Southern California Bioethics Committee Consortium Newsletter
"The Balance Sheet" March, 2014 Vol. XXXI

Next Meeting, Thurs. March 20, 2014

Greater Los Angeles Veterans Affairs Medical Center
Wadsworth Bldg. (500)11301 Wilshire Blvd. LA 90073
Operator: 310-478-37116400 (6th floor), room 640
SW corner San Diego Freeway (405) & Wilshire Blvd.
Exit Wilshire Blvd West from San Diego Freeway,
Immediate right on to campus west of freeway
Free parking in visitor lots 5:30 pm dinner 6:00 meeting

Introductions and Announcements

- Upcoming lectures and other educational events.
- An Update on Recent POLST Developments: Changes to the form, etc. Poonam Bhatla and Jeannie Meyer.
- A Case Presentation and Discussion: Moral Distress in the ICU – Roles and Responsibilities for the Ethics Consultant. Deborah Kasman and Stuart Finder 8:30 adjourns

Conferences

*Wed 4/9, 7 - 8:30 p.m. **The Euthanasia Debate: International Perspectives** Loyola Marymount University U Hall, Ahmanson Auditorium1 LMU Drive, 90045 John Keown, D.Phil., Ph.D., Kennedy Institute of Ethics. Georgetown U, and Christopher Kaczor, Ph.D., Prof of Philosophy, LMU

*4/10-11 Coalition for Compassionate Care of CA 6th annual Conference **Exploring New Horizons in Palliative Care** info@coalitionccc.org

*9/22-25, LA, CA The California State Association of Public Administrators, Public Guardians and Public Conservators(CAPAPGPC) annual PAPGPC Training and Certification Conference and Certification Conference **CAPAPGPC is the certifying body for over 700 members from 58 counties responsible for individual estate & medical/personal decisions.**

Murray's Musings by Ken Murray, MD

The Visibility of Bioethics

One limitation of our specialty is its visibility. The things that we think about and touch upon are things that people find engaging and fascinating, I think mainly because they are at the edges of human activities and conduct, sometimes even "fringe".

It is uncommon in my experience that physician ethicists are thought of as anything but outstanding practitioners. Could it have to do with the thoughtfulness that goes into every decision? Perhaps. but it strikes me that that thoughtfulness is often an opaque process to many of our fellows, who may not think that way habitually.

So, I would like to advocate that part of the job is to generate a higher visibility. What we want to do is to get our colleagues to think "I'm not going to do that, because it leads to a questionably ethical situation", rather than "Oops! That was sure a mistake in retrospect!"

I am a fan of Art Caplan, Bioethicist at NYU, not necessarily because I agree with his viewpoints (I don't always), but because he is *out there,* in the media, in symposia, very publicly visible. I see his name almost every week.

Why I think that is good, is because I feel that we've had a decline in ethical thinking generally in our society. Acting ethically seems to have been replaced with "because something is legal to do, it is ok to do it", which we all know is crazy. One could even say that ethical thinking is the hallmark of an advanced culture.

But that requires signposts, guidance, and thinking on the issues, and most people in life do so only rarely, and often only when it involves them personally. But this can change with exposure. We all have platforms where we can express our opinions. If we don't, we need to develop them, and use them regularly. When high-profile cases such as McMath come along, I believe that we have an obligation to write and speak about it in our respective barnyards. People are hungry for perspectives, and others will supply them if we don't. If we have a regular avenue of communication, we are far more likely to be heard, and to be "trusted advisors." A perfect example of this going wrong was the "death panels", that was driven by non-medical zealots. I saw few ethicists prominent in the discussion. I think we can do better.

(Ken Murray is a family physician who directed a large multispecialty group and has contributed to the New England Journal of Medicine, NPR and other media outlets.)

From the Halls Observations by The Bioethics Institute Dept of Theological Studies LMU, U. Hall 4500

Medical Error and Physician's Apology

Richard Boudreau, MA, MBA, DDS, MD, JD, PHD
Attorney at Law & Faculty Loyola Marymount Univ.

Given today's litigious social climate, the propensity for medical errors to remain undocumented is a risk factor that stands to detrimentally impact not only the practitioner but also all those involved, including the hospital or clinic. Weighing this risk while at the same time respecting the patient's ethical right to know the truth presents a dichotomy that may be equally resolved with a simple two-word phrase: I'm sorry.

Determining when an apology is warranted is an ongoing process as hospitals and other health care facilities grapple with producing such policy. Patient demands in relation to an error are: 1) being told what occurred; 2) having the guilty party assume responsibility; 3) being assured enough was being done to prevent the same thing from happening to someone else; 4) given an apology. Although there is concern that an apology is tantamount to an admission of guilt, patients observing that the physician was honest and sincere seemed to understand that they had suffered and thought better of the physician as a result.

