

BENO



● **From the President and Editor**

Robert M. Taylor, MD, FAAN, FAAHPM

Greetings from Boston, Massachusetts. I am writing this farewell to the members of BENO and the readers of *BIO Quarterly*, as I begin my new job as Associate Medical Director of Care Dimensions Hospice and Palliative Care. I have spent the last two to three months completing all the complex and mundane tasks required by such a move, including finding a place to live, moving my belongings, applying for a medical license in Massachusetts, and, finally, beginning a new job. Those activities have interfered with my efforts – and good intentions – to pull together the June issue of *BIO Quarterly*. However, thanks to the combined efforts of many, we seem to have succeeded in doing so, although somewhat belatedly.



Alan Murphy



Stephanie Fabbro

As I am resigning as president of BENO, you will be electing my replacement shortly. However, I am pleased to be able to report that we have two volunteers to take over as co-editors of *BIO Quarterly*: Alan Murphy and Stephanie Fabbro. Alan was introduced to the readers of *BIO Quarterly* last issue. Stephanie is new to our organization, having recently completed training in bioethics at OSU and then joining the university as a new ethics faculty and clinical consultant. She is a dermatologist with a long-standing interest in bioethics and education and has contributed a piece to this issue. She has also been nominated to join the board of BENO.

In the interest of recalling the history of BENO, one our founding members, Marty Smith, STD, informed me that the organization's

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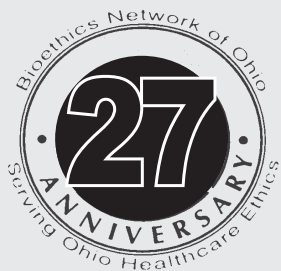
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From the President *continued from page 1...*

original president, Brendan Minogue, in 1993, had written a brief description of BENO’s early history which was published in the *Cambridge Quarterly of Healthcare Ethics*. I was able to obtain permission from *CQHE* to republish the article in this *BIO Quarterly*. I hope that recalling our history will help us appreciate and value BENO and the efforts of our founders whom we have begun to honor at our annual meetings.

Although I won’t be living and working in Ohio for the next several years, Ohio will always be my home and I expect to return someday after I retire from full-time clinical practice. I will maintain an interest in the future of BENO and am glad to report that it remains in good hands. The Board and officers share a strong commitment to the organization and to supporting bioethics in Ohio.



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● Looking Back at the Early Days of The Bioethics Network of Ohio (BENO)



Brendan Minogue, Ph.D. is professor emeritus of Philosophy and Religious Studies at Youngstown State University. He is the author of *Bioethics: A Committee Approach* (1996) and of numerous articles in the field of bioethics. Prof. Minogue is a founder and past president of BENO and was honored for this service at BENO's annual conference in April 2016.

The Bioethics Network of Ohio (BENO) has existed for about 2 years. Our first steering committee meeting took place at Case Western Reserve University in June 1990. About 15 people came to this first meeting, and since then BENO has grown to over 300 members. We have two kinds of members. Individuals, such as doctors, nurses, healthcare administrators, educators, and members of ethics committees, compose the bulk of our members. However, hospitals, nursing homes, and other healthcare institutions have joined as institutional members.

One of our main goals is to increase communication among those professionals in the state who have a genuine interest in the problems of bioethics. Most of our members have had valuable practical experience in the area of bioethics. They serve on ethics committees, or teach bioethics in universities or hospitals, or have administrative responsibility in the management of bioethical dilemmas that emerge within a given healthcare setting.

One of our main goals is to increase communication among those professionals in the state who have a genuine interest in the problems of bioethics.

To achieve our goal of enhancing communication, the network has taken on four responsibilities. First, we have set up an electronics network that allows the membership to communicate with one another instantaneously. We are “on line” through the Cleveland Freenet and Case Western Reserve University’s Telecomputing Laboratory. Cleveland

State University’s Bioethics Certificate Program, not only has given us a vast amount of assistance in providing and maintaining our network hardware but also has given us a solid system operator, Jenny Gabriel, who manages the flow of information into the network. We have introduced a lot of people to the joys of electronic communication, but we have much more work to do before we can realize the unbelievable potential of electronic networking.

