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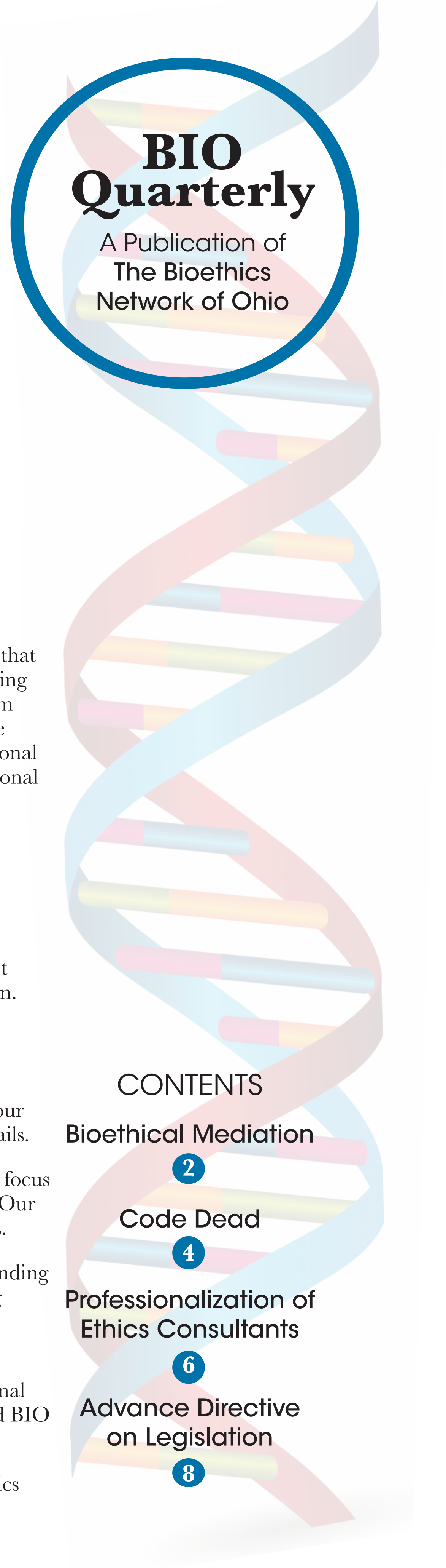

From the President

Donna F. Homenko, PhD

As I welcomed everyone to our 24th Annual Conference on May 2nd, I realized that the mission of BENO is alive and well - a packed conference auditorium with smiling faces ready to learn and be inspired. Professional development is an umbrella term that ranges from investigation through reading, enrollment in coursework or online activities, in-services at your health care institution, or attendance at local and national conferences. BENO has been and will continue to be a contributor to this professional development.

I am pleased to report about this year's conference program. We had an outstanding array of speakers with enlightening topics who transported us through time from the horrific acts against humanity during the Holocaust to our future roles in ethics consultation. In between we learned how to address burnout and deal with limited resources affecting patient care.

Planning for the 2015 25th Anniversary Conference is already underway. Mark your calendars for Friday, May 1, 2015 at the same Dublin location. Stay tuned for details.

The planning committee will review the 2014 conference evaluations and begin to focus on BENO's accomplishments during the last 25 years. There are many of them. Our unique organization covers bioethics in Ohio and across the health care disciplines.

News Flash! BIO Quarterly has a new editor with a familiar face – our long-standing colleague Marty Smith. The publication will remain in print form as well as being online and will be filled with new features and columns.

Please consider contributing an article or sharing a brief case deliberated by your ethics committee. We encourage students and residents to submit an essay or journal reflection. We can always learn from each other's experiences. I know BENO and BIO Quarterly will contribute to your ongoing professional development.

Finally, visit our website, www.BENOethics.org, for announcements about the Ethics Consultation course and upcoming events.

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An Innovative Approach to Clinical Ethics Consultation: Bioethical Mediation

Victoria M. Kumorowski, JD, LLM, MJS, DMin, Director of the Spiritual Care Department and Clinical Mediator, Genesis Health Care System, Zanesville, OH.

[This article is a revised, condensed version of a portion of the author's DMin. dissertation, entitled "Bioethical Mediation: A Reconciling Pathway to Healing," published in 2012, and available in the library at Ashland Theological Seminary, Ashland, Ohio].

