

BENO

BIO Quarterly

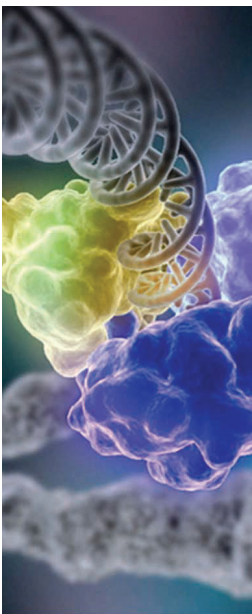
A Publication of
The Bioethics
Network of Ohio



● BENO and the Modern Bioethics Movement

Brendan Minogue, PhD, is Professor Emeritus of Philosophy and Religious Studies, Youngstown State University. He received his doctoral degree from Ohio State University in 1974. He taught medical ethics and served on the Human Values in Medicine Committee at the Northeastern Ohio Universities College of Medicine (NEOUCOM), and served on the Infant Care Review Committee, and Human Subjects Research Committee at Forum Health. His publications include a book entitled, *Bioethics: A Community Approach*. Brendan is a founding member of BENO and BENO's first President.

The nineteen-sixties were not only the decade of youthful revolution, but also the decade of bioethical revolution. While BENO was not present at the creation, it was nevertheless a natural outcome of this new revolutionary approach to medicine, which now has become the new standard of care. Many factors contributed to this bioethical revolution. Generally speaking, it was an ongoing movement in



which individual autonomy, under the banner of *patients' rights*, as well as social considerations, were reluctantly admitted into the practice of medicine. More specifically, the health care system began receiving an enormous amount of economic support from private and governmental insurance programs, such as Medicare. These insurance programs demanded a voice in determining how the medical system treated the sick. In addition the early stages of the bioethical revolution were driven by technological transformation. Medical technology itself forced us into revolutionary change by creating new problems, which required us to think about our old assumptions regarding the practice of medicine. New technologies, such as Dialysis, produced skyrocketing medical inflation during the late sixties, and this inflation spawned our current concerns with rationing. Cardio-pulmonary Resuscitation entered the practice of medicine at about the same time, and the

CONTENTS

Bioethics Week

6

Can Health Care Providers Love Their Patients?

8

Putting Patients Before Publicity

10

continued on page 3...

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

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Quarterly deadlines are the
15th of February, May, August
and November.

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WELCOME New BENO Members

Individuals

Angela Lee, BSRT

Joint Township Dist. Memorial Hospital, St. Mary's OH

Bonnie Javurek, MEd

Cleveland Clinic, Cleveland OH

Dan Waters, MA

Mercy St. Charles Hospital, Toledo OH



From the President

Sharon Darkovich, RN, MA, BSN, CPHQ

It is hard to believe that Spring is nearly here. I am thankful for the mild winter and looking forward to Spring activities including BENO's annual Conference.

This Conference will be our 26th, having completed and celebrated a major milestone of 25 years in 2015. The upcoming Conference promises another line-up of great speakers. See the article on page 9 and visit the BENO website for the Conference brochure and to register.

BENO also looks forward to welcoming another group of participants to the Ethics Consultation Course and to honor those who will graduate by awarding their certificates at the annual Conference. The course begins April 28th. If you are interested but have not yet signed up, contact Anne Lovell, Course Coordinator, via the website.

The BENO Board will have several positions opening this summer. If you have an interest in serving on the Board, there is additional information in this edition of *BIO Quarterly* on page 9. New members to BENO are always welcome, and membership information is on the BENO website as well.

BENO continues to grow and the Board continues to look for ways to involve our membership and *BIO Quarterly's* readers in more of BENO's activities. We welcome contributions to *BIO Quarterly*, suggestions for conference topics, or suggestions for dynamic speakers.

I am looking forward to seeing you at the annual Conference and hope you will continue to be part of BENO's success by reading and sharing *BIO Quarterly* with your colleagues.

Sharon Darkovich, BENO President
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ongoing challenges associated with end-of-life care became an everyday topic of conversation. Transplantation and the associated challenges to redefine “death” were also gaining the public’s attention and challenging some of our most basic ethical concepts. Finally, the development of extensive new tools associated with managing neonates entered our shared consciousness and challenged our deepest values regarding our children.

