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KAREN ROTHENBERG: LAWYER, TEACHER, MENTOR, FRIEND. . .

A. TERRY WALMAN, M.D., J.D.*

My first encounter with Karen Rothenberg was a referral "to look her up" from Walter Wadlington, professor of Legal Medicine at the University of Virginia, where I had been an undergraduate, and then medical student. At the time, I was a young faculty member practicing and teaching at the Johns Hopkins School of Medicine. It was the mid 1980's and, after several earnest years of academia, I had gone back down to UVA in order to pick Walter's brain about how I, as a physician and an educator, could better understand why medical doctors were so afraid of lawyers, liability, and lawsuits in our professional lives and interactions.

Wadlington listened to my tales of woe, cross-examined my observations and opinions, and then suggested actions well beyond my wildest intentions. If I really wanted to understand litigation, legal philosophy, and lawyers, he counseled, then I needed to attend law school. He advised that one of his most energetic and thoughtful former students had recently begun teaching about law, medicine, and the ethics of health care, at the University of Maryland in Baltimore, just across town from where I practiced at Hopkins.

After some serious introspection, I sat for the LSAT's, made the application to the law school, and within the year found myself attending classes while maintaining my clinical and teaching responsibilities in the medical school. In addition to the core curriculum, I signed up for every Law and Medicine related class offered. This is how I came to know and appreciate Karen Rothenberg as a mentor and a friend. I credit her with reminding me of the importance of zealously advocating on behalf of the people for whom we care.

Allow me to recount one of my favorite Rothenberg tales:

I was the Attending anesthesiologist on-Call one busy weekday evening at the Johns Hopkins Hospital (JHH). As the senior-most in-house physician representing my clinical service after hours, I was responsible for the utilization and management of surgical services and operating rooms after normal hours and through the night, until the following morning's regularly scheduled surgical procedures.

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That evening the neurological surgery service requested Operating Room time to perform brain surgery on a 62 year old in-house female patient I will designate as "JC". JC had already been hospitalized at JHH for more than six weeks, having undergone a craniotomy under general anesthesia for biopsy and drainage of a large right frontal mass brain abscess shortly after admission. Material from the drained infection was thereafter incubated in bactericidal cultures in order to determine appropriate antibiotic treatment. Her condition having improved after a ten day regimen of intravenously administered antibiotics, JC was then switched to oral antibiotics, the usual treatment in such cases.

Unfortunately, JC's condition had begun to decline after the change to oral antibiotics. A repeat CT scan revealed that not only had the original abscess become larger, but several new collections were present. A second diagnostic brain operation for repeat culturing and abscess drainage was proposed by the neurosurgeons. In spite of being informed by her doctors of a very grim prognosis without a second craniotomy, the patient now refused a second neurosurgical procedure.

I learned this medical history from the resident physician anesthesiologist whom I had sent to interview JC prior to the proposed surgical intervention. The resident also tried to explain that although the patient had adamantly refused the proffered procedure, the surgical consent form had been signed by a third person of no relation to the patient, and that party's representation was "Court Appointed Guardian." Under more ordinary circumstances I would have waited to meet, interview, and gain my own informed consent for intraoperative anesthesia care from a patient when they were brought to the Operating Room Suite, especially given that it was already a busy evening, and all indications pointed to no relief in sight.

In my earlier years as a medical student, I had developed an intense interest in the ethics of Medical practice and care of the patient. Now I was simultaneously a faculty physician teacher, and a law student at Maryland. Practicing what I preached to my own students and young physicians: "*When in doubt, talk to the patient*!"; I went to study the medical chart, meet with JC in her hospital room, and unhurriedly have a conversation with her about anesthesia care for the proposed operation.

I verified what the resident physician had reported, and learned there was more to the story. JC had a long history of "chronic schizophrenia", yet lived alone in an apartment in Baltimore, and functioned reasonably well with the aid of Adult Psychiatric Services(APS). She regularly consulted with a community psychiatrist and a psychiatric nurse practitioner. Her primary APS psychiatrist had attested to her capacity to understand her medical condition(s), and her ability to make her own health care decisions.

During this month and a half JHH sojourn, JC had self-consented for two CT scans, an unrelated minor endoscopic procedure, and she had been solicited, and signed into, a research protocol to participate in an experimental study evaluating a new X-ray contrast dye used in the first CT procedure! Consent for the initial brain biopsy, requiring general anesthesia, was signed by the patient's estranged adult daughter under emergent conditions, because JC's responsiveness had deteriorated rapidly. The daughter, thereafter repeatedly chastised regarding how her mother had not wanted the original surgery, refused to become involved a second time. No other family members were available to approach for consent.

JC and I had a long conversation about her staunch and continued refusal of a second brain biopsy. Over the previous month, seven different JHH neurosurgeons had visited JC, urging her to agree to a second operation. During the same period she had undergone a half dozen evaluations by staff psychiatrists to assess her decision-making capacity. Despite understanding the grim prognosis, JC adamantly refused the proposed surgery, but she did not refuse any of the other treatments or any other in-hospital care offered.

Having established that JC's clinical situation had not substantially changed over a three week period, I contacted the lead neurosurgeon who had requested O.R. time and anesthesia services. Apprising him of how busy the O.R. schedule had already become with add-on emergencies, he acknowledged that her condition was chronic rather than emergent and withdrew the request, saying the operation had been put off for some time now, and could safely be postponed for the next day.

It was getting late, but my next activity was an unusual one. I called Professor Rothenberg at home and explained the JC saga to her in some detail. We talked at length, and then she queried:

"Didn't you once tell me you were a member of the JHH Medical Ethics Committee?"

