Volume 26.... 2016.... Number 4

BENQ

BIO Quarterly
A Publication of
The Bioethics Network of Ohio

Ohio's Legalization of Medical Marijuana

Hilary Mabel, JD, *is a fellow in the Cleveland Fellowship in Advanced Bioethics. Prior to pursuing a career in bioethics, she practiced employee benefits law. She received her Juris Doctor from Harvard Law School.*

Earlier this year, Governor John Kasich signed into law a bill legalizing medical marijuana in Ohio. The law, known as House Bill 523, took effect on September 8, 2016 and has several provisions important for healthcare providers.

First, because physicians are prohibited under federal law from prescribing medical marijuana, the law permits them to "recommend" treatment instead. Physicians seeking to recommend medical marijuana in their practice must be certified to make such recommendations through the State Medical Board of Ohio. Moreover, in order to receive medical marijuana, patients (and their caregivers) must be registered with the State of Ohio Board of Pharmacy. A patient or caregiver's registration application must be filed by the patient's physician and must include certain certifications—namely, that (1) a bona-fide physician-patient relationship exists, (2) the patient has been diagnosed with a qualifying medical condition, (3) the physician requested from the Board of Pharmacy a report for the patient covering the preceding 12 months, and (4) the physician informed the patient of the risks and benefits of medical marijuana for that patient and that the benefits outweigh the risks. Specific rules regarding the certification requirements for physicians and registration requirements for patients and caregivers have not been promulgated yet by the State Medical Board or the Board of Pharmacy, respectively.

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Bio Quarterly
is published four times a year by Bioethics Network of Ohio,
2653 Ramsay Road
Beachwood, OH 44122
PH 216.397.4445

www.BENOethics.org

Submissions

to Bio Quarterly are encouraged. Manuscripts may be original material or reprint with permission. Appropriate subject/topics include: issue analysis, cases, report of institutional activity or programs, legisative and policy commentary and book reviews. Please submit your article electronically to **smithm24@ccf.org** for consideration. Quarterly deadlines are the 15th of February, May, August and November.

Robert M. Taylor, MD, FAAN, FAAHPM
President

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Ohio's Legalization of Medical Marijuana *continued from page 1...*

Pursuant to House Bill 523, a patient will be eligible for treatment with medical marijuana if he or she has one or more of the following qualifying medical conditions:

- AIDS;
- Alzheimer's disease;
- amyotrophic lateral sclerosis;
- cancer;
- chronic traumatic encephalopathy;
- Crohn's disease;
- epilepsy or another seizure disorder;
- fibromyalgia;
- glaucoma;
- hepatitis C;
- HIV;
- inflammatory bowel disease;
- multiple sclerosis;
- pain that is either chronic and severe or intractable;
- Parkinson's disease;
- PTSD;
- sickle cell anemia;
- spinal cord disease or injury;
- Tourette's syndrome;
- traumatic brain injury; and
- ulcerative colitis.

A patient may also petition the State Medical Board to approve additional medical conditions. The law permits only the following forms of medical marijuana consumption:

- edibles;
- oils;
- patches;
- plant material;
- tinctures;
- vaporization; and
- any other form approved by the state's Board of Pharmacy.

An individual may petition the Board of Pharmacy to add additional forms of consumption to the list, but smoking, any other form of combustion-related consumption, and any form that is considered attractive to children are strictly prohibited.

Additional important restrictions and requirements exist. A physician may not recommend medical marijuana for him or herself or a family member, and may only recommend medical marijuana for a patient who is a minor after obtaining consent from the patient's parent. The law also imposes certain annual reporting and continuing medical education requirements on physicians certified to recommend medical marijuana. Pursuant to the law, a patient's use or possession of medical marijuana cannot be used to disqualify the patient from medical care or from listing for transplantation.

The law requires that the State Medical Board and Board of Pharmacy adopt rules regarding the portions of the medical marijuana program each administers by September 8, 2017 and that the program be fully operational by September 8, 2018. So although medical marijuana is currently legal in Ohio under House Bill 523, it is possible that the infrastructure for the program—and thus patients' access to medical marijuana—will not be implemented as a practical matter for some time.

● Defending a Functionalist View of Higher Brain Death

Samuel H. LiPuma *has both Bachelors (1984) and Masters (1986) degrees in philosophy from the University of Dayton (Dayton, Ohio), and a Certificate of Advanced Study in Bioethics from Cleveland State University (2003). He is an Associate Professor of Philosophy at Cuyahoga Community College (Cleveland). His current research and publications are in the areas of palliative sedation and brain death. He has been a member of BENO for 15 years.*

Joseph P. DeMarco *has a PhD in philosophy from The Pennsylvania State University, in State College (1969). He is currently Professor Emeritus in the Department of Philosophy at Cleveland State University. He is author or co-author of five books and numerous journal articles.*

[This article, re-printed here with the permission of the authors who hold the copyright, was previously published in the Journal of Clinical Research and Bioethics, 2016; 7(2). The article is based on and summarizes the authors' previously published work, *Reviving Brain Death: A Functionalist View,* Journal of Bioethical Inquiry, 2013; 10.3: 383-392].

