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Do shrinking resources at hospitals mean less patient safety?

Will the decade-long emphasis on quality help now?

For the past decade, patient safety and quality care — and all the assistant care policies and standards associated with quality initiatives — have been directed at improving efficiencies of both cost and process within health care institutions.

But how will these efforts to avoid preventable errors and improve health care quality fare during a historic downturn in the economy? According to **Peter Angood**, MD, senior advisor on patient safety at the National Quality Forum in Washington, DC, we don't yet know, because there is no data to tell providers yet. However, he also says there's “no doubt that many facilities are feeling the economic downturn.”

“This patient safety movement is a little over a decade old — it's been this high focus — and in this past decade, we really haven't had an economic downturn to the level we're currently going through. So, in many ways, this is uncharted territory,” he says.

But already there are reports that emergency department visits have increased, Angood says, although it is not known if that is due to seasonal fluctuation.

The NQF in early March released its “Safe Practices for Better Healthcare — 2009 Update.”

“Those practices are tangible methods that organizations can utilize both for their systems and processes of care, as well as at the individual provider level to improve the safety and quality within their organizations,” Angood says.

Angood suggests that “it is important for organizations to focus in on efficiencies of care, because we all recognize that there's a certain degree of inefficiency and waste in health care systems.”

The NQF has another initiative, the National Priorities Partnership, that has “a specific focus area on the efficiencies of care,” he adds.

“So, if you couple efficiencies with a focus on safety and a continued focus on quality, then organizations are going to have an improvement in their resource consumption, and they won't be

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getting into the difficulties of poor quality and poor safety, because they're cutting corners and cutting costs where they shouldn't be," Angood says.

Guarding against a decrease in safety

Angood says there may be staff layoffs, and — yes — hospitals and other providers are employing “all sorts of financial strategies” to help their organizations “save their money and increase their revenues.”

However, he says, “Organizations, if they are smart, continue to emphasize the safety and quality processes in their facilities, because it's well

recognized if you have complications or increased complications, then your resource consumption goes way up.”

Treating complications of care provided in an institution often brings with it such circumstances as increased length of stay and decreased availability for other patients in that institution, he says.

“A lot of smart hospital leadership will be focused more on patient safety and quality to help with their resource management,” Angood says.

Balancing needs and wants

Indeed, **Doug Bonacum**, patient safety officer at Kaiser Permanente in Oakland, CA, says that individuals in positions like his “may not spend enough time thinking about how they prioritize opportunities that they're going to go after.”

Bonacum says that by that he means, “at the extreme,” the patient safety officer could say every preventable event — regardless of how often it occurs or the harm it creates — ought to be “eradicated, because it's preventable. So that's what our patients would expect, that's what the public should expect, and that's what we should expect of ourselves.”

“Ultimately, I think, to have that vision — it's a beautiful vision and an important one — clearly at Kaiser Permanente, we have statements like that about eliminating bloodstream infections, for example, eliminating pressure ulcers, for example, but I think what patient safety officers sort of fall short on is helping the organization, which has [patient safety] as the opportunity, but also [has] other demands and opportunities . . . and how to rationalize all that,” Bonacum says.

In periods of shrinking resources, Bonacum says, it's people in positions like his where “the burden of proof” exists to “present that information in a way that their leadership can understand and act on, and in a way that also understands that there are resource constraints and other priorities that the organization is trying to go after.”

But it is true, he said, that during periods over economic downturn, “the burden goes up.”

Angood suggests that “one of the simplest, low-cost approaches” for an organization to rely on to achieve patient safety and quality care is “to have the leadership understand the importance of safety and quality in the processes of care.” ■

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Managing Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com).

Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

Production Editor: **Ami Sutaria**.

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Editorial Questions

Questions or comments?
Call **Karen Young**
at (404) 262-5423.