"Yes." I responded.

KR: "What do they have to say about this?"

TW: "I am not aware this was ever brought to the committee's attention." I answered. "Besides, what good would that do now?

KR: "By your actions tonight, you've bought some time, and the agreement by the surgeons that this is not a medical emergency could be an important issue. Call for a meeting of the Ethics Committee in the morning, and see what happens. . ."

She ended the conversation by acknowledging that I was the first student ever to call her at home, and then thanked me for the consultation!

I wrote a note in the chart recounting my discussions with JC, and the neurosurgeon's concurrence there was no necessity to perform emergency anesthesia (and surgery) that evening. Upon relief from my overnight duties I

requested a Medical Ethic's consultation regarding JC's resolute refusal to undergo general anesthesia for the proposed neurosurgical repeat craniotomy, then left the O.R. suite to get some sleep.

A subgroup of the hospital Ethics Committee held a heated two hour meeting discussing various ways of dealing with the matter, but no consensus was reached. Because the court order appointing a guardian was perceived as final, the competency issue itself was never addressed. The subgroup determined there was nothing more they could do, and that JC should have the surgery. Meanwhile, a whole series of judicial events began to unfurl later that morning. . .

Having learned of the delay in surgery, one of the hospital attorneys expressed concerns of substantial legal liability if JC were to suffer further injury before the surgery was performed. Thus motivated, said attorney telephoned JC's Adult Protective Services(APS) court-appointed guardian, who in turn contacted the court-appointed attorney who had represented her in the guardianship determination.

Guardianship had been granted in reliance upon Maryland's 'Emergency Protective Services' statute (Section 13-709), and involved an informal telephone conference call between the various parties and the deciding judge. Because of the emergent nature of the guardianship request, JC's attorney had neither sufficient time to meet with his client, nor adequately review her chart. Additionally, there was no record as to any opportunity to cross-examine one or more of the several neurosurgeons urging surgical intervention, nor the four psychiatric practitioners who variously addressed JC's capacity regarding medical decision-making.

The attorney representing JC''s interests petitioned the original judge for a rehearing. At this point the Court expressed a desire to meet JC, and ordered the second hearing to be held in her hospital room. Essentially the same group of players from the conference call hearing attended the bedside iteration, but the majority of time was devoted to a conversational exchange between JC and the judge. This lasted about thirty minutes, whereupon the court took the matter under advisement. Although I knew of the in-hospital rehearing, I was not requested to attend, and chose not to.

Sometime later I was summoned to the judge's courtroom by JC's attorney, where I was sworn in to give testimony regarding my actions as the attending physician anesthesiologist the night I was on call. This resulted in rather brusque cross-examination by the hospital's attorney, (as a faculty member/employee, *my attorney*?), who demanded to know why I had refused to give anesthesia to JC for a court-ordered emergency life-saving brain operation! I responded that I had (a) taken care to pre-operatively visit and interview JC, (b) familiarized myself with her medical history, (c) found her to be quite conversant on the risks and benefits of the proposed procedure, and (d) understood from the primary

neurosurgeon that the request for anesthesia and O.R. time was not emergent, and thus was withdrawn at his suggestion to a later date and time. I also explained that in the absence of the time constraints of a legitimate medical emergency, the informed consent for anesthesia care was not implied, and therefore would be separate and distinct from the guardianship signed consent for surgery.

A few days later, the judge issued his opinion stating (in part): ". . . The decision to undergo treatment is a personal one which should reflect the patient's perspective . . . [JC] has repeatedly been told the details of the suggested course of treatment and the almost certain consequences of the failure to proceed with treatment . . . Her negative response is a rational one, although contrary to the recommendations of the medical staff. Accordingly, the court finds that [JC] is competent to make, and has made, a rational decision concerning her medical care." With this decision, the judge dismissed the petition for guardianship.

Professor Rothenberg and I conferred numerous times about the resolution of JC's dilemma, the processes involved in its resolution, and the various lessons to be learned from the encounter as a whole. I credit her with helping me to further appreciate some fundamental principles common and essential to both law and medical practice:

1) Diligent advocacy on behalf of the person(s) we intend to help, be they client or patient, are the essence of who we are, and what we do.

2) An individual who is prepared and willing to stand up and speak out for a cause they have reason to believe in can make an enormous difference.

3) With pertinent new information, a lawyer (or a physician) can jump start a process previously thought to be irretrievably lost.

After the successful dismissal of the petition for guardianship, the legal advocacy was complete, but the medical care continued. Since no surgery to obtain additional bacterial culture information could be obtained without the expressed consent of the patient herself, the neurosurgeons consulted their colleague specialists in Infectious Disease to utilize the previously obtained bacterial cultures and information to design a new plan of antibiotic therapy. JC's antibiotics were changed, and she responded to a new combination of intravenous agents.

In ten days she was determined to be well enough to be discharged to a nursing home, her symptoms having substantially diminished. After the fact, it was determined that JC had several major dental infections seeding her brain with bacteria which had caused the abscesses. These dental infections were treated and the brain abscesses did not recur. Several years later, JC returned to JHH to undergo successful prosthetic total hip joint replacement. Her informed consent for anesthesia and surgery was never challenged.

This medical and legal dilemma entitled "Competency to Refuse Live-saving Treatment" was presented at the The 2nd International Conference on

Health law and Ethics, London, July, 1989. [KR assisted in the preparation and attended the presentation.][1]

1. For discussion of the ramifications of this legal and medical encounter *see* S. Van McCrary, A. Terry Walman, *Procedural Paternalism in Competency Determination*, 18 J. OF L., MEDICINE, AND ETHICS 108, 108-113 (1990).