



California Pacific
Medical Center

A Sutter Health Affiliate
With You. For Life.

Bulletin of the Program in Medicine & Human Values

Ethical Times

NO. 14, SPRING 2008

Inside

2 Ethicist is In

3 On the Calendar

- Andereck measuring ethics
- Summer Workshop-2008
- Committee member lecture
- Paris 2008

New Additions

4 Manage Your Own Health Care (cont.)

5 Happenings

- Andereck on Healthcare
- Jonsen's 'Big Easy'
- Bramstedt's Bustling
- New Publications

6 Stop Talking Medicaese

Manage Your Own Health Care!

Katrina A. Bramstedt, PhD

Can you imagine pulling into a drive thru and stating: "I'd like a chest X-ray colonoscopy, full genetic profile, sperm count, and a cholesterol test, please." While this might seem shocking or even comical, Americans have many not so different opportunities for their health care. This is due, in part, to the fact that the Food and Drug Administration (FDA) allows medical products and services to be marketed directly to patients, rather than only to physicians as in many other countries.

In the US, newspaper, magazine, and television ads routinely market prescription medications and medical devices such as pacemakers directly to patients. Patients still cannot buy these products directly; they still need a physician's prescription, so why advertise? Manufacturers of these products will tell you their purpose is to educate and inform the public about currently available treatments, but their purpose is also to create brand awareness. Manufacturers want patients to request a specific product (e.g., Viagra®, Lipitor®, Avodart®, Lamisil®) from their physicians. In reality, marketing is more about brand awareness and sales than disease treatment.

The newest trend in direct marketing to patients is personal clinical laboratory



CONTINUED ON PAGE 4

Quality Colloquium

On January 24th-25th, the Program proudly hosted a Colloquium on Quality and Ethics. The newly developed field of Quality Assurance attempts to apply scientific methods for the improvement of health care delivery. The field of Ethics is devoted to assuring that the rights and welfare of patients are respected. Until our Colloquium, these two fields had not conversed. Ten distinguished scholars from around the country, representing health care economics, medical ethics, quality assurance, hospital administration and health policy, arrived at CPMC to find points of contact between these two important fields. The exciting conversations that ensued ranged from broad theories to practical solutions in the search to identify how these two seemingly distinct fields can integrate into one mission, aimed at the benefit of our patients. Our guests extended these conversations at a pleasant evening attended by some of the Program's supporters. The conversation will continue in collaboration with the American Medical Association and the Joint Commission on Accreditation of Health Care Organization. A report is being prepared for publication. Watch for further developments.



Beyond Medicine.

Ethicist is In:

Turning off my implanted cardiac defibrillator.

Today's Ethicist is Albert R. Jonsen, PhD

Inquirer:

I am a cardiologist. One of my patients is a 79 year old man for whom I provided a cardioverter-defibrillator six years ago, after he suffered a severe heart attack. This is, as you probably know, an electrical device implanted under the skin of the chest which delivers a shock to correct ventricular fibrillation that would ordinarily be fatal. He has had about five episodes in the last six years, all successfully controlled by the device. A year ago, he was told that he had extensive lung cancer. He underwent a course of chemotherapy with little effect. He still feels pretty well and is remarkably calm and composed about his dying. He came to me yesterday to inquire about turning off his defibrillator. He feels that he would rather take the risk of dying from a heart attack over a slow and possibly painful cancer death. Is it ethical to agree to his request?

Ethicist:

As you know, doctor, a general agreement has emerged over the last thirty years that it is ethically acceptable for a doctor to discontinue technical life support at a patient's competent request or when its use becomes futile. This consensus covers many different forms of medical life-support, but is usually applied to the use of a respirator to support breathing or a dialysis machine to supply kidney function. There were very few internally implanted life support systems. The pacemaker was one of the first; now the defibrillator is another. Even the Catholic Church, usually so conservative about protection of life, has consistently taught that some technologies can be considered "extraordinary," that

