Southern California Bioethics Committee Consortium

The Balance Sheet

A forum for topics of interest to members of the bioethics community

Volume 9, Issue 2 March 2015

March 26, 2015 Agenda

5:30pm Dinner (thanks to our sponsors)
6:00pm Meeting
Announcements
Presentations
Simulation Software as a tool for ethics education
Shannon Peter, MD
Oregon Death with Dignity Act and SB 128
End of Life Option Act—history and update
Stefanie Elkins, California Medical Outreach/Organizing Manager and Dr. David Grube, National Medical Director, Compassion & Choices
Additional perspective by Ron Koons, MD
Counter proposal by Ron Miller, MD

Physician Aid-In-Dying

Physician aid-in-dying (PAD) has been legal in Oregon for over 18 years. Recently Washington, Vermont, Montana, and New Mexico have made this available to competent terminally ill patients. A Medscape survey of 17,000 doctors in the United States found that 54 percent supported legalizing PAD in 2014, up from 46 percent in 2010.

Bills to legalize PAD have been introduced in 15 states including New Jersey, Pennsylvania, California as well as the District of Columbia.

Summary of Last Meeting

1. Case presentations by Jim Hornstein, MD
Case #1: A 27 y/o sustained a GSW resulting in cervical cord transection and permanent ventilator dependent quadriplegia, deemed capable of making informed decisions. The question of whether to honor his consistent refusal of a permanent tracheostomy and a G-tube was brought to the Bioethics Committee. Their recommendations were a) have a single physician be responsible for ongoing discussions about health care decisions, and b) have the patient consult with a Physical Medicine & Rehabilitation physician to understand more clearly what life would be like if he accepted the interventions. The patient agreed with caveat that he could at any time rescind that decision. The learning outcomes for the staff was that they acknowledged what they didn't know and that there are different degrees of fullness of informed decision making.
Case #2: Adult male with terminal pancreatic cancer causing small bowel obstruction discovered as outpatient that marijuana (MJ) alleviated his nausea and anxiety. Despite Bioethics Committee support, which included creative measures, the request to use MJ during hospitalization was denied by hospital risk management on the basis of it being a smoke-free facility. Other issues raised were absence of a hospital policy on medical marijuana, absence from hospital formulary, lack of dosing guidelines, no source of supply and federal anti-drug laws that could impact Medicare and Medicaid payments. The outcome for the patient was that more aggressive palliative treatments were instituted.
2. Discussion: Is it indicated or appropriate for SCBCC to issue a statement regarding torture such as "It is never ethical for physicians (and other licensed

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"Hope is not a plan."

Murray's Musings

The PBS documentary "Being Mortal," based on Atul Gawande's book *Being Mortal: Medicine and What Matters in the End*, is outstanding. He takes a little bit of a different slant in his perspective on death: he is really writing about the journey of doctors, not so much the perspective of patients, as Ira Byock does in *The Best Care Possible*. As such, he is drawing back the curtain of medicine about the experience of doctors and revealing that to the public.

In one interview he says, "Talking to palliative care doctors about how I might have had my conversations differently with [his patient] was a revelation." Kind of an amazing statement for a surgeon, and hopefully something that enlightens other practicing physicians.

Gawande is, in my opinion, one of our current national treasures, who seems to have found that "sweet spot" between technical excellence and understandable explanations for lay people. His book is currently #14 on the Amazon bestseller list. More importantly, he is a persuasive writer who is impacting policy and practice. Few of us rise to that level of influence.

If you've not read his writings in The New Yorker, you can catch up with him at http://www.newyorker.com/contributors/atul-gawande I highly recommend them.

You can watch the documentary and read interviews at http://www.pbs.org/wgbh/pages/frontline/health-science-technology/being-mortal/dr-atul-gawande-hope-is-not-a-plan-when-doctors-patients-talk-death/

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

CONTROVERSIES: "Why I Hope to Die at 75"

http://www.theatlantic.com/features/archive/2014/09/why-i-hope-to-die-at-75/379329/

Ezekiel Emanuel, oncologist, bioethicist and vice provost, University of Pennsylvania, stirred up a controversy with this September 2014 Atlantic Monthly article. He cited statistics and anecdotal evidence suggesting that by age 75 most of an individual's significant contributions to society have been made. "Doubtless, death is a loss....But living too long is also a loss. It renders many of us, if not disabled, then faltering and declining, a state that may not be worse than death but is nonetheless deprived. It robs us of our creativity and ability to contribute to work, society, the world. It transforms how people experience us. We are no longer remembered as vibrant and engaged but as feeble, ineffectual, even pathetic." He was not advocating suicide (he's a vocal opponent of physician aid-in-dying) bur rather stating a wish (one that his family abhors). Pushback came from several quarters. Here are some examples:

Victor Davis Hanson (National Review, Sept. 9, 2014) finds Emanuel's perspective particularly disturbing owing to his prominence in the health care policy debate and his input into the crafting of the ACA. He cited Sophocles and Benjamin Franklin as ones who made significant contributions well past age 75.

Michael Hiltzik (LA Times, Oct. 15, 2014) countered Emanual's dismissiveness of contributions made by older individuals by enumerating the contributions of Verdi, who created "Falstaff" at 74, Phillip Roth, who published "Nemesis" at age 77, and Richard Posner, 77, an influential and respected federal appeals court judge.

