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Bulletin of the Program in Medicine & Human Values

Ethical Times

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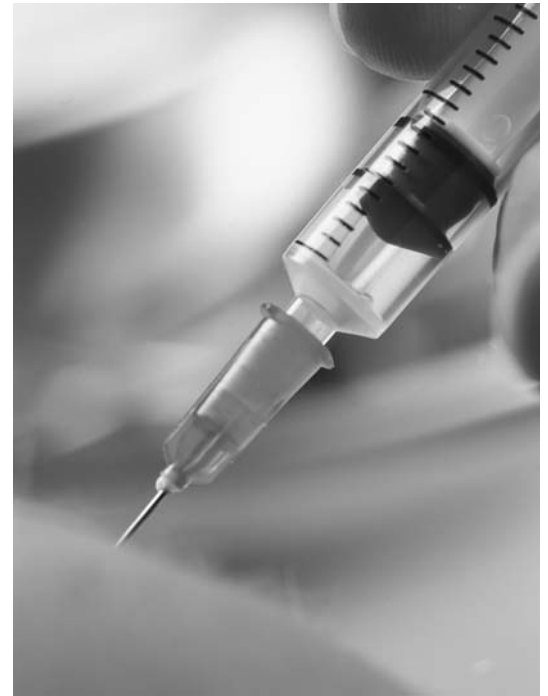
New Additions

Mandatory Vaccination for HPV: A New Twist on the Vaccination Debate

Katrina A. Bramstedt, PhD

CASE: Mary Austin's routine school physical exam became an uncomfortable experience for all those involved when Mary's mother objected to human papillomavirus (HPV) vaccination for her 11 year-old daughter. Mary's long-time pediatrician informed Mrs. Austin that the HPV vaccination was safe and effective in preventing the HPV infection and its potential consequence, cervical cancer. Also, very few serious vaccine side effects have been reported. Even though the vaccine would be available at no cost through the government's Vaccines for Children Program, Mrs. Austin still refused to allow Mary to be vaccinated, informing the pediatrician that such a vaccine might prompt Mary to engage in premarital sexual activity. Disagreeing with her mother, Mary, voiced her desire to receive the vaccination.

Last year the US Food and Drug Administration approved Gardasil®, a vaccine for the prevention of human papillomavirus infection and its potential consequences (e.g., cervical cancer, anogenital cancer, and genital warts). Currently, Virginia is the only state that requires HPV vaccination for girls (those entering 6th grade); however, parents may refuse such vaccination after receiving literature that describes the link between HPV and cervical cancer. In this way, Virginia gives parents a method of opting out of the vaccination mandate. Texas has a similar program, enacted by the Governor's executive order; however, it is currently being challenged by the Texas



House of Representatives. Several other states, including California, are considering similar vaccination mandates.

School vaccination programs have a history of controversy, yet the US Supreme Court has upheld their constitutionality. Currently, all 50 states have laws requiring immunization as a condition of school enrollment; however 48 states include a vaccination exemption based on religious grounds, and 19 states include an exemption based on philosophical grounds. A large nationwide study conducted in 2002 found that 12% of parents were opposed to

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The Ethicist Is ...an ethics consultation?



by Albert R. Jonsen PhD

Today's Ethicist is Albert R. Jonsen, PhD

He lay there, with occasional jerky motions of fingers, yawning from time to time and even opening his eyes with a blank stare. No visitor entered the room. Nurses cleaned him, changed his linen, adjusted the tubes and bottles around his bed. The team of doctors in training, with the senior attending physician, briefly visited, reviewed some statistics, gazed at him for a moment, then left. One day, a senior nurse spoke: "I think its time for an ethics consultation."

She lay there, silent, hardly moving, not noticing her sons and daughters and her grandchildren who were constantly around her bed. A breathing tube snaked into her neck. Her frail arms were black and blue from the many needles threaded into her veins. The attending physician engaged in a long, wrenching conversation with her sons and daughters, and then stated, "Perhaps an ethics consultation might help."

An ethics consultation? Another mysterious procedure of modern medicine? What is it? Who does it? How does it work? Today, over 80% of American hospitals provide ethics consultation. CPMC is one of those and its ethics consultation service is experienced and competent. Certainly, most people are familiar with consultations among doctors. The internist may suggest a surgical consultation when skilled advice

about whether or not an operation might be useful. Your primary care practitioner may recommend a consultation with a cardiologist to obtain opinions about the treatment of a heart condition. Consultations have always been a part of medical care. Even the ancient father of medicine, Hippocrates, advised Greek physicians of the 5th century BC, "When in difficulty or ignorant about treatment, do not hesitate to call in one more expert in order to learn by consultation the truth about the case." (Precepts VIII). But can we presume physicians so ignorant about ethics that they have to call in an expert? Anyway, who is an expert about ethics?