Second, we have started a hard copy newsletter appropriately entitled The BENO Newsletter. The Newsletter keeps our membership up to date on topics such as the Patient Self-Determination Act and the state’s new advance directive law. The Newsletter also assists our membership to adapt to our “on line” facilities. Finally, every issue ends with a bioethics case study, along with commentary from two opposing perspectives. The Newsletter is a genuine asset to the Network.

Third, we have organized two statewide conferences at which the membership convenes. Our first conference was held in the northeast part of the state at Case Western Reserve University’s School of Law in June 1991. We held our second meeting (June 1992) at Ohio Dominican College in the central part of the state in Columbus. We were more than pleased with our enrollments at both conferences; over 125 people attended each of these meetings. One of the highlights of our last meeting was a Policy Table to which our members brought their institutional ethics policies and discussed some of the virtues and vices of these policies.

continued on page 11...



● Removing Implantable Defibrillators at the End of Life: An Ethical Analysis



Austin Lail is a pharmacy student at Cedarville University. He will receive his B.S.P.S. in December 2017 and his Pharm D. degree in May 2020. He works as Research Assistant for the Center for Bioethics at Cedarville, directed by Dr. Dennis Sullivan.

Dennis M. Sullivan, MD, MA (Ethics) is Professor of Pharmacy Practice at Cedarville University. He received his MD from Case Western Reserve School of Medicine and an MA in bioethics from Trinity University in Chicago. As a member of the faculty at Cedarville University, he primarily teaches medical ethics and law. He directs the university's Center for Bioethics.



An implantable cardioverter defibrillator (ICD) is a potentially life-saving device that can help reverse an abnormal cardiac rhythm, such as ventricular tachycardia (VT) or ventricular fibrillation (VF). Operated by batteries, ICDs are typically implanted posterior to the clavicle. They are designed to detect and cardiovert abnormal heart rhythms when they occur.

ICDs are frequently implanted into late-stage heart failure patients to rectify sudden arrhythmias, which are potentially life-threatening. However, the goals of therapy may need modification as the patient approaches the end of life; patients who once found that the benefits of an ICD outweighed its burdens may reverse that assessment. In particular, ICD shocks can be painful for patients and distressing to patients' families. [1] So the question becomes: is it ethical to turn these devices off in a hospice or palliative care setting? This article will examine the moral and ethical principles that govern such treatment withdrawals.

Background Definitions and Clinical Context

Thanavaro describes an ICD as follows:

[An ICD is] a specialized device designed to directly treat tachyarrhythmia. If the patient has ventricular arrhythmia, the device senses a ventricular rate that exceeds the program threshold; the device may deliver either anti-tachycardia pacing or defibrillation. [2]

These devices are placed just posterior to the clavicle and lateral to the sternum. Shocks are given by the device to rectify certain deviations from sinus rhythm. Guidelines for the use of an ICD include secondary prevention of sustained VT and VF, usually in the context of coronary ischemia. A typical clinical scenario that may employ an

ICD is that of worsening chronic congestive heart failure. Patients with genetic diseases that alter the QT interval and lead to VT and VF may also be candidates for ICDs. [3]

An ICD is different from the more common pacemaker. Although ICDs and pacemakers are implanted in the same location, they differ in functionality. A pacemaker uses low-energy electrical signals to address ineffective heart rhythms due to ischemic damage to the sinoatrial node that ordinarily regulates the human heart, or in the face of complete heart block. Unlike an ICD, a pacemaker does not have the ability to defibrillate in order to treat the most severe arrhythmias. When an ICD activates to defibrillate a patient's heart in the throes of a life-threatening arrhythmia, the ICD uses an electrical signal

