Memoirs of a long path: implementing clinical bioethics in Mexico

Abstract

This essay describes my experience trying to implement clinical bioethics in Mexico. I emphasize my desire on the remarkable experience I had at the Cleveland Clinic’s Department of Bioethics in 2013 and all the teachings I learned there that did not exist in my country so besides reflecting on this long path trying different projects to make it a reality, I face and write the many challenges still to be overcome in Mexico, being the cultural one the most difficult considering that the clinical bioethicist is not even thought or considered in our hospital structure. This essay demonstrates how important clinical bioethics is in a country like Mexico but how little understanding of it there is among both, professionals and common citizens.

Introduction

Twelve years have passed since I started studying bioethics. But actually living bioethics, that started four years ago when I had the chance to put my knowledge, at least what I thought that was, to the test in an actual hospital environment. What they call “Bedside Bioethics”. And it was there when I discovered, in one hand, that blackboard bioethics are very different from “bioethics on the patient’s bedside”, and therefore I had to learn new concepts, theories, paradigms and read new authors, learn different methodologies, and understand diverse principles; on the other hand, I discovered that bioethics is very far away from being an exact science. My experience at the Bioethics Department of the Cleveland Clinic was the beginning of a long and fruitful experience for learning and implementing clinical bioethics in Mexico.

This experience left a very profound mark on me: my theoretical knowledge fell apart with my first encounter with the suffering of an ill patient; words and arguments vanished when I started hearing terms like “autonomy”, “the patient’s best interest”, “terminal quality of life”; the jigsaw puzzle the bioethicist who was training me was solving amazed me. I don’t know if it was because of its complexity or its impossibility, but it was something that I had never faced before, even with my two years studying a Master’s degree in Bioethics.

Did they ask the patient what he wants? What exactly is the objective of this treatment? After the expected time frame: will the medical or therapeutic actions be kept or is it time to revalue them? What is the economical, familiar and social situation of the patient? What did he or she used to do before getting sick? Is the patient expected to improve or survive? How is the patient’s life going to be after this? Is treatment A adequate for this patient with this determined conditions and characteristics? Or is it an extraordinary measure and if so, is this justifiable. And if so, what should be the criteria for this? What is expected of the intervention? Is it necessary?

All of these and many more questions would flow through my head again and again during the month I spent in the Department of Bioethics at the Cleveland Clinic. Cases came and went; some were closed in a couple of hours because of the death of the patient. It was said amongst the bioethicists “when they finally call the bioethicist, it’s because things are going bad”, and, in most cases, it was true. (This makes the case, perhaps for early intervention, as many, now are urging, though this yet has to widely come about).

I also remember that in more than one case, after the day ended and after reflecting about all these doubts that were still unresolved, tears would run down my cheeks; tears of impotence, tears of pain for the suffering of others, tears of sadness for those who had died without much we could have done. But sometimes, at sunset and when my shift was over, in the horizon I would see the reddish sky with warm orange tones extended over the blue background: those were signs of hope; omens of a future fruitful labor.

Those were the moments when I would feel satisfied for the puzzle I had just put together and, with just one recommendation, a person’s condition had improved: the bioethicist had performed bioethics. The mission had been accomplished and as it was true that the bioethicist was only called when things were going really bad, it was also true that the bioethicist’s work –sometimes very little–was completely worth it. It could be because the patient had improved, because the chance to die beside their loved ones had been given, because treatments that would not let the patient rest had been stopped. As many options as cases and as many cases as patients, but in the end the result were the same: the intervention of the bioethicist had been worth it.

The story I’m telling gives sense to these pages. When I came back from understanding–with my whole being–what being a bioethicist really was, and how it affected the lives of people, an idea came to me: to implement something similar to what was going on at the Cleveland Clinic, a bioethics consultation service. But I came upon a fundamental problem: unfortunately, in Mexico, bioethics is a subject which is just being discussed, and therefore, there is a lack of knowledge of what it is and what it is used for.

It was only until 2011 when, with the initiative of the National Bioethics Commission, all the institutions which provide hospital services were obliged to have their own Bioethics Hospital Committee. And since then, the subject has been brought up more frequently. Nevertheless, its functions, what it does, how it is done, and when must it intervene, are still vague for many.