But while economics and technology surely made us aware of our new bioethical problems, they did not provide any new understanding regarding the ethical management of these emerging medical technologies. Indeed many health care professionals felt a little bit like Dorothy in the **Wizard of Oz**, who exclaimed to her dog “Toto I don’t think that we are in Kansas anymore.” To come to grips with these ethical problems, our society turned to the humanities.... the great wellspring of free and open conversation regarding ethical values. The humanities had taught us that we need not have all the answers to our challenges in order to have a thoughtful, factual, and caring conversation regarding our alternatives. Practically speaking, this meant that the health care system needed to admit philosophers, theologians, and writers, as well as social scientists into the discussion of how best to treat patients.

The humanities had taught us that we need not have all the answers to our challenges in order to have a thoughtful, factual, and caring conversation regarding our alternatives.

At first many medical professionals considered this admission of the humanities and social sciences into the practice of medicine a “messy business.” Health care professionals want answers not just questions. As a philosopher, I remember feeling a little uncomfortable with this demand for answers. I was much more comfortable with exploring questions rather than providing detailed answers. However, if humanities’ educators were going to be bioethical educators, then we had to respond to this demand for something more than humanistic exploration. But how were we supposed to meet this demand for positive, content rich answers, which our new medical colleagues were demanding?

For many of us who were new to bioethical education, the answer involved turning to that humanities discipline, which most resembles concrete shared values... **the law**. This is worth repeating. The law is part of the humanities. The law never was and never will be a set of facts, though factual considerations are very relevant to it. It is more accurate to view the law as our shared response to problematic facts. Furthermore, the law is more than a set

of mere opinions. In addition, the law is neither a purely private nor a purely public matter. Furthermore, the law was no stranger to the “messy business” associated with making tough decisions even in the presence of ambiguity and opposing visions of the good life. Finally, every health care professional spends their working days dealing with the subjective, private patient, who has an objective, public



disease. Health care professionals know what it means to treat the patient....not just the disease. This notion that we humanists could use the discussion of relevant legal decisions to entice health care professionals into the discussion of fundamental values and rights was the cornerstone for building a revised body of knowledge called Bioethics.

This use of the law enabled bioethics education to become clarified by the nineteen eighties. We bioethics educators were not going to be pure philosophers or theologians or historians or literary theorists. We were going to accept a set of abstract values, which were beginning to emerge within a developing legal consensus. However, bioethics educators were not going to leave their concern with exploring values completely behind. Bioethics was going to continue to explore the ways in which public values, expressed within the emerging legal consensus, needed to be continually revised in the light of medical practice. In short, because medicine always required more than our legal abstractions could provide, bioethics began to concentrate on hospital-based ethics policies and guidelines, which more concretely directed the use of medical technology. These policies and guidelines were not laws. They did not have the coercive force of law. But these hospital policies and guidelines were not mere private, ethical opinions. While hospital ethics policies had no binding legal force, they did rest on experience, successful practice and ethical reflection. They emerged from the application of new technologies but they were also thoughtfully responsive to the challenges present within the management of these new medical technologies. In short, hospital ethics policies were viewed as tools aimed at bringing about respect for the rights of persons, as well as good medical consequences. Most importantly, they were the subject of constant review by multi-disciplinary professionals. This was the soil in which BENO grew, and it is this same soil which continues to fertilize our organization.

continued on page 4...

But it was not just bioethical educators who needed to change, if we were to effectively manage the new bioethical problems. Traditional physicians, nurses and health care administrators were also going to change as well. We were all going to try something slightly new! We were going to take seriously the idea that patients not only had kidneys and livers, but they also had rights and values, which also needed to be understood. **Biology and ethics were essential, if we were to become expert care givers.** In short, while understanding bodily organs would continue as the primary focus of the health care professional, appreciating the rights and values of the patient would grow in importance within this new, technologically altered practice of medicine.