In recent decades, advances in science and medical technology have raised many complicated and profound medical, legal, ethical, relational, and spiritual issues. Some of the issues raised by genetic and reproductive technology are even global in nature, and they require us to focus anew on the meaning of human existence. Some of them need to be addressed from both an international and an intergenerational, as well as an individual, perspective. These complex issues cannot be adequately resolved by arbitrarily applying the core principles of bioethics [1]. Instead, they require a more collaborative approach to decision-making, one that does not allow either autonomy or paternalism to reign supreme.

In recent years, changes in government regulations, managed care, specialization, and advances in medical technology have made it more difficult for health care professionals and patients to develop trusting relationships [2]. Changes in the roles of physicians and other health care professionals, along with a greater emphasis on patient's rights, have increased the number of conflicts within modern health care systems [2].

The practice of modern medicine often involves confronting uncertainties and requires taking a multidisciplinary approach to problem-solving. Shared decision-making is essential in order to make wise decisions that benefit both individual patients and society as a whole. However, conflicts may arise within the decision-making process because physicians, nurses, other members of the healthcare team, patients, and family members all come from different backgrounds and have different perceptions of the issues and different expectations of the healthcare system [2, 3].

Advances in medical technology have made it possible to prolong both life and the dying process, and they have led to an increase in medical decision-making at the end of life. The fast-paced and complex nature of the modern health care system often requires physicians and other health care professionals to work long hours and to react quickly in crisis situations [4]. Conflicts are bound to develop, especially when grieving family members and clinical teams disagree about whether or not to withhold or withdraw life-support.

In those cases, shared decision-making often requires simultaneously addressing emotional concerns and ethical issues that greatly affect the quality of a patient's life or death. Rational decision-making is usually not possible until those concerns are addressed. Openly communicating and seeking to resolve those concerns are essential to make the decision-making process a healing experience for everyone involved in a patient's care.

These modern developments illuminate the need for a more informed and inclusive way of quickly addressing the profound ethical issues that arise every day in modern healthcare. They demonstrate the need to address health care conflicts in a respectful way that promotes both personal and professional growth. They highlight the need to rely upon an innovative approach to clinical ethics, one that is facilitated by a trained bioethical mediator.

Bioethical mediation is a facilitative form of ethics consultation and mediation first developed in 1978, by Nancy Dubler and Carol Liebman at the Montefiore Medical Center in New York. It brings patients, family members, physicians, and other members of the healing care team together to address the intimate and time-sensitive issues that often arise in patient care. The process helps to relieve suffering by giving each participant a voice and an opportunity to express his or her fears and concerns. If the patient has decision-making capacity, the patient participates in the confidential process. If the patient lacks decision-making capacity, the patient's family members or surrogate participate in the confidential process.

This transformative form of mediation provides a quick and inclusive approach to applied clinical ethics. In contrast to traditional ethics consultations, bioethical mediation enables all involved in the process to feel heard [5]. In many ethics consultations, only health care professionals are involved and committee members focus on giving advisory opinions about the issues raised by the health care providers. In bioethical mediation, an impartial mediator uses listening and reframing skills to promote enhanced communication among everyone involved in a patient's care, and participants are encouraged to work together to arrive at a principled resolution. [5,6].

Bioethical mediation also differs greatly from arbitration and adjudication, in which either an arbitrator or a judge decides the case. It is much less emotionally draining on the parties, much less time consuming and much less expensive than litigation [4]. It is also much more helpful in resolving the profound ethical and emotional concerns that arise in clinical cases than the evaluative type of mediation which focuses on achieving an economic settlement.

In summary, the bioethical mediation process is often used to:

1. Help participants quickly address concerns that need immediate attention;
2. Facilitate communication among everyone involved in a case, allowing all participants to feel "heard;"
3. Promote a holistic understanding of the needs of the patient;
4. Focus participants on the goal of healing;
5. Promote development of more attentive listening skills and a more open way of relating;
6. Enable participants to address and resolve ethical issues, misunderstandings and conflicts (10);
7. Enable health care providers to explain adverse events, including medical errors, express an authentic apology, and provide fair compensation [7]; and
8. Promote resolution and forgiveness

The bioethical mediation process focuses participants away from blame toward resolution and forgiveness. It can provide a safe forum for the open and honest disclosure of adverse events, including those involving medical errors. It can enable practitioners to disclose medical errors (and to make authentic apologies) in a healing way that prevents litigation [2]. It can also empower them to acknowledge their own feelings of sorrow and guilt and to empathize with patients and family members affected by medical mistakes.

