MEETING SEPT 24, 2015
Greater LA VA Medical Center Wadsworth Bldg.
500, 11301 Wilshire Blvd. LA 90073 6400 6th FL
Operator: 310-478-3711
SW corner San Diego Frway (405) / Wilshire Blvd.
Exit Wilshire Blvd, West from 405, right on to
campus west of freeway, free parking in visitor lots
5:30 PM free dinner (no RSVP needed)
6:00 meeting
1. Case Presentation: Joseph Raho, PhD, UCLA
   Clinical Ethics Fellow
2. Should Ethics Consultation be Available to
   Nursing Facilities? Christine Wilson, JD
3. Roles and Responsibilities in Ethics
   Consultation – Stuart Finder, PhD, Cedars Sinai

**** Upcoming Conferences****

--Oct 20-25 ASBH
American Society for Bioethics and Humanities
Annual conference, Houston

--Nov 5-6 KP National Bioethics Symposium
Professionalism and Shared Decision Making:
Back to the Future
Hilton Universal City
John Lantos MD, Cynda Rushton PhD RN as
keynotes
SE&OID=50 to register

--Fri Nov. 13 noon to 2pm
California Hospital, 1440 So Grand,
Bioethics Seminar
An Insider’s View from the Mental Health
Perspective
Elyn Katz, attorney and author of
The Center Will Not Hold, My Journey Through
Madness
CME and lunch provided
Call (310) 9180 321 for details

Weigh in with the Editor
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MEDICAL HUBRIS AND ITS EFFECTS
ON PATIENT OUTCOMES AND END-OF-LIFE CARE
http://well.blogs.nytimes.com/2015/08/20/wondering-if-i-
hastened-a-patients-death/?partner=rss&emc=rss&_r=1

Dr. Mikkael Sekeres, director of the
leukemia program at the Cleveland Clinic,
in this self-scrutinizing article examines the
appropriateness of his guidance regarding
treatment of a patient in his mid-60’s
confronting leukemia with a very poor
prognosis. The patient died after a very brief
course of harrowing chemotherapy and its
complications.

“I was left wondering, not for the first
time in my career, if I had launched someone on
a path toward premature death. At the very least,
I was guilty of that act of hubris of which oncologists
are often accused: giving chemotherapy to a person
only days before his death.”

A study published in the journal Cancer
revealed, “Among 330 older adults with leukemia,
approximately 60 percent received chemotherapy...
With a median follow-up of two years, 88 percent
of people had died.”

Fifty-one per cent of the remaining days of
those who received chemo therapy were spent
either hospitalized or in clinic and “within 30 days
of death, almost 85 percent of patients were
hospitalized, and 45 percent had received
chemotherapy.” Those treated with chemotherapy
were half as likely as those not receiving treatment
for their leukemia to enter hospice, which included
only 22 per cent of the total.

“Perhaps in focusing on the 10 percent or so of
people who enjoy a long survival following their
leukemia diagnosis, whom we can’t routinely
identify when we discuss the potential benefits of
chemotherapy, we neglect to emphasize equally
the 90 percent who don’t, the amount of their lives they will spend in health care settings, and alternative ways of living out the time they have left...

“But if we do call attention to the majority, will we be preparing them appropriately for the remaining time they have on this earth?” wonders Dr. Sekeres, “Or dashing what hope they have of defeating their cancer?”

**Hot Topics: Vaccines**

**“SB 277 HAS PASSED**

**BUT WHAT HAPPENS NEXT?”**


**Impetus for passing SB 277:**

Rates of personal-belief exemptions doubled since 2007. (California Dept. of Public health data) and vaccination coverage thought to be low enough to jeopardize herd immunity. The recent 2015 measles outbreak was attributed to a result of insufficient vaccination compliance. Evidence shows strict vaccination laws reduce risk of vaccine-preventable illness.

**Does SB 277 violate 1st Amendment right to freedom of religion?**

Adults are allowed to reject medical treatment on the basis of religious beliefs. However, the 1st Amendment does not provide for religious exemptions to “generally applicable” laws that aim to protect the general public health. No legal precedent in U.S. Supreme Court exists with regards to the applicability of the 1st Amendment rights to vaccination policies. Two appellate courts recently ruled that 1st Amendment rights do not entitle religious exemptions to vaccinations.

