

TRIBUTE

DOING CLINICAL ETHICS

CHEYN ONARECKER, MD, MA (BIOETHICS)

“Dr. Orr, is this a situation where it would be permissible to withdraw care?” asked one of my classmates. Looking intently at the student and ensuring everyone was listening, Dr. Orr answered, “We may withdraw certain treatments, but we never withdraw care.”

It has been 16 years since I heard Bob’s response to that student’s question. Whether I am teaching clinical ethics to medical students or discussing a complex case with members of my hospital ethics committee, I often find myself repeating Bob’s profound insight. His statement has the same impact on my students and colleagues today as it did on me in that classroom many years ago.

The opportunity to study clinical ethics with Bob was what ultimately convinced me to pursue an advanced degree in bioethics. I had heard him speak on this topic at a conference a few years prior, and I knew that spending time with him would make a significant difference in how I directed the ethics committee at my hospital and taught the residents and students in our family medicine residency. When I enrolled in Bob’s class, I had no idea that one day I would teach several courses with him, use his approach to clinical ethics to change how my hospital ran its ethics committee, and pass his teaching methods on to hundreds of students, residents, and colleagues. In the process, Bob became a friend and mentor. Not only did he help me grow in my understanding and practice of clinical ethics, but he also helped me appreciate the incredible privilege we have been given to serve God and our fellow human beings through medicine.

A brief overview of Bob Orr’s professional career is quite impressive. While the term “career” suggests a single path, Bob had two distinct careers. The first was as a family physician, for which he was honored as Vermont Family Physician of the Year in 1989. Although he never forsook his calling as a family physician, he shifted his focus in 1990 when he embarked on a second career as a clinical ethicist after completing his postdoctoral fellowship in clinical ethics at the University of Chicago.¹ At that time, clinical ethics consultations in hospital settings primarily utilized the full committee approach. When an ethics issue arose in a patient’s care, the chairperson would convene a group of twelve to fifteen individuals—including nurses, social workers, physicians, chaplains, attorneys, laypersons, and administrative staff—to review the case and offer recommendations to the medical team. While this model benefited from input from individuals with a wide range of expertise, it proved inefficient and unwieldy.

Bob, trained in the individual consultant model, recognized the challenges of obtaining timely consultations with a full committee, primarily due to the difficulty of scheduling meetings with a large group of professionals during busy hours. When he established the Ethics Committee service at Loma Linda University Medical Center in 1990, the ethics committee conducted only two or three consultations per year. Within two months, Bob was performing two or

Cheyn Onarecker, “Doing Clinical Ethics,” *Ethics & Medicine* 39, no. 1 (2023): 32–36.

three consultations each month. His emphasis on the individual consultant model significantly contributed to my development as an ethicist.

In his teaching, Bob favored class participation over traditional lecturing. He believed that the most effective way to learn clinical ethics was through hands-on experience in consultations, *doing* clinical ethics rather than just talking about it. Using clinical cases from his own practice, Bob allowed students to engage with what it would be like to participate in all three consultation models employed in hospitals—the full committee, the subcommittee, and the individual consultant. First, he would present an ethics dilemma to the entire class, simulating a full ethics committee discussion. Then, he would divide us into groups of four or five and ask each group to review the case and present its findings and recommendations, like an ethics subcommittee. After our presentations, Bob shared the recommendations he provided in the original case. They were always better than what each of our student subcommittees produced, but we were learning. I would hurriedly jot down Bob's every comment, hoping to replicate what I learned once I completed the course and returned to my own institution.

Finally, he would assign homework. Our task was to complete two reports as individual consultants, with no collaboration with other students. Bob would grade these reports and provide us with feedback. As a result, rather than just trying to memorize definitions of key concepts, we gained a practical understanding of terms such as decision-making capacity, informed consent, surrogate decision-making, standards for decision-making, advance directives, and futility by using them in our case reports and discussing them with Bob in class.

For Bob, the fundamental question for a clinical ethicist was not whether a particular treatment *could* be used; that was a question the medical team could appropriately address. Instead, the crucial question for the ethicist was whether we *should* provide the treatment. He approached clinical ethics from a Christian worldview, carefully applying practical wisdom. Although he recognized the importance of the four principles of ethics—autonomy, nonmaleficence, beneficence, and justice—he also considered other fundamental principles, such as the sanctity of life and the significance of virtue and integrity for ethicists. Bob acknowledged the tension between our desire as healthcare professionals to cure illnesses and alleviate suffering and the humbling realization that we cannot always prevent death or eliminate suffering. This realization frequently arises in clinical ethics, since most ethical dilemmas revolve around end-of-life decisions. Therefore, he encouraged fellow Christians to pray for guidance and wisdom from the Holy Spirit when deliberating on ethics cases. Although he was open about his Christian foundations, he believed that his approach to clinical ethics could be followed by individuals from all backgrounds.