A model for establishing an effective error disclosure program includes some basic concepts such as coming right out and admitting wrongdoing at the first disclosure meeting and keeping things clear and concise. The more that

discussion occurs in real time, the more it is part of the normal discourse between physicians and patients and the less it seems like something that ought to merit a malpractice suit.

Whether it was a system or personal error, apologies can be tailored to reflect the genuine intent of the speaker: 1) I am sorry for doing that/not doing this; 2) I apologize for the system's application failure; or for an undetermined reason why the error occurred--this happened while I was on duty, and as such, I accept onus for the outcome.

Effectively tailoring a medical error disclosure involves utilizing understandable policies and procedures attuned to the needs of both patient and family, communication that incorporates the critical components of compassion, commitment, and concern; mediation that opens communication; venting; flexibility in how conflict resolution is approached; and an apology.

We are fallible, mistakes will happen even in the best institutions involving the best and most well-meaning clinicians. A medical malpractice lawsuit can damage and even destroy the health caregiver's career, but to remain quiet is not only a breach of personal and medical ethics, it defies the growing trend toward the incorporation of enterprise risk management where upholding onus is concerned.

Disclosing the mistake impacts many others besides the practitioner, which is why the notion of enterprise risk management is taken into consideration where apologizing is concerned. Careful education, process development, and training can overcome concerns. Recent data illustrates how accepting culpability through full disclosure and apology can - in many situations - actually fend off litigation rather than encourage it; health care providers who are more inclined to look the patient directly in the eye and offer a genuine "I'm sorry" stand to empower themselves with a renewed ethical and professional conscience.
Generally, hearsay precludes the statement, however, the Admissions exception brings it in. "Apology Rule" "Apology Shield Law" and "I'm Sorry" statues, distinguish "fault statements" from "apology" statements. If it's an apology statement, it's privileged in civil proceeding,: as long as there's a general sense of benevolence, the apology statement is privileged.
Several states, including CA have such provisions – unfortunately, it's not universal.

If a physician makes a mistake which injures the patient, it is an ethical duty to tell the patient. Expressions such as "I'm sorry," whether or not they convey an admission of responsibility, demonstrate caring and empathy.

The ethical approach for the physician is to specify what is best for his/her patient. Should an error occur, the physician should be sensitive to both professional and personal moral duties, and act accordingly.

***** Weigh in with the Editor*****: kfgorlitsky@gmail.com

Contributors: Ken Murray, M.D., Richard Boudreau, M.D, J. Freidma Jessica Freidman, MS3 KSOM

Head On

Parents of one of the 20 children slain at Sandy Hook Elementary school by a troubled teen, have initiated a foundation to investigate the etiologies and treatment of brain disease that fosters or aggravates tendencies toward violent behavior. Jeremy Richman, a PhD with experience in neuroscience and his wife Jennifer Hensel, trained in molecular and cellular immunology have organized a foundation dedicated to investigating potential sources of the violent behavior like that which took the life of their child in December 2012.

The team of advisors to the Arivelle Foundation is studying neurochemical, nutritional and environmental factors as well as social indicators that might be modified to help prevent such tragedies.www.aviellfoundation.org

Approaching the Bench

Guantanamo Bay: Gitmo detainee challenges force-feeding procedures WASHINGTON -- A detainee at Guantanamo Bay is challenging force-feeding practices at the facility imposed on prisoners who go on hunger strikes:

Miami Herald 3.11.14 Associated Press
http://www.miamiherald.com/2014/03/11/3988203/gitmo-detainee-challenges-force.html#storylink=cpy

A Medical Ethics–free Zone?

Excerpted from New England Journal of Medicine 7/ 11/13
George J. Annas, J.D., M.P.H., Sondra S. Crosby, M.D., Leonard H. Glantz, J.D.; NEJM369:101-103JDOI: 10.1056/p1306065
.... Constitution Project's bipartisan Task Force on Detainee Treatment concluded in April that "forced feeding of detainees [at Guantanamo] is a form of abuse that must end" and urged the government to "adopt standards of care, policies, and procedures regarding detainees engaged in hunger strikes that are in keeping with established medical professional ethical and care standards."1 …

Stating in its Declaration of Malta on Hunger Strikers the WMA (World Medical Association comprising medical societies from almost 100 countries). ... "Forcible feeding [of mentally competent hunger strikers] is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment.".2 …Physicians may not ethically force-feed any competent person, but they must continue to provide beneficial medical care to consenting hunger strikers. That care could include not only treating specific medical conditions but also determining the mental competence of the strikers, determining whether there has been any coercion involved, and even determining whether the strikers want to accept voluntary feedings to continue their protest without becoming malnourished or risking death.4 …