However, the necessity of creating these types of bodies inside hospitals in our country has been a very big step in the progress of bioethics in Mexico. A big step, nonetheless, insufficient. In other words, it is still not very clear what the role of a bioethicist is, its profession is still questioned and moreover, from my personal experience, when I have gone to create a permanent bioethic program in public and private hospitals, the answer I have received is always: What is the use of that? What does it do? What good can it do?
Likewise, I have received the impolite comments from some doctors that, when hit with the astonishing fact that the person proposing this is a philosopher, dare to answer: “what can you, being a philosopher, tell me, a doctor?”. As if being a doctor were more important than being a philosopher. I could just as well answer the same way: “what can you, being a doctor, tell me being a philosopher?”. What is true is that prudence is wiser than self-centredness, and that is why I choose to answer the traditional: “bioethics is not only clinical, it is also constituted by philosophy and law and in fact some possible options compiled after considering as deeply and fully as possible concerns from many others field ranging from psychology to economics. But apparently my answer has not satisfied many yet.

What this reflects is the utter lack of knowledge on bioethics, first as a science and then as a practice. People are unaware of the benefits it can give society and, most importantly, patients. That being said, I think my experience can be divided into two big stages: the first one, when I came back and thought that the fight had to be a frontal one, in other words, I had to start this battle in the battle front: hospitals; and the second stage that started a few months ago when, due to adverse circumstances in the hospital, I discovered that maybe my battle needed a little bit of strategy, and maybe the place to begin was not a hospital but a classroom. This way, educating and training students in clinical bioethics became a priority because it represented the opportunity to get to the same result but without so much exhaustion and, better yet, with improved perspectives.

Down below I will briefly describe the ups and downs of these two stages with the idea of stimulating others to continue this battle even when the ground appears, at times, discouraging.

First part: beginning in hospitals: when necessity is not enough

The first sign that confirmed my wish to implement a Bioethics Clinic in Mexico was that in the year 2014 I was invited to participate in the Bioethics Hospital Committee at the General Hospital of Mexico “Dr. Eduardo Liceaga”. This is the biggest hospital in the Country and it has approximately 1,300 beds. It is also characterized for being a teaching hospital and for having a very wide experience in almost all units. Medical procedures that have not been performed in any other hospital in the country have been performed there, and to it go patients who require a very high level of specialization and interdisciplinary work that other hospitals do not offer. Therefore it is a benchmark at a national level, and taking part of their Bioethics Committee is a real privilege.

After installing the committee and after its official presentation, we agreed on meeting every fifteen days. Our meetings consist of, up until now, going every second Tuesday at 12:00pm to a two hour long meeting. I mention this with the objective of highlighting that this is the beginning of a long and difficult path for those of us who dedicate our time to bioethics in hospitals, because it means having to plan and organize work schedules in a way that every fifteen days you have time for a two hour long meeting. In addition, due to the traffic experienced in Mexico City, the average commuting time is about an hour and a half. So we are talking about a total of five hours just for one session. If a person has a regular job it is very difficult to ask for 5 hours off of work every fifteen days, and if a person is lucky enough to plan their own schedule –which is my case– it implies not accepting classes on Tuesday mornings, which means a lower monthly income.

Tossing aside the difficulties mentioned above, the meetings were carried out regularly in the stipulated day and time. The problem was we didn’t have cases yet. We would discuss administrative issues, different unit problems, personal matters, but cases and the reasons why we were there appeared to never arrive. So, it became very tedious to invest five hours every fifteen days to discuss administrative or bureaucratic issues knowing that we could be doing something else. Nevertheless, in a way, I knew that was how it would work in the beginning and that eventually we would get some cases.

It is also worth mentioning that we did not have a physical place inside the building to carry out our meetings. The hospital management knew about us and we had the general manager’s approval and support, but we didn’t even have a place to put our office supplies or our file cabinet. It was thanks to the good management of the committee’s president that, after many months, we were assigned a space inside the hospital’s library –where we could not enter with our bags or backpacks because we had to leave them at the entrance. Little by little, with the help of the Volunteer Ladies we were able to get a table, chairs, a file cabinet, and more supplies that we needed. If we did not even have a place to hold our meetings, of course that the hospital did not provide us with a secretary to do the required paperwork, send letters to the chiefs of the different units, receive the cases, etc. We did not have a computer, printer, or any office equipment. We were basically adrift.