An ICD's life-saving shocks may become burdensome when prolonging life is no longer the patient's goal

with significantly higher energy level than the signals used by pacemakers. The higher-energy signals used by ICDs, though essential to ICDs' function, can be painful to the patient. Thus, while pacemakers and ICDs are equally invasive, ICDs may be more burdensome than pacemakers over an extended course of treatment. [4] Newer implantable devices have both pacemaker and anti-arrhythmia functions; they may act in "pacing mode only," or on demand as needed to cardiovert patients in VT or VF. [5] Nonetheless, from an ethical standpoint, these functions should be considered separately because of the difference in the burdens they impose on the patient. An ICD's life-saving shocks may become burdensome when prolonging life is no longer the patient's goal, as when a patient chooses to forego other forms of aggressive treatments for life-threatening conditions. [1,6]

Ethical Analysis

Patient autonomy and the related right of patients to refuse treatment are paramount principles in modern medical ethics. Patients with decision-making capacity may always forego a life-saving treatment, or may ask for its withdrawal if the perceived burden outweighs the benefits. In a patient without decisional capacity, surrogates make such decisions. Effective and beneficial treatments should be pursued, but only if the treatment goals align with the patient's own interests. [7]

In a palliative care or hospice setting, some treatments that would be beneficial in other contexts may merely prolong the dying process, and it is ethically permissible to withdraw them. For example, IV antibiotics for a worsening infection with sepsis may be withdrawn if the patient wishes, even though the burden is minimal. The treatment might prolong the dying process, and may not be within the treatment goals of an informed, decisional patient. [8]

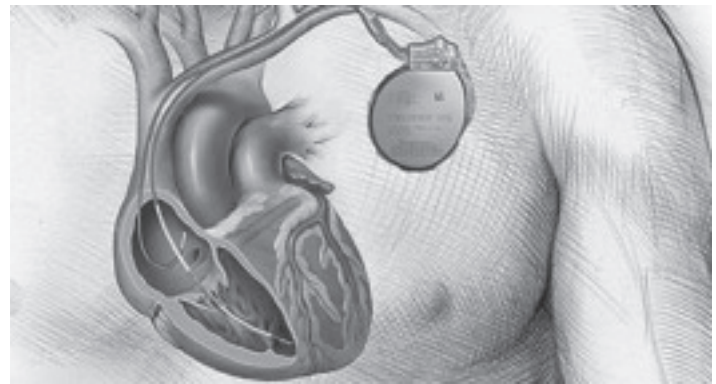
By contrast, the ethical status of an ICD may appear to differ from IV antibiotics because an ICD, unlike an antibiotic, is internal and automatic. But the burden imposed by an ICD differs from those imposed by IV antibiotics, too. If left active, an ICD will continue to attempt cardioversion of VT and VF even if the patient is close to death and has a “do not resuscitate” order. In one study, 8% of patients experienced a shock minutes before their death. [1] Nonetheless, many physicians are uneasy with the idea of deactivating such devices.

An ethical classification scheme is necessary to better understand the discomfort of clinicians to withhold or withdraw certain treatments. Daniel Sulmasy has suggested one such analysis, dividing treatments into various subcategories. [9] According to Sulmasy, some treatments are *regulative*; i.e. temporary or intermittent therapies that cause the body to return to a normal state of homeostasis. Examples might include an antibiotic or antipyretic to treat an infection.

On the other hand, some treatments are *constitutive*; they take over a function that the body can no longer perform by itself, due to permanent damage to an organ or system. Mechanical ventilation in the face of pulmonary failure is one example. Note that constitutive treatments can be further divided into two subcategories: *substitutive* and *replacement*. Substitutive treatments provide the needed function in a manner different from the original organ or system. As mentioned earlier, a ventilator fits this moral description, but renal dialysis could also be described in this way. [9,10]

Replacement treatments provide function in a similar way to the original diseased organ or system. Two clear examples are a kidney transplant and a replacement heart valve. In both cases, the treatment not only functions like the original, but it has become incorporated into the body to the point that it might be considered part of the self.