By 1990, many of us had slowly started to come to a new self-understanding. We were Bioethicists. Out of this new self-awareness, BENO took root here in Ohio. Following a bioethics meeting at Youngstown State University, a number of us including George Kanoti, Marty Smith, and Jackie Slomka from Cleveland Clinic; Stuart Youngner and Stephen Post from Case Western Reserve University; and Jim Reagan from St Elizabeth's Hospital in Youngstown began meeting at the Cleveland Clinic and other medical and educational facilities around the state. Our goal was to build an organization which would continue the conversation about improving bioethical education and policy development. But we were also thinking broadly about those procedures which we should follow when, in conjunction with physicians, we actually began to manage bioethics cases on the floors of hospitals or other health care facilities. Organizations like BENO were developing across the country and all of these organizations were

Our goal was to build an organization which would continue the conversation about improving bioethical education and policy development.

taking root because there was a felt need to put flesh on the bioethical, legal skeleton. For example, it was easy to admit that we should respect a patient's right to say "no" to a prolonged technological death, but it was quite another to ethically manage an Intensive Care Unit (ICU). This latter task involved asking a host of new questions such as: what do we do when a patient or family demands technological services which only produce "prolonged death"? In short, the abstract nature of rights makes them very easy to misuse. Rights indeed be used to support improved quality of care but rights can also function as a pseudo substitute for quality medical care. At the time, it was quite common to spend a king's ransom in the ICU with no clear prospect of accomplishing any medical value other than profoundly debilitated, biological existence. Furthermore, while we had

law to give us some general guidelines, we also had judges telling us that they did not want to be called to the bedside every time we faced a problem.

To replace this "ad hoc" system of appealing to judges to make the difficult decisions, hospitals were suddenly required to develop ethics committees, which could develop ethics policies, which would effectively manage the difficult cases, which our problematic technologies had precipitated. Hospitals were also required to develop educational programs aimed at preparing physicians and nurses to apply these new ethics policies. Finally, hospitals were obligated to set up procedures, which represented a reasonable approach to managing these new bioethics cases. As we have said, the common legal consensus was abstract. To apply



it required concrete decisions. While the courts did not require hospitals to find the right answers, it did obligate hospitals to show that doctors were not being arbitrary or making their own decisions based on their private ethical values. Hospitals were being obligated to demonstrate that their practitioners were making decisions in the light of the common legal consensus. Legislatures and jurists had given us an abstract, common consensus regarding the management of bioethical cases, but when it came to particular persons, in particular crisis settings, hospitals were obligated to follow reasonable policies and procedures aimed at providing a thoughtful and respectful approach to patients.

These new obligations, which were being imposed on health care institutions, gave BENO its purpose. BENO was going to be the professional organization which helped both individuals and organizations practice bioethics in Ohio. However, BENO took a somewhat creative approach to accomplish this goal. We were going to rely on ourselves. We were going to form a network of our fellow Bioethics practitioners here in Ohio with the aim of sharing our best bioethical practices. We concentrated on identifying professionals, throughout the state, who worked within health care institutions, and who were both interested and responsible for bioethics policy development and education.

Institutions were reluctant at first to spend time and money on issues related to ethics. Ethics was not a revenue source. The ethics committee was not a dialysis unit, which generated income. If anything, it was a revenue drain. But there was no doubt that institutions were going to face ethical challenges. Facing these challenges required that hospitals demonstrate that they were not flying by the seat of their pants. Institutions needed a multi-disciplinary, “in house” mechanism aimed at applying a “best practices” approach to the challenges of bioethics. These practices would be broadly consistent with good medicine, as well as the national legal consensus, which was slowly taking shape.

To accomplish its task, BENO needed to attract practicing health care experts into our membership, and we wanted them to enter into a feedback relationship with all of our members. We wanted them to educate us, and we wanted to offer them a network of fellow professionals who were developing the required best practices. We wanted to be Ohio’s resource for best ethical practices and education. When something worked, BENO wanted to know about it. When something did not work, we were especially concerned to learn about it, so that our members did not repeat it. This remains our ongoing task.