Kim Geiger (Chicago Tribune, Nov. 11, 2014) reviewed Emanuel's essay and reports an AMA vote about the ethics of his perspective. A proposal to issue a statement that publicly disagrees with this assertion, though voted down, demonstrates the concerns felt by some regarding Emanuel's perspective that a life becomes less valuable with age.

A Theory of the Good in Medicine

From the Halls

Beneficence remains the central moral principle in the ethics of medicine encompassing all of the components in the complex notion of the patient's good. In defining a vision of beneficence, I offer a broad scope that goes beyond the strict medical values to embrace the moral and other values of the patient.

In addition to its considerable contributions to health, medical technology can also serve to prolong the suffering of the terminally ill and make death a long drawn out process.

The principle of beneficence, that is, "to do good," has been frequently cited in support of medical decisions. However, deciding what is "good," within the realm of medical possibility is often difficult. Is it "good" to sacrifice one twin to save the life of the other in cases of conjoined twins? Medical science can keep the bodies of patients alive long after all signs of consciousness have ceased. Is this "good"?

The news tells us of parents confronting medical decisions regarding their children and situations in which families face the awful choice of whether or not to use extensive life-sustaining procedures in cases where a positive outcome is almost certainly doubtful. Then again the news occasionally reports on a comatose patient who "awoke" after years in coma.

The complex and often controversial principle of beneficence balances the benefits of medical intervention against possible harms or risks. This is the tricky ethical territory that requires a logical systematic approach. This task constitutes a diligent search for a coherent philosophy of medicine and, therefore, offers considerable insight to the complicated problems created by the wonders of modern medicine. The goal is to make beneficence, that is, what is “good” the overriding value of medical practice, rather than various rights which are the contention of some ethicists, or, as others have argued, ‘consequences.’ As this suggests, one must negotiate the tricky path between rights and consequentialism.

Consequentialism is a class of normative ethical theories holding that the consequences of one’s conduct are the ultimate basis for any judgment about the rightness or wrongness of that conduct, and is distinguished from deontological ethics, which derives the rightness or wrongness of one’s conduct from the character of the behavior itself rather than the outcomes of the conduct.

A theory of “the good” in medicine provides a template, an ‘ordering principle,’ which can be used effectively to resolve conflicts between ‘social and individual good,’ and act as a framework for a ‘beneficence-in-trust’ model.

Although beneficence is the key overriding principle in medicine, there is no one principle of ethics that should govern all health care practice; beneficence coupled with concern for the best interest of the patient, including autonomy, is one which works best when there is a cooperative and consensual relationship between patients and physicians.

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

REVIEW *Hope in Hell: Inside the World of Doctors Without Borders* by Dan Bortolotti, provides a fascinating look at the inner workings of the 1999 Nobel Peace Prize winning group also known as Médecins Sans Frontières. Ethical conundrums are very much a part of their daily work. What do you do if you injure a local person in a traffic accident? Do you follow your instinct and provide care or do you go immediately to the local authorities? After a worker died at the hands of an angry mob, the rule is to report first then provide care. What if you find yourself in the midst of a genocide? When this happened in Rawanda, they requested an armed response because, "genocide cannot be stopped by doctors."

Summary (*Continued from Page 1*)

health care providers) to participate or provide support for torture"? While there was a near consensus that a statement that participation in torture would violate the most basic tenant of the medical profession -- to "do no harm" -- the concern was whether the SCBCC as an organization has the authority to speak for all its members, and possibly the institutions from which the members come. To date the SCBCC has only issued one policy statement, consensus guidelines to help member institutions develop a policy for unrepresented patients.

3. Death by Neurologic Criteria is the subject of the conference co-sponsored by SCBCC and Loyola Marymount University on January 18. Dr. Schneider expressed the hope that from this conference will emerge a consensus policy concerning death by neurologic criteria.

Thank you to Neal Sheade, MD, for taking notes.

My Own Life

Oliver Sacks On Learning He Has Terminal Cancer

Over the last few days, I have been able to see my life as from a great altitude, as a sort of landscape, and with a deepening sense of the connection of all its parts.

There will be no one like us when we are gone, but then there is no one like anyone else, ever. When people die, they cannot be replaced. They leave holes that cannot be filled, for it is the fate — the genetic and neural fate — of every human being to be a unique individual, to find his own path, to live his own life, to die his own death.

I cannot pretend I am without fear. But my predominant feeling is one of gratitude. I have loved and been loved; I have been given much and I have given something in return; I have read and traveled and thought and written. I have had an intercourse with the world, the special intercourse of writers and readers.

Above all, I have been a sentient being, a thinking animal, on this beautiful planet, and that in itself has been an enormous privilege and adventure. "

Excerpted from The New York Times Opinion Pages, February 19, 2015. http://www.nytimes.com/2015/02/19/opinion/oliver-sacks-on-learning-he-has-terminal-cancer.html

Calendar

March 19-20, 2015
Wednesday, April 8
7:00—8:30pm
Health Care Professionals Participating in Torture:
An Ethical Interrogation
LMU Bioethics Institute
bellarmine.lmu.edu/bioethicslecture

Wednesday, May 20, 2015
SCBCC Meeting
Greater Los Angeles Veteran Affairs Med. Ctr.

October 22-25, 2015
American Society for Bioethics + Humanities
17th Annual Meeting
Houston, TX