Abstract:

We provide a brief overview of the history of brain death showing how the cardiopulmonary model (CPM) of death became problematic due to the technological innovation of mechanical ventilation beginning with its use in the 1950s. We then examine difficulties that emerged with what was to become the received view of brain death known as Whole Brain Death (WBD). We argue that these challenges are never satisfactorily met by defenders of WBD. We also argue that a return to a CPM leads to even greater conceptual difficulties. Given that there are serious difficulties with both WBD and the CPM, we introduce a new version of higher brain death which we refer to as a *functionalist view*. We argue that a functionalist view of higher brain death can be defended more consistently than WBD and the CPM. Our defense introduces the notion of basing death on mental processing as opposed to traditional notions of higher brain death which used problematic and imprecise concepts such as consciousness and personhood.

Our defense introduces the notion of basing death on mental processing as opposed to traditional notions of higher brain death which used problematic and imprecise concepts such as consciousness and personhood.

I. Brief Overview on the History of Brain Death.

There are three standards that have been considered for determining the death of a human being. The oldest is the cardiopulmonary model (CPM). Under the CPM, human beings are considered dead when they permanently cease to breathe and circulate blood. Historically, this view of death worked quite well, and it is relatively easy to document. (1) However, due to technological innovation of mechanical ventilation, the CPM, for the first time in human history, seemed inadequate. In the late 1950s some of the first few patients kept alive through mechanical ventilation fell into a deep coma. They seemed to be neither fully alive nor fully dead to their physicians. (2) As a result the term "irreversible coma" was first coined. (3) The term "Brain

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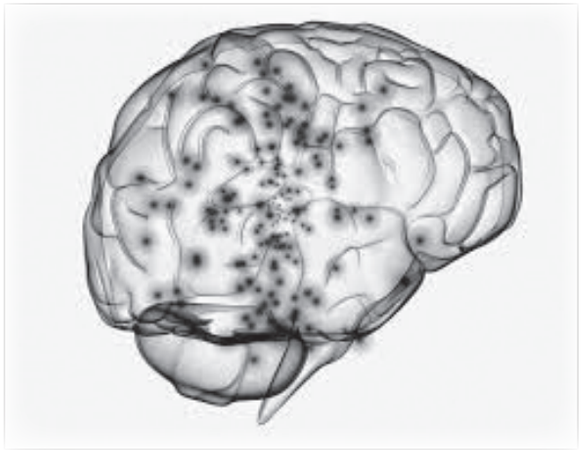

Death" was first used by Robert Schwab in 1963. Some doctors were disturbed by the semi-alive state they had created for their patients. (4) The apparent fact that people still breathing could be, in reality, dead inspired the Harvard Criteria of 1968 (5) documenting death as associated with irreversible coma.

The Harvard criteria used the following four measures for determining death:

- Unreceptivity and unresponsivity,
- No movements or breathing,
- No reflexes, and
- Flat EEG.

The criteria also demanded that all tests be repeated after 24 hours, documenting that no change resulted. The second was to rule out that the test results could be from either hypothermia or a temporarily depressed nervous system induced by therapeutic drug interventions. This established irreversible coma as a form of death as reflected in the thesis statement of the Harvard members, "Our primary purpose is to define irreversible coma as a new criterion for death." (6)

For the first time in human history, it seemed legitimate to declare a human being dead based on the permanent cessation of brain activity even if a person had a beating heart and breathing lungs. What is also remarkable is the general acceptance of this notion of death by the general public. This is reflected in the fact that every state accepted the standard into law. Thus, there is a general consensus among the public that death for the human being need not be tied only to a CPM. There was a recognition that without a functioning brain, the functioning of the rest of the human body was irrelevant to distinguishing life from death.

The Harvard criteria operated, albeit somewhat imperfectly, throughout the 1970s (7, 8) until the 1981 President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research sponsored the Uniform Determination of Death Act. (9) Here the Commission set a more specific standard for determining death which became fully enacted, more or less as in the model code, as law in all 50 states of the United States and in many other countries. (10) This model became known as WBD. The WBD standard for determining death is, "Irreversible cessation of all functions of the entire brain, including the brain stem." (11)

An alternative view, promoted mostly by philosophers and bioethicists, emerged centering on the notion of consciousness. Since there is strong empirical evidence that the upper region of the human brain is responsible for conscious states, this became known as higher brain death (HBD). (12) HBD never gained traction among medical practitioners or policy makers. It has not been enacted into law. Problems regarding the exact nature of consciousness and a lack of verification criteria with respect to establishing the presence of consciousness precluded it from being seriously considered as an alternative to WBD.

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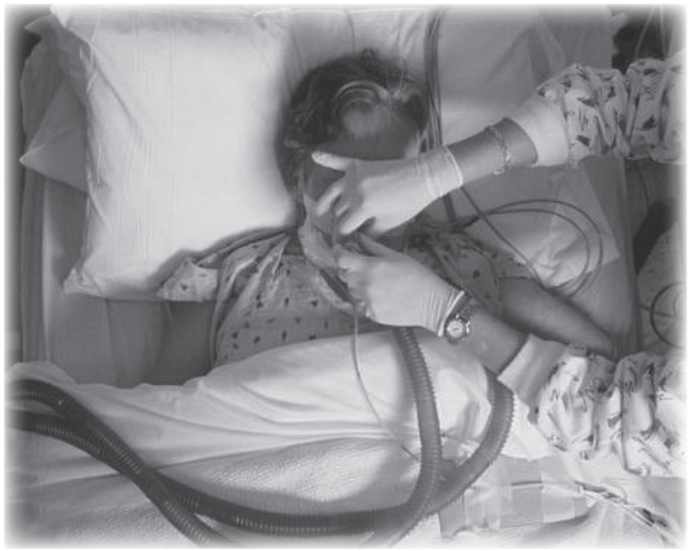
Little was questioned about the WBD model over the next 20 years until the neurologist D. Alan Shewmon wrote a seminal article questioning the legitimacy and consistency of determining WBD. (13) Shewmon bases his view on several functions brain dead patients have been able to carry out. Some of the more remarkable ones include wound healing, sexual maturation, maintenance of body temperature, and gestating a fetus. Due to the reaction to Shewmon's article, a second President's Council was convened in 2008 which resulted in a White Paper on brain death. (14) In the White Paper the notion of WBD is defended as the best standard for determining the death of a human being.

