilemmas arising in the care of critically ill patients at New York-Presbyterian Weill Cornell Medical Center.

"WE REMAIN A DEATH-DEFYING CULTURE FOCUSED ON INDIVIDUAL NOTIONS OF CONTROL AND A DEEP-SEATED BELIEF IN THE ALMOST LIMITLESS POSSIBILITIES OF MEDICAL TECHNOLOGY."—DR. JOSEPH FINS

increasing attention. The era of doctor-as-superman was closing; the right of patients to be fully informed and make decisions about treatment was gaining ground. The principle of patient autonomy became one of several principles established as the basis of medical ethics.

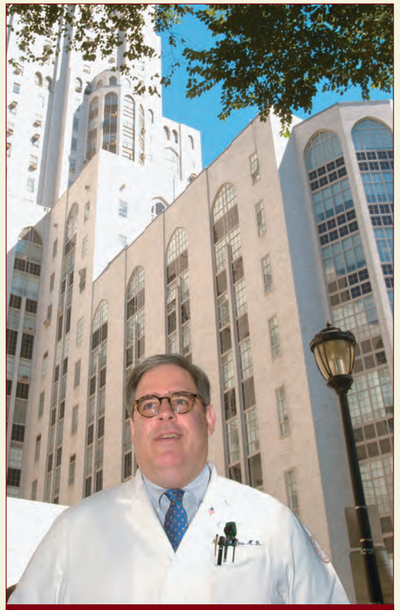
But patients are real people whose stories are easily lost in the consideration of abstract moral principles. Fins felt more at home with Dewey's notion that principles should be understood as hypotheses to be tested against the particulars of a morally ambiguous situation. Dewey called his process of moral inquiry "the construction of good."

"I am struck by this notion that good—in practice—often needs to be constructed," Fins said in his lecture. "Good practice is readily apparent when there is no ambiguity. More often than not, however, the good in its complexities is difficult to recognize. Dewey suggests that good practice emerges from moral engagement in the world through a deliberative process of cultivation and inquiry. Indifference to detail, context, and particulars becomes the enemy of goodness because it undermines the construction of good.

"Like the good host who listens to and is interested in his guests," Fins adds, "clinicians need to learn how to become engaged by the details and nuances of each patient's story."

Fins is, in effect, reinvigorating the concept of the caring physician and fighting against the trend in managed care to view medicine as a commodity. The Healthcare Chaplaincy in New York recognized this when it bestowed on him the "Wholeness of Life Award" in 2001, saying that he goes "the extra mile to insure that patients and their loved ones are treated as whole persons deserving of honesty, patience, and respect." The organization cited him for "lively human empathy" brought to bear on the human problems of medical ethics. Fins knows how to lead people in difficult straits to a consensual decision.

"The medical ethics committee he heads has had a tremendous impact on end-of-life issues and ethical issues in medical practice," says Dr. E. William Davis '47, vice president of medical affairs at New York-Presbyterian Hospital. "The whole issue of patients' rights and medical ethics has taken off like you can't imagine. At this point he has an international reputation. He's being asked to speak and address issues all over the country and worldwide.



DR. FINS OUTSIDE THE TOWERING NEW YORK-PRESBYTERIAN HOSPITAL

"He has pioneered a dignified approach to dealing with patients who have insurmountable medical problems."

Such skills were needed in the case of a 91-year-old man near death with complications from Parkinson's disease. His wife had a story to tell, but busy residents talking to her in hallways while their pagers sounded had no time for details. She was angry and insisted that everything be done for her husband, including cardiopulmonary resuscitation. Members of the medical staff believed resuscitation would be futile and were frustrated with her.

Later conversation with her in the quiet of a solarium revealed that his wife had spent 15 years caring for her husband, but his health had declined precipitously when her own infirmity required her to move him to an excellent nursing home. For her, the decision to write a do-not-resuscitate order was the "fateful capstone of a long life together," not the "end game" of a two-week hospital stay, says Fins. When the attending physician suggested to her that she felt responsible for her husband's demise, she broke down and cried because she had not kept him at home.

Remarkably, no one had explained to her the natural progression of advanced Parkinson's disease. Once she understood that she was not responsible for his current condition, she was able to consider his situation objectively and soon consented to a do-not-resuscitate order.

A physician is unlikely to hear crucial details without making time in the proper setting. Careful attention to narrative detail, however, is itself a casualty of today's medical climate in the United States. Forty million uninsured Americans have only marginal access to any physician, let alone one able and willing to listen carefully to patients' stories. Others face busy doctors weighed down by the demands of managed care. A highly regarded 1995 study found that terminally ill patients in hospitals frequently received inadequate relief from pain and that their preferences regarding end-of-life care were either unknown or ignored.

Terminally ill individuals are particularly susceptible to pitches about therapies far outside the medical mainstream, which worries Fins. Patients have been driven to alternatives because mainstream medicine has not always been attentive to their needs. For these and other reasons, alternative medical therapies are popular—ranging from those known to be effective to suspect or even fraudulent treatments. [See sidebar.]

A major report from the Institute of Medicine in 1997 advocated a wide range of reforms to end-of-life care, including reform of restrictive prescription drug laws, better pain management, and improved education of physicians. The report spawned blue-ribbon panels in 20 states, and many focused on the medical curriculum about death and dying, which was "conspicuous mainly by its relative absence," in the words of the institute's report. Since then the American Medical Association has undertaken a massive educational effort to improve professional competence in this area.