After discussing which was the most adequate way to alert the hospital of our presence, we agreed to write some letters to the chiefs of units on which we would tell them we were at their service for the analysis and resolution of cases with bioethical dilemmas. The letters included our contact information and the information of where they could find us (an email address) and, some time later, a telephone extension that the hospital was so kind to provide.

One of the units that started getting close to us, although it was only to gain moral authority, was Obstetrics and Gynaecology and Maternal-Fetal Medicine. They asked us to attend their meetings and they consulted us for some of the cases they had. Then we realized it was necessary to have a form with which the consultation could be standardized for all cases, at least the general data. So we implemented a consultation and case analysis request form that I created from what I had seen and learned in the Bioethics Department at the Cleveland Clinic. Then we asked them to fill in the corresponding section: the reason of the consultation and the clinical data.

It is important to note that, as it happens in other places, in the beginning it is common to be consulted for affairs that do not correspond to ethical dilemmas or ethical affairs involved with clinical cases. The reasons for consultation seem to be one of the most complicated parts to detect and, nevertheless, for the bioethicist is important to know the motive for the consultation as well as what is expected from them. If the case is up to social work or human resources, the bioethicist will not be able to resolve it. But even if the bioethicist has the capacity to resolve it, it would not be correct for them to do it because it would be over-involvement.

That was the way we started the arduous task of making sure that every time we were consulted for a case, the doctors –who usually be the ones requesting the consultation– knew what were the real reasons for the consultation, to know if it was up to bioethics or not. (For that we needed them to send us a properly filled request form, so we could have all the relevant facts to begin studying the
It is noteworthy that in Mexico, unlike in the U.S., we do not count with electronic patient files, which means that having access to the patient’s clinical case is merely impossible if you are not the treating doctor, the chief of unit where the patient is, or someone close to them. So our only source of information was what was written on the consultation form. This made it harder for us to give resolutions, because we lacked crucial information.

Be that as it may, the oncology unit and the neurology unit started making consultation requests. It was the same for everyone: we would teach them to detect an ethical dilemma related with the case, or to study the problem they thought involved bioethics, and together realize that it was actually a human resources concern.

I remember a situation that illustrates the above mentioned problem. Once we were consulted for a case of a resident who was being bullied. He followed the protocol and announced it to the competent authorities, but without success. The case moved up to the general management and to us. Inside the committee the positions were divided: there were some that said we had to take the case because it concerned the violation of the resident’s human rights because the bullying had gotten too far; and there were some –me amongst them– who thought that bullying is not really a matter of bioethics, at least not clinical bioethics. Faced with this scenario I sensed that not even us inside the committee had a clear idea of why we were there, which were the situations when we had to act, and which situations were better off in the hands of someone more competent to face it. In other words, what did not concern us.

This debate inside the committee—with much divided opinions—made me think that we needed more training. We needed to create a training program inside the committee where we could all learn more about bioethics and, particularly, learn more about a committee’s extents and limitations. Therefore, we created a capacitation program where one of the moral themes we started off with was Clinical Bioethics.

It seems extraordinary, but Clinical Bioethics did not exist in Mexico. It is studied in some Phd and graduate programs, but it is all about general bioethics and, its common grounds. The closest thing to clinical bioethics we had was the Hospital Bioethics Committees that by law had been established in all hospitals since 2011. Now, as it is known, a committee has a defined schedule for their sessions, so it is not present at the hospital the whole time; and for it to work it also has to go through a process of discussion to reach common agreement. So it becomes a problem when there is the need for prompt attention and resolution of ethical dilemmas. That meant that the idea of having an in house bioethicist to answer and attend cases quickly and at any moment did not exist in Mexican reality, nor the means for capacitation and formation that this person had to have.

