*Southern California Bioethics Committee Consortium*

# The Balance Sheet

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

Volume 9, Issue May 2015

## *Wednesday, May 20, 2015 Agenda*

5:30pm Dinner (thanks to our sponsors)
6:00pm Meeting
Announcements
Presentations

*Argument against AB 637, which would allow NPs and PAs to be signers of POLST forms*
Ron Miller, MD

*Argument against SB 128 (End of Life Option Act)*
Miriam Cotler

*Moral distress and suicide by physicians and other healthcare providers*
Elizabeth Bromley, MD, PhD

*Demonstration of the Balint group process for healthcare providers*
Dr. Bromley and Diana Jochai, PhD

## Digging Deeper

**A** rabbi cannot permit physician-assisted suicide, but it is still possible to have compassion for the suffering of terminally ill individuals contemplating such a decision while not endorsing or even condoning it. Rabbinic authorities assume most cases of suicide are not willful and instead look for mitigating circumstances such as fear or anguish or insanity on the part of the one committing suicide, or if they thought it was a meritorious act to prevent other transgressions. There are times when Jewish Law may permit praying for a suffering terminal patient to die, yet at the same time it obligates us to do everything possible, including violate the laws of Shabbat, to prolong their life.
*Excerpted from "When a Jew Requests Assisted Suicide" by Rabbi Jason Weiner in the April 2015 issue of Torah Musings.*

## Hot Topics

### Physician-author not sold on California's End of Life Option Act

In an interview with LA Times columnist Patt Morrison, family physician and author of "How Doctors Die," **Ken Murray**, raises concerns regarding the End of Life Option Act. "It's easy to see that someone could be coerced or guilt-ridden into feeling they need to get themselves out of the way. In the era of HMOs, where saving money [is] a predominant thought, you could see incentives created to treat people with terminal illnesses by assisting them in committing suicide. You have to worry about that."

Dr. Murray advises independent oversight. "For example, you're a managed-care patient and want to do this — you would need a physician outside your HMO to evaluate your situation at its expense."

"Many in the psychiatric community feel a person who has major clinical depression isn't really competent to make a decision about life and death. This is acknowledged in the law but only to the degree that a primary-care physician should evaluate whether a person is depressed, and [if so] the person should obtain psychiatric consultation. When you poll psychiatrists, 90% of them said they could not evaluate someone for major depression in a short visit. So if a psychiatrist cannot do it, you wonder how a primary-care physician can be making that diagnosis."

"Polling [finds] there's about 50% acceptance when it's described as physician-assisted suicide, but when it's described as 'compassionate passing' or 'aid in dying,' the acceptance rate goes [as high as] 68%

"...palliative care and hospice medicine are highly effective but...not as widely available as they could or should be, so a lot of people die without the aid of this advanced form of healthcare.

*Excerpted from LA Times Opinion page, April 29, 2015*

# Secrets, Politics and Torture

**FRONTLINE, May 19, 2015**

The Hollywood film Zero Dark Thirty, about the hunt for Osama bin Laden, became a blockbuster when it premiered in 2012.

Behind the scenes, the CIA secretly worked with the filmmakers, and the movie portrayed the agency's controversial 'enhanced interrogation techniques' — widely described as torture — as a key to uncovering information that led to the finding and killing of bin Laden. This Frontline documentary reveals the many challenges to that narrative. It contrasts the dueling versions: that laid out by the CIA, which maintains that its now officially-shuttered program was effective in combating terrorism, and the Senate torture report released in December 2014, which found that the program was brutal, mismanaged and — most importantly — didn't work.

Drawing on recently declassified documents and interviews with prominent political leaders and CIA insiders, the film examines how the secret interrogation program began, what it accomplished and the bitter fight in Washington over the public outing of its existence. "We've found that, faced with 9/11 and the fear of a second attack, everybody from the head of the CIA, to the Justice Department, to the president asked 'Can we do it?' — meaning, can we do it legally — not, 'Should we do it?' says veteran FRONTLINE filmmaker (and 2014 Peabody Award winner), Michael Kirk. In a previous documentary, Kirk traveled to the Abu Ghraib prison in Iraq to make 2005 documentary, "The Torture Question."

"As the debate over how far the U.S. should be willing to go in the fight against terrorism continues, we felt it was important to tell the story of this CIA program, comprehensively, in documentary form," Kirk says. "What we've found raises some very tough questions."

*http://www.pbs.org/wgbh/pages/frontline/secrets-politics-and-torture/*

# CONTROVERSIES: Vaccine Bill Passes First Hurdle

A California bill that would limit vaccine exemptions to medical necessity passed the state Senate on May 14, 2015. The bill has generated intense debate, pitting personal rights against the public's health.

"Medical waivers [should] only be available for children with health problems," maintains Sen. Richard Pan (D), pediatrician from Sacramento and the lead author of the bill. "Every child deserves an opportunity at education and every child deserves an opportunity to be safe at school." The proposal has generated such an angry debate that Pan has received added security, with some opponents posting "images online comparing Pan to Adolf Hitler."

Parents have been on both sides of the issue, with some calling the vaccination plan an unconstitutional government overreach and others saying it was necessary to save lives.

Carl Krawitt, told lawmakers that he feared for his 6-year old son's life during the measles outbreak because the boy could not be vaccinated while he was being treated for leukemia.

Robert Moxley, a Wyoming attorney who represents families who say they've been injured by vaccines, testified that the proposal would not stand up in a court challenge. Pan said courts have validated public health measures. "Across California, pockets of low-immunization rates have forced communities to spend large amounts of resources to contain outbreaks."

Pan pointed out that the recent measles outbreak is evidence that our levels of community (herd) immunity are dangerously low because of the increased use of the personal belief exemption.