The process can help to preserve trusting relationships between healthcare providers and patients (and/or family members). It can bring parties together to create resolutions which can involve non-monetary, as well as monetary considerations [3]. It can promote patient safety and lead to corrective actions that prevent future errors [3]. If used to resolve a case before a written claim is filed, it can protect a physician's reputation by eliminating the requirement that his or her error be reported to the National Data Bank [8].

To accomplish all of the goals outlined above, bioethical mediation needs to be based upon a bio-psycho-social-spiritual model of care, which recognizes healing as a dynamic inner process involving body, mind, and spirit. It needs to be undergirded by an inclusive moral framework that recognizes there are no easy answers, and that enables participants to openly address the complex ethical issues that frequently surface in modern health care. The process needs to be facilitated by a trained bioethical mediator who has cultivated the core competencies for healthcare ethics consultation outlined in the 2011 Report of the American Society for Bioethics and Humanities [9]. It needs to focus upon maintaining trust and open communication within professional-patient relationships. 10,11].

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Visit our website, BENOethics.org, to set up an account so you can join using a credit card. If you prefer to pay using a check, see the membership form on page 11.

● "Code Dead": Wrong Words for an Important Message

Jonathan Wiesen, MD, Critical Care Fellow,Cleveland Clinic

With some routineness, *The New York Times* (NYT) publishes thoughtful essays on death and dying, and the challenges faced by patients, families and health care professionals during such emotionally-laden situations. On April 10, 2014, such an essay written by Jessica Nutik Zitter, MD, was published in the NYT and titled: "A 'Code Death' for Dying Patients." The author is a board-certified physician in both critical care and palliative medicine. In her essay, she reports her training (and re-certification) to rescue patients from the brink of death through "Code Blues" and through the use of "highly sophisticated tools" and "technological wizardry." She notes that, "Like a midwife slapping life into a newborn baby, doctors now try to punch death out of a dying patient."

Dr. Zitter also reports that she was never trained to "unhook these tools" and she never learned how to help her patients die. Thus, she asserts that we need "a Code Death," and that physicians "must learn at least something about midwifing death." Toward this end, she recounts how she prepped and orchestrated the deaths of three of her terminally ill patients in an intensive care unit after assigning roles to a resident physician, an intern, a medical student, bedside nurses, and a respiratory therapist. "We worked like the well-oiled machine of any Code Blue team."

Dr. Zitter has an important message for her readers, namely, that death is a clinical situation requiring expertise, insight, practice, excellent care and communication, and multidisciplinary team coordination. Her notion of "a Code Death," however, is a bit overstated. Codes were instituted to provide immediate attention, with highly protocol-ized, evidenced- based algorithms, for situations where every second impacts the well-being and outcome of a clinical emergency. The term "code" should not be used flippantly in reference to routine clinical management situations, or when interventions necessitate the coordination of multi-faceted and multidisciplinary care. There is no "Code Heart Failure" or "Code Hypotension," despite their obvious need for urgent, coordinated attention; nor is every procedure a "code" even though there can be multiple role responsibilities and designations. It would therefore seem somewhat strange to refer to "a Code Death" if there are no long-term negative outcomes that would result from less immediate and urgent implementation of care for dying patients. In fact, better care for the dying seems to result from reflective, calming, compassionate conversations with patients and/or families; and thoughtful consideration of the uniqueness of each patient's story as care plans are devised.

> ***In fact, better care for the dying seems to result from reflective, calming, compassionate conversations with patients***