So another problem arose: as we gained ground in some of the hospital units, we had more and more cases, and many times there was no one at the office to attend them (as I mentioned before, we did not have a secretary or someone to answer our phone), because we only used it to hold our two hour meetings every fifteen days. If a case arrived via email and it required a prompt consultation that same day, sometimes we had doctors who could help us because they were working at the hospital, but some other times they could not help us because they had their own medical appointments, surgeries or other things to do, and so, no one would attend the consultation request.

Not having someone to be there, if not every day, at least some days a week, to receive consultation requests, answer phones, and with the time to attend the unit meetings (organ donor committee, morbi-mortality, and transplant units invited us to their weekly or monthly meetings) was a huge problem we had to face.

It was as if all our work and our presence—we had been there for more than a year by then—would suddenly overgrow us and we could not handle it. Soon we had a lot of complaints about why there was no one at the office when people would look for us, why were we unable to resolve the cases we had, why were we not going to the meetings we were invited to, why were we not receiving the consultation request forms on time, etc. It was a complaint storm, very frustrating, yet understandable.

Ultimately, we understood what was happening: none of us were receiving a salary for a full time job within the committee or for receiving consultation requests. The people who worked at the hospital were hired as doctors, lawyers, social workers, nurses, amongst other duties, and they were being payed for what was expected from them: to perform the tasks they were hired to do. The rest of us who were external to the hospital (three of us) worked in other places an hour and a half away from the hospital and with other occupations the rest of the week, so none of us could attend the unit meetings and much less attend consultations which needed prompt response. We had to wait fifteen days to discuss them, which was very frustrating and fruitless to the person who made the consultation and, of course, for the patients.

This made us ask the director for a secretary who would help us receive the cases and, with that, help us put out the initial fire locating one of us who could attend the call. After months of insisting, we were assigned a person to work with us twice a week, which did not solve the problem entirely, but it was a start. A few months later we received a notification explaining that, for unrelated issues, that person would not help us anymore. And as if that had not been enough, when we held the next meeting after that person was removed from their position, most of the furniture we had at the office and the telephone we had were gone because this person had taken them. Unbelievable, isn’t it? But that is what happened. An official report was issued but we never got our supplies back. Those were the adventures of a bioethics committee fighting to establish itself inside a hospital.

A few months later we were assigned another secretary who also worked at the library so she wasn’t physically present in our office, although she did help us check, every once in a while, if any new cases had arrived and attend people who would arrive and did not know where our office was (it is noteworthy that one of the things we wanted was to put up a sign on our door that read “Hospital Bioethics Clinic”, but we could never do it because even though we followed the procedure we never got a response, so our office, until today, does not say anything, which makes it more complicated for people who do not know us to find us).

Several months went by and we still could not attend the cases we got on time. There were internal quarrels because some asked for the consultations to be made as early as possible and some others—including me—thought that we could not plan that ahead and that urgent cases were going to come up and nobody was going to be able to review them; also because the external members found it more difficult to get to the meetings, etc. The meetings we were holding...
were usually about personal and interpersonal problems, internal problems with the hospital, etc. Without sense or purpose.

Facing this moment of confusion within the committee and knowing that we needed to find an in house bioethicist so we could provide our services of clinical bioethics correctly, I sensed it was time to summarize what had been done and present the situation to the hospital’s general manager.

To me it was the perfect time to suggest the formal instauration of a permanent bioethics consultation service, so that way there would always be someone to answer the requests. I had already written about the challenges we would face when trying to implement a permanent bioethics consultation service in a hospital¹ and one of those challenges was the economic factor. To maintain a 24 hour service requires hiring more than one bioethicist with a salary that corresponds to his or her professional formation and that significantly raises the cost. In addition, it made it more difficult not to have qualified people who knew, from the inside, the consultation request form, the most common problems, how to address a case, what questions to ask, conflict management, etc. My proposal was clearly going to be, although innovative, somewhat complicated.

After analyzing what was going on and the importance the General Hospital had, in the teaching sense and it being a national benchmark, I realized that what happened in that hospital would be replicated almost immediately, at least by the hospitals dependent on the Department of Health. That meant that this hospital was the seedbed for the future of bioethicists in the country. And so I committed to go to the hospital more days every week, thinking that by doing so, little by little, the inertia of the consultations would expand and, therefore, create the need for an in house bioethicist.

