

TRIBUTE

ROBERT ORR, MD: EDUCATOR

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I probably first encountered Dr. Bob Orr in Toronto—close to 40 years ago. We were both attending a conference—sponsored by the Christian Medical & Dental Associations (CMDA)—that was intended to be an introduction to faith-based medical ethics and would drum up interest for this relatively unheralded discipline. Up to that point in time, the topic of medical ethics was relatively nascent—largely secular—and the notion of faith-based medical ethics was essentially unheard of. John Kilner (representing the Master of Arts in Bioethics degree program at Trinity International University) was the primary speaker at the



conference, but as I recall, Dr. Orr also had a significant part as well. After the conference, I remember driving back to Buffalo, New York and was in deep thought regarding Micah 6:8—one of the several verses mentioned that weekend. I knew the verse well but had never heard it applied in a medical context—let alone a medical-ethical context.

Subsequently, I entered the Master of Arts in Bioethics at Trinity and became directly involved with The Center for Bioethics and Human Dignity, which was also affiliated with Trinity. The program, and the Center, were awash with opportunities to see, to meet, and to hear from various luminaries in the field of medical bioethics—espousing Christian medical-ethical thinking. Most of these individuals were of the Christian persuasion, and all were highly educated and articulate. Bob Orr was one of the frequent visitors to this forum and regularly spoke in various venues. His background experience and storied situations made for interesting and educational presentations.

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As a student in the Bioethics program, I sat in many courses—and several of them were taught by Bob Orr. I particularly recall an introductory course on medical ethics consultations where the class consisted of an interesting mix of medical and non-medical folk. This combination of students presented a particularly interesting dilemma: how to engage medical and non-medical individuals at the same time. Not surprisingly, the medical people identified and quarantined the medical issues with great alacrity and arrived at medical-ethical solutions with relative ease. The non-medical students, however, struggled with the medical terminology and labored with how to approach the ethical decision-making process. However, Bob was adept to the challenge as a seasoned educator and was up to the task of helping the non-medical individuals identify the salient medical-ethical issues. In doing so, Bob was able to engage both levels of medical understanding and was able to promote robust discussion so that we all were able to grasp some of the essential notions and understand some of the problems germane to addressing the medical issues represented in the consultative process. We all felt heard and educated, and we all came back for more the next day.

In one of the classes for the Master's program, Bob introduced us to the classic clinical ethics text by Jonsen, Siegler, and Winslade¹ and the "Four-Square" method of considering medical ethical decision-making. "One of many methods . . ." as I recall his introductory comments, ". . . and easy to remember and easy to use." Part of the teaching was the purposefulness of staying "above the line" and not immediately going "below the line"—where the quadrant with "Quality of Life" is relegated. "Above the Line" had to do with medical facts and personal preferences—all good, appropriate, and necessary information to know. He had many examples of the pitfalls of immediately being "Below the Line," and I still use examples of this issue when I teach today. There was a particularly striking example of a patient who had some particular neurologic deficit but could "talk your ear off" about automobiles. Bob's observation went something like this: if talking about cars was his "quality of life" at this particular time in his life, then who are we—as medical professionals—to assume or dictate otherwise? Discussions such as this are essential to the learning process and markedly add to the collective wisdom of approaching medical-ethical issues.

Fairly early in my training as a budding medical ethicist, I was wondering the typical "why, how, where, when" questions. I thought that Bob would be a good person to help me unpack these issues. Being about 50 years of age at the time, and leading a thriving pediatric practice in Buffalo, New York, I was unsure if the educational effort was worth the money and time that I was removing from my family life and personal coffers. Back from an afternoon at a Chicagoland park concert, Bob agreed to offer me a few minutes of his time before dinner. His question to me was "Why in the world—particularly at your age and state of life—do you want to do this stuff?" My answer, which most likely was particularly unmemorable, as I do not recall it, must have satisfied Bob. He subsequently took a look at the cover of the ethics book that I was reading that afternoon; next, he gave me a couple of suggestions of additional reference texts having to do with the discipline of medical ethics that should be in my personal library; and lastly, he strongly suggested a couple of other books to read for the next course. Thankfully, he did not tell me that I should not be in the program.