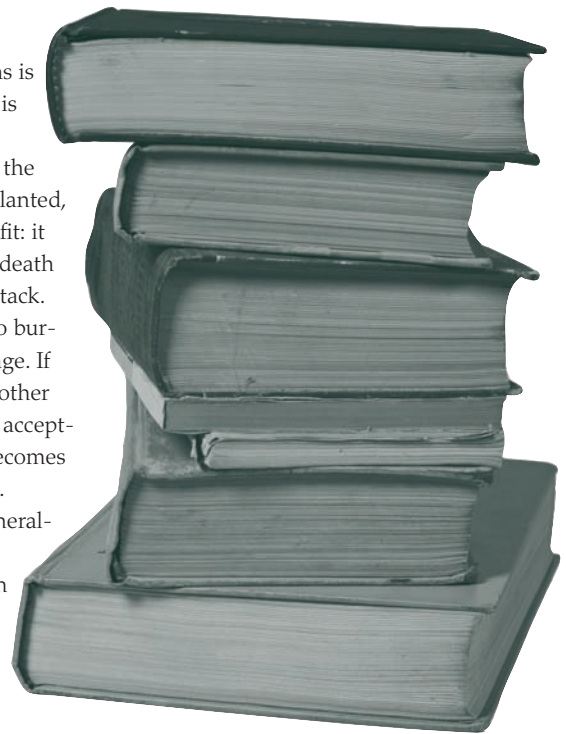
is, not morally obligatory, when they impose burdens greater than their benefits on the patient. Most secular ethicists, and many other religious ethicists would take a similar position.

The question is whether defibrillators or pacemakers or the heart support system called Left Ventricular Assist Device, which are all implanted as an adjunct to an essential organ, is the same as an external machine. Might it be thought that disabling the function of these organ adjuncts is closer to euthanasia than ethically acceptable withdrawal of external life support? Is not the doctor "causing" the patient's death, rather than just "allowing it to happen"? Is not the patient asking the doctor to collude in his suicide, which is ethically and legally unacceptable?

Perhaps the fastest way to an answer of these many questions is to ask a basic ethical question: is the presence of the implanted device a benefit or a burden to the patient. Clearly, when first implanted, it would be intended as a benefit: it would rescue the patient from death in the event of a lethal heart attack. However, benefits can turn into burdens when circumstances change. If the patient's death from some other condition is anticipated, and is accepted by the patient, the device becomes an obstacle to that desired end. According to what ethicists generally call the "principle of proportionality," a burden greater than a benefit may be omitted, even if the result is death.

This ethical argument is close to the traditional Catholic doctrine that allows the omission of extraordinary means of treatment. It is also similar to a venerable Jewish teaching, expressed in a story. A venerable rabbi was on the point of death. Outside his bedroom, a woodcutter was chopping wood. The noise distracted the angel of death who was on the way to take the soul of the rabbi. The learned rabbis around his bed debated whether it was lawful to tell the woodcutter to stop, so that death could come. They judged that the noisy obstacle to the angel's arrival could be silenced.

My advice is not, of course, that of a Catholic theologian or a Jewish rabbi. These scholars might have qualifica-



ETHICIST IS IN, CONTINUED

tions about such matters as how immanent death might be. Still, I believe that the majority of bioethicists would agree in principle with their ideas: if death is expected and is unavoidable, and if the patient understands and desires that death not be prevented, any further treatment that would delay death may be omitted, even if that “treatment” is a mechanical and internally implanted organ support system. This would not be suicide nor euthanasia but a legitimate form of allowing death to take place.



New Additions

Staff Changes:

Our Research Assistant, Lylian Yuen, left the Program in February to pursue other endeavors. In her place, we have brought on Alexis Lopez. Alexis is a Bay Area native and a recent graduate of the University of California, Berkeley. He comes with experience researching anti-microbial compounds in tropical plants in Costa Rica, inves-

tigating medical plant usage in Trujillo, Peru, program evaluation at Asian Health Services in Oakland, as well as tutoring high school students in the East Bay. He was a 2007 recipient of the Howard Hughes Medical Institute’s Biology Fellows Summer Research Grant. Alexis will be working with us for a couple of years before heading off to medical school.



