A Woman (and Man) without a Country

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Lying in bed, the shriveled 86-year-old Australian woman appeared almost bionic. Congestive heart failure had rendered Mrs. A unable to breathe without a ventilator, and her failing kidneys kept her tethered to a dialysis machine 24 hours per day. Despite this, daily rounds in the ICU would find her pleasant and warm, and she would show off pictures of her grandchildren in Australia to the team members with tears in her eyes. She had been visiting her son in the United States when she had "the big one." Several months later, she had recovered cognitive abilities, but her heart was too weak to sustain her unaided. As a freshly minted physician and scared intern, I was awed by the series of events that had led this woman to our ICU and the conundrum that kept her there. She desperately wanted to return home to Australia and live out her days with her family. She was not ready to give up life without seeing her grandkids. The cost of transport was prohibitive, and the Australian medical system would require Mrs. A's family to pay too much for her continued care. Her children had stated that they would not be able to continue her dialysis if she were to return home. Going back home was not an option. She would not see her grandchildren again. Her medical condition and the complications of healthcare financing made her a woman without a country. What were our obligations to this woman? As physicians? As a society? Questions like this tore at me throughout my medical school clerkships and early in my medical residency.

Before I met Mrs. A, I had spent much of my undergraduate elective time pursuing courses in philosophy, sociology, and in the relatively new area of inquiry known as science, technology, and values. I was fascinated by questions at the interface of science and society. I was never sure why I had this affinity, but it stuck with me throughout my medical training.

Medical school has a way of pressing any interest in nonmedical topics out of one's neurons, probably because of the sheer amount of information one must digest during the process of becoming a physician. Immanuel Kant, emotivism, and Renee Fox yield their cognitive real estate to the Krebs cycle and asthma treatment guidelines. Although medical schools have improved their focus on ethics and the humanities over the past decade, there remains something about the socialization process involved in becoming a doctor that numbs the ability to focus on bioethics with any fervor. I fought against this as much as I could, asking questions regarding autonomy's dominance and enjoying electives in medical literature and the "touchy-feely" side of the doctor-patient relationship.

Exposure to patients like Mrs. A in my internal medicine and pediatrics residency led to a position on the hospital ethics committee. The obligations of residency caused me to miss more committee meetings than I was able to attend. Nevertheless, I found a formal outlet to discuss subjects such as the technological imperative and the role of

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life-sustaining therapies in the context of the modern American medical system with others who did not yawn when I brought up such topics.

During my pulmonary and critical care fellowship, I discovered a wealth of options for the ethically minded at my institution. In lieu of a traditional research pathway, I was able to demonstrate to my fellowship committee the utility of acquiring further formal ethics education. Completing a master's degree in philosophy with a focus on bioethics provided the conceptual and theoretical tools required for bioethical inquiry. A fellowship in clinical ethics offered the substrate for thought and relevance. Although this path has been considerably more taxing than I had anticipated, it has been ultimately rewarding and has allowed me to fill a needed niche to remain in academics.

Academic medicine is a data-driven world. Empirical research is the rule, and deviations from this rule often present a hurdle to a well-defined career path. Although empirical ethics has come into vogue in the medical literature recently, I find it difficult to argue for an "ought" from what we can only discover as "is" within this methodology. My interest lies more in the philosophical-theoretical realm of traditional ethical analysis. Within academic medicine, philosophical-theoretical rarely pays. Competing for funding with such projects as "The Normative Obligations Regarding Nonbeneficial CPR Utilizing a *Modus Ponens* Argument" is not the easiest way to obtain career-sustaining grant funding.

Therefore, I realized that my passion for ethics must be grounded in the clinical arena and must provide instrumental value for those in my clinical division. Relevance in an academic medical center for physician-ethicists includes participation in clinical ethics committees, ethics consultation, and education. Luckily, these are roles for which I also have a passion and am more than happy to fill in order to justify my philosophical-theoretical time.

Even at this early point of my career, being the first dedicated ethicist in my clinical division has proved satisfying. My focus on ethics has fostered discussions within our clinical division that probably would not have otherwise come about and has revealed a latent interest in ethics among most, if not all, members of our division. My interest and scholarship provides a justification for discussion of some of these issues, and I hope this dialogue has brought about a normative cognizance that would not otherwise have been realized.

Aside from a few well-seasoned bioethicists who traverse the medical literature, there is surprisingly little in most physicians' reading material that deals with theoretical bioethics. A rich and robust literature exists but does not often reach those on the front lines of patient care. I hope that my role as a physician-bioethicist will serve as a bridge between philosopher-academicians and daily caregivers by presenting those on the front lines with well-reasoned arguments for doing *X* or not doing *Y*. The current difficulties with healthcare reform and the impending crisis in healthcare financing will make such arguments both imperative and timely. One can only hope that the pragmatic need to control healthcare costs will give well-argued theoretical and normative theories instrumental value they have not previously enjoyed. The need for bioethicists, both theoretical and applied, should only increase. My educational background has made me well equipped both to contribute to this conversation and to comment on issues of professionalism and the ends of medicine as the discussion progresses.

I have heard those who have taken a path similar to mine refer to feeling

like a ''person without a country.'' I understand this feeling. Straddling daily patient care with an eye toward philosophical-theoretical issues in bioethics puts me in a relatively unique academic position. Outside of a few well-regarded institutions with historically strong programs in bioethics, the value of a physician-ethicist is not always immediately apparent to those in academic medicine. This has made for a training path that has been difficult at times but ultimately very rewarding. Finding a ''country'' between my medical division and the world of biomedical and clinical ethics that is comfortable and welcoming has become much easier as I have melded my pulmonary and critical care practice with more experience-based confidence in my ethics work.

Mrs. A passed away quietly one night in the intensive care unit after months of discussion regarding what the proper course of action should be for her situation. We found no easy solution to the dilemma of where and how to continue her care, so she stayed with us until her demise. I think of Mrs. A from time to time and reflect on the fact that my career has been formed, at least a bit, by her pleasant demeanor and *her* country problem. As I settle into my home in the world of medicine, I continue to seek ethical solutions to problems like hers.