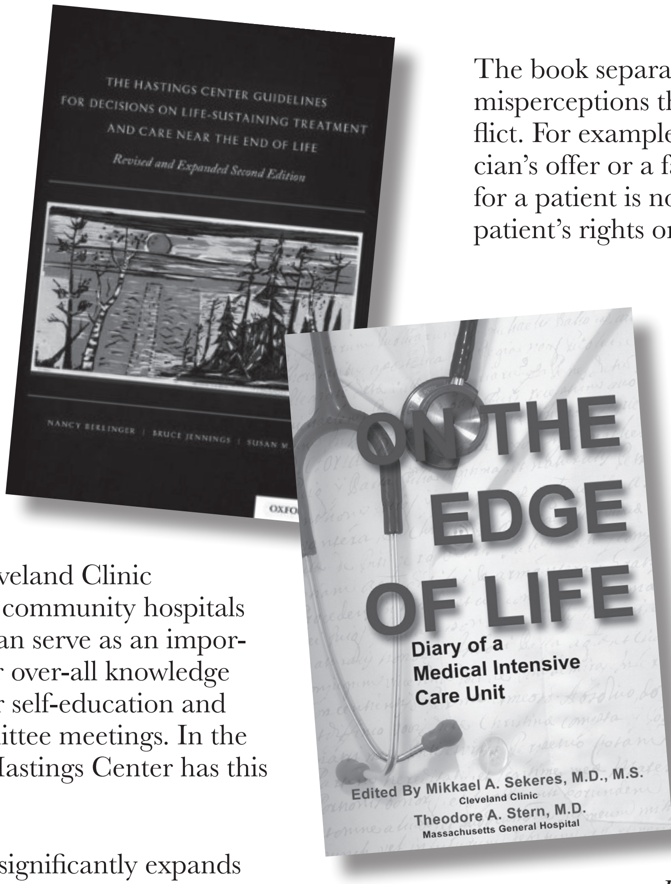
Certainly a title using "Code Death" grabs our attention, and Dr. Zitter's primary message is a very important one about educating, training, practicing and even certifying physicians and other clinicians in the skills associated with the care of the dying. But calling all of this "a Code Death" will likely communicate an unnecessarily ambiguous message, and will dilute the importance currently assigned to "code" situations.

I encourage you (and your colleagues and ethics committee members) to access and read the article for yourself, and then discuss and strategize about how the continuing education of your clinicians should change if the care of dying patients is to be improved.

The author appreciates Marty Smith's input and editing assistance in the writing of this article.

The Book Store

Marty Smith, STD, Director of Clinical Ethics, Cleveland Clinic



Two books have come to my attention and are worthy of your attention (and perhaps even your purchase!!). The first is *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life* (Nancy Berlinger, Bruce Jennings, Susan Wolf; Oxford University Press, 2013, 240 pages). Historically, a high percentage of ethics consultations have focused on end-of-life issues. This remains true at the main campus of the Cleveland Clinic where I work, and at our eight community hospitals in northern Ohio. This book can serve as an important resource for updating your over-all knowledge about end-of-life issues, and for self-education and discussion at your ethics committee meetings. In the promotion of this book, The Hastings Center has this to say about their publication:

> "[This book] updates and significantly expands the Center's groundbreaking comprehensive ethics guidelines, first published in 1987. The original edition was foundational in shaping the ethical and legal framework for medical decision-making in the U.S. It was cited in the U.S. Supreme Court's 1990 decision in the case of Nancy Beth Cruzan, which established the Constitutional right of patients to refuse life-sustaining medical treatments and affirmed the authority of surrogate decision-makers for patients without decision-making capacity.
>
> The new book synthesizes the past 26 years of research and innovation in quality improvement, patient safety, and palliative care, with insights from more than 60 experts in medicine, law, nursing, and other disciplines, as well as from the disability community and patient advocates. Two important new features include guidance on making decisions for seriously ill or dying children and a discussion of the views of people with disabilities who face decisions about life-sustaining treatment.
>
> The book separates fact from fiction, clarifying misperceptions that can lead to problems or conflict. For example, readers will learn why a physician's offer or a family's request to "do everything" for a patient is not an effective way to respect a patient's rights or to ensure that a patient receives good care. The publication also explains a patient's right to refuse life-sustaining treatment, with a clear description of how treatment refusal differs from physician-assisted suicide. It describes what all patients should expect, including pain and symptom relief and respect for their preferences in all treatment and care plans."