● Future Challenging Opportunities

Allow me to close with a few remarks regarding what, I think, lies ahead for us. The first challenging opportunity we face involves new medical technology. While medical technology continues to alter the face of medicine, it has not done so without some unexpectedly negative consequences. Indeed it seems as if technology’s beneficial opportunities always come with some disruptive challenges. Because this pattern of technological innovation is likely to continue, BENO should be prepared, not only to understand these new technological developments, but also to separate the wheat (the beneficial opportunities) from the chaff (the unexpected harmful consequences). BENO will surely need to keep abreast of emerging medical technologies. But BENO is more than a collection of technologically competent health care professionals. Because our roots remain in the humanities, we sometimes need to call “time out” so that all of us can think about how to manage the unexpected consequences and implications of new medical technology. The ethics of human subject research has taught us that medical technological development can harm patients, even if it is well intentioned. We therefore need to find ways to validate our technological applications before we universally introduce them into hospitals across the state. If you wish to call this medicine’s “guilty until proven innocent” attitude, then so be it. But whatever you name this medical attitude, we need to incorporate a critical approach to new medical technologies, which impact the lives of patients.

...we need to be aware of how easy it is to cross the line and sacrifice the patient’s rights and/or medical interests for the sake of cost containment.

The second challenging opportunity which we face has been brought on by the successes which American medicine has made over the past decade on the issue of cost containment. Medical inflation is being reduced across the medical economy. This was needed. During the first stages of the war against medical inflation, cost containment was accomplished with relatively benign strategies such as reducing the over-supply of health care services. This accommodation of supply to need seemed necessary as well as very practical. In addition, public and private health insurance companies have driven medicine in the direction of cost-conscious case management and the preferred use of generic medications. These forces, with some exceptions, have seemed beneficial and consistent with patient interests and patient rights. Many of us accept the idea that there is no fundamental inconsistency between the health care professional having a duty to keep costs under control, as well as a fiduciary responsibility to the patient’s rights and medical welfare. However, even if we accept this broad consistency, we need to be aware of how easy it is to cross the line and sacrifice the patient’s rights and/or medical interests for the sake of cost containment. Once again, BENO cannot predict what cost containment tools will be introduced to reduce medical inflation. Many such strategies will work in the sense that they will be effective and consistent with our fiduciary commitment to the patient. But it is my hope that BENO will apply a critical attitude toward anti-inflation practices which sacrifice important medical and human values for the sake of cost containment.



● Celebrate Bioethics Week!



Marty Smith, STD, is the Director of Clinical Ethics at the Cleveland Clinic. He is a member of BENO's Board of Trustees, a faculty member for BENO's 2015-2016 Ethics Consultation course, and the editor of BIO Quarterly.

At BENO's Board of Trustees' meeting in September 2014, the Board voted unanimously to declare a state-wide, annual Bioethics Week to be held during the week leading up to BENO's annual conference. Therefore, in 2016, Bioethics Week in Ohio will be April 25th to April 29th, culminating with the 26th annual conference at the OCLC Conference Center in Dublin, OH.

Bioethics Week / April 25th - 29th

Celebrating Bioethics Week within your organization and institution can have multiple purposes. The BENO Board hopes that on a local level at your health care facilities, Bioethics Week will be an opportunity to raise awareness of your organization's clinical ethics resources, and to inform your clinical colleagues about the functions and services of your ethics committee and its members.

How might you celebrate Bioethics Week within your organization? Here are some suggestions:

- An information table near the hospital's cafeteria, staffed by ethics committee members during high-traffic times. Hand-outs could include:
 - *A one-page flier listing ethics committee members, functions, and how and when to access the ethics consultation service.
 - *A Patient Rights brochure.
 - *Copies of Ohio Advance Directives (Living Will and Health Care Power of Attorney).
 - *A list and summaries of your organization's ethics-related policies and procedures.
 - *Raffle tickets for gift cards.
 - *Bite-size candies!
- Clinical ethics educational events such as a Bioethics Grand Rounds, nursing in-services, "lunch and learns," and journal club discussions.
- Information and education about your ethics committee and ethics consultation service distributed through in-house publicity mechanisms (e.g., hospital newsletter or TV channel).