SOURCES

- **Peter Angood**, MD, Senior Advisor on Patient Safety, National Quality Forum, Washington, DC. Phone: (202) 783-1300.
- **Doug Bonacum**, Patient Safety Officer, Kaiser Permanente, Oakland, CA.

Zoloth: Shrinking resources require redefinition

Healthy populations need “healthy health care systems”

While some focus on the specific policies and standards of achieving a safe, quality health care system in the United States within the existing system, **Laurie Zoloth**, PhD, professor of bioethics at Northwestern University in Chicago, suggests a broader approach is necessary to achieve “healthy health care systems.”

To accomplish that end, Zoloth says, “Obviously, there are two things that I think are equally important, and they come from utterly different directions.

“The first direction is a powerful reconsideration of what health care means, [that is,] to have health care, and the commitment from the Obama administration to have a robust and inclusive system of health care, as opposed to just a market-based, catch-as-catch-can series of collaborations and alliances.”

Zoloth suggests that such efforts, beginning with the health care summit orchestrated by the present administration in early March, “will draw a far wider coalition to solve a problem . . . obviously we can’t continue to have a healthy economy without healthy health care systems.”

She illustrates this with the specter of individuals falling into bankruptcy due to, in many cases, the cost of their health care. “Really, no insurance,” covers the cost of care adequately, she says.

“Saying ‘yes’ means saying ‘no’”

In an economy that makes it “difficult to retain one’s equanimity of spirit,” Zoloth suggests that “health care is a fixed given.”

“We have to care for people. To care for people,

we have to run hospitals. They’re the least able to take any cuts,” she says. “But I do believe that saying yes to universal health care means saying no to something. Saying yes means saying no in health care reform.”

By that, she says she means that some health care practices that are now considered acceptable will need to be renegotiated.

“Let me be blunt: One of those practices is how much money doctors make in America, vs. any other place in the world,” Zoloth says. “There’s a direct line between the fact that there’s not a universal health care access system in the United States and the fact that doctors, by and large, especially specialists in the United States, make far more money relative to other professions . . . That’s just a fact.”

Regardless of whether it’s the cost of health care insurance or the cost of medical training and medical education — all of which are cited as factors in the cost of care — something additional must be considered.

“There’s a sense of right to livelihood that has to be part of the discussion,” she says. “It can’t just be that patients get less care, or that patients have to pay more, or that certain procedures are considered too expensive.”

Everyone in the health care professions and associated businesses, including drug company executives “all have to put remuneration on the table,” she says.

The politics of choice

While hospitals across the country address factors such as the increase in uninsured patients due to job losses associated with the economic downturn, Zoloth points out that the public health care system in Cook County in Chicago “shut down critical aspects of the health care system” beginning in 2008 due to budget constraints.

Zoloth maintains that such decisions are not inevitable.

“It’s completely a political decision,” Zoloth suggests. “If there’s a political will to maintain excellent health care, and to say there should be a preferential option for the poor, then there will be a way to do it.”

“When we talk about the big salaries and the bloated bonuses for CEOs” such as occurs in public and Congressional discussions of the banking industry today, she says, “that means health care CEOs, too. The market model that failed in the banks also needs to be carefully examined in the

SOURCE

• **Laurie Zoloth**, PhD, Director of the Center for Bioethics, Science and Society, Feinberg School of Medicine, Northwestern University, Chicago. E-mail: lzoloth@northwestern.edu.

health care professions,” Zoloth explains. ■

Obama moves to allow federal funding for ESCR

“Potential to better understanding and treatment”

By executive order, President Obama on March 9 raised the spirits of many research scientists — and those who hope for potential cures to disease — by announcing his decision in favor of “removing barriers” to “responsible scientific research involving human stem cells.”

While some hailed the decision as a move in the right direction, others oppose it from a moral perspective, while others said embryonic stem cell research is no longer necessary given the availability of other sources of stem cells.

The president’s executive order states: “Research involving human embryonic stem cells and human non-embryonic stem cells has the potential to better understanding and treatment of many disabling diseases and conditions.

