A New Role for the Pulmonologist 
Bringing Bioethics Back to the Bedside

The pulmonologist, in his role as critical care physician, is in a unique position regarding the bioethical crisis facing medicine today. In ICUs, interacting with patients, other physicians, staff, and administrators, he faces a barrage of end-of-life dilemmas—resuscitation, withholding and withdrawing of support, medical triage and distributive justice, cost-benefit analysis, defining futility of care. It is in ICUs that such crises occur with the greatest frequency, making decisive bioethical thinking all the more urgent.

Traditionally, medical decisions are made at the bedside by the clinician, interacting with patients or their surrogates, and are founded on the doctor-patient relationship. Following the recent transformations in the health care field, both scientific/technological and political/social, the role of the physician has evolved from a paternalistic model, benevolent and authoritarian, to one more democratic and egalitarian. Much has been said about doctors losing compassion and being excessively greedy, overspecialized, technology-oriented, and impersonal, which has led to great consumer frustration. However, a biopsychosocial model of medical thinking is slowly replacing the old, narrower biomedical model, reshaping the conceptual framework of medicine into a new dimension, more wholesome and integrated. Humanistic qualities, summarized as integrity, respect, and compassion, are now expectations of the internist, to be taught, observed, and measured by training programs and the certifying boards. Empathy is now included in the curriculum of many medical schools, in the hope of raising physicians’ potential for sensitivity and understanding (New York Times, June 3, 1992, p A1). Slowly, physicians are regaining what many have seen as their lost humaneness.

Bioethics developed out of the vacuum created by the explosion of new technological possibilities and the failure of the medical establishment to promptly respond to the challenge. It has become a new medical specialty, with its own instruments and procedures—committees, consultations, policies, educational programs—and is still striving to measurably demonstrate its effectiveness. After an initial spurt of theoretical growth, bioethics settled on a clinical role, as a practical field offering assistance in patient care. Bioethical literature, first limited to philosophy journals and textbooks, now fills the pages of medical periodicals and the most respected textbooks of medicine. Enshrined as clinical medical ethics, it should now become ingrained in the professional ethos of this generation of physicians. As a clinical discipline, bioethics has arrived at the bedside to stay.

Pulmonologists, like other physicians, often utilize methods of integrative reasoning, such as physiopathologic and clinicoradiologic correlations. To those we should now add ethiophysiologic correlations when making our management decisions. We have overcome our embarrassments and difficulties and can now make routine inquiries, detached and neutral, into our patient’s intimate and sexual practices, as just one of many disease risk factors. However, still we cannot talk with our patients about their death and dying. We have yet to overcome our difficulties with our own mortality and professional vulnerability so that, freely and without inhibitions, we can feel comfortable openly talking about advance directives, the appointment of surrogates, issues of triage and cost-benefit, the emotional burden of caring for terminally ill patients, and confronting the futility of so many of our actions.

In a teaching community hospital, during rounds in the ICU, we found that, unless we systematically addressed the bioethical dimensions of each case, often our actions felt incongruous, if not outright futile. In conference rooms or at the bedside, in bioethics committees or during “ventilator rounds,” a global biopsychosocial strategy tempered with ethical considerations became a sine qua non component of clinical judgment. To our surprise, fears of objections notwithstanding, we found patients and their families by and large remarkably receptive, often ahead of the medical team as far as bioethical preparedness was concerned. Students, residents, medical staff, nurses, social workers, chaplains, hospital administrators—all participated and learned how to think bioethically, teaching each other and growing in the process. We learned that, as a matter of fact, no case is free of bioethical connotations: if nothing else, casually asking about advance directives or a durable power of attorney can bring out profound and meaningful reflections from patients, helping them open up and reveal their deepest selves. Despite busy schedules, ICU staff members have welcomed the stimulation and enjoy the enrichment such discussions add to their otherwise stressful and overworked schedules.

Bioethics has popularized its grand theoretical prin-
principles: autonomy, beneficence, non-maleficence and justice. At the bedside, patient autonomy becomes alive and real, no longer the abstraction of philosophical papers or committee discussions. At the bedside, face to face, the doctor-patient relationship becomes the live bond it is meant to be. At the bedside and nowhere else is empathy actually possible. Momentarily focusing on the patient, away from charts, printouts and equipment, real life unfolds: real people in real time and space. Respiration transcends the ventilator, the PCO₂, and the respiratory muscles, as breathing, a clinical image, becomes the most eloquent metaphor for life. Pulmonologists lay on the hands, search for paradox, and seek the face for signs of distress and suffering.

The coming reforms in health care will certainly add to the bioethical strains we already experience. We will face even harder decisions, such as rationing care, brought upon us by limits in resources. Pulmonologists certainly can play a role in the coming policy debates either in committees or at the bedside. We do not have to wait for every hospital to have a philosopher-ethicist to dictate bioethics to the staff. We do not have to send every physician to bioethics school. Neither can we afford to wait for every bioethical device to be statistically validated or proven beyond doubt: we may cause more harm and pain by our omission than by getting actually involved. Bioethics information is now widespread and at the fingertips of the clinician: in medical school curricula, scientific programs, paper pamphlets of professional organizations, the mainstream clinical literature — there is a plethora of educational instruments at our disposal.

Pulmonologists are heirs to the learned tradition of wisdom and scientific rigor of internal medicine. Having now mastered the skills and procedures of new technology, we find ourselves uniquely positioned to bridge the new and the old, linking the physical and mechanical with the ethical and psychological. We are at the forefront of bioethics: retreat or avoidance is no longer an option. To start, all we must do is to study, to discuss, to put it into practice. If doctors with their patients do not, who will? If not at the bedside, where? The time is now.

Nelson Kantor, M.D., F.C.C.P. Chicago

References
1 Luce JM. Ethical principles in critical care. JAMA 1990; 263: 696-700
2 Terry PB, Elliott MW. The pulmonary physician and the hospital ethics committee. Chest 1989; 96:1175-78
5 Spiro H. What is empathy and can it be taught? Ann Intern Med 1992; 116:843-46
12 Siegler M. A legacy of Osler: teaching clinical ethics at the bedside. JAMA 1978; 239:951-56

Preflight Medical Screening of Patients

Each year, more than 450 million passengers fly commercially on US air carriers. While the number of disabled passengers is not known, it has been estimated that there are 43 million disabled persons in the United States, including over 2.5 million with asthma, COPD, or other chronic lung diseases, and their number in the traveling public is growing rapidly. In addition, persons who have experienced a recent illness or injury away from home, or who wish to transport relatives or associates to receive medical care elsewhere, often look first to the airlines for help.

Federal legislation, such as the Americans With Disabilities Act of 1990 and the Air Carrier Access Act of 1986 and its regulations, have encouraged airlines to increasingly make provision for and facilitate travel by passengers with disabilities or medical problems, such as through the provision of on-board wheelchairs and in-flight oxygen. However, physicians and passengers must recognize that commercial aircraft are not air ambulances, and that flight attendants have little or no medical training and no legal obligation to tend to the medical requirements of passengers.

Physicians and other health professionals travel frequently, and may be willing to lend medical assistance in an emergency, but their presence and involvement cannot be guaranteed. Also, the medical kit mandated by the Federal Aviation Administration is limited in content, being intended for emergency use only and not to support ill or injured patients during routine transport.

Despite the comfort and convenience of modern