With this idea in my mind and in my heart I decided to take the first step and talk, firstly to the committee’s president to explain that I was aware of the urgent need to have a much wider coverage that would allow us to attend the developing cases and implement a constant and permanent bioethical support, I also explained that I was aware of the costs involved and that, in order to do it, it should have been contemplated at the beginning of the year on the hospital’s budget—it was the middle of the year by then. What I was proposing was his authorization to go three days a week in the mornings and stay there almost immediately, at least by the hospitals dependent on the Department of Health. That meant that this hospital was the seedbed for the future of bioethicists in the country. And so I committed to go to the hospital more days every week, thinking that by doing so, little by little, the inertia of the consultations would expand and, therefore, create the need for an in house bioethicist.

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So we had the general manager’s and the committee’s president’s authorization and our good will to dedicate our time to get this service going. Soon we realized that was not enough. Despite our efforts, the internal discord that had arisen inside the committee started to wreak havoc. It looked as if only those who worked for the hospital could and should go to the units to do all the work, as if the external members (I was one of them) did not have the right to think that they had the same appointment in the committee as everyone else. The interesting things was that those who thought they had the right to be the ones to represent the Bioethics Department were not the ones who were going there three days a week. Then everything started to get complicated: the more the units we visited, the more diffusion work that was done, so we would visit more units which resulted in getting invited to more meetings. That resulted in even bigger problems and even more internal quarrels that ended up dividing us into two factions: those who worked for the hospital and thought they owned the committee (those who think that if they are not the ones doing a task, it is better for it not to be done at all), and the rest of us who were trying to swim upstream, using our own economic resources and giving our time for a dream that drove and excited us.

Had I remained there, the fractures would have been irrecconcilable. That was why I decided to step back for some time, leave the hospital and return to my routine giving classes—an activity I had stopped in order to dedicate more of my time to the hospital—, let things cool off for a while. But a few months after making that decision I took a deep look inside myself and wondered: why did it go that way? What had I done wrong? I devoted myself to a project I believed in and trusted and, in the end, it had failed.

That thought haunted me for a while, and anger and frustration lived inside me and made me lose objectivity. Was it really worth to keep fighting to implement a consultancy service in Mexico? Was it ever going to flourish?

Second part: from a frontal strategy to a cross-cutting strategy: educate in order to act

As I was trying to make bioethics work in a hospital environment in my country, I complemented my strategy with what I did for most of my time: teaching.

Since the time I came back from Cleveland I wanted to transmit what I had seen and thought to be urgent for Mexico, so I started talking about it in my classes. It was not exactly a Clinical Bioethics class but I started to introduce some concepts, examples and literature I had learned in Cleveland; and happily I noticed that the students were very interested on the subject. To them it was the same as it had been to me in the beginning: something new that did not exist in our country, something that we needed and was not being taught; because of that the attention started to grow.

Some identified more with the cause than others, but those who did want to devote themselves to bioethics found in what I was proposing a new opportunity, a virgin field that represented a new way to do bioethics, a challenge for bioethicists in Mexico.

With this vision and this momentum of knowing that there were more of us who envisioned an opportunity niche, I started shaping the idea of creating a private bioethics consultancy service. And that was how the CBA (Applied Bioethics Consultancy in English) was
created. An idea that I founded and distributed in several hospitals and privately for approximately one year.

The matters got more complicated when, after all the formalities and having paid the related fees to register the consultancy as a brand, the paperwork did not go through and the payments still had to be done. And after a year we had not been able to make the idea permeate in hospitals or in a more personal scale with family or friends. People thought that a Bioethics consultancy had to be, like the committee’s work, voluntary and, therefore, free of charge. So when we would establish a price for the analysis of a case or for giving counselling, people would get discouraged and never fully understand why the service had a fee.

Now I want to stop to mention something that, I suppose, has happened in other countries, but that in Mexico still represents a problem, and that is the fact that talking about bioethics in my country means talking about something vague and unclear. So much so that people do not think of a bioethicist as a professional, conventional wisdom tells us that someone can understand and analyze cases, give an opinion or some advice voluntarily, but it is never thought of as a profession and, therefore, it is not related with paid work. Bioethics is “something done out of good will and anybody can do bioethics”. [But philosophy is recognized in academic centers. Is there a disconnect? Perhaps worth a comment]

There is a generalized lack of knowledge towards the preparation required to take on a case and give a bioethical suggestion, the roles played by a bioethicist, about their professional capacity, and the value of a bioethicist’s work. To me it seems that, in part, this lack of knowledge comes from the fact that we do not have a properly regulated model for bioethicists, because there are no paid bioethicists based on the professional demands, and because bioethics has not been taken—because of this—to a more practical level.