“Advances over the past decade in this promising scientific field have been encouraging, leading to broad agreement in the scientific community that the research should be supported by Federal funds,” according to the order.

Obama also stated that for the past eight years, presidential actions by the Bush administration have limited the authority of the Department of Health and Human Services, including the National Institutes of Health, to conduct such research.

“The purpose of this order is to remove these limitations on scientific inquiry, to expand NIH support for the exploration of human stem cell research, and in so doing to enhance the contribution of America’s scientists to important new discoveries and new therapies for the benefit of

humankind,” he said.

What did previous “barriers” limit?

President Bush made the decision in 2001 to allow federal funding for embryonic stem cell research under more limited circumstances than had the Clinton administration. At that time, **Gregory Pence**, PhD, a bioethicist who teaches that discipline to medical students at the University of Alabama at Birmingham (UAB), suggested that President Bush’s decision would basically mean “shutting it down” — at least in the United States.

Research on embryonic stem cells was allowed to continue using private funds, and it also continued — often with public funding — in other countries.

Contrary to what some might have expected as a result of Bush’s actions, Pence tells *Medical Ethics Advisor* after Obama’s decision, “During the last decade, people were highly stimulated and motivated to try to find another way to produce the same results — in other words, pluripotent stem cells, without using human embryos.”

In fact, a Japanese researcher — in what Pence described as “one of the more sensational experiments, maybe of this century,” discovered how to create what Pence calls “an induced pluripotent stem cell, that’s basically identical to the human stem cell.”

“Even with all the culture wars . . . we still somehow got to the same point,” Pence points out. “Now, we have an extremely valuable other means of doing the same [type of research]. Now, which is the best? Who knows?”

“It’s really great that now we have human embryonic stem cells to try again, because maybe nature made them best. But now we actually have two or three different tools to use, [but] it’s all very complicated by lots of different things, including technique, politics, and fraud.”

ESCR brings polarization

“What isn’t going to go away is the culture wars, and the politicization about this,” Pence declares. “As long as people think of embryos as . . . a tiny little baby, then people get very upset when they hear about embryonic research.”

Indeed, **Charles C. Camosy**, PhD, an assistant professor of Christian ethics, who teaches Roman Catholic bioethics, at Fordham University in Bronx, New York, thinks President Obama’s deci-

sion was “a mistake.”

“There are two reasons why I think it was a mistake. One . . . I’m just not a fan of research that is without [an individual’s] consent and kills members of the species homo sapiens in order to medically benefit other members of the species homo sapiens.”

Camosy believes that “from a biological point of view, the embryo is just a member of the species homo sapiens, at a different level of development. And Christians in particular, but, I think most people would say, particularly vulnerable members of our species deserve a special level of protection, because we have a history, especially in this country, of dominating the weak members of our species for the benefit of the others.”

Deciding upon allowing embryonic stem cell research is not “doing a very good job of avoiding it,” he says.

One argument in favor of ESCR is that the frozen embryos left over from fertility treatments and often used in ESCR would otherwise simply be discarded, Camosy says. He is not in favor of “fertility treatments, which he says allow for all of these “extra” embryos to be just shoved into cryogenic frozen storage.”

“The reason we have all of these thousands of embryos in frozen storage is that when we do in vitro fertilization, we create too many, and we don’t know what to do with the extras,” he says.

Even if cloning of embryos is not allowed and researchers use only embryos that are already in existence, there is still a problem. The problem, as he sees it, is that you are destroying an embryo as a means to the end of other individuals.

“If that’s the argument, then that applies to a lot of other human organisms, too,” he says. “Death row inmates are going to die anyway; terminally ill patients are going to die, anyway. Would it follow that any member of the species homo sapiens can be killed if we can find some medical benefit? That doesn’t seem like we want to go down that road.”