The practice of ethics consultation began in American medicine about thirty years ago. The reason was not that doctors were ignorant of the ethics of their profession. It was, rather, that what those ethics instructed them to do had now become very unclear. Again, the great Hippocrates set the standard for ethics: "Act always for the benefit of your patient and do them no harm." (Epidemics). As medical technology grew more complex, it became difficult to know what to call a benefit or a harm. The woman in our second case has had a severe stroke. The doctor has just told her children that she is unlikely to recover and if she does, she will live a very limited life. Is continued life a benefit? Would she be harmed if the respirator were removed and she died quietly? The man in our first case is in a condition known as

persistent vegetative state. A brain injury has so damaged the structure of his brain that he will never recover consciousness, never again communicate with the world. Is it a benefit to sustain his life?

The woman's children must make the decision about whether continued life would be a benefit for their mother. On the basis of their knowledge of her, they must judge whether she would choose to live with extensive paralysis, unable to communicate with them. The man in persistent vegetative state has no known relatives, no one to estimate what he would want for himself. The benefits and harms in these cases are not the medical facts in which doctors are so expert. They are decisions about human values, intrinsic to medicine but going far beyond medical knowledge.

In this setting, the idea of an ethics consultation arose. Persons who were scholars in moral philosophy and in moral theology were just entering medical education to teach this more complex form of medical decision making to students. They were occasionally asked to join in discussion about patients, like the ones described above. What could they bring to these discussions that a sensitive doctor, a compassionate nurse, a loving child might not bring? Certainly, their knowledge of ethical philosophy, a rich and ancient field of thought, would be of little value in the emo-

ETHICIST, CONTINUED ON PAGE 3

tional immediacy of the hospital room. Well, no and yes. Someone trained in ethics is accustomed to putting particular problems into larger contexts, to interpreting the situation in light of certain broad principles that should guide human actions.

As these new ethicists engaged in discussions with doctors, patients and families, they began to perceive how broad principles, such as respect for persons, fair treatment of diverse persons, and so forth, could be shaped to fit the cases in the clinic. Also, as many such cases accumulated, the variety of solutions could be shared and criticized in the growing literature of the field. Laws and legal decisions about similar cases provided some socially approved directions for certain problems. The ethicist, now called a "clinical ethicist," is expected to bring all this to a consultation.

The clinical ethicist does not "render a decision." Like other medical consultants, clinical ethicists draw together the facts of the case, the

views and opinions of the providers of care and the family. They weigh this information against the current general views in their field and then offer what they consider reasonable options. It is important that those who care for the man in persistent vegetative state to know that it is the common opinion of ethicists, supported by many legal cases that such a patient, who cannot by definition experience any benefit from treatment or, indeed, from life experience, might be allowed to die. It is important for the woman's family to know that the basis of a good decision in her case is their judgment about what would be in her best interest, based on what they know of her values and style of life. They should know, as well, that a decision not to prolong her life can be judged ethically appropriate, if it is based on a judgment that the harms of being alive in her condition would be greater than the benefit of being alive. This is called by ethicists, "the principle of proportionality." It is a necessary interpretation of Hippocrates' injunction to benefit and

do no harm, since those two states never come in separate boxes, but are related in ways that require informed and sensitive judgment.

CPMC has an ethics committee. All American hospitals are required to have an ethics committee. CPMC's committee consists of 25 doctors, nurses, social workers, chaplains and several clinical ethicists. Whenever our doctors or nurses, or families, seek an ethics consultation, either one of the clinical ethicists or a team of three committee members will respond. About 100 such consultations are requested each year. When the case is reviewed, the participants are interviewed and, in most cases, a resolution conformable to ethics, law, and agreeable to all parties is reached. The cases are unquestionably distressing. Physicians may be uncertain how to proceed. Families may be emotionally tormented. The ethics consultation reveals options that offer a sensitive, compassionate way through these distressing cases.



On the Calendar

Seminar Announcement: "Innovations in Palliative Care"



Wednesday, October 3
6:30 PM

UCSF Laurel Heights

Co-sponsored by the Sutter Health Institute for Research & Education, the CPMC Program in Medicine & Human Values and the San Francisco Medical Society.

Representatives from palliative care programs from local hospitals and programs will present latest clinical and other advances in providing state-of-the-art end-of-life care. Ethical perspectives will be provided by representatives from our Program. Open to all interested clinicians. For information, contact Steve Heilig at the SFMS, (415) 561-0850 x270

heilig@sfms.org

Andereck: Dr. Andereck has accepted an invitation to present Seton Medical Center's annual ethics lecture, in November.