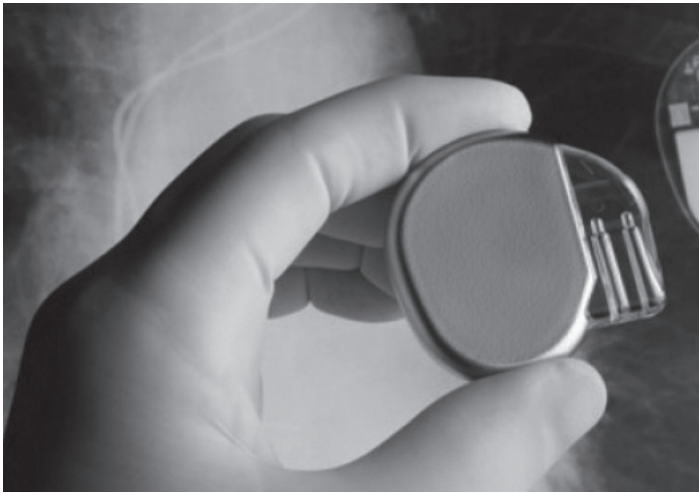
In an end of life setting, even constitutive treatments may become optional, depending on patient-centered goals, but only those that are substitutive. A moment of reflection will make this clear: it is sometimes ethical to discontinue a ventilator or renal dialysis, whereas it would not be ethical to “discontinue” a transplanted organ or a heart valve (both replacement treatments). [10]



Given this background, how do implanted cardiac devices fit into this ethical framework? At a *prima facie* level, it might appear that both pacemakers and ICDs are replacement treatments, inasmuch as they are internal to the patient, function automatically, and seem a part of the self. Yet further analysis reveals flaws in this reasoning, and may indicate moral differences between the two kinds of devices. In particular, ICDs only function when needed to return the heart to normal sinus rhythm. Though internal to the patient, most feel that ICDs are regulative in nature. [10]

A pacemaker, on the other hand, seems to act in a more constitutive way. In cases of complete heart block or another cardiac pathology, the heart's normal function completely depends on the pacemaker to keep the patient alive. Furthermore, many would make the case that the device is a true replacement for the lost normal conduction pathway, making it ethically problematic to discontinue under any circumstances (this implies, of course, that the patient's pathology is such that the heart is completely dependent on the pacemaker for an effective rhythm). This may explain why physicians generally see ICD deactivation as ethical, but are much more likely to regard pacemaker deactivation as equivalent to euthanasia. [9,11]

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All of this philosophical analysis flies in the face of both the American Heart Rhythm Society (AHRS) and European Heart Rhythm Association (EHRA) consensus statements in 2010, which consider pacemakers and ICDs to ethically equivalent. The statements consider the discontinuation of either type of device to be as morally acceptable as the withdrawal of any other technology. [12,13] Nonetheless, many physicians continue to be uncomfortable with this analysis.

One attempt to provide clarity, at least with regard to the status of ICDs, is provided by England and colleagues. According to their analysis, if an ICD is a treatment, it can be withdrawn (for appropriate clinical reasons) without the consent of the patient, much like a medication can be withdrawn. However, if an ICD is a non-treatment option, and effectively part of the body (like a replacement therapy as described by Sulmasy), this creates logical flaws, and would not allow any practical modification of the device once implanted. England and colleagues propose the novel category of an “integral device,” that is both a part of the body but also an intervention made by the physician. This gives ethical ground for modifying an ICD, even deactivating its resuscitative function, as long as there is concurrence between the desires of the patient and the conscience of the physician. [14]

Conclusion

The authors of this short review lean toward the view that ICDs are regulative in function, or at least integral devices that can be withdrawn, so that the function of the device does not interfere with compassionate palliative care or hospice management. In contrast with the AHRS and EHRA consensus statements, however, we concur with a number of physicians that pacemakers are more problematic in this regard.