Camosy suggests, additionally, that science, and therefore business interests that follow advances in science, thus far have not justified ESCR. Camosy says that ESCR is “just one of many, many, many kinds of stem cells research, and the only proven therapies that are out there from stem cell research are not from embryonic sources.”

Even with such research continuing in other countries and privately in the United States, Camosy says, “We’ve had exactly zero therapies from embryonic stem cell research, and we’re not even close. Even the most optimistic pro-embry-

onic stem cell research people say we’re years, if not decades, away from having even one viable therapy for human beings from embryonic stem cell research.”

Equalizing the playing field

Patricia Backlar, an adjunct professor at Oregon Health and Science University in Portland, says she believes that “with federal funding going forward, it would equalize the playing ground. Let me put it this way . . . there’s a big organization in this country for doing scientific research. So, I see [ESCR] as a great advantage that now we will get federal funding.”

Backlar, a bioethicist, had what she refers to as a “front-row seat” to the ethical debates over ESCR in the ‘90s, when she served on President Clinton’s National Bioethics Advisory Commission.

Even with the additional funding, there is no way, Backlar says, to place a time-frame on the potential scientific achievements and potential therapies resulting from ESCR.

Pence says some of the “greatest medical advances in the last century” have occurred with stem cell research. He also says the American budget for medical research, including the NIH and other agencies, is like the great treasure chest of the world for science.

“Previously, under George W. Bush, things couldn’t be linked. You couldn’t use the treasure chest for one of the greatest advances in medicine. It’s absurd,” Pence says.

Still, he suggests that there have been “many grandiose and alarmist claims made about human embryos and what will happen if we use them. Grandiose in terms of the medical benefits — alarmist in terms of damage to little babies or

SOURCES

- **Patricia Backlar**, Adjunct Associate Professor, Department of Psychiatry, and Senior Scholar, Center for Ethics in Health Care, Oregon Health Sciences University, Portland. Backlar is also Research Associate Professor of Bioethics, Portland State University.
- **Charles C. Camosy**, PhD, Assistant Professor of Christian ethics, Fordham University, Bronx, New York. Phone: (718) 817-3207. E-mail: camosy@fordham.edu.
- **Gregory Pence**, PhD, bioethicist and professor of arts and humanities, University of Alabama at Birmingham.

to society.”

Likening the amount of U.S. funds available for research to a treasure chest, he says that’s why you could see “all those scientists very happy” on the day that Obama announced his decision in The White House, “because now there’s a chance that things can really move forward,” Pence says.

‘I don’t think [the advances are] going to be as rapid as, say, Michael J. Fox hopes and needs, and that’s unfortunate,” Pence says. “But Mother Nature just doesn’t give up her secrets so fast. We’re on the right track now.” ■

“Why I Chose Bioethics as a Profession”

[Editor’s note: This month’s interview is with Laurie Zoloth, PhD, professor of bioethics at Northwestern University in Chicago.]

Q: Why did you choose bioethics as a profession?

A: The question of why I became a bioethicist is really a fascinating one to think about, because I was working as a nurse in infant intensive care. And I was in Jewish studies in philosophy graduate school, and I thought of the nursing part as the thing that enabled me to do something as esoteric as study ethics and philosophy and Jewish studies and literature and religion. I was really thrilled to be in graduate school and studying exactly what I wanted to study. And meanwhile, I had to work night shift to pay for it all.

But what happened was the dramas at the bedside became completely compelling, and it was just at the time that the field of clinical ethics was beginning to emerge and be written about. There have been some precedents, OK, so there had been scholarship, actually, but it hadn’t been as prominent of an idea.

Clinical ethics consultation was still in its infancy

Q: About what time was this?

A: Mid-80s. And the Kaiser Permanente system had just hired its first bioethicist, John Golenski. It was just after a major case, and there had been some issues about bioethics. And so I went to him ... at the time, and I introduced myself to him. And I said I’m really interested in

learning and studying about it, and he was a Jesuit priest wearing clerics — this was early on, before he got into the order. And I said, ‘I think the work you’re doing is terrific, and I’m interested in bioethics committees.’”