Jonsen & Bramstedt: Both Drs. Jonsen & Bramstedt will represent the Program at CPMC's Nursing Ethics Symposium, in November.

Bramstedt: Dr. Bramstedt will lecture at the November 2007 NATCO meeting.

mandatory school vaccination programs. Another study found that 69% of parents who refuse vaccination for their children do so based on fears regarding vaccine safety. Indeed, concerns have been raised about a possible link between vaccination and autism, acute lymphoblastic leukemia, autoimmune disorders, and mercury poisoning. In general, these links have not been scientifically proven; nonetheless, fears persist. Other reasons for parental refusal include religious doctrine (e.g., Christian Science) and protest of governmental control. Current school vaccination programs generally consist of measles-mumps-rubella, diphtheria-tetanus-whooping cough, hepatitis B, polio, and chickenpox. Of these, only hepatitis B can be acquired via sexual contact (though there are other routes as well).

Like hepatitis B, HPV is transmitted via sexual contact and can be fatal if the female victim develops cervical cancer. Because the route of transmission of HPV is sexual contact this may generate parental concern that their daughters will view the vaccine as giving them greater protection than the vaccine actually provides (e.g., protection against HIV-AIDS, other sexually transmitted diseases, or pregnancy). There are also concerns that sexually active girls who receive the HPV vaccine may disregard the

need for routine PAP smear exams, thus delaying a timely diagnosis of cervical cancer if it develops. Because cervical cancer can be present without any symptoms, prompt diagnosis is essential in order to effectuate early treatment (surgery, radiation, and/or chemotherapy), and to increase the chance of the treatment's success.

Because the HPV vaccine is new, there is no information about its long-term safety. Medium-term data (5 years) show no significant side effects. Viewing this along with the significant consequences of cervical cancer (treatment side effects, financial costs, loss of fertility, risk of death), HPV vaccination seems an ethically appropriate choice for parents to make for their young daughters. Indeed, the US government has removed any potential financial barriers that would prevent access by including the HPV vaccine in the Vaccine For Children program which provides free vaccines to those without insurance.

From an ethics perspective, one could argue that there is a social obligation for parents to vaccinate their daughters against HPV. Because physical signs of HPV infection can be absent, it can be unknowingly transmitted to others. Vaccination can prevent the spread of the virus to others, protecting them from physical harm. HPV vaccination could also be

a public good in that there is the potential for such vaccination to reduce society's medical expenses. Also, HPV vaccination can be a method of self preservation in that it promotes a healthy society. This is important considering that the US Centers for Disease Control estimates that 80% of women will have acquired HPV by the time they are 50 years old.

What if, as in the case example, a child wants the vaccine but the parents refuse? It would seem that information about HPV and cervical cancer could be presented to girls as young as 9 years of age in a manner that they could understand. This said, California law does not have a provision which would allow minors to consent to vaccinations in the setting of parental refusal. Additionally, if Mary and her father agreed to vaccination but Mary's mother continued to refuse consent, the California Medical Association would advise the matter be addressed with the intervention of a juvenile court.

On balance, it seems that the benefits of HPV vaccination outweigh its currently known risks, making vaccination programs ethically appropriate. Further, because the benefit profile is so significant (and the risks few), informed children should be allowed to receive free vaccination without parental consent.



Program Projects

PEI Progress

The initial stages of our research project in the Intensive Care Unit, Proactive Ethics Intervention, has begun with a smooth start. The pilot phase was recently completed. Enrollment for the main study will

ensue in the coming weeks.

We eagerly look forward to the benefits this initiative will bring to CPMC.



Happenings

Bioethics Retreat

The 2007 International Bioethics Retreat took place at Saint Catharine's College, University of Cambridge, June 18-22. Countries represented, in addition to the US, included: Argentina, Granada, Italy, Monaco, Qatar, South Africa, Sweden, and the United Kingdom. John Harris, Director of the Institute of Medicine, Law and Bioethics at Manchester University School of Law, delivered the David Thomsma memorial lecture. Professor Harris addressed the controversial topic of "Enhancement" and whether advances in technology to "make better people" are morally justified. Participants in the Retreat are encouraged to share their research works in progress and in this spirit other topics raised involved: Stem Cell Research and Therapy; Neuroethics; Nanotechnology; End-of-Life Care; Culture and Ethnicity; Transplantation; Medical Education; Professionalism, and Gender issues. Next year's Retreat will be held in June in Paris.