II. Problems with WBD.

Although WBD remains the received view for determining the death of a human being, closer scrutiny reveals serious inconsistencies with this standard. One such problem has been the insistence on what constitutes the permanent cessation of the functioning of the brain. It has been well documented that "nests of neurons" can continue to function after WBD has been verified. Robert Veatch has used this point to argue persuasively against WBD:

> The idea that functions of "isolated nests of neurons" can remain when an individual is declared dead based on whole-brain-oriented criteria certainly stretches the plain words of the law that requires, without qualification, that all functions of the entire brain must be gone. …By the time the whole-brain-oriented definition of death is so qualified, it can hardly be referring to the death of the whole brain any longer. (15)

As a further defense when these inconsistencies are raised, apologists for WBD like James Bernat (16) dismiss this type of brain activity as lacking any significance. They claim that such activity reflects isolated instances of the brain and is not reflective of "the organism as a whole." Bernat goes so far as to claim that after adding the expression, "organism as a whole" to the standard WBD definition regarding the permanent cessation of the entire brain, "… [WBD] provides a failsafe mechanism to eliminate false positive brain death determinations." (17) Still, J. McMahan argues that the "organism as a whole" concept leaves significant difficulties. (18) McMahan demonstrates that there is no empirical basis on which to justify what constitutes the organism as a whole. McMahan uses Shewmon's evidence that many functions occur with no real central brain integrator. McMahon also points out that the notion of an organism as a whole cannot be a conceptual claim. Brain functions could be mechanically replaced, as are other organ functions. The mechanical replacement of a function of the brain thought to be accountable for central integration would not, for McMahan, serve as a distinguishing mark between life and death. "It is very hard to believe that such a change could make the difference between life and death in an organism, either as a matter of fact, or, especially, as a matter of conceptual necessity." (19)



There are additional problems for WBD advocates. Consider the case of dicephalus twins. Almost everyone agrees that in these cases, two distinct persons share one body. (20) What dicephalus twins demonstrate is that we identify life with mental processing (consciousness) more than anything that has to do with biological functioning. (21) If one of the twins was to permanently lose the capacity for all mental processing, one would be hard pressed to consider that twin still alive in any meaningful sense. But that is just what a WBD advocate would have to admit.

This thought experiment could also be reversed with the same result. Let us suppose that we are able to transplant the head of one of the twins onto a machine that took care of all other bodily functions. Then clearly, this twin would still be alive as a human being in every meaningful sense of the term, even though it only had a functioning head and brain while all of its other biological functions were managed mechanically. Shewmon concludes, "The point is simply that the orthodox, physiological rationale for [WBD] is precisely physiologically untenable." (22) The WBD standard does not properly account for the notion that our mental capacity can be distinguished from our other biological functioning. A person need not be an "organism as a whole" to be considered alive so long as she has the capacity for functional mental states.

Though WBD has significant difficulties with respect to achieving an objective, consistent standard, it received fur-

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ther support from the 2008 White Paper of the President's Council. Here the Council attempts to further defend the biologically-based foundation of WBD as developed by Bernat and others. "All organisms have a needy mode of being.… To preserve themselves organisms must—and can and do—engage in commerce with the surrounding world." (23)

The authors of the White Paper go on to cite three fundamental capacities that organisms must retain in order to realize this engagement with the world:

> 1. Openness to the world, that is, receptivity to stimuli and signals from the surrounding environment;
>
> 2. The ability to act upon the world to obtain selectively what the organism needs; and
>
> 3. The basic felt need that drives the organism to act as it must, to obtain what it needs, and what its openness reveals to be available. (24)

The authors then claim that the determination of WBD properly accounts for the failure of the organism to satisfy all three categories. They also claim that Shewmon does not account for the "drive" an organism must maintain to be considered alive. Isolated biological functions maintained after the declaration of WBD documented by Shewmon occur with no drive or engagement with the world. "But Shewmon misses the critical element: the drive exhibited by the whole organism to bring in air, a drive that is fundamental to the constant, vital working of the whole organism." (25)

We find the argument of the White Paper flawed. It does not account for the distinction between biological and mental functioning demonstrated by the case of dicephalus twins. It also plays on an equivocation concerning the term "openness" to the world. For instance, a human being that blinks when air is puffed in her face is "receptive to stimuli," but one would be hard pressed to consider that a sign of life if all mental processing was permanently lost. It would be little different from a mechanically built face that blinked from the same stimuli. Lastly, a fully conscious but highly disabled human being could have all biological functions maintained mechanically, could also have no felt need as a result, but is obviously still very much alive.