And I think you need some help. You need a feminist. You need a woman to work with you, you need a Jew, not just a Jesuit, and you need a nurse. Hire me; I’ll do all three things for you. So ... he let me intern for a year.

At the time, I was studying with David Hartman, who is a philosopher who is a Canadian and Israeli philosopher, and he said to me, he was my professor, and he said, ... You’re right in the middle of an extraordinary set of dilemmas and concerns, which is — how does modern medicine, now that we can do everything — should we do everything? And you’re right in the middle of an intensive care unit.

And since John Golenski was teaching at the Graduate Theological Union, too, it presented a really unique opportunity for me to do both the theory and the practice at the same time. And I followed Golenski around to learn how he did case consultation. That, for me, was interesting. At that point, that was the most interesting thing, that is, how did you work your way out of a dilemma when you were actually at the bedside?

It was a long time ago, and people didn’t know the word bioethicist ...

So, I became a bioethicist largely because there was an extraordinary set of dilemmas that were taking place, in the field of medicine as our capacities grew. And I was part of the people — in essence, I was concerned with the same issues.

The babies we were saving, which were able to save, were, you know, had terrible complications that left them so disabled and their families so devastated — of course, we had to raise the question of — what are the moral implications of this sort of technology on the actual lives of actual parents and families?

For me, those are critical issues, and I was able to turn to philosophy to take a look at them, and that was one part.

The second part was, there wasn’t the health care system — and there still is the drama of justice, so for me, the issue of social justice was so acute working at an impoverished community where the infant mortality rate was so very high.

Even with Kaiser, where I guess people all had ... health care coverage, the social milieu that the units were in was so catastrophic that we were constantly confronted with the question of justice.

So, it was impossible to really do medicine without thinking of justice. And it was at that time that Oregon was having its discussions about how it would reform its health care system. So, this was later. I had been looking around for a topic on which to do my dissertation work. And then, too, the fact that John Golenski was a consultant on the Oregon Health Care Decision Project, and he would come back from those meetings discussing that . . . whereby I was able to have a first-row seat in the health care decision-making process.

And at that point, I began [studying] with Karen LeBacqz. And she and Carol Robb — people at the Graduate Theological Union at Berkeley in my program — were primarily justice theorists.

So, we immediately turned our attention from clinical ethics to justice issues within health care. It was a time in which — for the first time we had a field emerging around a set of important moral questions. One was about the use of technology and the extent of technology — and two, it was about the catastrophe of the health care system that for the first time had lost its central safety net when unions lost power, and when jobs no longer entitled you to health care benefits. And, in fact, there was a growing number of people who were completely uninsured. That was a phenomenon of the late 80s and 90s, when there was a disconnect between employment and health care benefits, and so that led to a lot of interesting questions about justice.

The other part is having early and great teachers . . . people who said to me, early on, this is a field in which it's important to maintain your disciplinary particularity, and bring that particularity to a larger discussion.

Q: Do you mean what you uniquely brought to the discussion?

A: What I uniquely bring to it, which is justice theory, which is social ethics, they call it social ethics in religious studies, which is justice theory, a long tradition of moral philosophy, and

also a separate and long tradition of Jewish philosophy — all of which is focused on these issues from a particular venue. ■

HHS publishes proposal to rescind 'rule of conscience'

New rule would reverse policy supported by Bush

At the urging of the Obama administration, a policy to rescind the so-called "rules of conscience" for health care providers means that battle lines have been drawn once again over the question of when life begins — among other moral and scientific questions in reproductive health.

The proposed rule would reverse a policy that took effect Dec. 18, 2008, as pushed forward by the Bush administration after a three-month review period that began in August.