If bioethics has a future in Mexico, it is inside hospitals and in a permanent way, that is to say, as Clinical Bioethics and as Bioethics Consultancy Services.

Having made this parenthesis explaining the conception of bioethics and the bioethicists in Mexico, I return to my educational experience.

Lastly, after some time I decided not to spend more time or resources in the Consultancy I had created. The bureaucratic process was still going on, the cost was still high, and there was no income. So the whole project meant spending money, and a mental and emotional toll, because even though I tried to communicate the importance of the idea, bioethics consultations were not in the horizon of Mexican mentality. So I closed that chapter.

During all those months several people told me that the only way to start something as big as a change in mentality and a cultural change was through education. They insisted in making courses and designing study programs to teach clinical bioethics. There was some truth behind what they were proposing: most of the people who took bioethics courses—either in university where I worked or at some other—were doctors who were already working at hospitals and, if I managed to teach them and make them aware of the urgency and the need for bioethics on the patient’s bedside, they would take those ideas to their own hospitals, and that would be an easier way to start.

This was a very appealing idea but it implied giving up the possibility of being the one working at the hospitals doing bioethics. It was resorting to a safer strategy that would let me win more battles without being the one at the battle front. I would be limited to creating the strategy, and training and educating those who, very soon, would be doing that which I longed to do.

After defeating my own ego I decided that it was worth a shot, that if things had not worked out at the hospital with a frontal battle, maybe it was time to try other strategies; and educating, at the end of the day, did not look like such a bad idea. I had done it all my life and I knew how to do it.

I started looking for opportunities in my university to pass on the knowledge and, with the excuse of sharing official content, I started transmitting a couple of ideas about clinical bioethics, mainly to medical students. Nevertheless, time was running against me because I still had to teach the official program for the class, plus the little clinical bioethics I could. A seed was certainly being planted, although not exactly as I would have liked it.

Then I remembered that there was a Clinical Bioethics class taught at the PhD program. When I was responsible for coordinating said program I designed that class and did it according to what I had learnt in Cleveland. So I asked the university if I could teach that class, I began all the paperwork and I proved to them that I could teach that class. I was interested in imparting that class because most of the students taking that program were already doctors who worked at a hospital and, therefore, the seed would spread quickly and more effectively.

But once more the doors were shut in my face. The university had already given me the class with the authorization of the director of the School of Medicine. A few weeks after the course began I was told I could not impart the class because I was not a medical doctor and that class had to be taught by one. But I had designed that class! And as far as I remember I never stipulated that only a physician could teach it. In fact, that is not written in the official program for the class! When I designed it, I made sure that it was specified that philosophers who had been formed in bioethics and with verified experience in the field of clinical bioethics could teach the course. Something happened and in the end I was not able to teach that class. How should I proceed? Once more, the idea of halting my dream came to my mind several times. The next were very difficult months because even though I tried, all that which gave me hope and that I could picture with total clarity, ended up falling apart against any effort. I did not know if I had to continue or if I had to stop.

Something within me was telling me it was time to reconsider my strategy. The battle that had taken place in the educational ground had also been a frontal one and it had been somewhat startling so the time had come to readjust my strategy.

That way I continued to teach my classes that ranged from philosophy to general bioethics. But little by little, I started to notice that I could include, in a cross-cutting fashion, subjects, concepts and clinical bioethics content, and so I did. Through clinical cases, clinical bioethics reading material, examples and anecdotes that had happened to me in Cleveland and at the General Hospital, I taught the official content of the class but, at the same time, I gave a “little extra”. Not only was I transmitting information, but I actually managed to transmit the passion I felt for doing bioethics on the patient’s bedside, and the urgency to do bioethics in Mexican hospitals.
Little by little the students I had that were already doctors who worked at a hospital started to transmit the idea and they also started taking it to their own places of work. That was how I realized that the strategy which had the most benefits was this one: teaching, transmitting knowledge and spreading love for doing that in which you believe in.