Republican Minority Leader Bob Huff has said that he's concerned that unvaccinated children would be forced into homeschooling, which could deprive them of resources and socialization afforded by schools, asserting that recent outbreaks have not constituted a crisis. "If we were talking about an Ebola outbreak and we had an inoculation against that, I would probably have a different [perspective].

Opponents are preparing to take their fight to the state Assembly this Summer

*Based on reporting by Judy Lin of the Associated Press and Tara Haelle of Forbes Magazine.*

# Consequentialism And Deontology Regarding Torture

## From the Halls

With respect to torture, I am reminded of interesting concepts regarding 'moral psychology.' In general, we can divide ethics into two basic notions: consequentialism which views the consequences of an act, and deontology looking at the act itself apart from its consequences. A consequentialist might reason that torture inflicts suffering and reduces happiness; however, if it promotes more happiness than suffering, it is justified. It has been shown that torture isn't very effective in producing reliable intelligence, but if it were proven effective a consequentialist would endorse it. From a deontological perspective, torture is wrong as an act, and the act of torture will always be wrong. The consequences cannot justify torture no matter how good.

What we have, then, is two competing moral systems; one is an emotional reaction that condemns actions (deontological) and the other more analytic and dwells on the consequences of an act (consequentialism). Obviously, this should not be interpreted to mean that one is purely emotional and the other purely rational. The two notions interact within the basic framework of morality.

Moreover, one should be careful not to confuse 'moral psychology' with analytical logic. In other words, one should not 'psychologize' a moral discourse to the degree that we determine truth or falsity based purely on psychological origin. Both consequentialists and deontologists proffer their respective positions, and it is incumbent upon us to remember that the social consequences of an act may be more important than the act itself, and yet no less intuitive and 'pre-cognitive' than our trust in deontological judgments; hence, a dual system exists requiring more thought regarding the 'how and why' one system may override the other

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### On The Passing of

**William Zinsser,** author of "On Writing Well," whose gifts went beyond the world of editors. Those eager to learn how to enjoy later years with grace can learn from a scholar who, while acknowledging some loss of function with age, was still gamely willing to share his remaining personal attributes and talents with any comers.

Glaucoma infringing on his already impaired vision, forced him to terminate a 70 year writing career. He creatively addressed this challenge in 2012, sending a written invitation to friends and former students "to attend the next stage of my life."

He made himself available to "help with writing problems and stalled editorial projects and memoirs and family history; for singalongs and piano lessons and vocal coaching; for reading and salons and whatever pastimes you may devise that will keep both of us interested and amused…no project too weird."

*Excerpted from the NY Times obituary by Douglas Martin, May 12, 2015*

### Bioethics Time Line

**1967** St. Christopher's Hospice in London founded by Dame Cicely Saunders
**1969** Founding of Hastings Center for Ethics and the Life Sciences
**1971** Georgetown's Kennedy Institute for Ethics, first university-based bioethics center
**1974** Connecticut Hospice, first in USA
**1983** University of Chicago's MacLean Center for Clinical Medical Ethics, focusing on research and consultation at medical schools
**1974-1978** Commission for the Protection of Human Subjects of Biomedical and Behavioral Research continuing to the present with Presidential Commission of the Study of Bioethical Issues.
**1986** Hospice care a covered benefit by Medicare
**2006** Palliative care board-certified specialty in USA

*D.P. Sulmasy MD, PhD, C. Brick MA, P.A. Mackowiak, MD. Eleanor Roosevelt's Last Days: A Bioethical Case Study. AJM. 2015. 128:437–440*

## Summary of March 25, 2015 Meeting

1.Presentation by Dr. S. Peter of Simulation Software as a Tool for Ethics Education, to be used in the education of "early learners" of clinical health care ethics. Potential future uses include helping to map patient preferences in different situations. The VA has purchased this system. Contact Jamie.Owen@va.gov. See the program at www.decisionsimulation.com or http://virtualpatients.eu (open source)

2. Presentation by Stephanie Elkins of Compassion & Choices on the Oregon Death with Dignity Act and California's End of Life Option Act, which cleared the state Senate Health Committee March 25. She referenced a Medscape survey that showed more physicians favoring than opposing physician aid in dying.

3. David Grube, National Medical Director, Compassion & Choices, discussed his experience with the Oregon Death with Dignity Act. He cited the most common reasons patients requested aid in dying:

#1 Loss of autonomy;
#2 Loss of ability to participate in desired activities;
#3 Loss of dignity.

He shared documentation that fears of abuse predicted at the implementation of the law have not been realized and no efforts to expand the scope of the law have been made. He explained that the Oregon law stipulates that what constitutes dignity in dying is defined by the patient. Implementation of the law has caused an increase in and improved use of hospice. He recommended reading Being Mortal; Dying in America and Aid in Dying: The Ultimate Argument.

4. R Koons, MD, emphasized that the physician caring for/assisting the patient should be familiar with and spending a great deal of time with him/her. His impression is that when patients ask about assistance n dying, they fear the process of dying, not death itself.

5. Stanley Terman, MD, presented a video outlining his concerns with SB-128

1. Inadequate provision for psychological assessment for mental illness which might be affecting request for aid in dying (AID).

2. Inadequate informed consent and explanation of alternatives to AID (e.g. refusal of fluid and nutrition).

3. Should be required that MD have patient's explain when/if they request that their family not be informed, or refer to psychiatrist/psychologist.

6. Robust question and answers/discussion followed touching on the influence of semantics on patients making choices, articles disputing the claims of the Oregon experience, problems of implementation of SB 128 in nursing homes, the promise of legislation that there would be societal funding support for hospice which hasn't materialized.

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