References

1. Goldstein NE, Lampert R, Bradley E, Lynn J, Krumholz HM. Management of implantable cardioverter defibrillators in end-of-life care. *Annals Of Internal Medicine*. 2004;141(11):835-838.
2. Thanavaro JL. ICD Deactivation: Review of Literature and Clinical Recommendations. *Clinical Nursing Research*. 2013;22(1):36-50.
3. Russo AM, Stainback RF, Bailey SR, et al. ACCF/HRS/AHA/ASE/HFSA/SCAI/SCCT/SCMR 2013 appropriate use criteria for implantable cardioverter-defibrillators and cardiac resynchronization therapy. *Journal of the American College of Cardiology*. 2013;61(12):1318-1368.
4. Hutchison K, Sparrow R. Ethics and the cardiac pacemaker: more than just end-of-life issues. *EP Europace*. 2017:eux019.
5. Epstein AE, DiMarco JP, Ellenbogen KA, et al. 2012 ACCF/AHA/HRS focused update incorporated into the ACCF/AHA/HRS 2008 guidelines for device-based therapy of cardiac rhythm abnormalities. *Circulation*. 2013;127(3):e283-e352.
6. Nambisan V, Chao D. Dying and defibrillation: A shocking experience. *Palliative Medicine*. 2004;18(5):482-483.
7. Beauchamp TL, Childress JE. *Principles of biomedical ethics*. 7th ed. New York: Oxford University Press; 2013.
8. Pellegrino ED. Decisions at the end of life: The use and abuse of the concept of futility. *The dignity of the dying person* Vaticano: Libreria Editrice Vaticano. 2000:95.
9. Sulmasy DP. Within you/without you: biotechnology, ontology, and ethics. *Journal Of General Internal Medicine*. 2008;23 Suppl 1:69-72.
10. Karches KE, Sulmasy DP. Ethical Considerations for Turning off Pacemakers and Defibrillators. *Cardiac Electrophysiology Clinics*. 2015;7(3):547-555.
11. Kapa S, Mueller PS, Hayes DL, Asirvatham SJ. Perspectives on withdrawing pacemaker and implantable cardioverter-defibrillator therapies at end of life: results of a survey of medical and legal professionals and patients. Paper presented at: Mayo Clinic Proceedings 2010.
12. Lampert R, Hayes DL, Annas GJ, et al. HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CIEDs) in patients nearing end of life or requesting withdrawal of therapy. This document was developed in collaboration and endorsed by the American College of Cardiology (ACC), the American Geriatrics Society (AGS), the American Academy of Hospice and Palliative Medicine (AAHPM). *Heart Rhythm*. 2010;7(7):1008-1026.
13. Padeletti L, Arnar DO, Boncinelli L, et al. EHRA Expert Consensus Statement on the management of cardiovascular implantable electronic devices in patients nearing end of life or requesting withdrawal of therapy. *Europace*. 2010;12(10):1480-1489.
14. England R, England T, Coggon J. The ethical and legal implications of deactivating an implantable cardioverter-defibrillator in a patient with terminal cancer. *Journal of medical ethics*. 2007;33(9):538-540.

remarks or behavior be removed, for fear of being labeled a “difficult patient”. [1]

It is also recognized that once bearing a diagnosis such as factitious disorder, a person’s medical care may be negatively impacted as physicians may use this to explain new and unexplored medical complaints. If a patient with factitious disorder develops new and unexplained manifestations of their illness, it should go without saying that they should be objectively evaluated. Physicians would be well advised to utilize this approach first and foremost, as up to 50% of patients with a somatoform disease will be eventually diagnosed with an organic disease that may explain at least some of their symptoms. [2] In this case, the patient had gone to other institutions and was told repeatedly that his symptoms were due to his self-mutilating behavior, purportedly without any new or additional workup. The patient’s care certainly seemed

disorder often do not discuss this diagnosis, as it is a fixed false belief that generally cannot be altered by discussion of the medical facts themselves. In dermatology, where we often encounter patients with delusions of parasitosis, we may use indirect terminology like “concern for infestation” to reference the delusional disorder, as a way to reference the patient’s problem without unintentionally breaking the patient’s trust.

The medical record is also an important legal document. Physicians must not feel intimidated to alter a medical record solely in response to an argumentative or aggressive patient. The clinician’s impression of the event or the interaction should continue to be just as important as the patient’s in the case of an amendment dispute. If, upon careful review, the documentation is still determined to be factual and accurate, the physician should not feel compelled by external pressure to modify it.