From that I understood which was my mission, why I had gone to Cleveland. I understood the feeling that I was the one supposed to do something with that lack of knowledge in my country, but it definitely was not going to be working at a hospital, but through forming people who would work there.

After looking at the gratifying results this brought—little by little more and more people started believing in the importance of having a bioethicist on the patient’s bedside, with a lot of passion— I decided to create a diploma course in Bioethics Consultancy. This time it would work. The course would be specialized in forming people to be bioethicists, so they could attend cases very quickly and be ready to bring guidance in moments of confusion and vulnerability. I designed the subject in accordance with what I had learnt at Cleveland and what I had studied in several books about forming bioethicists, the experience I had from going to seminars, conferences, academic events related to clinical ethics, and the consultancy services.

The International Conference of Clinical Ethics and my friendship with Dr. George Agich from whom I learned how a philosopher has to begin with, getting him or she involved in a hospital without being too conspicuous—were of particular relevance. I presented the diploma course and the paperwork was done, and just as I thought I had learned the lesson and that everything would be easy, I was met with a refusal: my course had been rejected and I was asked to work on it with the School of Psychology.

The idea of working with my colleagues of the School of Psychology was very appealing to me because, as we all know, working with bioethics on the patient’s bedside many times involves going into very stressful situations, and a person has to be prepared to deal with conflict and times of crisis. So instead of looking at this as an inconvenience, I saw an opportunity to improve and broaden the diploma course. I had many meetings with psychology professors and, indeed, even though it was not what I had originally proposed, the course was enhanced and, after presenting it once more, it was finally approved. The name changed from Consultancy to Assistance, but I believe that the essence was maintained. It still has not started and we will eventually see the results, but, at least we are moving ahead in capacitación subjects. So far, this has been my experience in the field of education.

Conclusion

It has been a long path since 2013, and many difficulties have been faced to implement clinical bioethics in Mexico. The cultural, economic and the demographic aspects, and the geographical situation of Mexico City, have all been factors that have played against me. But in reality, none of that is new, my colleagues at the bioethics department at the Cleveland Clinic warned me: “it’s going to be a long way”.

In spite of it all, I am convinced that when someone wants something with all of their hearts, they will always find a way to do it. Maybe not as fast as they would like it or the way they would have preferred it, but the strength a dream has is always stronger than the adversities it faces.

Maybe what has worked better for me is to keep my eyes on my goal. In other words, not forgetting that I was lucky enough to discover a new bioethics world in Cleveland and that said gift was given to me for a reason. I have to do something with that which I have received and learned. I have to give a little back of that I have received for free. I still think that it was not by chance that things aligned so I could go to Cleveland. I had to go and I had to do it in order to get back to my country and promote the implementation of a new way to conceive bioethics and bioethicists.

Maybe I will change my strategy a million more times, and maybe I will make a lot of mistakes on the way, but if I do not forget my goal is in what I saw happened to patients and their families when the case was taken by a bioethicist and reassurance and clarity came in the middle of chaos and desperation, then I will not forget that this, in spite of it all, is worth it.

One of the most important things I have learned is that we have to be humble enough so we do not let go of our dreams; but also to know that our dream is going to move with its own will. We have to be humble enough so we do not get stubborn with a specific way of doing something, even if we believe it’s the right way. Projects and dreams have their own drive and their own time, and without any help they find their way, we just have to be ok with knowing that the path might not always be the same as the one we thought would be.

Four years have passed since my stay at the Cleveland Clinic and I know that there still is a long way to go; but I have learned a lot from everything and I am very thankful for these experiences. Because in the end, all has taken away and all has added to this project in which I believe in. And I am sure that one day clinical bioethics, bioethics on the patient’s bedside, and permanent jobs in hospitals for bioethicists, will become a reality and not just an idea that is trying to find a cause. We just have to push it when the time is ready and wait for it to gain enough momentum on its own.

Acknowledgments

None.

Conflicts of interest

The authors declare there is no conflicts of interest.

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