Guantanamo officials have consistently sought to medicalize hunger strikes by asserting that protestors are "suicidal" and must be force-fed to prevent self-harm and

"save lives."2 The DOD's 2006 medical "Instruction" on this subject states: "In the case of a hunger strike, attempted suicide, or other attempted serious self-harm, medical treatment or intervention may be directed without the consent of the detainee to prevent death or serious harm." ….Refusal of treatment with the awareness that death will soon follow is not suicide, according to both the U.S. Supreme Court and international medical ethics.2 ,,,www.globallawyersandphysicians.org/storage/AgendaHungerStrikeMeeting.pdf is the text and a summary of a meeting on physician participation in hunger strikes. A more troubling argument is that military physicians adhere to different medical ethical standards than civilian physicians — that as military officers, they must obey military orders, even if those orders violate medical ethics…., the decision to force-feed prisoners is made by the base commander. …In April **the American Medical Association appropriately wrote the secretary of defense that "forced feeding of [competent] detainees violates core ethical values of the medical profession."(**Ed. Emphasis**)** We believe that individual physicians and professional groups should use their political power to stop the force-feeding, primarily for the prisoners' sake but also for that of their colleagues. They should approach congressional leaders…..and state clearly that no military physician should ever be required to violate medical ethics. …**Professional organizations and medical licensing boards should make it clear that the military should not take disciplinary action against physicians for refusing to perform acts that violate medical ethics. …civilian physician organizations, future employers, and licensing boards should make it clear that military discipline action in this context will in no way prejudice the civilian standing of the affected physician.** *published 6/12/13, updated 6/ 26/13, NEJM.org.*

Ed's note: It is important to separate the arguments regarding political protest from the efforts to address patients with Anorexia Nervosa which present their own extremely challenging responses.

Belgium extends Right to Die to terminally ill Children From an La Times Op- Ed piece 2/20/14, columnist Meghan Daum noted the Belgian Parliament recently passed a law allowing terminally ill children to request aid in dying as adults there have been able to do that since 2002, Other European countries have similar measures. This will make Belgium the first to extend the right to minors faced with "constant and unbearable suffering." Polls indicate that 75% of the public supports the law. The legislation is the first of its kind to cover children of any age who can prove a "capacity for discernment," Children requesting such assistance must be suffering from pain that doctors have deemed truly unmanageable. They must get approval from their parents and their medical team, and they must be evaluated by psychologists. They must make the request several times and demonstrate that they understand what they're asking for. They must already be close to death.

The Netherlands has a similar process. In the 12 years since its children's euthanasia law (affecting children over 12) was passed, only five children have received aid in dying. In all but the rarest cases, pain and suffering were managed through palliative care. Data from Oregon — where medically assisted death for the terminally ill (but not for children) has been available since 1998 — have consistently shown that far more patients obtain lethal prescriptions than use them, though patients often report having greater peace of mind knowing the pills are there if they need them.. Last year, 122 patients filled such prescriptions; only 71 took them. A Gallup poll conducted in May found that 70% of respondents would allow physicians to end a terminally ill patient's life "by some painless means." Oregon, Washington, Vermont, Montana have granted doctors some ability to aid patients in dying..mdaum@latimescolumnists.com

Student's Corner *offering students an opportunity to raise ethical concerns that arise during training*

KSOM USC Medical Student II Vamsi Aribindi, member Student Ethics Committee poses:

A doctor sees a middle aged woman, a lifelong smoker, who has recently quit with some difficulty. Later, the patient develops ulcerative colitis and presents with a moderately severe (not life threatening) episode which has not responded to corticosteroids or other pharmacological treatment. Ulcerative colitis and tobacco abuse have an unusual relationship: smoking seems to have a protective effect against ulcerative colitis through an unknown mechanism.

It is conceivable, if the patient resumes smoking, the ulcerative colitis might go into remission. Telling the patient this could jeopardize her resolve to abstain from smoking, regardless of whether or not she wants to know. Is it justifiable for the doctor to withhold the information from the patient tin the hope of preserving abstinence from smoking? Does the determination change depending on: 1) The severity of the disease- (causing depression or requiring surgery). 2) The education level of the patient, and the likelihood that the patient's own research will uncover the link 3) The doctor's judgment about whether the patient would want to know, or would want to keep her resolve to quit smoking intact? *(Contact Ed.with comments to be published in next Bioethics Newsletter.)*

SCBCC Steering Committee