Southern California Bioethics Committee Consortium

The Balance Sheet

Volume 9, Issue 1 January 2015

Mature Minor Doctrine

The Connecticut Supreme Court has upheld a lower court's ruling that mandated chemotherapy for a 17-year old with Hodgkin's Lymphoma. Cassandra C. had refused treatment despite the estimated 85% chance of cure for her disease. The ruling states, in part, "This court agrees with the trial court that, even assuming that the mature minor doctrine applies in this state, the respondents have failed to meet their burden of proving under any standard that Cassandra was a mature minor and capable of acting independently concerning her life threatening medical condition."

According to uslegal.com, the "mature minor" doctrine provides for minors to give consent to medical procedures if they can show that they are mature enough to make a decision on their own. It is a relatively new legal concept, and as of 2002 only a few states have enacted the doctrine into statute. In several other cases state high courts have adopted the doctrine as law.

In the states where it exists, the mature minor doctrine takes into account the age and situation of the minor to determine maturity, in addition to factors and conduct that can prove maturity. The mature minor doctrine has been consistently applied in cases where the minor is sixteen years or older, understands the medical procedure in question, and the procedure is not serious. Application of the doctrine in other circumstances is more questionable. Outside reproductive rights, the U.S. Supreme Court has never ruled on its applicability to medical procedures.

Excerpted from http://healthcare.uslegal.com/treatment-of-minors/the-mature-minor-doctrine/

Death by Neurological Criteria

A half-day conference for healthcare professionals, bioethics scholars, policy-makers, and the public exploring religious, ethnic, and legal perspectives on death by neurological criteria.

Sunday, January 18
8:00am to 12noon

Ahmanson Auditorium
Loyola Marymount University

Co-sponsored by SCBCC and
The Bioethics Institute at LMU

Student's Corner

Currently being debated by medical students is the 17-year-old girl forced to undergo chemotherapy for Hodgkin's lymphoma. With the support of her mother, she refused treatment aware that non-treatment would likely lead to her death and that treatment reports an 80-95% rate of success. Cassandra believes chemotherapy will destroy her quality of life. Unfortunately, an ethics consultation did not take place to gain a full understanding of both sides and determine true capacity.

America currently has a graduated approach to rights and responsibilities such as driving, voting, legal contracts, and purchasing alcohol or firearms. At 17, or even 18 as legal adults, we are not very confident of our future, many of us changing our minds daily. But, does this make it okay for someone else to make decisions for us even with the support of loved ones?

As doctors in training, this is a very real concern to us. Is it better to err on the side of keeping her alive with the hope that as she matures she will be happy

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"Docs *versus* Glocks"

Editor's Note: In July 2014, a three-judge panel of the Court of Appeals, 11th Circuit, upheld a Florida law restricting what doctors can ask patients about gun ownership. The plaintiffs in the case (Wollschlaeger v. Governor of Florida) have asked that the case be reviewed by the full eleven-judge panel.

Murphy's Musings

This decision is creating some friction. The reasoning goes that the State has an interest in regulating information given to patients: California does not allow questions about sexual orientation to be asked if accompanied by a recommendation the patient can undergo psychological therapy intended to change that orientation, if desired. Numerous states codify what must be told to potential breast cancer patients. The form and manner of "informed consent" is often dictated by the state.

This Florida law was generated by a couple dismissed from a practice because they refused to disclose such gun information.

Fortunately, the questions are allowed to be asked, and the answers recorded, if it is considered "clinically relevant" to the specific situation, which gives a considerable amount of discretion to the clinician.

While some might argue with the concept that one should only be entering clinically relevant information in the medical record — I personally often included notes about interests of the patient as I got to know them. Is it "relevant" to document the location and caliber of firearms and bullets on everyone or merely relevant in a small hunting town or an urban neighborhood plagued by gang violence, or… Alaska?

It looks like our Florida colleagues must thread the eye of the needle, as they address concerns of gun owners, balanced against protection of children or potentially suicidal patients.

Ken Murray, MD. Family physician (retired), regular contributor to medical journals on health policy

John Hamlin writes in the August 11, 2014 issue of The Atlantic Monthly that "...3,000 U.S. children [will] die this year as a result of gunshot wounds….almost all of them in their own homes, and most commonly shot by other children."