III. Problems with the CPM

At first glance, given the significant problems emerging with WBD, a return to the CPM can seem appealing. However, the CPM may have even greater conceptual difficulties. For instance, Shewmon must admit that a fully functioning human body with no brain activity must be considered alive. Shewmon considers such a person to be, "…very sick and disabled, but not dead." (26) Carrying this thought further, we can imagine a human being with no head at all still being declared alive on this standard. Miller and Troug, in defense of CPM, take just such a stand considering the decapitated living person as merely repugnant but not absurd. (27) John Lizza, in a critical commentary, argues that this scenario is clearly beyond repugnancy and is indeed absurd. (28)

…we use the term "mental processing" as best characterizing the distinguishing mark between life and death for the human being.

IV. Defending HBD Based on Mental Processing

The earliest arguments developed in support of what would eventually come to be known as HBD centered on the notion of consciousness. (29) Consciousness is a difficult term to conceptualize. Consciousness implies awareness, but there is evidence that much of our mental life occurs on a preconscious level. (30) Because of this we use the term "mental processing" as best characterizing the distinguishing mark between life and death for the human being. We think this is supported by the general public as evidenced by the relatively quick acceptance of brain death. Had biological functioning of the body been solely important,

brain death would have been rejected. Furthermore, a human being permanently and completely void of all mental functioning, from fully preconscious to fully self-conscious, is dead in every meaningful sense of the term qua human being regardless of how much biological functioning continues. Human biological functioning that occurs with absolutely no corresponding mental states would be no different than the functioning of a computer program that produces outputs based on inputs, or the swinging open of the grocery store door as it "senses" the presence of an oncoming customer. What emerges from this debate regarding standards of death is that attempts to demarcate the difference between life and death qua human being cannot be based exclusively on empirical findings. It also includes cultural standards and influences. We argue that basing human death on the complete and permanent absence of all mental processing offers the least arbitrary standard possible and is consistent with the conception the general public holds as a distinguishing mark.

...basing human death on the complete and permanent absence of all mental processing offers the least arbitrary standard possible and is consistent with the conception the general public holds as a distinguishing mark.

To further illustrate this point, consider a comparison between two suicides. In the first, the person commits suicide at age 25 by ingesting poison and dies a full biological death soon after ingesting the poison. In the second, the person decides to no longer live, but does not want to be associated with the stigma of suicide. So the person creates a setting for herself where she is able to be completely void of all mental states permanently at the flip of a switch, and all of her other biological needs will be met by machines. She flips the switch at age 25 and remains in this state of a total mental blackout for 50 years until she dies of natural causes. We argue that in both cases, the person is dead at age 25; from the time that she permanently destroyed the capacity for mental life. It is just that in the former case she also destroyed all of her biological functioning by ingesting poison. In the latter case she maintained biological functioning, but with the permanent cession of all mental functioning, became as dead qua human being as in the other case. That these cases are indistinguishable is supported by the fact that there would be no difference for all

others attempting to interact with the two individuals. One would go to a grave and one would go to a bedside, but the result experientially would be the same. We would be visiting a completely unresponsive, non-conscious entity. Such a situation, perhaps, is best reflected in the landmark case of Nancy Cruzan who lost all mental functioning due to an automobile accident. (31) Her tombstone marks not only her birth and biological death dates, as is traditionally the case. It also included the time she "departed" which corresponded with the permanent cessation of her mental life at the time of her automobile accident.

V. Concluding Remarks

The movement to any brain death standard is of profound significance. It reflects the need to demarcate death beyond mere biological functioning of body parts. We argue here that the most consistent standard of brain death should be one based on the permanent cession of all mental processing. For this properly reflects that what is essential for human life is not a beating heart or a breathing lung, but rather the capacity for a mental life.

Footnotes and References:

1. There were instances of misdiagnosed deaths even using this standard, but it was not nearly as prevalent or problematic as brain death determinations were to become. For more information on the problem of misdiagnosed deaths using the CPM model, see Bondesen, J. (2001), Buried Alive, W. W. Norton and Company, New York, N.Y.

2. In 1959 two landmark cases occurred. The first was cited by Werheimer and Jouvet who coined the term "death of the nervous system." The second was cited by Mollaret and

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Goulon. [See Wijdicks EFM, (2011), Brain Death, Oxford University Press, 2nd Edition, Oxford, N.Y. p. 4].

3. Mollaret and Goulon first coined the term "coma depassé" or "irreversible coma."

4. Goulon thought this was unsettling and wondered, "where the patient's soul dwelled."

5. Beecher, HK, et al. (1968), Report of the ad hoc committee of the Harvard Medical School to examine the definition of brain death: The definition of irreversible coma, JAMA, 205: 337-340.

6. Beecher, p. 337

7. For instance, see Tucker v Lower (1975) for one of the first court cases involving the use of brain death as a legal criteria for death.

8. The landmark case of Karen Ann Quinlan also stirred debate regarding the determination of brain death. For more information on the Quinlan case see the Karen Ann Quinlan Memorial Foundation webpage, http://www.karenannquinlanhospice.org/history/

9. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (1981), Defining Death: Medical, Legal, and Ethical Issues in the Determination of Death, Washington DC: U.S. Government Printing Office.

10. Wijdicks, EFM, (2002), Brain death worldwide Accepted fact but no global consensus in diagnostic criteria. Neurology 58.1: 20-25.