This book can serve as an important resource for updating your over-all knowledge about end-of-life issues

The second book will be of interest to those who work with medical and clinical trainees, trainees themselves, as well as the general public. The book's title is, *On the Edge of Life: Diary of a Medical Intensive Care Unit* (Mikkael Sekeres, Theodore Stern; MGH Psychiatry Academy, 2014, 216 pages). The book aims to explore the intersection of medicine and ethics, and to help prepare people for what they might experience in a general hospital. It is based on the musings of Interns and Residents in the Internal Medicine Residency Training Program at the Massachusetts General Hospital, as entered into a seven-volume "Medical Intensive Care Unit (MICU) Journal" over a twenty-year period, beginning in January 1980. In describing the book, one of the authors, Mikkael Sekeres, writes:

> "The entries recorded in the seven-volume "Medical Intensive Care Unit (MICU) Journal" cover a twenty-year period, beginning in January, 1980, and reflect the unguarded reflections of these interns and residents as they are thrown into the chaos of the Massachusetts General Hospital intensive care unit, the last resort of medical care for much of New England, where only the sickest of the sickest patients are referred. Join these young doctors as they struggle with extremes of medical care, the outrageousness of humor in the midst of such despair, their first encounters with death, and

continued...

ultimately take a step back to appreciate the miracle of survival as the human spirit triumphs over medical calamity. It is remarkable that, even as these interns and residents themselves toil through 36-hour, sleepless shifts, they steal away for a few minutes to write an entry in this diary, to place their experience in a greater context. It is even more incredible that their words, recorded at the peak of vulnerability, have survived.

We have taken the liberty of reorganizing the entries into chapters based on common themes (e.g., "Humor", "Life and Death"), thereby violating their chronology. Within chapters, too, we have tried to organize entries based on common threads (e.g., within the "Humor" chapter, jokes related to urinary catheters have been placed together). Our intent was to enable the reader to complete entire chapters in a single sitting. As a further aid to readers who do not work in health care, we have created a running glossary that defines medical terms and jargon unique to the field of medicine. We have also weighed-in with our own comments after one or more entries or following a particularly jarring statement. In doing so, we have attempted to provide a common voice that can be heard throughout the book, placing some entries in a larger context and making sense of some of the more obtuse entries. Our intent was to make these interjections as unobtrusive as possible."

Join these young doctors as they struggle with extremes of medical care, the outrageousness of humor in the midst of such despair

● While We Wait for the Professionalization of Ethics Consultants.

Marty Smith, STD, Director of Clinical Ethics, Cleveland Clinic

At the 24th annual BENO conference on May 2, 2014, I made a plenary presentation (the annual Jim Barlow Memorial Lecture) that I titled, "The Future for Ethics Consultants: Professionalization, Certification, Licensure … Oh My!!" I shared with conference attendees that as part of my preparation for the presentation, I peered into a crystal ball … and projected that within the next 5 to 10 years there will be a certification process in place for clinical ethics consultants. My prognostication includes that the certification process will be given a boost by one of the regulatory bodies (e.g., a new Joint Commission or CMS standard), and that all ethics consultation services (ECSs) will be required to have at least one certified ethics consultant.

If my crystal ball has some accuracy, my predictions raise the question: What should we do in the meantime? My answer includes the following recommendations for you, your ECS, and for myself and those with whom I work.

> **Know the content of and measure yourself and your ECS against the Core Competencies report** (2nd edition) from the American Society for Bioethics and Humanities (ASBH) [1]. This document lists and describes the domains of knowledge and the assessment, process and interpersonal skills needed to provide quality ethics consultations. The document also describes emerging standards and benchmarks for all ECSs, e.g., having a policy and practice of open access, and a thorough and systematic process for conducting ethics consultations; documenting ethics consultations both in patients' medical records and through internal tracking mechanisms; and subjecting consultation activities to a continuous, comprehensive, and accountable quality improvement process. Every ECS and Ethics Committee (EC) should have a few copies of this ASBH publication available for review, discussion, and guidance, and for orienting new EC members

Dedicate some time at every EC meeting to self-education. The goal here is to keep ourselves up-to-date about clinical ethics issues, various analyses of these issues, and ethical justifications for proposed resolutions and strategies to address these issues. Resources for the self-education segment of EC meetings are many: ethics-related journal articles and book chapters, case studies from journals such as *The Hastings Center Report* or *The Journal of Clinical Ethics*, and even thought pieces from *The New York Times* (in this issue of *BIO Quarterly*, see the article by Jonathan Wiesen). Useful case-study books that include both case presentations and thoughtful analyses include *An Ethics Casebook for Hospitals, Practical Approaches to Everyday Cases* (Kuczewski MG, Pinkus RLB. Georgetown University Press, 1999), and *Complex Ethics Consultations, Cases That Haunt Us* (Ford PJ, Dudzinski DM, eds. Cambridge University Press, 2008). One or two EC members could be appointed as the EC Education Subcommittee to plan this segment of each meeting; and someone could monitor national developments by occasionally checking ASBH's website (asbh.org), especially looking for minutes or reports from ASBH's Clinical Ethics Consultation Affairs Committee.