Summer Workshop – 2007

The second annual Summer Workshop in Medical Ethics was advertised with the slogan, "Sorry, Not Everybody Likes Vanilla!" This modest humor was used to draw attention to a serious issue faced by hospital ethics committees: the matter of how ethical discussions and decisions should be made when cultural moral values diverge. This topic was chosen in part because of feedback received at last year's Workshop, but also because it

plays a continuous part in ethics consultations here at CPMC. Ethics Committee members from throughout northern California, the majority being staff from Sutter institutions, joined lecturers Henry S. Perkins, MD; John R. Stone, MD, PhD and September Williams, MD, in a two day venture that elevated awareness and understanding of the magnified role culture plays during end-of-life discussions.

As a Program, we were again pleased with the attendees' level of knowledge and participation as well as the wisdom provided by all guest presenters. We hope to expand our attendance next year. The time and topic will be announced.

Grant Received

The Program has received a generous grant from the William Randolph Hearst Foundation to support one of our projects, Proactive Ethics Intervention to Improve ICU care. With this grant, which will provide partial funding for the project over three years, we hope to make the care in the ICU more patient-centered and reduce unnecessary suffering.

Andereck Lecture Series

Dr. Andereck did double duty in late July, as he lectured at afternoon and evening Grand Rounds at Alta Bates Summit Medical Center, presenting his "Lessons Learned" talk.

Jonsen Lecture Series

On May 7th, Dr. Jonsen, Emeritus Professor in the Department of Medical History and Ethics at the University of Washington, gave the 2007

Charles Bodemer lecture in medical ethics in Seattle. His talk addressed issues in global bioethics. In July, Dr. Jonsen enjoyed an opportunity to lecture a group of new physicians in training at Children's Hospital in Oakland about interpreting the Hippocratic Oath.

Bramstedt Lecture Series

Dr. Bramstedt managed to find time between ethics consults to lecture both locally and out of state. An in-house lecture for Transplant Grand Rounds opened May with a talk on ability of patient's to pay for transplantation. She then lectured at the American Transplant Congress here in San Francisco on the topic, "Ethical Issues in Pediatric Re-transplantation." Golden Gate Donor Services was the next stop, as Dr. Bramstedt explained the current hot topics in transplantation. Later that month at the UNOS Region 5 Educational Forum, she lectured on the continuing issue du jour, organ tourism. Finally, NATCO, the Organization for Transplant Professionals where Dr. Bramstedt chairs the Ethics Committee, invited her to lecture at their August annual meeting in New York. This was in addition to their June meeting at which she lectured in Tempe, AZ.

Corrections:

In Issue No. 10, Dr. John Stone was listed as Director of the Tuskegee National Bioethics Center; he should have been listed as Associate Professor.



In the News

KPIX Interviews

Dr. William Andereck was contacted for interviews twice by local CBS news affiliate KPIX channel 5. On May 21 Dr. Kim Mulvihill interviewed him about the ethics of determining the sex of a baby. On June 1, the topic was

the tuberculosis traveler having his identity released to the public.

Organ Insight

Dr. Katrina Bramstedt was approached twice to discuss transplantation issues: South

Carolina's State News asked in April about the broad topic of organ donation and The Washington Diplomat called in July to interview her about organ tourism.

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Stop Talking Medicalese

Coma: The condition in which a patient has lost consciousness, due to a brain injury, and cannot be aroused to a wakeful state. Coma is usually a temporary condition. If it persists for a period of time without improvement, it can develop into the "persistent vegetative state," (PVS), a condition in which it is highly unlikely that the patient will ever again be conscious of surroundings.

Euthanasia: Literally, an easy death; a vague term, originally used to describe an act in which a doctor deliberately caused the death of a suffering patient. Today, the term carries so many meanings that it should be avoided in general discussion. It causes more confusion than clarification.

Terminal illness: A vague term with no definite medical meaning. The federal regulations for reimbursement of hospice care use "terminal" for a patient who, despite good medical care, is not expected to survive more than six months. In general medical usage, it refers to a serious illness that is very likely to cause death, although death may be delayed by certain forms of treatment. It should not be used to describe the unfortunate situation in which a patient's death is expected to occur quite soon. In this case, "death is imminent or likely to occur within a few hours or days" is more exact.



New Additions

Research Assistant

Lylia Yuen joined our Program in mid May, the first Research Assistant for our PEI project. Her background is in social science and she arrives having spent the past five years of her professional life working in the health care field. We welcome Lylia to our growing team.

Summer Intern:

Our Program is pleased to announce the hiring of Alon Neidich, our bioethics summer intern. Alon is a recent graduate from University of Chicago who is taking an academic year off prior to medical school enrollment. He will spend the majority of his time assisting with our PEI project, while being mentored by ethicists Dr. Jonsen and Dr. Bramstedt.

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