11. President's Commission, 1981.

12. For more information on HBD, see Veatch, RM, (1975), The whole-brain-oriented concept of death: an outmoded philosophical formulation. Journal of Thanatology 3: 13-30; Youngner, SJ and Bartlett, ET, (1983), Human death and high technology: the failure of the whole-brain formulations. Annals of Internal Medicine 99.2: 252-258; and Batavia, A I, (2002), Disability versus futility in rationing health care services: Defining medical futility based on permanent unconsciousness—PVS, coma, and anencephaly. Behavioral Sciences & the Law 20.3: 219-233.

13. Shewmon, DA, (2001), The brain and somatic integration: insights into the standard biological rationale for equating "brain death" with death. Journal of Medicine and Philosophy 26.5: 457-478.

14. President's Council on Bioethics, (2008), Controversies in the Determination of Death, Washington, D.C. Retrieved at https://bioethicsarchive.georgetown.edu/pcbe/reports/death/

15. Veatch, RM (1993), The impending collapse of the whole-brain definition of death. Hastings Center Report, 23.4: 18-24, 19.

16. Bernat, JL, (2006) The Whole-Brain Concept of Death Remains Optimum Public Policy. The Journal of Law, Medicine and Ethics, 34.1:35-43.

17. Bernat, p. 39.

18. McMahan, J, (2006), Alternative to brain death, The Journal of Law, Medicine & Ethics 34.1: 44-48.

19. McMahan, p. 46.

20. Bondeson, J, (2001), Dicephalus conjoined twins: a historical review with emphasis on viability. Journal of Pediatric Surgery 36.9: 1435-1444.

21. We use the term "mental processing" over "consciousness" and "personhood" due to the lack of clarity and consistency over the meaning of the terms "consciousness" and "personhood."

22. Shewmon, p. 474.

23. President's Council, p. 60.

24. President's Council, p. 61.

25. President's Council, p. 63.

26. Shewmon, p. 471.

27. Miller, FG and Truog RD, (2009), The incoherence of determining death by neurological criteria: A commentary on Controversies in the Determination of Death, a white paper by the President's Council on Bioethics, Kennedy Institute of Ethics Journal, 19.2: 185-193.

28. Lizza, JP, (2009), Commentary on The incoherence of determining death by neurological criteria, Kennedy Institute of Ethics Journal, 19.4: 393-395.

29. See above Veatch (1975); Youngner and Bartlett (1983); and Battavia (2002), footnote 12.

30. For more evidence of how preconscious or subconscious mental activity can impact behavior, see Damasio A, (1999), The Feeling of What Happens, Harcourt Brace Jovanovich New York. NY; and Haidt J, (2001), The emotional dog and its rational tail: a social intuitionist approach to moral judgment. Psychological Review 108.4: 814.

31. For more details on the Cruzan case, see Colby WH, (2002), The Long Goodbye: The Deaths of Nancy Cruzan. Hay House Inc.

● Newly Elected BENO Officers

After many years of dedicated service to BENO as a Board member and then as President, Sharon Darkovich, RN, MA, BSN, CPHQ, stepped down as President during the summer of 2016. Sharon routinely encouraged the readers of *BIO Quarterly*, through her letter "From the President" in each issue, to get involved in the organization, participate in annual conferences, and make an impact on quality patient care at their home institutions. Sharon's leadership will be missed by all!

Through the annual summer election process, the President's baton has been passed to newly elected BENO President **Robert M. Taylor, MD, FAAN, FAAHPM**, who is Associate Professor of Neurology and of Clinical Medicine in the Center for Palliative Care at The Ohio State University Wexner Medical Center. Bob has been an active member of BENO since the mid-1990s and was a presenter at several BENO conferences. He has served multiple terms on BENO's Board of Trustees, including serving as Vice-President for the past year.

Succeeding Bob as BENO's Vice-President is **Cassandra D. Hirsh, DO**, a pediatric Palliative Medicine physician in the Haslinger Family Pediatric Palliative Care Center at Akron Children's Hospital. Cassandra has been on the BENO board for the last 3 years serving as both a member and Chair of the Nominating Committee. She is also a member of the Ethics Committee at Akron Children's.

Congratulations to both Bob and Cassandra!

Margot Eves, JD, MA, Staff Bioethicist at Cleveland Clinic, continues in the Officer position of BENO's Treasurer.

WELCOME
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Individuals

Wayne Decker, MA, MDiv
UH Parma Medical Center
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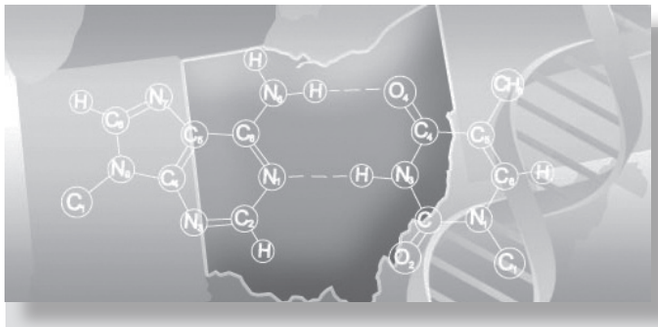

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- **Network** with experienced ethicists statewide.
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Visit our website, ***BENOethics.org****,*

● 2016 Election Results for BENO's Board of Trustees

Through the Summer 2016 election process, three current members of BENO's Board of Trustees were re-elected to the Board, and three nominees were elected to the Board for the first time.