Build an ECS infrastructure with the goals of standardization, efficiency, and awareness and ease of access to the ECS. Based on the emerging standards and benchmarks noted in ASBH's *Core Competencies* (see above), every ECS should have an ethics consultation policy, set of procedures, and protocol. The policy should address such issues as open access to the ECS (i.e., anyone with a legitimate interest in a patient situation should be allowed to request ethics assistance); notification of the primary physician when a consult is requested; if and when a patient or surrogate should be notified about a request for an ethics consult; and whether the ECS accepts anonymous requests for consults. ECS procedures and protocols could include a standardized template for documenting in patients' medical records, and a checklist of routine process steps to be followed for patient-centered consults. The ECS infrastructure should also include mechanisms for "marketing" the ECS to personnel, patients and families (e.g., brochures, in-house TV, intranet website, pocket cards, fliers), and a standardized and well-publicized way for consult requesters to contact the ECS.

Rigorously engage in Quality Improvement activities. For me, this starts (but does not end) with good data collection. How many consults did your ECS have during the past month or year? From which clinical units are the consults arising (e.g., ICU, regular nursing floors)? Which professionals are requesting ethics consultations (e.g., physicians, nurses, social workers, chaplains)? What are the reasons and value-laden concerns for which consults are being requested? With systematized data collection for each consult, you should eventually be able to answer these questions (and more) with ease and in an ongoing manner. Analysis of the aggregated consult data could prompt educational and informational interventions, and ethics-related policy work. Beyond good data collection, we should engage in routine retrospective review of our ethics consultations. Did we follow a thorough and systematic process? If there was a deviation, was it appropriate? Did the ECS articulate solid ethical justifications for its recommendations? Did the documentation in the patient's medical record use accessible and understandable language for front-line clinicians? As a result of the retrospective reviews, what process improvement steps should be implemented to raise the quality of ECS activities going forward?

My crystal ball tells me that professionalization of ethics consultants is in our future. But it would be a mistake for us to sit back and passively wait for that day to dawn. In the interim, we should actively work to increase our clinical ethics knowledge, improve our consultation skills, and establish high quality ECSs to the benefit of patients, families, and health care professionals and personnel.

1. The American Society for Bioethics and Humanities. *Core Competencies for Healthcare Ethics Consultation*, 2nd Edition, Glenview, Illinois, 2011.

Recent Amendments to Ohio's Advance Directive Legislation

Anne Lederman Flamm, JD, Staff, Department of Bioethics, Cleveland Clinic

The Ohio Legislature recently amended several statutory provisions related to advance directives. Effective March 20, 2014, the amendments of House Bill 126[1] do not alter the clinical functions of durable powers of attorney for health care or living wills, and will not likely change clinical care. However, those who assist patients with completing advance directives may want to consider how the amendments might impact their guidance and advice.

I. Amendments Affecting the Durable Power of Attorney for Health Care (DPAHC)

Ohio Revised Code § 1337.12 enables a capacitated adult to create a DPAHC, the legal document in which the "principal" – in the clinical setting, the patient – appoints an "attorney in fact," often called the surrogate or proxy decision maker, to make health care decisions in the event the patient loses decision making capacity (DMC). Amendment § 1337.12(A)(1) allows the DPAHC to authorize the appointed surrogate to obtain information concerning the patient's health "immediately upon the execution of the instrument or at any subsequent time and regardless of whether the principal has lost the capacity to make informed health care decisions…". The statute explicitly clarifies that this potentially immediately accessible information concerning the patient's health includes protected health information as defined by 45 C.F.R. 160.103 – HIPAA, as most of us know it. In a parallel change, amendment § 1337.13, which delineates the scope of the appointed surrogate's authority, grants the surrogate the authority to obtain immediate access to the patient's health information so long as the DPAHC authorizes it.

those who assist patients with completing advance directives may want to consider how the amendments might impact their guidance and advice.