On the Calendar

Andereck measuring ethics:

In May, Dr. Andereck will travel to Chicago to participate in an invitation-al gathering sponsored by the Ethical Force Program of the American Medical Association. The topic, “Measuring Ethics Quality in Healthcare,” continues the discussion of quality that was the focus of our Program’s research colloquium.

Summer Workshop:

Members of hospital ethics committees, who have expressed an interest in our third annual Summer Workshop in Clinical Ethics, please note that we have reduced our Workshop from two days to one. This was done in hopes that more people might be able to attend a single day session. We hope

to be able to provide several of these one day workshops during the year and eventually develop a continuing “capacity building” program for ethics committee members. This single day will be Saturday, June 14, 8:30 AM – 5:00 PM; the reduction in time includes a cost reduction. Attendance fee is now \$130.00.

Committee member lecture:

Nina Topic, RN, CNS, California Pacific Ethics Committee member, will lecture on transplant ethics, June 20-24, at the North American Transplant Coordinators Organization, Introductory Course for the New Transplant & Procurement Professional, in Tempe, Arizona. See www.natco1.org for more information.

Paris – 2008:

The International Bioethics Retreat, an annual conference of invited bioethicists from around the world, co-sponsored by our Program and the Alliance for Science, Ethics & Technology, will take place in Paris, June 22 – 27. The event will be hosted by the Institut d’Etudes Politiques de Paris, known as “Sciences Po”, the highly selective institution that has traditionally educated the French political and diplomatic elite. Our program will be represented by Dr. William Andereck, Dr. Katrina Bramstedt and Wes McGaughey; each will present their current research projects. Tomi Kushner and Antonio Kruger will also attend.

MANAGE YOUR OWN HEALTH CARE, CONTINUED FROM PAGE 1

"Medical care is best obtained via a therapeutic alliance between a patient and his/her doctor."



services. Individuals are given the opportunity to order their own lab tests without the knowledge of their personal physician or insurance company. Specifically, individuals contact the laboratory service directly and are given paperwork which details the specific tests that the patient wants to order. Hundreds of tests are available including general laboratory chemistries that might detect diabetes, elevated cholesterol, gout, prostate cancer risk, etc; genetic testing (DNA and paternity), tests for sexually transmitted diseases, autoimmune and blood disorders, as well as drug screening and infertility testing. The patient then takes the paperwork to the local lab that is contracted with the service and submits their specimens (e.g., blood, urine, semen) for analysis. The patient pays for the services directly and does not involve their insurance company. The laboratory results are then given directly to the

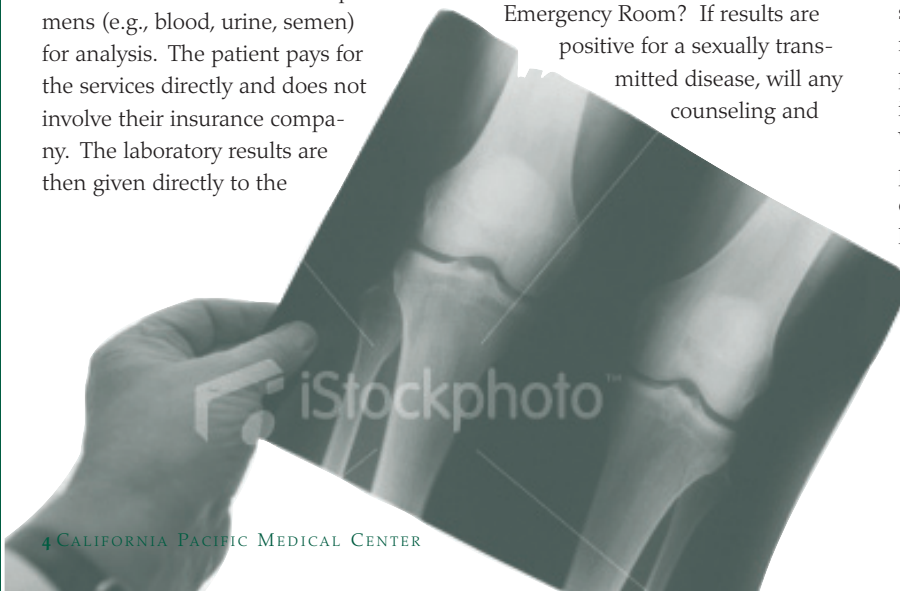
patient, not the patient's doctor, insurance company, or employer.