**If all children have a right to receive an education, could SB 277 violate?**

In many states (including California), receiving an education is legally recognized as a “fundamental right.” However, the U.S. Supreme Court and Constitution have never recognized a right to education. The state of New York’s Supreme Court ruled in 1904 that the “state’s constitutional right to attend public schools may be subordinated to ‘restrictions and limitations in the interest of the public health.’” Viemeister vs. White, became the leading right-to-education case that also discusses vaccination policy.

**How will SB 277 be enforced?**

Currently in California (as in many states), the schools and day-care centers are responsible for ensuring that their entering students have received all required vaccinations. When a student is not compliant, they often allow that student to begin classes anyway— as an educational institution looking out for children’s academic welfare—on condition that the student’s parents promise to get their child his or her missing vaccinations. When such promises are not kept, the schools do not face penalties for failing to follow-up with these parents, even under SB 277.

But “forcing school administrators…to act against the educational interest of their charges” turns “trusting relationships with parents into adversarial ones…”

A small group of doctors from within the tightly-knit anti-vaccination community could begin to broadly interpret “medical” exemptions and thus loosely grant them, which could undercut the intent of SB 277.

**Is there any way to limit the issues of enforcement of SB 277?**

Some have proposed that “state laws should instead task health departments with enforcement responsibility for vaccination mandates. When children are permitted to enroll with incomplete vaccinations, schools and day-care centers could notify the health department, which could conduct the necessary follow-up.”

**Are we really going to strengthen our herd immunity?**

By barring students who are non-compliant on vaccines from schools and day-care centers, SB 277 indeed will achieve the goal of making these venues safe for other children who are either too young to be vaccinated or who have an illness that prevents them from receiving necessary vaccinations. The reality of unvaccinated home schooled children still jeopardizes public herd immunity.

2. Is SB 277 coercive? Are we rendering informed consent meaningless for some?

A portion of the population will be those who are against vaccinations, but still consenting to
them because home-schooling, providing a nanny, and/or moving out of the state are not options for them. Some may argue that informed consent will be essentially pointless for this population, as they would virtually NOT be consenting to the vaccination, but accepting it simply because they are being coerced to do so.

Concerns about “Physician Aid in Dying” bill


Despite efforts to safeguard against this, Dr. Aaron Kheriaty, director of the medical ethics program at UC Irvine, School of Medicine, said that low-income and underinsured patients would inevitably feel pressure to end their own lives in some cases, when the cost of continued treatment would be astronomical compared with the cost of a few lethal pills.

Barbara Wagner, a cancer patient in Oregon said that her insurance plan had refused to cover an expensive treatment but did offer to pay for “physician aid in dying.”

“As soon as this is introduced, it immediately becomes the cheapest and most expedient way to deal with complicated end-of-life situations,” Dr. Kheriaty said. “You’re seeing the push for assisted suicide from generally white, upper-middle-class people, who are least likely to be pressured. You're not seeing support from the underinsured and economically marginalized. Those people want access to better health care.”

Reflections on the Web

Gov. Jerry Brown, once a Jesuit novitiate intent on becoming a priest, is pondering the possibility of vetoing SB 128, “a bill that affords physician aid in dying.” Various members of the SCBCC have joined a robust discussion around this issue.

An oral preparation would be made available to terminally ill at a patient’s request and with a physician’s prescription for the purpose of affording a compassionate dying when other means such as palliative care are not adequate to control pain and preserve dignity.

Issues raised were the potential for slippery slope (“should the proposed legislation have included a consultation about depression?”) and a concern that patients near the end of life are often agreeable to whomever speaks to them last. (CP)

Safeguards include: preventing insurance companies from considering the medication use as suicide. “Suicide of a healthy person is far different, from a person who does not want to die, but does want to shorten the agony of dying by any method...” (RK)

“The law (would) allow people to have access to a form of medical care that is currently restricted. No patient, no family member, no HCO, and no attorney is oblige to participate in the associated options.” (CM)

Ron Koon listed the Oregonian’s reasons for accessing this option including:

1) loss of autonomy,
2) unable to engage in enjoyable life
3) loss of dignity
4) losing bodily function control
5) burden on family friends caregivers
6) inadequate pain control
7) financial (3.2%)

Ed’s note: Might these concerns be addressed more creatively? i.e.:
1) efforts made to facilitate remaining communication skills, perhaps electronically,
   --permitting personal options that do not necessitate participation by a physician that may feel obligated by an interpretation of the Hippocratic Oath that may preclude deliberately hastening death
2) enhancing recreation afforded frail people
3) recognizing/honoring, as a society, the gifts of age
4) assistance in preserving dignity while managing loss of body hygiene controls
5) reducing burden on families by establishing a fund for end of life and respite care for all
6) improving pain control
7) social supports for financial concerns.
Implications of ‘Precision Medicine’
Richard Boudreau, MA, MBA, DDS, MD, JD, PhD
Loyola Marymount Univ. Bioethics Institute