The re-elected Board members are:

- **Asma Mobin-Uddin MD, FAAP**, Clinical Bioethicist at The Ohio State University Wexner Medical Center for Bioethics and Medical Humanities. Asma is also a staff pediatrician at Nationwide Children's Hospital in Columbus, and she serves as a member of OhioHealth's Joint Ethics Advisory Committee (JEAC) and on their Clinical Ethics Competency Task Force, a subcommittee of JEAC that educates and trains hospital-and community-based personnel to be effective members of medical ethics committees.

- **Steven J. Squires, MEd, MA, PhD**, System Director of Ethics, Mission and Values Integration, Mercy Health. Steven became a BENO Board member in 2013 and has served as an annual conference Chair. Prior to coming to Ohio in 2012, he was the Director of Mission and Ethics for Trinity Health in Livonia, MI. His PhD is in Health Care Ethics from Duquesne University.

- **Kathryn Westlake, RPh, MA, PharmD, BCOP**, Clinical Pharmacist, University Hospitals Case Medical Center in Cleveland. Kathy has been a BENO member for over 10 years and served on the Board for 3 years. She received her Master of Arts degree in Bioethics in 2000 from Case Western Reserve University. She developed and teaches a one hour elective class in Pharmacy Ethics at Northeast Ohio Medical University. .

The newly-elected Board members are:

- **Alan Murphy, PhD**, Clinical Ethicist at OhioHealth for Riverside Methodist Hospital and the system's community-based services. Alan earned his PhD in Religion (concentrated in ethics) at Vanderbilt University, and has Master's Degrees from Lexington Theological Seminary and Yale Divinity School. He recently moved to Ohio.

- **Amy Patterson, MSN, MA, RN, CCTC**, Nurse Educator, University Hospitals, Ahuja Medical Center, Cleveland. Amy has been a registered nurse for 19 years and spent most of her nursing career in critical care and transplant nursing. She has a Master of Arts in Bioethics from Case Western Reserve University and a Master of Science in Nursing Education from Georgetown University. She is a member of the hospital's Ethics Committee.

- **Curt A. Sheldon, MD, FACS, FAAP**, Professor of Surgery, University of Cincinnati. Curt has been a practicing surgeon in Ohio for over 30 years. He has taken BENO's Ethics Consultation Course and is nearing completion of a Masters Degree in Philosophy at the University of Cincinnati (with an emphasis on Ethics). He has presented at the annual conferences of the American Society of Bioethics and Humanities for the past three years.

Mobin-Uddin | Squires | Westlake | Murphy | Patterson | Sheldon

● Sacred and Profane: Balancing the Sanctity of the Human Body with the Mechanics of Cadaver Dissection

Michael Dauzvardis, PhD, *is Assistant Professor of Medical Education at the Loyola University Chicago Stritch School of Medicine. He holds a doctorate in anatomy and has been recognized by the Stritch students with numerous teaching awards.*

The essay is reprinted with permission from Reflective MedEd (http://reflectivemeded.org)

Often heard on the first day of anatomy lab:

"Oh— I'm so glad the cadaver doesn't look real. It is gray and ashen. The skin is wrinkled and the head is shaven. I can do this— I'll make the first cut."

In fall, in medical schools across the country, students begin their initial rite of passage on their journey to becoming a physician by undertaking the task of cadaver dissection. It is the job of the anatomy faculty to assist the students in this profane act by teaching them how to use scalpels, long knives, saws, hammers, and chisels in the disassembly of the human body. At the same time, it is also the job of the anatomy faculty, campus ministry, and other enlightened students to hit the "spiritual reset button" and remind all dissectors not to neglect the "human" in human dissection. Most medical schools now have an opening (and closing) ceremony focusing on the sacredness of the human body and the unselfish gift and generosity of the donors…

During lab, if I notice students, other faculty, or even myself getting a little too blasé with the removal of an organ or disarticulation of an extremity, I begin to engage in a little exercise I call "PERHAPS"…

Perhaps… this 92 year old cadaver was named Frank.

Perhaps… Frank was an only child and his parents cried when he was born.

Perhaps… Frank played baseball in an empty sandlot in Chicago and broke both a window and a bone in his right foot.

Perhaps… Frank worked evenings and weekends in his grandfather's bakery during high school.

Perhaps… Frank stormed the beaches of Normandy during World War II.

Perhaps… Frank made love in the back of a '47 Chevy.

Perhaps… Frank married his high school sweetheart.

Perhaps… Frank cried at the birth of his first child.

Perhaps… Frank was a police officer.

Perhaps… Frank worried that his daughter would contract polio.

Perhaps… Frank knew exactly where he was when President Kennedy was shot.

Perhaps… Frank marveled at the landing of the first man on the moon.

Perhaps… Frank suffered at the hands of the 1969 Cubs.

Perhaps… Frank bought his first color TV in 1970.

Perhaps… Frank cried at the wedding of his daughter and the birth of his first grandchild.

Perhaps… Frank cried when his parents passed.

Perhaps… Frank loved to fly-fish.

Perhaps… Frank loved to partake of scotch on the rocks.

Perhaps… Frank loved to play Hearts, 31, and Risk.

Perhaps… Frank was diagnosed with cancer.

Perhaps… Frank came to realize that the gift of his body would help future doctors perfect their craft.

Perhaps… Frank's wife, children and grandchildren cried at his passing.

Also often heard on the first day of anatomy lab:

"He looks so peaceful— almost asleep. Let's cover his face and groin until we are ready to study those regions. Did you notice his tattoo? – and the scar on his foot? Does anyone want to make the first incision?"