- A poster or easel display near high foot-traffic areas (e.g., cafeteria, main elevators) with information about Bioethics Week and the ethics committee, and photographs of ethics committee members.
- Recognition and appreciation of the service provided by ethics committee members, through certificates or plaques for years of service.
- Showcasing Quality Improvement projects initiated by the ethics committee or the ethics consultation service.
- Promoting BENO membership.
- Promoting attendance at BENO's annual conference, April 29, 2016, in Dublin, OH!!

This list of activities is certainly not exhaustive, and you and your ethics committee members should think creatively about what will work at your institution. Most importantly, somehow and in some way, celebrate Ohio's Annual Bioethics Week by raising awareness of your clinical ethics resources and by educating front-line professionals, personnel and administrators about clinical ethics issues.

What: A twelve-month course with the goal of enhancing core competencies necessary for gaining proficiency when functioning as a clinical ethics consultation team member.

How: Educational methods include didactics, mentoring, small peer group interactions, three independent projects, and reading assignments.

When: Five full-day sessions beginning April 26, 2016. Remaining dates to be determined.

Where: Columbus, Ohio

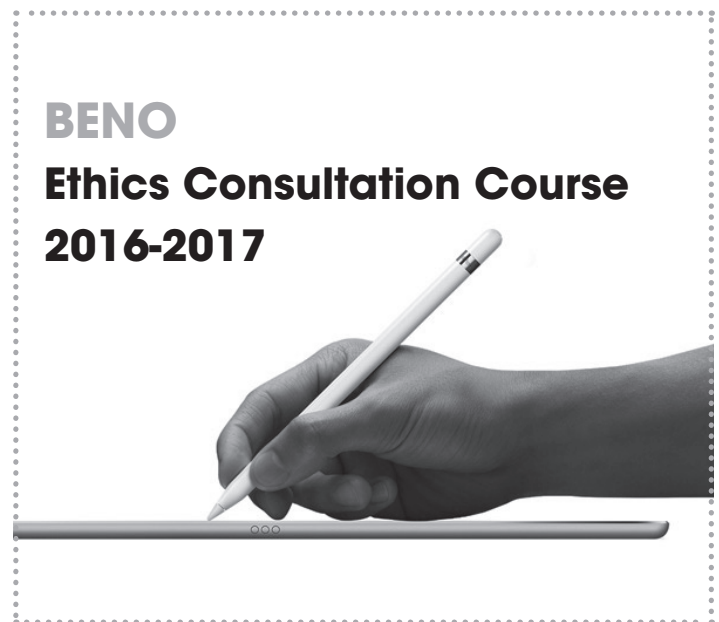
Participants: Maximum of 18.

Registration Fees: Physicians, \$675; Non-physicians, \$600.

CME/Contact/Clock hours: Applications to be submitted for 20 hours of CME and other CEUs.

Materials provided to participants (costs included in registration fee): (1) *Core Competencies for Healthcare Ethics Consultation*, 2nd Edition, 2011; (2) *Improving Competencies in Clinical Ethics Consultation, An Education Guide*, 2nd Edition, 2015; (3) Hester DM, Schonfeld T. *Guidance for Healthcare Ethics Committees*. Cambridge University Press, 2012; and (4) handouts and power point for each didactic.

Registration: Deadline April 1, 2016. Contact Course Administrator Anne Lovell: Annelovell65@gmail.com



Participants in BENO's 2015-2016 Ethics Consultation Course gathered in Columbus, Ohio on January 30, 2016 for their final "didactic day." Certificates for course completion will be awarded at BENO's annual conference on April 29th.

● Can Health Care Providers Love Their Patients?



Jennifer Blumenthal-Barby, PhD, MA, is an associate professor of Medicine and Medical Ethics with the Center for Medical Ethics and Health Policy at Baylor College of Medicine and has an adjunct appointment in Philosophy at Rice University. She received her B.S. in applied health science and a minor in philosophy, magna cum laude with University Honors, from Bowling Green State University in May 2002, and her Ph.D. in philosophy, with a specialization in bioethics, from Michigan State University in May 2008.

[This Blog entry is re-printed with Dr. Blumenthal-Barby's permission].

