

cial assets, not just with the management team at provider-only conferences, but with patients and families themselves.

We should address the ethical questions in the clinical situations we face daily, not to the exclusion of tertiary care ICU cases, but not to dwell on them either. Let the neurologists deal with the neurologic aspects of the comatose patient's ethical dilemma; let us deal with the primary care clinical ethical issues — including overall case management — and help with the family in a comprehensive way. Orr and Moss demonstrate this approach with the *JABFP* case report of the man with amyotrophic lateral sclerosis, but what about exploring the ethical questions in more common cases?

Dr. Pence is concerned that physicians will be challenged by antiphysician sentiment as we fulfill the patient advocate role inherent in clinical ethics. We may be challenged, though I think Dr. Pence is creating a false sense of conflict. As family physicians, we are dedicated not to any specific medical ideology, but to using our skills, both professional and personal, to provide the best care for our patients.

According to the American Academy of Family Physicians,

The family physician is educated and trained to develop and bring to bear in practice unique attitudes and skills which qualify him or her to provide continuing, comprehensive health maintenance and medical care to the entire family regardless of sex, age or type of problem, be it biological, behavioral or social. This physician serves as the patient's or family's advocate in all health-related matters, including the appropriate use of consultants and community resources.⁵

Finally, I agree with Drs. Orr and Moss that there is a great need for the participation of family physicians in the teaching and practice of clinical ethics. Christie and Hoffmaster said as much in their book *Ethical Issues in Family Medicine*.⁶ Still, we shouldn't need to become who we're not; we should develop who we are.

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References

1. Orr RD, Moon E. Effectiveness of an ethics consultation service. *J Fam Pract* 1993; 36:49-53.
2. Orr RD, Moss R. The family physician and ethics at the bedside. *J Am Board Fam Pract* 1993; 6:49-54.
3. Pence G. Clinical ethics and the family physician. *J Am Board Fam Pract* 1993; 6:80-2.
4. Brody H. *The healer's power*. New Haven: Yale University Press, 1992.
5. American Academy of Family Physicians. Definition of family physician. Adopted by the Congress of Delegates of the American Academy of Family Physicians, 1975.
6. Christie RJ, Hoffmaster CB. *Ethical issues in family medicine*. New York: Oxford University Press, 1986.

The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: I would like to thank Dr. Tunzi for his thoughtful comments on my recent articles on ethics consultation in family medicine.

In the *JFP* article,¹ Dr. Moon and I were describing an ethics consultation service, developed in the department of family medicine, which offers service to all departments in a tertiary care medical center, because that is who recruited and hired me and that is where I have most of my experience. We did not mean to imply that "family physicians must approach medical ethics the same way that other medical specialists do." In that article, we referred to the forthcoming *JABFP* article,² which had the thesis that family physicians are uniquely qualified to do ethics consultations.

Dr. Tunzi characterizes my work as "that of a traditional clinical ethicist who happens to be a family physician, not a family physician who does ethics." I am a family physician first, and I use those skills when I do an ethics consultation. I trained in a program in traditional clinical ethics, and I use much of the knowledge that I gained there when I do an ethics consultation. I do not consciously try, nor do I think I should or could, to separate these personae. I believe that the management and family conferences that I facilitate are different from those held by other clinical ethicists because of the family medicine perspective as outlined in the *JABFP* article. We did not make it clear in the article that patient and family members are present at most of our management conferences.

I agree with the author that "We should address the ethical questions in the clinical situations we face daily." I teach family medicine residents in their outpatient clinic, and I try to do just that. There is, unfortunately, a dearth of literature on outpatient ethical dilemmas.

I agree with Dr. Tunzi's concern about Professor Pence's perception that "... most of the problematic cases ... involve patients who are comatose"³ and his conclusion that neurologists are therefore most suited to do ethics consultations. His observation does not match my experience. In the *JFP* series, 35 percent of the adults had decision-making capacity, and many others without such capacity were not comatose. I am currently analyzing a series of 64 ethics consultations in children and find that ventilators and pulmonary status are more frequent determinants than coma. Careful reading of reports of other series of ethics consultations clearly shows a wide variety of issues raised in a wide variety of patients. Although many neurologists are sensitive to ethical issues, and some serve as clinical ethicists, I believe that the neurologist's perspective is neither as broad nor as applicable as is that of a family physician.

I am also curious about Dr. Pence's statement that there is "... a growing trend ... to bill for consul-

tation." I know of no clinical ethicists who bill. LaPuma has recently completed a national survey and found only 5 clinical ethicists who charge for their consultation services (personal communication). Perhaps Professor Pence knows something about third-party reimbursement that would be of benefit to others.