● In the Literature: A Book Review

Anne Lovell, BSN, MSN, *is a retired nurse practitioner in Clinical Genetics and a former member of the Ethics Committee and Consultation Team at Cincinnati Children's Hospital. She was an ethics educator at the University of Cincinnati and at Xavier University. She has been a member of BENO's Board of Trustees for over 12 years, and is a faculty member and the administrator for BENO's annual Ethics Consultation Course.*

Hoffman, Sharona (2015). *Aging with a Plan: How a Little Thought Today Can Vastly Improve Your Tomorrow*. Praeger Publishers, Santa Barbara, CA. ISBN: 978-1-448-3890-3.

Sharona Hoffman is a Professor of Law and Bioethics, with experience as a member on Cleveland's University Hospital Case Medical Center ethics committee. In that capacity, she served as an active participant in discussions about treatment controversies and decision making for incapacitated patients without proxies. Then, over the last several years, Ms. Hoffman experienced personal challenges while caring for her elderly parents and mother-in-law as they aged, became ill, and died. This background gave her direction to consider what might be termed a "best practice" approach for individuals and families in their efforts to care for and support aging relatives, and to navigate what is often extremely complex decision making around legal, medical, financial, emotional, and ethical choices with or for their loved ones.

Using an interdisciplinary approach drawn from her background in law and bioethics, Ms. Hoffman supplements her advice with evidence of scholarly research and analysis, and with a wealth of personal anecdotes, as she states, "to make the book engaging and a fairly easy read." The book is certainly that—well-organized, incredibly detailed, and clearly written, whether one reads it from cover to cover, or consults it by chapter for guidance for a specific need or question. Topics covered include "money matters," community living, in-home assistance, long-term care, coordination of care, and end of life issues. Chapter 8 – "Exit Strategies: Maintaining Control at the End-of-Life" – includes discussions about palliative care, suicide, directing one's own care, and religious beliefs. The author emphasizes advocacy, by or in support of the elder person, finding appropriate care providers who "treat the patient, not the disease," and coordination of care by providers. Those who have been engaged in patient care as a vocation know all too well how important this is, but also how difficult it may be to enlist such persons. At the end of each chapter, Ms. Hoffman includes a "preparedness checklist" which summarizes take-away messages and outlines practical next steps for readers.

This book may differ from others on the subject of aging and elder care in that, in addition to "this is what you should think about or do," Ms. Hoffman includes very thoughtful and practical suggestions and strategies for going about getting things done in the most respectful and considerate manner. There is an entire chapter devoted to "Driving While Elderly," providing a compassionate perspective that balances statistics of elder driving accidents and incidents, with the inherent difficulty addressing the surrendering of one's right to drive because of concerns for harm to self and others. This is a topic that can often lead to conflicts within families.

Ms. Hoffman includes very thoughtful and practical suggestions and strategies for going about getting things done in the most respectful and considerate manner.

Ms. Hoffman does not purport to have all the answers to the many practical and ethical issues of aging and supporting those who are aging, but this book has MANY answers, and offers a wealth of information that can lead to further thought and finding a best plan for individuals and families. It is highly recommended.

ASBH 18th Annual Meeting

AMERICAN SOCIETY FOR BIOETHICS + HUMANITIES

October 6 – 9, 2016
Hyatt Regency Washington on Capital Hill
Washington, DC

WHO SHOULD ATTEND

The American Society of Bioethics and Humanities (ASBH) Annual Meeting is designed for physicians, nurses, attorneys, historians, philosophers, professors of literature and the humanities, members of the clergy, social workers, and others engaged in endeavors related to clinical and academic bioethics and the health-related humanities.

PURPOSE

The ASBH Annual Meeting is an arena for interdisciplinary exchange among professionals in the fields of bioethics and the medical humanities.

OBJECTIVES

After participating in this meeting, attendees should be able to

• discuss emerging issues in bioethics and the medical humanities

• discuss and apply recent research findings related to bioethics and the medical humanities

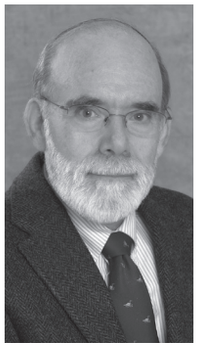
• reflect on the place of critical distance in bioethics and the medical humanities.

For more information and to register, go to asbh.org

Featured Speakers:

Julie Saba, MD PhD
Doubling Time: Chronicles of a Cancer Insider

The distance between doctor and patient is as small as the distance between the doctor's mouth uttering a diagnosis and the patient's ears. Empathy is a crucial aspect of doctoring and, being human, doctors will sooner or later seek empathy as patients. As an oncologist and cancer researcher who also has leukemia, the presenter has scrutinized the condition from every angle and will share her alternating perspectives as she moves forwards on all fronts.



Paul S. Appelbaum, MD
Consensual vs. Coercive Mental Health Treatments: New Manifestations of an Old Dilemma

Coercive approaches date to the very beginnings of organized mental health treatment. Despite the expectation of reformers in the last third of the twentieth century that coercive approaches would wither away, they have not disappeared and may not even have diminished. This presentation looks at the practice of coercive interventions, the justifications offered, and the likely future of nonconsensual approaches to mental health care.