Ms. Clara [name changed] is one of our patient partners on a PCORI [Patient-Centered Outcomes Research Institute] funded project. PCORI is unique in that they aim to include patients and other stakeholders in all stages of research—from conceptualization of projects and their aims to the dissemination of results. We've been working closely with Ms. Clara and other patient partners for almost two years now. A few months ago, when visiting Ms. Clara in the hospital, her eyes became teary and she exclaimed, "I love you guys. I just feel like you really care, and you mean so much to me."

This gave me a great deal of pause: can we tell one of our patient partners that we *love* her in return? Do we love her? What would that mean? I relayed this story to one of the members of Ms. Clara's health care team, who replied, "Oh yes, *everybody* loves Ms. Clara."

This was the first time I had ever encountered the language of love in the professional setting of health care. And I wondered: Can doctors or other health care providers really love their patients? And is that appropriate?

Perhaps the contemporary philosopher who has thought the most about and developed the most robust account of love is Harry Frankfurt. This account is outlined in his book, *The Reasons of Love*. According to Frankfurt, love is a particular mode of caring that is defined by several characteristics.

1. Love involves a concern for the existence of the beloved and for its wellbeing (for its own sake).
2. Love is particular. There is no substitute for the beloved.
3. Love involves identification. As Frankfurt writes, "the lover is *invested* in his beloved: he profits by its successes, and its failures cause him to suffer" (p. 61).
4. Love, as a form of caring, is diachronic. Meaning that the person desires to continue loving the beloved—it matters to the person that their love continues, and they take steps accordingly.
5. Love is not up to us and is not established by reason. Love is, as Frankfurt puts it, a "volitional necessity"—what we find ourselves loving is a bare fact (due to

nature or circumstance) that gives content to and makes commands of what we will and what we do. In other words, love gives reasons and not the other way around. Love sets "final ends" for us.

Given this account, how plausible is it that a health care provider could love a patient? It seems that characteristics 1 and 3 are probably fairly commonly satisfied in the context of a provider-patient relationship. Characteristic 2 *may* be satisfied, though it might also be the case that the situation is best described differently (e.g., as caring for the patient in front of him/her who could easily be replaced by another patient). Characteristics 4 and 5 are more difficult. It may be quite unlikely that a health care provider has any desire to continue loving the patient and feel that they need to take steps to foster that continuation. Likewise, though the provider may feel that their caring for the patient (along with their professional obligation) gives them reason to do certain things, it may be a stretch to conceptualize this as involving any final end setting.



And then there is the normative question of whether it is *appropriate* for a health care provider to love a patient or to tell a patient that they love them. According to Frankfurt, there is a way in which this normative question does not make sense, given that love is not something we do (or should) have much control over. But setting this point aside, certainly providers can to *some* extent shape their thoughts and emotions and as such shape

what they care about or love. The central ethical question seems to me to be whether loving Patient A would give rise to unfair treatment to other patients. In that case, such love becomes problematic, given that the professional and ethical norms of medicine (which lean towards non-partiality) are fairly distinct from the norms of private life. Given the nature of love, this seems to be a significant moral concern. Some patients are simply more lovable than others—but the less lovable deserve equal amounts of care and attention.

Although, as Frankfurt also says: "Morality can provide at most only a severely limited and insufficient answer to the question of how a person should live" (p. 7).

● Call for BENO Board Nominations!

BENO's 26th Annual Conference:

"Bioethics in Ohio:

Current Clinical Challenges"

Friday, April 29, 2016, The Conference

Center at OCLC, Dublin, OH

.....

For more than 25 years BENO has been and continues to be the only statewide organization serving Ohio as an educational resource in health care ethics. BENO provides a unique opportunity for continuing education and networking with colleagues from across the State. Invite your colleagues and students, and join us for this day-long conference.

Plenary Sessions include: "Surrogate Decision Making in the Internet Age," "Ethical Issues in Surgical Innovation," and "State of the Art Palliative Care: Access, Justice and Quality."

Breakout Sessions will address the ethics of chemotherapy for advanced cancer patients, parental refusals of treatment for religious reasons, the role of clinical ethics in fostering interdisciplinary professionalism, an update of MOLST in Ohio, justice arguments for measles vaccination in children, current legal issues in bioethics, and surgical informed consent.