People in the United States remain deeply divided over issues of death and dying. Notwithstanding a 1997 Supreme Court ruling that there is no constitutional right to physician-assisted suicide, the issue is far from settled. While some individuals wish to hasten death, scientists are seeking to prolong life by manipulating the molecular basis of aging.

"We remain a death-defying culture focused on individual notions of control and a deep-seated belief in the almost limitless possibilities of medical technology," Fins observes.

At the end of life, when technology can offer no more than palliative help, most people want a loved one, or proxy, who will make informed choices when the dying person is no longer able to respond. Fins characterizes the ideal relationship as covenantal, not contractual, thus allowing room for the proxy to make decisions that require judgment and discretion. "When capacity is lost, he has written, "the covenant between patient and proxy is embodied in shared memory. Memories remain an enduring legacy to the proxy, who must draw on this inheritance for guidance."

Some individuals, like Eunice Thomas, will be fortunate enough to have physicians who can advise them and their proxies with the benefit of knowledge and experience. Ten years after Fins first met Mrs. Thomas, Jennifer called to say that her mother was experiencing abdominal pain but did not want to come to the hospital. She wanted to die at home. So he decided to make a house call. As he listened to the crackles in her lungs, he realized she was near death. One final indignity awaited. Fins wanted to provide her with an opioid for pain relief, but as he called one pharmacy after another, he discovered that the right pain medication was not available in the underserved area of the Bronx, where pharmacies worry about crime. Eventually, he found a pharmacy in an affluent community miles away that stocked the medication.

Ten days later, he attended Mrs. Thomas's funeral. Her family asked him to give a eulogy. As he entered a black church in the Bronx, he was immediately embraced and treated as an honored guest by the large assemblage of family members.

"I felt accepted and loved," he remembers. "Viscerally, I felt the weight of caring for someone who was so beloved by so many. To know that such a precious life had been entrusted to my skill was almost overwhelming. Tears came to my eyes."

[*patient and family names are used with the permission of Jennifer Thomas.]

ALTERNATIVE MEDICINE: A FLAWED REPORT?

Acupuncture, European herbals, naturopathy, homeopathy, Ayurvedic medicine—these and many more therapies are becoming increasingly common, thanks to factors such as the cultural diversity of American society and the difficulty many individuals have obtaining affordable access to mainstream medical care.

Studies show that half of all adults use some form of complementary or alternative medicine, creating a $30-billion growth industry. In 1992, the National Institutes of Health established the National Center for Complementary and Alternative Medicine; its research budget has increased from a modest $2 million per year then to $100 million now. Among academically-oriented medical centers, New York-Presbyterian Hospital has been a leader in investigating techniques such as biofeedback and aromatherapy.

Dr. Joseph Fins's reputation led President Clinton to enlist his service on the White House Commission on Complementary and Alternative Medicine Policy—a task that would present him with a difficult decision of his own.

The purpose of the commission was to ensure that public policy maximizes the benefits to Americans of these therapies. Fins was sworn in by former Secretary of Health and Human Services Donna Shalala in the vice president's ceremonial office. Clinton was at Camp David, attempting to negotiate a Mideast peace accord. "It was," says Fins, "a more optimistic time."

For a year and a half, the commission met every two months for two to three days, hearing more than 1,000 witnesses and hosting numerous town meetings. It issued its report and recommendations in March of 2002. Fins, clearly troubled by the final draft, coauthored a dissent to the majority report. His dissent was covered by national media.

"Many of the commission's recommendations did not take into account that the world had changed since July 2000," Fins says. "We now have no federal budget surplus and are at war. The commission should have developed research priorities and paid more attention to alternative therapies that may pose a health threat."

A world of difference exists, in his view, between acupuncture, aromatherapy, and meditation—which have been shown conclusively to have benefits—versus, for example, chelation therapy for heart disease or ozone therapy for cancer, neither of which has been shown to be efficacious. Limited research dollars, Fins believes, should be directed toward therapies supported by at least a modicum of clinical evidence and scientific underpinning.

Moral issues raised by the commission's report particularly trouble Fins. The commission heard testimony that many people who do not have ready access to conventional medical care use alternative therapies as a less expensive substitute.

"It is worth considering whether these individuals would prefer to have a drug benefit over access to unproven supplements...if they had the resources to receive care from primary care practitioners," he wrote. "While there is room for diversity in the health care system, we should not be a party to creating a separate but unequal care system. We must never foster a second tier of medical care for those who are economically disadvantaged."

Fins asserts that most Americans prefer safety over ease of access to alternative therapies, contrary to views expressed by the majority report. As evidence, he cites dietary supplements: Their use has been declining and the majority of Americans support increased regulation of supplements, including FDA review. Public attitudes have changed, he suggests, with publicity about St. John's Wort and drug interactions, the potential liver toxicity of Kava, and the presence of heavy metals in some Asian preparations.

Throughout the commission's deliberations, Fins argued strenuously for a more science-based approach, and he believes his efforts moderated the final report—but not enough. "It was a hard decision not to go along with the group," he says. After writing the dissent with a colleague, he arrived home at 2 a.m. on a Sunday, flipped on the television and heard an infomercial touting calcium as a treatment for heart disease while dismissing cholesterol as a causative factor. "That's bunk," he says. "I went to sleep knowing I had done the right thing."