Amy Kuebelbeck
Perinatal Hospice and Palliative Care: Continuing a Pregnancy When a Baby's Life Is Expected to Be Brief

After receiving a prenatal diagnosis that their baby has a life-limiting condition, some parents wish to continue the pregnancy and embrace whatever time they may have with their child, even if it is only the time before the birth or a few minutes after the birth. This relatively new patient population can be supported through the innovative model of perinatal hospice and palliative care, a compassionate and practical response to one of the most heartbreaking challenges of prenatal testing. The presenter will share her own story and offer insights through the words of many parents who have walked this path.

● Toward Certification of Ethics Consultants – Redux

Marty Smith, STD, *is a full-time clinical ethicist at the Cleveland Clinic. He is a member of BENO's Board of Trustees and editor of BIO Quarterly. He was a member of the "Quality Attestation" Task Force of the American Society for Bioethics and Humanities, and is currently a member of ASBH's Healthcare Ethics Consultant Certification Task Force.*

At the annual BENO conference in 2014, I was the presenter for the Jim Barlow Memorial Lecture. The title of my presentation was: "The Future for Ethics Consultants: Professionalization, Certification, Licensure … Oh My!!" Included in my presentation was a summary of the activities and progress of a task force of the American Society for Bioethics Humanities (ASBH) that focused on "Quality Attestation" as a prior step to Certification of healthcare ethics consultants (HCECs). This task force envisioned a two-step process for Quality Attestation of consultants: 1) submission of a portfolio of ethics case consultations to be evaluated by experts in the field, and 2) an oral examination focused on case discussions. Step 1 in this process was successfully piloted with 23 participant-consultants. For a variety of reasons (including financial resources), step two (the oral examination) was never operationalized. The activities and outcomes from the work of this task force are summarized in two peer-reviewed journal articles. (1, 2).

In the spring of 2016, the ASBH Board of Trustees authorized the first steps toward what could emerge as a voluntary Certification process for ethics consultants.

In the spring of 2016, the ASBH Board of Trustees authorized the first steps toward what could emerge as a volunteer Certification process for ethics consultants. The Board approved a proposal that included an initial expenditure of ASBH's reserve funds and the contracting with a corporation expert in psycho-metrics, surveys, and test development. The aim of this new initiative is to conduct a national survey of HCECs to better delineate and understand the actual roles and activities of HCECs, and to ascertain the feasibility and interest among HCECs to have available a certification process. During the summer of 2016, a thirteen member HCEC Certification Task Force was named

to serve as content experts and to reflect the diversity of HCEC roles in working with the psycho-metricians.

On ASBH's website (asbh.org), the following information is provided regarding the process and timeline for these initial steps that could lead toward Certification:

> "The specific aim of this project is to take two steps in the process of designing a credible, sustainable certification program to improve the quality of HCEC services. The first step is to evaluate the demand for a HCEC certification program and to assess the sustainability of such a program. The second step is a role delineation study to clearly delineate domains and tasks that characterize proficient performance and ensure that the content specifications of an exam accurately reflect current practice. Content validity is established by linking exam content to the competencies (e.g., knowledge and skills) identified in a role delineation study. The process is designed to meet industry standards for legal defensibility and credibility…. It is anticipated that the task force will complete its charge by April 2017."

I recommend to readers of BIO Quarterly to occasionally log on to ASBH's website to look for news and developments related to this potential Certification process

As I gaze into my crystal ball, I continue to believe that the "professionalization" of HCECs will continue. A significant next step (which is not a certainty but I predict will happen) is the development and availability of a voluntary Certification examination within the next few years. I recommend to readers of *BIO Quarterly* to occasionally log on to ASBH's website to look for news and developments related to this potential Certification process. Even more concretely, keep an eye out for an announcement there that the feasibility and role delineation survey is available – and then participate in the process by completing the survey.

References

1. Kodish E, Fins, J, Braddock C, Cohn F, Dubler N, Danis M, Derse A, Pearlman R, Smith M, Tarzian A, Youngner S, Kuczewski M. Quality Attestation for Clinical Ethics Consultants: A Two-Step Model from the American Society for Bioethics and Humanities. Hastings Center Report 2013; 43(5): 26-36.

2. Fins JJ, Kodish E, Cohn F, Danis M, Derse AR, Dubler NN, Goulden B, Kuczewski M, Mercer MB, Pearlman RA, Smith M, Tarzian A, Youngner S. A Pilot Evaluation of Portfolios for Quality Attestation of Clinical Ethics Consultants. American Journal of Bioethics 2016; 16(3): 15-24.

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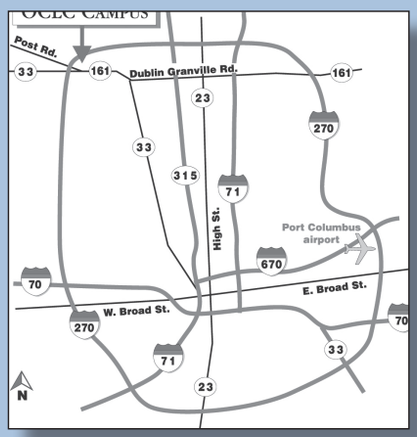

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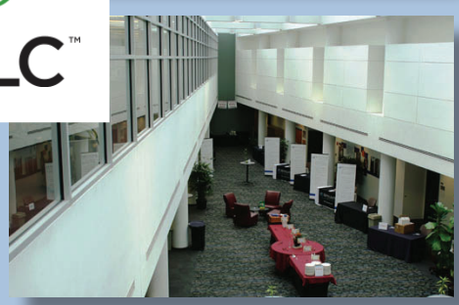

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