Conference Registration Fees, Before April 3, 2016:

BENO members: Individual and
Institutional - \$150.00

Non-members: \$175.00

Students: \$40.00

Conference Registration Fees, After April 3, 2016:

BENO members: Individual and
Institutional - \$200.00

Non-members: \$225.00

Students: \$50.00

Continuing Medical Education (CME): - \$40.00

Lunch is included with the registration fee. For additional information about the conference, hotels and registration, please visit BENO's website: www.BENOethics.org

Are you interested in being more involved in ethical issues and discussions occurring in Ohio? Does networking with colleagues in the field of health care ethics with diverse backgrounds appeal to you? If so, please consider running for a position on the BENO Board of Trustees.

There will be five board member positions available in the summer of 2016. The requirements to be a board member include being an individual member of BENO and being able to attend 4 board meetings each year (2 by teleconference; 2 in person, usually in Columbus). The term of service is 3 years.

If you are interested in running for a board position, please email me a short write-up about yourself (175 words or less), your credentials and current position, and why you are interested in serving on the BENO board. These write-ups will be shared on the ballot. Please send these write-ups to me by *June 15, 2016* so that we can distribute the ballots in a timely fashion.

If you have questions, please do not hesitate to contact me at chirsh@chmca.org. I, along with many other board members, will also be available at the annual conference in Dublin, OH on April 29th if you would like to speak in person.

I look forward to hearing from you soon!

Cassandra Hirsh, DO

Chair, BENO's Board Nominations Committee



● Putting Patients Before Publicity



Craig Klugman, PhD, is Professor and Chair of Health Sciences at DePaul University. He serves on the ethics committee at Northwestern Memorial Hospital and is blog editor for *bioethics.net*. He has authored over 200 articles and is currently editing a textbook on undergraduate bioethics. His research is in the areas of public health ethics and end-of-life issues.

[This Blog entry is re-printed with Dr. Klugman's permission].

Imagine if 5 million people learned about your hospital in a week. Would you want your hospital to be featured in a television reality show? Described as “unscripted authentic medical dramas,” such shows follow trauma cases from accident to emergency room. Over 2 seasons, *NYMed* followed stories at New York-Presbyterian Hospital, Lutheran Medical Center, University Hospital (NJ), and St. Luke's Roosevelt Hospital. Similar shows include *Hopkins*, *Boston Med*, *Save My Life: Boston Trauma* and *Boston EMS*. The idea behind these productions was to be a real-life counterpart to successful scripted medical shows like *Grey's Anatomy*.



One episode in the last season of *NYMed* featured the story of Mark Chanko who died after being struck by a truck when he was crossing the street. He was seen at New York-Presbyterian/Weill Cornell Medical

Center during the time of taping. The family was brought into a room and told the bad news. Sixteen months later, the patient's wife is watching TV and finds an episode of *NYMed* that featured her husband. Although his face was blurred, she could tell it was him. The rub is that no one in the family ever consented for his story to be broadcast. The family filed complaints with the New York State Department of Health, ABC, the US Department of Health and Human Services, and other agencies. They also sued ABC, the hospital, and the chief resident for damages. The appellate court dismissed the case a year ago. ABC said because their news division produces the show, they are protected under the First Amendment. The family has appealed and the video is no longer publicly available.

Producers approached a major Chicago hospital in recent months about becoming a site for a similar series. For the hospital, this is an unparalleled opportunity for public relations: One cannot buy 8 hours of television exposure during prime time. The series also offers an opportunity to

educate the public about the practice of medicine, which is needed to help manage unrealistic expectations generated by scripted medical dramas.