The Estate Planning, Trust and Probate Law Section (" EPTPL Section") of the Ohio Bar Association, which proposed these changes, explained its motivation in a published report. As described in the report, HIPAA regulations entitle an appointed surrogate to receive health information without a separate HIPAA authorization. Ohio law previously entitled the surrogate to receive health information only after the patient's physician determined that the patient had lost DMC. Per their report, "Members of the EPTPL Section and other attorneys have indicated instances where agents have been denied access to health information and, thus, have been unable to fully aid the principal."[2]

The Legislature's published Final Analysis of the changes offers no further explanation of its rationale for allowing a grant of immediate access in the DPAHC.[3] The surrogate's authority for decision making still requires the patient's loss of capacity. Yet even health care professionals actively caring for a patient possess only a limited authorization to access the patient's medical records on a "need to know" basis, reflecting the "minimum necessary" standard asserted by HIPAA. Under the revised Ohio statute, the surrogate's power to access the patient's medical record appears to parallel the patient's own unlimited power. Thus a suspicious spouse, greedy life insurance beneficiary or innocent genetic heir who is the patient's surrogate may have unlimited authorization to explore a capacitated patient's records. Under the new law patients can prevent unwanted access by omitting immediate authorization in the DPAHC. However, patients' appreciation for potential harms arising from such authorization is debatable, particularly if DPAHC forms that develop after this amendment include the immediate access provision without further explanation. The Legislature might use the notice provisions required by § 1337.17 to accompany any printed DPAHC form in the state to call attention to important privacy considerations, but these provisions have not been amended since their enactment in 2001. The existing required notice makes no mention of

any connection between a surrogate's appointment and his or her power to access the patient's medical records.

A new subsection of § 1337.12 enables the principal of a DPAHC to nominate a guardian, whether of person, estate or both, in the document, and to authorize the person nominated or the attorney in fact to nominate a successor guardian for consideration by the court. Existing law allowed individuals to nominate a guardian under a financial power of attorney (ORC § 1337.28); this amendment simply adds the option under the DPAHC. Consistent with existing law, the new subsection also states that the principal's subsequent nomination of a guardian revokes the prior nomination, and that the court will appoint a guardian in accordance with the principal's nomination "except for good cause shown or disqualification". Because a nominated person can decline to serve as guardian, clarifying prospectively the nominated person's willingness to service enhances the likelihood that the principal's nomination will result in the desired appointment. Provisions enabling the principal to waive the bond requirement for the nominated person, and to file the DPAHC with the local probate court for safekeeping, facilitate the guardianship appointment process should it become necessary.

Another addition to § 1337.12 may be important to clinicians when determining who holds surrogate decision making authority for a patient lacking DMC. Section 1337.12(E)(4) directs: "If a guardian is appointed for the principal, a durable power of attorney for health care is not terminated, and the authority of the attorney in fact continues unless the court … limits, suspends, or terminates the power of attorney after notice to the attorney in fact and upon a finding that the limitation, suspension, or termination is in the best interest of the principal." In other words, a surrogate named in a patient's DPAHC has priority for treatment decisions over a subsequently appointed guardian unless the court rules otherwise.

An additional, largely ministerial change effected by H.B. 126 makes the alternate attorney in fact, like the first named surrogate, ineligible to be a witness to the DPAHC's execution. The notice provisions required to accompany printed DPAHC forms in the state, which as noted above remain unchanged since 2001, assert the ineligibility for witnessing of the first-named attorney in fact, but have not been amended to reflect the alternate's ineligibility.

In other words, a surrogate named in a patient's DPAHC has priority for treatment decisions over a subsequently appointed guardian unless the court rules otherwise.

II. Amendment Affecting the Living Will

A final change effected by H.B. 126 adds a provision to § 2133.04, which describes revocation of a living will declaration. Declarants' ability to revoke a living will by executing a more recent one remains unchanged. However, the amendment establishes the presumption that a valid living will declaration revokes all prior declarations. The declarant can specify otherwise.

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1 All amendments cited herein were enacted under House Bill 126, 130th General Assembly of the State of Ohio, *available at*: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_126

2 Report of the Estate Planning, Trust and Probate Law Section, Ohio Bar Association, *available at*: https://www.ohiobar.org/General%20Resources/pubs/councilfiles/2012/Report_of_the_Estate_Planning_Trust_and_Probate_Law_Section_Nov_2012.pdf