The rule was published Tuesday, March 10, in the *Federal Register*. And as noted in the statutory background of the proposed rescission rule, "Several provisions of federal law prohibit recipients of federal funds from coercing individuals in the health care field into participating in actions they find religiously or morally objectionable."

Several organizations, including Planned Parenthood Federation of America (PPFA) in New York, had filed suit against the Bush policy (See **story in the March issue of *Medical Ethics Advisor*, page 28.**) PPFA was among the organizations recently that applauded the Obama administration's initiative to rescind the rules of conscience.

"This proposed rule clearly states that the Obama administration is committed to putting patients' care first," said **Cecile Richards**, president of PPFA, in a news release. "As was made clear at the White House Summit on Health Care . . . we should be working together to increase, not hinder, access to care.

"Patients, especially low-income women, deserve access to complete and accurate health care information and services, and [this] action shows that this administration understands and will meet this need. This is a commonsense fix."

Calling the Bush administration's policy "a dangerous rule" on its web site, the American Civil Liberties Union (ACLU) in Washington, DC, noted that the Bush rule "must be rescinded."

"We are pleased that the Obama administration

SOURCE

• **Laurie Zoloth**, PhD, Director of the Center for Bioethics, Science and Society, Feinberg School of Medicine, Northwestern University, Chicago. E-mail: lzoloth@northwestern.edu.

recognizes that this rule was essentially the Bush administration's parting shot against women's health and warrants careful review," said **Caroline Frederickson**, director of the ACLU Washington Legislative Office, in a news release. "The rule jeopardizes patients' access to important reproductive health services, especially for low-income and uninsured women who rely on federally funded health centers for care."

Jennifer Dalven, deputy director of the ACLU Reproductive Freedom Project, said in the release that "The Obama administration has taken the first step toward rescinding this rule that fails to properly balance protections for individual religious liberty and patients' access to health care."

For some, moral questions continue

David Stevens, MD, MA (ethics), CEO of the Christian Medical and Dental Associations (CMDA) in Bristol, TN, which has 16,000 members, disputes the notion that the rules of conscience were something "cooked up by the Bush administration."

He says that the Obama proposed rescission rule "actually rescinds all regulations" that would protect physicians from discrimination by institutions or other physicians if they exercise actions based on moral beliefs, such as refusing to perform abortions or sterilizations.

Instead of being a Bush-driven policy, Stevens notes, "There are laws that have been on the books protecting right of conscience going clear back to the Church Amendments, which actually happened in the '70s."

The Church Amendments followed the decision of *Roe vs. Wade* in 1973.

"[The amendments] said very clearly that you can't force people to participate in abortions and other things . . . that they have opposition to," Stevens says.

He also points to an AMA statement that says, "We affirm that neither physicians, hospitals, nor hospital personnel can be held to perform any act violating personally held moral principles."

That statement, according to Stevens, was last affirmed in 1997 by the AMA.

"The problem is, and what brought this to the forefront, is a number of abortion groups — Planned Parenthood and the ACLU — have had very well funded abortion access projects, whose goal is to get health care providers to participate in abortions," Stevens says. "And they've been fairly successful."

Comment period

There is a 30-day public comment period for the rule of conscience rescission proposal. That comment period ends April 9, 2009.

Planned Parenthood, in a news release on the Obama administration's decision, urged supporters to comment on the rule and show their support for the proposed rule.

"Planned Parenthood is using the latest technology to get the word out and encourage supporters to comment on the rule, including text messaging, social networking, and Twitter," according to the release. ■

Ethics consults: Procedures at OHSU and Mass Gen

Policies illustrate complexities

Susan Tolle, MD, director of the Center for Ethics at the Oregon Health & Sciences University in Portland, takes very seriously the center's role in providing consultative services to smaller, critical access hospitals in that state.

Perhaps not surprisingly, she says, "The most frequent issue by far, and that benefits from our policy, is withholding and withdrawing life-sustaining treatment. It's ever so much more common, by more than a hundred-fold."