I recall Bob mentioning a CMDA national conference when he sat in on a discussion of one of the recent statements proposed by the Ethics Commission for consideration by the society membership. Typically, Bob would have made contributions either to the statement itself, or at least directly to the individuals sitting on the commission during the process of composition of the statement. Apparently, Bob was sitting towards the back of the audience during the discussion, and a man sitting next to him mumbled something like “ethics, smethics, I just don’t have time for this stuff.” Bob said that he pondered the comment for a short while and mused that the doctor probably did not know who he was sitting next to that afternoon. I do not believe that they bumped into each other again at the event—probably a good thing.

“You are not a provider . . .” I can recall hearing Bob say this on multiple occasions and venues. He would continue with “. . . you are a medical professional.” His typical example of this nuance was that if someone put a few coins into a candy machine, then it PROVIDES the purchaser with a candy bar. The only choice is what type of candy bar you wanted to get for your money—often dependent on what type of mood you were in at the time and what was available at that time in the vending machine. There would be no professionalism with this action, and it would only be a service. In addition, if it is the wrong candy bar or defective in some way, there was no alternative or recourse; it was the choice that you made on your own at that particular point in time for some particular reason. He would often expound on this terminology, observing that a medical practitioner was a trained medical or surgical professional who would offer experience, skill, and sage advice. And, if the medical professional did not know the appropriate information, then (s)he could seek colleagues who might have additional experience with the medical issue at hand. The expertise, experience, knowledge, and desire to help that the doctor should be able to provide far exceeded the type of treat coming from a vending machine.

On several occasions, Bob and I collaborated on the composition of an ethics case that was to be submitted to *Ethics & Medicine*. Typically, this was an extremely cordial process, but on one occasion strong disagreements ensued. For some reason, in writing one of the cases, Bob and I could not agree on the “discussion” aspect of the case; we, as I recall, just had different recommendations as to what the “ethical” recommendation should be. Imagine that: this old “start-up” ethicist disagreeing with the experienced mentor! Nonetheless, Bob was most gracious, and as neither recommendation was ethically “out-of-bounds,” he suggested to the editor that both suggestions be published in the submission as “Recommendation One” and “Recommendation Two.”² Acknowledging that this made the article somewhat longer than most others, the editor accepted the submission while muttering something about “newbies” who think that they know more than the professor.

Bob was the instructor of my last course at Trinity, and he graded my final two papers—one of them being entitled “The Care of Joseph Saikewicz.” Typically, the professors who taught the classes would add substantial noteworthy comments in the margins of the paper. This was a primary method of both communication and teaching and (in the case of medical ethics) training for the real world. I often mused that I learned more from the thoughtful comments than I learned from the research and writing of the paper. As I leafed through the paper looking for comments—there were absolutely none! Recalling how panicked I was, it was unclear what

this meant. Finally finding a superior grade on the last page, and being much relieved, I guess that Bob felt that I had acquired an adequate base of knowledge of medical ethics. I never asked why he felt the paper deserved no comments—but that question may be just as well left unasked as well as unanswered.

Towards the end of his medical career, Bob finished compiling his medical-ethical consultation cases in his book *Medical Ethics and the Faith Factor*.³ This is an excellent set of case studies presenting hundreds of ethics consultations organized largely by organ systems. It is my understanding that the book is undergoing a revision that is being done by some of Bob's former bioethics students that he taught at Trinity International University. During this time, Bob also handed me the job of column editor of Clinical Ethics Dilemmas for *Ethics & Medicine*. I am sure that he assumed that I would also get submissions from the various medical individuals—as he had received from them in the past years—for possible publication in *Ethics & Medicine*. I looked forward to the opportunity. After a prolonged period of not getting submissions—and being understandably discouraged—Bob suggested that I contact the editor of his case study book and ask permission to republish adapted versions of some of the case reports with permission from Eerdmans Publishing. Having received permission from the editor at Eerdmans to move forward, Bob graciously released to me his electronic file of all the cases from his book. Imagine the blessing of having such easy access to the cases for secondary distribution for additional educational opportunities!

Thank you, Dr. Orr—thank you for modeling Micah 6:8 to me and encouraging me to act justly, to love kindness, and to walk humbly with my God.

REFERENCES

1. Albert Jonsen, Mark Siegler, and William Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 9th ed. (McGraw Hill, 2021).
2. Ferdinand D. Yates, Jr. and Robert D. Orr, “Clinical Ethics Dilemma: Is It Permissible to Shut Off This Pacemaker?” *Ethics & Medicine* 24, no. 1 (2008):15–8.
3. Robert D. Orr, *Medical Ethics and the Faith Factor: A Handbook for Clergy and Health-Care Professionals* (Eerdmans, 2009).

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