3 *Available at*: http://www.lsc.state.oh.us/analyses130/13-hb126-130.pdf

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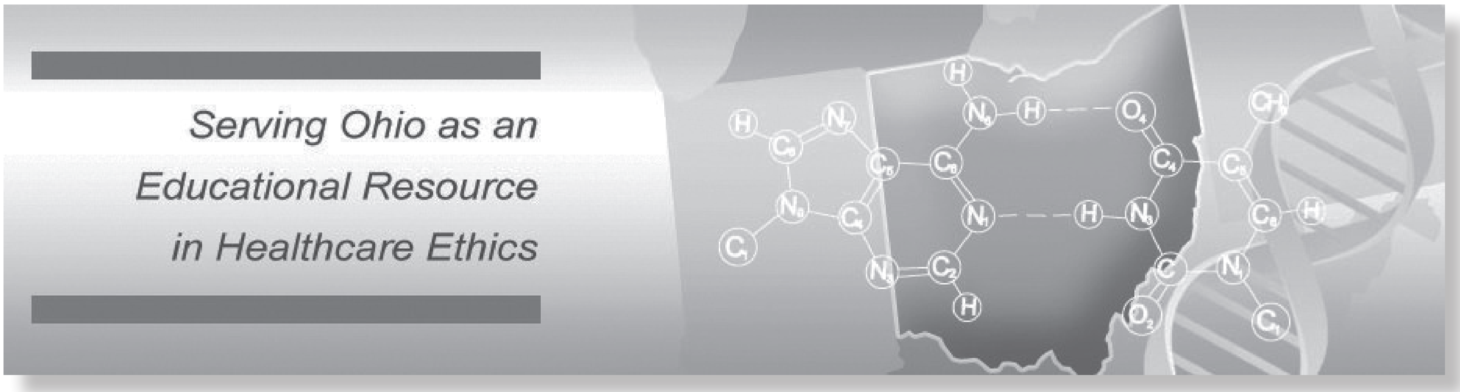

BIOETHICS NETWORK OF OHIO • **MEMBERSHIP FORM**

Individual Membership Levels:

☐ **INDIVIDUAL, Professional: $50, 1 year**

☐ **INDIVIDUAL, Professional: $90, 2 years**

☐ **INDIVIDUAL, Student: $25, 1 year**
(include copy of student ID)

• Individual Member benefits include a subscription to BIO QUARTERLY, discounted registration fee for the annual conference and access to special course offerings.

$__________ ADDITIONAL GIFT in support of BENO programs & activities*

$__________ TOTAL

Institutional Membership Levels:

☐ **Hospital Systems◊, $1500/yr.**
For health care systems with 2 or more facilities. Members receive 3 complimentary registrations at the Annual Conference plus a discount on all other registrations, 25 copies of the Bio-Quarterly and a certificate of membership.

☐ **Institutions, $350/yr.**
For clinical, non-clinical, health care or academic facilities. Members receive a discount for the Annual Conference, 15 copies of the Bio-Quarterly and a certificate of membership.

$__________ TOTAL

☐ **Check:** Visit our website at www.BENOethics.org to set up your account. Make your check payable to BENO and mail to **MA Marketing Communication, 2653 Ramsay Rd., Beachwood, OH 44122**

☐ **Credit Card:** Visit our website at www.BENOethics.org to set up your account.

(Please print)

Name or Contact Person ______________________________ Degree(s) ______________________________

Title ______________________________________ ◊ Institution ______________________________

Address (Circle work or home)____

City ____State __________________Zip ____________

Phone______/_________ FAX______/_________ Email____________________________________

◊ List all hospitals in your organization____

____

☐ Yes, you may use my information in the website password-protected directory

Please contact ljmarket@ma-marketing.net if you have any questions or want to verify your membership status.

* Your gift to BENO may be tax-deductable to the extent allowed by law.

Bioethics Network of Ohio
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Serving Ohio as an educational resource in healthcare ethics.

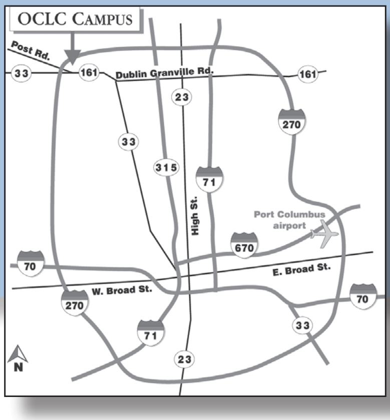
Save The Date!

Biothethics Network of Ohio

25th Annual Conference

Friday, May 1, 2015

OCLC™



The Conference Center at OCLC