Critical access hospitals are defined by the number of beds they have - in this case, 25.

"It's a trauma definition, but what it tells you is they're not very big," Tolle explains. "And so what is needed by our large hospitals, of which there are only a few large [ones], with interlocking health systems, and then by our critical access hospitals, is different, depending on the resources they have and their need for support.

Typically, the role of the OHSU ethics center is consultative, she says, although sometimes the center helps smaller hospitals in the state by providing a specific policy to a specific situation.

"Probably our most popular policy — [judged] by these hospitals calling — is our policy on conscientious objection," she says.

The state of Oregon has special needs for specific policies, as it is one of two states in the United States, including the recently passed measure in Washington state, to allow physician-assisted suicide (**See the cover story of the**

SOURCE

• **David Stevens**, MD, CEO of the Christian Medical and Dental Associations, Bristol, TN. E-mail: main@cnda.org.

January 2009 issue of *Medical Ethics Advisor*.)

"It has helped us think through much more exactly where boundaries are regarding moral conscience and involvement, and I would guess that our policy is much more sophisticated than most, because we have been put in so much of a spotlight about what is highly contested even in the state where it's been legal for 11 years," Tolle explains.

Tolle says that even though physician-assisted suicide is legal in Oregon, there are still a "substantial number — but not quite a majority" of health care providers who continue to oppose the practice and think it's morally wrong "and don't wish to be a party to it," she says.

"You're beginning to see why a very sophisticated policy might be useful," she says.

Developing policy

Developing policy is key to having good ethics consults, it would seem, giving providers, patients, and family a reference point for decision-making.

At Massachusetts General, clinical nurse specialist in ethics, **Ellen Robinson**, RN, PhD, is a member of that institution's Optimum Care Committee, which out of several ethics committees at the institution, focuses exclusively on end-of-life issues.

"We do some work with education and work with policy," says Robinson. "We actually have a set of policies that sort of guide us in our work, and we take responsibility for keeping those on what we feel are the cutting edges in ethics — end-of-life ethics."

The Mass General model for ethics consultations are utilized when there's "conflict or uncertainty regarding value-laden issues that come up in end-of-life care."

"For example, there . . . are certain tenets that have emerged ethically and legally pretty much through case law about the right to refuse life-sustaining treatment, in that withholding and withdrawing life-sustaining treatment are ethically and

legally equivalent concepts."

At times, the medical staff or nursing staff may have questions about whether certain actions are appropriate.

"They'll place a consult for clarification, if you will, around end-of-life practices, and so then, in addition, if there is conflict between the health care team and the family, or conflict within the health care team, or conflict within the family, or sometimes both, our committee would be pretty much immediately thought of as being called in in a consultative mode," Robinson explains.

The overriding goal of any end-of-life ethics consultation at Massachusetts General is to achieve consensus, i.e., consensus "with in the ethical and legal end-of-life standards."

Robinson points out that it is not within various professions' codes of ethics "to intentionally kill with an injection of medication.

While the primarily goal of a consult is consensus, Massachusetts General Optimum Care Committee also bases its decision on this "overriding idea: what would best promote a patient's dignity, and working toward a goal of creating consensus."

At Mass General, any member of the health care team, from the physician to a therapist, can call for a consult, Robinson says. Even the patient or the patient's family can request an ethics consult.

"It's not typical, but it's increasing," she says.

[Editor's note: Look for more examples of procedures and processes from OHSU and Massachusetts General in the May issue of *Medical Ethics Advisor*.] ■

NEWS BRIEFS

NHPCO reports one-year stay secured on benefits cut

The National Hospice and Palliative Care Organization (NHPCO) reported that the nation's hospice community "claimed a signifi-

SOURCES

- **Ellen Robinson**, RN, PhD, Clinical Nurse Specialist in Ethics, Massachusetts General Hospital, Boston.
- **Susan Tolle**, MD, Director of the Center for Ethics in Healthcare, Oregon Health & Sciences University, Portland.

cant victory” when President Obama signed The American Recovery and Reinvestment Act of 2009.