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to be impacted in a negative way by the electronic chart documentation, but this appears to reflect a lack of understanding by the new physicians involved of their obligations in his treatment, rather than the assessment done at our institution years ago.

With medical records increasingly transparent and available to patients, it is important to remember that certain documentation styles may be damaging to the patient-physician relationship. For instance, physicians caring for patients with delusional

In general, although it is important to remember the significance that the medical record may play in the way a patient is cared for in the future, it is also essential that medical documentation remain as objective and truthful as possible. The patient will always have the right to insert their statement of disagreement, but once you have obliged their request to change your own prior wording and assessment, it may be difficult to undo. Patients should continue to be treated with respect and, particularly in the case of factitious and somatoform



disorders, are still entitled to an objective medical workup in the light of new or persistent symptoms.

*Non-contributory details regarding the patient were changed in order to protect the patient’s anonymity.

References

1. Veterans’ Affairs National Ethics Teleconference. Ethical Considerations of Patients’ Requests to Have Their Health Records Amended. Recorded and transcribed May 31, 2006.
2. Kaplan HL, Sadock BJ. Kaplan and Sadock’s Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry. 8th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 1998.

● Response to Dr. Fabbro's Essay

Robert M. Taylor, MD

recently accepted a position as Associate Medical Director of Care Dimensions Hospice and Palliative Care in the Boston, Massachusetts area. Dr. Taylor had been Associate Professor of Neurology and Associate Professor of Clinical Medicine at The Ohio State University Medical Center for the past ten years. He received his AB from Harvard University in 1978 and his MD from OSU in 1985. He completed a medical internship and neurology residency at Dartmouth-Hitchcock Medical Center and a one-year fellowship in Clinical Medical Ethics at the MacLean Center for Clinical Medical Ethics at the University of Chicago.



Dr. Fabbro's essay: "When Patients Want to 'Correct the Record': Thoughts on Medical Record Revision" addresses a challenging problem that most physicians will face at some point in their practice. She uses the term "factitious disorders" to describe various behaviors that produce self-injury or self-harm, although sometimes that term is used to describe only intentionally produced self-injury or harm. Another term that can be used that may be more appropriate (and perhaps less judgmental) when the problem is felt

However, before addressing that question, it is useful to consider: how does one make such a diagnosis and how confident can one be about it?

In my training and experience, the primary rule is that one should first try to develop a clinical sense of the likelihood that the syndrome is non-physiologic. Dr. Fabbro mentioned some features of dermatologic conditions that should raise concern that the etiology is non-physiologic. In neurology, we look for patterns of deficits that are not consistent with the known neurological pathways, or for a temporal course that is atypical. Nevertheless, it is always prudent to perform appropriate tests to assure that the patient's presentation is not merely an atypical or embellished variation of a physiological syndrome. One rule I was taught, which is implied in Dr. Fabbro's article, is that a diagnosis of a non-

One way to approach the problem of dealing with non-physiologic disorders, is to ask "what are the diagnosing physician's duties?"

to be due to the patient's own actions, but when the etiology is unclear, is a "non-physiologic" disorder.

As Dr. Fabbro suggests, non-physiologic disorders are more commonly seen by some specialties than others; they are relatively more common in dermatology (her field) and neurology (my original field) than many other specialties. One way to approach the problem of dealing with non-physiologic disorders, is to ask "what are the diagnosing physician's duties?"

physiologic disorder should always be a provisional diagnosis, subject to re-evaluation and revision if new symptoms occur or new information contradicts the original diagnosis. Furthermore, one should search for positive support for the diagnosis; it should not merely be a diagnosis of exclusion – i.e. the inability to find a physiological cause. Likewise, having made such a diagnosis does not relieve the physician from the duty to appropriately evaluate new symptoms. Finally, one should seek an underlying psychological reason

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for the problem, e.g. a recent stressful event that may have precipitated the problem. Thus the patient's symptom typically provides him or her with a "secondary gain;" i.e. a social or relational benefit of some kind – often providing implicit "permission" to avoid fulfilling some particular social obligation.