WMA Declaration of Tokyo

Preamble. It is the privilege of the physician to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

Declaration (1 of 7). The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense ... and in all situations, including armed conflict and civil strife.

Adopted by the 29th World Medical Assembly, Tokyo, Japan, Oct. 1975; editorially revised at the 170th and 173rd WMA Council Sessions, Divonne-les-Bains, France, May 2005 and May 2006.

Death Fear

From the Halls

One of the emerging strategies outlined in the current literature is the use of existential philosophical principles in the creation of an operational psychoanalytic praxis. Because end-of-life issues often result in the desire by individuals to confront their existence (existential philosophy), the application of an existential psychotherapeutic approach has been introduced as a part of existing research. This has led to the identification of "death fear" as a major development in the presence of end-of-life assessments. An operational psychoanalytic model that addresses the issue of the fear of death has been identified as a major development in creating a workable psychoanalytic praxis. The underlying belief shared by researchers is that "fear" is inherent for both doctors and patients and requires understanding and compassion on both sides of the equation.

Richard Boudreau, MA, MBA, DDS, MD, JD, PHD. Attorney-at-Law and Faculty, The Bioethics Institute, Dept. of Theological Studies, Loyola Marymount University

Housing First: A Radical Idea That is Ending Homelessness

Utah's radical response to homelessness saves money. An estimated $8 -12,000 per year is spent to house a chronically homeless client versus over $20,000 paid out to medical facilities and in legal expenses including possible incarceration for one who is not housed.

Provided with low cost but protective housing, individuals who have experienced homelessness can better train and search for jobs. While some suggest that such social support is a disincentive to people who have had trouble providing for themselves, others insist it is not only a humane approach, but also a practical one that empowers and dignifies individuals formerly overwhelmed by poverty.

Colorado noted estimations of $17,000 a year to provide reasonable housing vs a $47,000 to cover expenses chalked up to the detritus of street living including medical and legal fees accumulated by the unhoused.

A case load of 2,000 chronic homeless was reduced by over 70 percent in Utah. Such numbers may be more manageable there than with California's hundreds of thousands of homeless. But one wonders if such a solution may have universal relevance. In Los Angeles, the Skid Row Housing Trust makes supportive housing the first priority and a precursor to other services.

Such solutions have largely been directed at the chronically homeless who often have substance abuse and mental health issues. They may have relevance to the temporarily homeless as well. One state's study suggested that immediate provision of stable housing significantly reduces the chance of repeat incidents of homelessness. Those instead relied upon shelter in temporary facilities were five times more likely to need those services again.

Reference: James Surowiecki's "Home Free?" The New Yorker, September 22, 2014

Student's Corner (*Continued from Page 1*)

and agree that it was the correct decision to force therapy upon her? Or is it better to err on the side of autonomy.

What if she goes through treatment, then takes her life shortly after due to unhappiness with the outcome? Is it also medical neglect to treat her despite what she believes would be beneficial for her mental health?

Our class is evenly divided with each side changing their minds each time more information is provided. Precedents in other aspects of the US law suggest that if people have the capacity to make a decision, they should be allowed to. This includes refusing treatment. Of course, this comes with a need for immense amounts of counseling and education for everyone involved.

Alexis Rounds, USC-KSOM, MSI

The CIA Torture Report

"No one in bioethics has been more outspoken that Steven Miles. He has published a book, several journal articles and even a blog on this website. But where have the rest of us been? We should all be outraged that not only basic human rights but that ethics of all kinds including deontology, virtue, ethics of care all say that treating human beings in these ways is wrong. A health care provider being involved is wrong. And given that the outcome of these interrogations was no new information than what had been learned through other methods, even utilitarianism would consider these actions wrong."

Excerpted from The CIA Torture Report: Health, Medicine and Ethics by Craig Klugman, Ph.D., http://www.bioethics.net/2014/12/the-cia-torture-report-health-medicine-ethics-in-cia-torture/

A Beautiful Death is a complete end-of-life guide for patients, families and caregivers as told through the story of one man's search for a good death.
http://web.consumerreports.org/endoflife.htm

Calendar

March 19-20, 2015
3rd Biennial National Nursing Ethics Conference
Hilton Universal City Walk
ethicsofcaring.org

Thursday, March 26, 2015
SCBCC Meeting
Greater Los Angeles Veteran Affairs Med. Ctr.