The 2015 State of the Union contained a brief reference to the topic of precision medicine. President Obama was referring to the improving ability of care-givers to individualize the treatment of many diseases. Despite the brevity of the message, the development of precision medicine has monumental implications. An improved understanding of the genetic pathogenesis of disease will:
1. advance our ability to assess and identify risk preventions;
2. provide a means to better classify and diagnosis disease;
3. better target therapy using existing and novel biologically based modalities;
4. reduce treatment side effects and make patient monitoring more precise.

The President’s budget request includes funding to help promote the development of precision medicine, which already has large tailwinds at its back due to the promise of improved disease and deformity treatment and prevention. The concept has arisen out of the science of genomics, proteomics, and bioinformatics which are subjects well familiar to bioethicists.

This new understanding of diseases is revolutionary, permitting investigators to subdivide diseases such as certain malignancies that were previously lumped together based on factors such as patient signs and symptoms or similar histopathologic appearances. Each new division of disease could carry a different pathophysiology, set of biochemical markers, and response to various treatment strategies. Thus, patients might have previously all received the same treatment for their disease or perhaps a variety of different treatments. Some of those treatments seemed to work for some patients, but not for others, without any rhyme or reason.

However, when subdivided by the relevant genetic differences, it will be possible to perform investigations that will reveal why patients previously thought to all have the identical problem differ in their response to various management strategies. The results will open the door to the individualization of medical care.

Just as with many new vistas in our abilities to control human diseases and deformities, ethical issues arise. This is particularly true with genomic research and care, because new boundaries of patient privacy will need to be drawn. In addition, gene manipulation is a cause for concern by many for both moral and ethical reasons.

Precision medicine brings the promise of improving our ability as clinicians to more precisely diagnose, manage, and even prevent human disease. This field also holds limitless opportunities for scientific investigations and benefits to each of us as potential patients. We, as health care providers, should recognize, appreciate, and reflect on the implications precision medicine brings.

Care giving “A moral act with unique power to enrich the lives of both giver and receiver. “The worst thing we can do is try to circumvent the…struggle for real human connection and steer medicine further in the direction …of becoming a massive customer service agency.”
Caleb Gardner, Lancet 9/12/15, Art of Medicine

Student’s Corner
What would you do?
“OUR FAMILY SECRETS”: PHYSICIAN ABUSE & MEDICAL STUDENT ETHICAL DILEMMAS
http://annals.org/article.aspx?articleid=2427613
(Submitted by an anonymous medical student to Annals of Internal Medicine)

Ed’s note: The reader is forewarned: the following is a disturbing account of a medical professional’s impropriety

“While he was cleansing and scrubbing her labia and inner thighs, he looked at me and said, ‘I bet she’s enjoying this!’ My attending winked at me and laughed… Man, I was just standing there trying to learn. The guy was a dirtball. It still pisses me off.’
David glanced at me. I asked, ‘When your attending said that and laughed, did you laugh, too?’ My question touched a nerve; perhaps my tone was accusatory. David snapped back, ‘Yeah, I laughed, but what was I supposed to do? Have you ever been in a situation like that?’ I looked up at David. ‘Yes, I have.’

[The attending physician had just performed a bimanual internal uterine massage and successfully stopped the bleeding in the anesthetized Latina patient with uterine atony.] ‘But then something happened that I’ll never forget.

Dr. Canby raises his right hand into the air. He starts to sing ‘La Cucaracha.’ He sings, ‘La Cucaracha, la cucaracha, dada, dada, dada-daaa.’ It looks like he is dancing with his feet, twists his body, and waves his right arm above his head. All the while, he holds her, his whole hand still inside her vagina. He starts laughing. He keeps dancing. And then he looks at me. I begin to sway to his beat. My feet shuffle. I hum and laugh along with him.

Moments later, the anesthesiologist yells, ‘Knock it off, assholes!’ And we stop.’

“After I finish my story, I glance at the students; some gaze down at the table in front of them, while a few others look at me with blank stares. They are all quiet. I know this is my silence to break.”