Once the diagnosis is determined to be likely, how honest should the physician be with the patient? This is often the most challenging aspect of this problem. It is my opinion that the physician, in his or her approach to the patient, should try to be simultaneously honest, supportive, and therapeutic. Being honest is often the most difficult element for the physician and, in the case presented by Dr. Fabbro, it is clear that the physician who originally made the diagnosis struggled with this. In his effort to avoid upsetting or offending the patient, he apparently was not clear that he suspected that he was causing the lesions himself, although that is what he wrote in the record.

Indeed, if there is an ethical error in this case, it may be the fact that the physician documented a fairly definitive diagnosis in the patient's chart, but did not inform the patient of this. Thus his subsequent anger is not only understandable, it is to some degree justified, in that he felt that his doctor deceived him; indeed, his anger is unlikely to be alleviated by the assertion that the physician's intentions were good. Perhaps, if he were unwilling to advise the patient of his diagnosis, the physician should have been less definitive in his chart documentation and also, perhaps, have documented in the chart what he said to the patient and why he was not fully honest with him.

But that gets us to the physician's other obligations of attempting



to be supportive and therapeutic. This requires an exploration of possible stressors and possible "secondary gain" the patient might be experiencing. In these situations, the diagnosing physician often feels unprepared to provide such support and also rarely is willing to devote the required time to do so. Thus, it is usually prudent to refer such a patient to an appropriate practitioner to provide this support for the patient.

Such a referral, of course, also requires some degree of honesty about the provisional diagnosis. In neurology we often refer to a physical, occupational, or speech therapist to provide both an opportunity and a pathway for the patient to recover. However, often a psychotherapist is the best option, to help explore the patient's underlying stressors. The other advantage of such a referral is that, if the patient is cooperative, the psychotherapist should be able to determine an underlying stressor that may explain the symptoms, and even possibly to improve them. If the therapist is unable to do so, further

work-up for a physiologic etiology is probably warranted. Thus, the referral can also serve a diagnostic purpose, which may make it more palatable to the patient.

In summary, the traditional challenges of evaluating and managing non-physiologic disorders are amplified by the modern electronic medical record. Thus the physician's duty of honesty to the patient takes on a pragmatic element that was less relevant in the past.

...the traditional challenges of evaluating and managing non-physiologic disorders are amplified by the modern electronic medical record.

Looking Back at the Early Days *continued from page 3...*

Fourth, we have divided the state into four regions, which we have called regional forums, to facilitate the development of more frequent, smaller meetings. These forums provide members with the opportunity to participate in and respond to current bioethics problems within the state and the nation. Our Newsletter and our electronic bulletin board print summaries of the forums' discussions. These forums are not miniconferences. Rather, they are participant driven in that they strive to stimulate discussion among our members.

Our network leadership has many future goals. First, we would like to become effective instruments for educating hospitals, nursing homes, and other healthcare institutions about ethics committees. Second, at the conclusion of our last statewide meeting, we reached a consensus regarding the need for BENO to make recommendations to the state legislature regarding changes in the advance directive law. This law went into effect in October 1991, and complaints throughout the state have been flowing into BENO since its inception. We are still at the discussion stage of this project, but given the energy that already is present in the network, I think that we will soon reach agreement on how to proceed with this task.

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A Thank You to a Founder



At this year's annual conference, James C. Reagan, PhD, left, received an award honoring him as a Founder and Founding Board member of BENO. Marty Smith, STD, right, also a founding member and long time Board member, presented the award.



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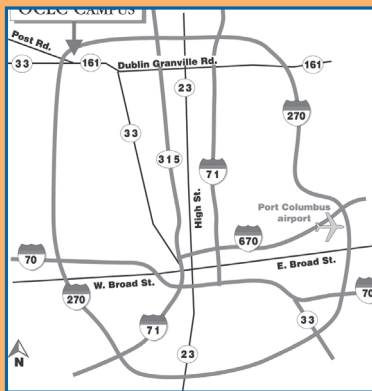
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