However, having heard about the incident with Mark Chanko, the hospital wanted some assurances for the production. For example, there were several allegations from previous versions that were of concern to staff. Among the allegations were:

- That camera crews in the ER wore scrubs so as not to stand out. This was of concern that patients might mistake the crew for health care professionals or for the filming being for medical purposes.
- That crews film first and consent later. The crew films all of the stories that might be of interest. Since this is real life, not every case will make for compelling television, nor can every outcome be scripted. Allegedly, consent was sought only after it was determined a case would be used in the show.
- That in some cases, the filming consent documents may have been just slipped in with other medical consent forms.
- That patients, families, and health care personnel do not have a right to ask material to be edited, deleted, or changed. This is pretty standard for news stories. What would happen if the cameras recorded a medical error or someone behaving less than professionally? This could be damaging to individuals, the hospital, and the health professions.
- That resident physicians felt that there would be coercion to participate. Even if someone did not consent, as the Chanko case shows, the simple fuzzing out of a face is no guarantee that a person would not be identifiable. This might affect future employment and licensing.

The American Medical Association has adopted statements expressing concern about these shows, in part, because they do not show a real physician-patient relationship and may mislead people about what is involved in surgery and other medical procedures. The AMA's Council for Ethical and Judicial Affairs Opinion 5.045 expresses concern about such filming and its potential violation of patient privacy

and confidentiality. In addition, the Opinion says, recorded patients should consent, patient care should not be influenced by the filming, patients have a right to request filming to stop, and physicians should realize their behaviors and actions may influence how the public perceives medical care.

The American College of Emergency Physicians revised a statement last June stating the “commercial filming of patients or staff may be done only if patients and staff give fully informed consent prior to filming.” The patient should be fully capacitated and have the right to rescind before broadcasting.

These shows offer an opportunity to demonstrate real medicine. But how real? Cases are chosen for their dramatic effect. The knowledge that one is being watched changes behavior (thus the argument to put the crew in scrubs and use hidden microphones on doctors so that people are less aware they are being watched).



The hospital made similar requests as part of their contract. Allegedly, the producers did not care for the restrictions. Thus, this institution courageously decided not to participate in the production based on the desire to put “patients first.” Confidentiality and privacy could not be assured with a commercial camera crew around. Putting patients above commercial advantage is appropriate. Putting patients above self-promotion should be what we expect of our physicians, nurses, and other health care providers. As the Hippocratics stated in their oft-quoted oath: “Whatever, in the course of my practice, I may see or hear (even when not invited), whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast.”

Whether shared on parchment, in conversation, or on video, at the end of the day patients ought to have their privacy protected, and in the health care sphere, their confidentiality respected. That is real medicine.

● Clinical Ethics Resources from the VA

The Veterans Health Administration’s National Center for Ethics has published on-line, over the past few years, a variety of tools that can be helpful for establishing, running, and assessing an ethics consultation service and clinical ethics program. These resources are available for free at **www.ethics.va.gov**. The following are a few specific examples:

Ethics Consultation: Responding to Ethics Questions in Health Care (2nd Edition). This primer provides an introduction to health care ethics consultation, including information on success factors for managing and assessing an ethics consultation service. It also outlines a step-by-step approach to conducting ethics consultations, from the request through to the evaluation, using the VA’s C.A.S.E.S. approach. This resource is intended for staff participating in ethics consultations, including leaders responsible for overseeing the ethics consultation service. <http://www.ethics.va.gov/integratedethics/ecc.asp#sthash.AKf6O144.dpuf>.

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Integrated Ethics Facility Workbook. This workbook is designed to help health care facilities assess current ethics quality, identify strengths and opportunities for improvement, set goals, and develop quality improvement plans. The workbook helps a facility understand how good its ethics consultation service is, how well it performs preventive ethics, and how effectively leadership supports ethics in health care. Completing the workbook for the first time establishes a baseline for improvement efforts. Repeating the workbook over time enables a facility to monitor improvements. <http://www.ethics.va.gov/integratedethics/workbook.asp>

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Ethics Consultant Proficiency Assessment Tool (EC PAT), Ethics Consultation Service Proficiency Assessment Tool (ECS PAT), and ECS Proficiency Assessment Tool-Data Collection (ECS PAT-DC).

These are tools for assessing ethics consultants’ knowledge and skills, including an automated way to create a profile of the collective competencies of an ethics consultation service to inform an improvement plan. <http://www.ethics.va.gov/integratedethics/ecc.asp#sthash.AKf6O144.dpuf> in the section called: “Tools to Assess Ethics Consultant Knowledge and Skills.”

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