It is broken by a 4th year medical student Vamsi Arbindi, apologist responder who explains in an online offering:

“Some of that desensitization is necessary for all medical trainees. Too much, and we become the doctors in this piece. It is easy to condemn other doctors as being terrible deviants and aberrations upon the profession. It is harder to face the truth that we will all move a little closer to being what they are during residency. For the sake of our patients, careers, and souls, we must remember not to go too far in that direction, and remember that our patients are people first, and problems second.

‘Anyone witnessing this type of conduct has an ethical duty to report it...’

Richard Boudreau, MD, JD

Murray’s Musings

Ken Murray is a retired family physician, author of “How Doctor’s Die” and contributor to NEJM and other popular periodicals.

ETHICS OF IDENTITY

I recently read an article in the Washington Post having to do with a poet, Michael, who couldn’t get his poem published until he submitted it to magazines under the name “Yi-Fen Chou.” He believed that he had a far better chance of publication with the pseudonym—-and he was right. Now it is being published in the anthology book Best American Poems. He was open about the pseudonym, and contacted the editor to make sure they knew.

Well, there was an explosion in the poetry community over these actions. My favorite line: “In a matter of about a day, the scandal was all over “Poetry Twitter,” which can be just as rancorous and swift to outrage as regular Twitter, but with a wider vocabulary.”

The issue of honesty in identity is interesting. We have a vast experience of people using pseudonyms because they see a disadvantage to using their own. This is very common for women, a prominent example being Joanne Rowling (J.K. Rowling). Was Charlotte Bronte doing something wrong when she published Jane Eyre as Currer Bell?

We who live here in “Greater Hollywood” should also be sensitive to the issue of the Hollywood Blacklist.....

Of course, in scientific literature, identity is important—-it is part of the ability to identify and replicate—-and reputations matter. We do have one disguise style, though, often referred to as “Gift Authorship.” Example: an author without an MD involving human research, who “needs” a physician on the article to give it authenticity. So one is sought out, asked to do some cursory review, and then added to the authorship. This is common, apparently, and quite controversial in the journalism industry. It’s a big deal!
Medicine has a rich history of pseudonyms in the literature. One famous example that produced enduring citation in medical textbooks for decades was written by Edgerton Yorrick Davis --- William Osler. Perhaps the concept that “fake” researchers might be getting published under someone else’s name might not be so far-fetched.

It is good to be skeptical.

**Summary Meeting of SCBCC 5-20-15**
Compiled by Neale Sheade (abbreviated by Ed.)

*Ron Miller, MD spoke in opposition to AB 637 which would allow NPs and PAs as independent practitioners to sign POLST forms.* He felt that many physicians have abandoned their responsibility in this matter. In subsequent discussion there was agreement that many non-physician health professionals do a good job of POLST discussions with their patients, and that it is unfortunate that so many physicians (for different reasons) do not engage with their patients in this process.

The relative merits of restricting POLST form signature authority to physicians as a means of ensuring that physicians do not abandon this responsibility as opposed to broadening access by allowing other providers to sign was discussed.

*Miriam Cotler, PhD made a very thoughtful presentation about the problems with SB 128: Physician Aid in Dying/Physician Assisted Suicide including the following points:
1) Potential for abuse of the most vulnerable;
2) Not enough is done to improve the care of the dying and clearly explaining all available options to patients in terminal stages;
3) Autonomy is not understood by the public or even many MDs and other health care providers – autonomy is a “negative right” to refuse treatments/procedures, not a “positive right” to have specific treatment/procedure administered by a physician who believes it is inappropriate, contraindicated, futile, etc.

Comments after her presentation included:

--“The definition/understanding of autonomy has gone unchained;”
--CMA changed its position, from “oppose” SB 128 to “neutral,” reportedly in response to pressure from medical student and resident physician members of CMA

*Elizabeth Bromley, MD spoke about the increased risk of suicide among physicians compared to general population, and greater risk among female than male physicians. Pre-disposing factors were discussed.

Q&A included Aaron Kheriaty, MD, psychiatrist and ethicist from UCI adding his perspective from working with physicians.

Factors considered were predisposing personality traits fostered by the medical training process, moral stress, burn-out, unrealistic expectations by the public and promised by health care organization marketing.

* The Balint Group Process, focused on giving the practitioner insight into problematic interaction he/she is experiencing with his/her patient was demonstrated. In a “closed group” one member presents a troubling case, then observes the discussion of the case by other group members, who try to put themselves in the positions of the various people involved and imagine what they might be experiencing.

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