I also question Pence's characterization of the role of the ethicist as "more passive" than that of the family physician. While the advisory role of the ethicist is different from the decision-making role of the family physician, I would in no way describe it as passive. I, and I believe most clinical ethicists, play a very active role in the care of the patient. Perhaps his statement represents a difference between ethics consultants with a clinical background and those trained primarily in philosophy. I further disagree that ethicists must "keep private" their "strong feelings and beliefs about current ethical problems." While they must not impose minority views, they are individuals with moral standing who should feel free to express opinions tactfully when asked or when otherwise appropriate.

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References

1. Orr RD, Moon E. Effectiveness of an ethics consultation service. *J Fam Pract* 1993; 36:49-53.
2. Orr RD, Moss R. The family physician and ethics at the bedside. *J Am Board Fam Pract* 1993; 6:49-54.
3. Pence G. Clinical ethics and the family physician. *J Am Board Fam Pract* 1993; 6:80-2.

Clinical Ethics in Family Practice

To the Editor: I am writing in reference to the recent editorial by Dr. Pence in *JABFP* entitled "Clinical Ethics and the Family Practitioner" (*J Am Board Fam Pract* 1993; 6:80-2). As a family physician who works with disabled persons and as a writer on bioethics, I am probably more aware than the average practitioner of what is being written in medical ethics and the societal changes that they involve.

As I am aware of what actually has been written by the ethicists that Pence cites¹⁻³ and of the trends that he mentions, I must sadly conclude that not only is Pence happy that modern ethicists are slowly pushing back the limits against taking human life but that he also wishes family physicians to "go forth and do likewise."

Modern ethicists (including Smith and Cranford¹) teach us to judge a person's worth by marketplace values, by his or her economic usefulness, or by IQ,^{4,5} so that we learn to see the marginal member of society as having "poor quality of life" or even as not meeting the criteria for personhood. As a result, we learn to see disabled persons as better off dead or merely as entities outside the moral and ethical boundaries of humanity, to be ignored, denied medical care,⁶ destroyed ("out of respect for their lost

personhood"^{4,5}), or used for the betterment of the strong.⁷

In political literature many claim that we are in a "culture war."⁸ Similarly, medical ethicists have questioned the very basic assumptions of traditional ethics.⁹ But by insisting that tradition is irrelevant and that religious viewpoints have no place in discussion of public policy, they have left a moral vacuum that allows those more aggressive to push their ideological agenda to the forefront while those who try to stem the tide soon find that "it is the bold bioethicist who dares to say, and continues to say, 'No'. As he or she may quickly discover, the profession leaves such sensitive souls behind as the discussion leads to the next thing."¹⁰

We can easily see the results: cost analyses that limit medical care according to economic usefulness, arguments on why we should use anencephalic babies as organ donors, and articles in some of our leading medical journals that nod in approval when the sick, depressed, or useless seek "aid in dying."

In such a utilitarian world, arguing against such things by using the concepts of trust, human decency, or the importance of a transcendent meaning of life might sound like romantic nonsense.

But pragmatic sociologists¹¹ are the first to point out that our "communities of memory," i.e., the laws, customs, and religious traditions, are society's way of encoding thousands of years of human experience on what is helpful for a healthy society and what deeds are destructive to the human ecology. Almost universally such traditions teach us to see the marginal inhabitants of our world — the fetus, the infant, the sick, the elderly, the handicapped — not as "useless eaters," but as our brothers, persons to be loved and attended, because the deity insists that caring for the poor, the sick, and the orphan is important; because a just society is one that provides for its most vulnerable citizens; and because such values as compassion and caring and responsibility strengthen the "subtle ties of human beings" without which no society can survive.

Yes, Dr. Pence, we family physicians have many lessons to teach medical ethicists. But until medical ethicists such as Brody, Cranford, (and maybe even yourself¹²) are honest enough to recognize how ideas very similar to your own have corrupted the Netherlands,¹³⁻¹⁸ or how such "politically correct" ideas have the capacity to destroy the civil rights of those who are vulnerable, our social ecology, and the physician-patient relationship, I doubt these lessons will be very welcome.

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References

1. Smith DR, Cranford R. Consciousness: the most critical moral standard for human personhood. *Am J Law Med* 1987; 13:233,241,247.
2. Wanzel SH, Federman DD, Adelman SJ, Cassel CK, Cassem EH, Cranford RE, et al. The physician's respon-