The law, according to NHPCO, includes a one-year moratorium on cuts in Medicare funding for the more than 4,700 hospice programs in the United States, a move that had been made by the Bush administration last year (See *Medical Ethics Advisor’s* March 2009 issue for full story on pg. 31.)

NHPCO said the phased funding cut would have taken \$135 million away from hospices in FY2009, threatening quality end-of-life care for patients and eliminating about 3,000 jobs. ■

NCSL to conduct Health Disparities Project in U.S.

The National Conference of State Legislatures (NCSL) in Denver announced in early March that it has launched the Health Disparities Project in an effort to not only identify possible disparities in health care for minorities in the United States, but also to inform policy makers to reduce any disparities.

“The short-term goal of the project is to provide resources and databases for state legislators to assess how state policy — either in place or under consideration — will impact health care quality and access for racial and ethnic minorities,” said Melissa Hansen, a health policy associate at NCSL.

The NCSL said in a news release that, for example, American Indian women are almost two times as likely to die from cervical cancer than white women. African-American men, it said, are diagnosed with heart disease less

often, but are 30% more likely to die from it than white men.

“This does not take into account those who remain undiagnosed, due to disparities in access to preventive care,” the NCSL said.

The best practices and policy options discovered through the Health Disparities Project are expected to provide state legislators with access to various state models that work to reduce health disparities.

NCSL said it will work with lawmakers to help them understand how specific policies either narrow or widen disparities in health care for racial and ethnic minorities.

The project is being conducted with support from the U.S. Department of Health and Human Services Office of Minority Health. ■

Hastings Center, Yale establish program in ethics

The Hastings Center, an independent bioethics research institution, and Yale University have announced the establishment of the Yale-Hastings Program in Ethics and Health Policy.

Hastings Center cofounder, **Daniel Callahan**, and **David H. Smith**, director of Yale’s Interdisciplinary Center for Bioethics, formalized what the two entities called long-standing ties between the two institutions at a signing ceremony at Yale in January.

“At a time when bioethics has more relevance than ever, The Hastings Center welcomes the opportunity to work closely with our colleagues at Yale to develop new knowledge and new insights,” said **Thomas H. Murray**, president of the Center in a statement.

One aspect of the new collaboration is the inclusion of Yale faculty on Hastings Center projects, and Hastings scholars on Yale projects, as well as the development of new joint projects.

At the center, current projects include research into the role of medical technology in rising health care costs, values in health care reform, ethical guidelines for end-of-life care, the use of psychiatric medication in children, sports enhancement, and synthetic biology. ■

CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

CME objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- **discuss** new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
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- **learn** how bioethical issues specifically affect physicians, patients, and patients' families. ■

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CME Questions

12. What does Peter Angood, MD, senior advisor on patient safety at the National Quality Forum in Washington, DC, say is the "one of the simplest low-cost approaches" for an institution to achieve quality patient care and patient safety?
 - A. Have leadership understand the importance of safety and quality in the processes of care
 - B. Have in place a punitive system for health care providers in the event of an adverse event
 - C. Create a system of competition among health care providers to provide quality care
13. President Obama made a decision to reverse the Bush administration's policy on federal funding of embryonic stem cell research to permit federal funding for ESCR.
 - A. True
 - B. False
14. Laurie Zoloth, PhD, Director of the Center for Bioethics, Science and Society at Northwestern University in Chicago, suggests that creating healthy health care systems through health care reform, may require rethinking standards of care.
 - A. True
 - B. False
15. The conscience rules in health care:
 - A. allow physicians to discriminate against other physicians
 - B. protect physicians who choose not to perform certain treatments or procedures based on moral beliefs from discrimination
 - C. apply only to physicians
 - D. both B and C.

Answers: 12. A; 13. A; 14. A; 15. D.