Early in Bob's ethics course, I discovered that he particularly disliked the term "provider" when referring to a healthcare professional. He made this clear during class when a student used the term in a case presentation. With a wink, he jokingly threatened to fail anyone who used the term in a case presentation or written report. Despite his warning, I accidentally included the word in one of the reports I submitted. Although he did not fail me, he reminded me that I was not just a provider. I would come to realize over the years his admonition was quite prophetic. In his view, there is nothing wrong with the term "provider" when it refers to internet services or

life insurance. However, as he pointed out in his 2012 White Coat Ceremony address to Loma Linda medical students, a provider focuses on doing, whereas a professional focuses on being:

Some say that over the next four years, you will learn to be a provider who develops contractual relationships with consumers I prefer to think of my relationship with my patients as a covenant relationship—it is a promise. I promise to always seek your best interests rather than my own.²

I have not forgotten this lesson, and I frequently share this wisdom with students and colleagues to counter the current trend that seeks to reduce a physician to merely a provider of services.³

One of the enduring benefits of learning and teaching clinical ethics with Bob was gaining insight into the process and format he developed, along with Wayne Shelton, for conducting and documenting ethics consultations.⁴ Since taking Bob's class, I have reviewed hundreds of consultation reports in various formats, ranging from brief notes to extensive three thousand-word essays. The brief notes often leave readers unclear about the ethical analysis the committee used to make their recommendations, while the lengthy reports can be too time-consuming for busy clinicians to read.

In his ethics course, Bob emphasized that a key to the success of the Orr-Shelton format is limiting the report to two single-spaced typed pages. Although it requires efficient writing, the two-page limit allows enough space to include a narrative of the relevant events, a discussion of pertinent ethics principles, the rationale behind the committee's recommendations, and a list of those recommendations. At this length, even a busy nurse or physician can find the time to read the report. Bob wanted the report not only to convey the recommendations of the committee but also to educate the reader. In time, clinicians would become familiar enough with the process that they would rely less on the ethics committee. Over the past 15 years, dozens of healthcare professionals who have requested ethics consultations from our committee have expressed approval of our reports and have learned to address many of these issues on their own. I often sent Bob copies of comments from physicians praising the process and format of our consultations.

During the final two years of my master's degree in bioethics, I had the privilege of teaching several clinical ethics courses with Bob. With each course, he gradually transferred more teaching responsibilities to me. Although he never explicitly stated it, I knew he was slowly stepping back from teaching. To prepare myself for the possibility of leading a class on my own, I kept detailed records of his responses to students and how he addressed various issues in class. Eventually, he asked me to take over his "Clinical Issues" class at Trinity International University, as he wanted to spend more time with his wife, Joyce, traveling and speaking.

For many years after our time teaching together, I would consult with Bob on challenging hospital ethics cases. Bob loved discussing these cases, and I believe he enjoyed pointing out when I struggled to identify what he considered the obvious solutions to specific issues. My ethics committee members were always impressed, often wondering what oracle I had consulted when we would conclude a session without knowing what to do, only for me to return the next day with a list of recommendations that addressed the ethics issue perfectly. Frequently, I would send Bob a copy of one of my consultation reports and ask for his feedback. In the

recommendations section, I would intentionally include phrases like “it would be permissible to withdraw care” or “healthcare provider” to see how closely he was paying attention. He never missed an error and always responded with clever, often sarcastic remarks.

In one of the last conversations I had with Bob, I spoke to him about the impact he had on the practice of clinical ethics. His perspective and approach to clinical ethics consultation had directly or indirectly influenced thousands of healthcare professionals during his career. I reminded him that his work would go on to impact thousands more through the ongoing efforts of those who had benefited from his teaching. As was typical, he was very modest about his accomplishments. He was more focused on his family and how privileged he felt to have been able to work with so many wonderful colleagues in his career. What inspired him, more than any recognition or award, was his faith in a loving God, the love of his family and friends, and the joy of fulfilling God’s call on his life to be a physician.

During the early years of my career, I often wondered what it would be like to study under or practice alongside a pioneer in the field of medicine. I would listen to conference speakers recount their experiences with renowned surgeons, cardiologists, and other internationally recognized physicians or scientists. For the past 16 years, I have had the privilege of sharing stories with students and colleagues about how I had the opportunity, not only to learn clinical ethics from one of the true pioneers in the field, but to become one of his friends.

REFERENCES

1. In 1999, the American Medical Association honored Bob with the Isaac Hays & John Bell Award for Leadership in Medical Ethics and Professionalism.
2. Robert D. Orr, “Will You Be a Provider or a Professional?” *Ethics & Medicine* 29, no. 3 (2013): 147–50.
3. For more on the negative consequences of adopting a view of physicians as “providers of services” see Farr Curlin and Christopher Tollefsen, *The Way of Medicine: Ethics and the Healing Profession* (Notre Dame Press, 2021).
4. Robert D. Orr and Wayne Shelton, “A Process and Format for Clinical Ethics Consultation,” *Journal of Clinical Ethics* 20, no. 1 (2009): 79–89, <https://doi.org/10.1086/JCE200920112>.