Such a service seems very convenient and private. The idea of not involving one's insurance company so as to avoid placing potentially sensitive information (e.g., HIV status) in one's record is enticing. But there are several ethical concerns with these personal medical services. Firstly, it is doubtful that the average patient, not trained in any medical or scientific specialty, would have a clear understanding of what the laboratory results mean. Is a result that is slightly outside the "normal range" something to worry about? Should a certain laboratory result give cause for the patient to go to the

Emergency Room? If results are positive for a sexually transmitted disease, will any counseling and

medication be sought? Through what means? Above all, what does a particular test result mean when separated from an overall understanding of the health of a patient?

Medical care is best obtained via a therapeutic alliance between a patient and his/her doctor. This is because patients lack the medical knowledge, training, and skills to diagnose, treat, and manage their medical needs. Patients need clinicians to help them with all these activities. It is a two-party system, a team. Lab results alone do not help patients and may, in fact, confuse them. Lab results alone do not necessarily definitively diagnose a disease, but they may rule out some conditions. Lab results also do not give any sort of treatment to a patient or provide the patient with any information on their prognosis. Without a physician to work with the patient, lab results are simply numbers on a piece of paper. Further, if one's lab results all appear "normal" this could encourage some people to substitute this service in place of



an annual physical examination by their doctor.

It is understandable that some patients fear their insurance company and worry that "negative" results could harm them by raising their monthly premiums or even cause policy cancellation. It is also understandable that some patients fear that their employer could discriminate against them (or even fire them) if they were to find out they had a medical condition that was physically or cognitively debilitating. These fears, however, must be balanced against the State and Federal protections that are in place for patients with regard to privacy, confi-

dentiality, employment protection, and discrimination. These fears should not put patients in a position of trying to become their own physicians. The harms that could result from this are many, including delayed diagnosis, misdiagnosis, failure to seek treatment, self-treatment, and undue anxiety. Also, there is the potential for patients to spend money on medical tests they have no need for. Patients and physicians must work together as a team—no patient is an island.



Happenings

Andereck on Healthcare:

Dr. Andereck spoke on one of his favorite topics to members of the Pacific Union Club: "The Depersonalization of Healthcare in America." It was a well received presentation that touched on the changing nature of the doctor/patient relationship in modern American health care.

Jonsen's 'Big Easy':

Dr. Jonsen delivered the key note address at New Orleans' Ochsner Clinic Conference, "Protecting research subjects as times change." His speech was on the history and ethics of research.

Closer to home: As he did last year, Dr. Jonsen presented an Ethics Grand Rounds to the staff at Alta Bates Medical Center in Berkeley.

Bramstedt Bustling.:

Due to illness, Dr. Bramstedt was unable to give her lecture "Dealing with Difficult Patients and their Families," to the Northern California chapter of the American Case Management Association. Fortunately, CPMC ethics committee member Kate Ettinger was able to take her place and present the lecture at Eden Medical Center.

Dr. Bramstedt did take part in two media interviews; first was with Canadian newspaper, The Medical Post. She spoke with them on the ethics of insurance coverage for overseas organ transplantation. One week later, she spoke with AARP Magazine on the topic of direct marketing of prescription medical products to patients.

Recent Publications:

The current issue (Winter 2007) of Journal of the History of Dentistry contains a paper written by Dr. Jonsen. "The Sins of Specialists" appeared as part of a colloquium on ethics in dentistry. <http://www.histden.org/journal.htm> Dr. Bramstedt has a paper in the March issue of Current Opinion in Organ Transplantation titled "Alcohol Abstinence Criteria for Living Liver Donors and their Organ Recipients." She was invited to write on this topic due to a scarcity of available organs and the high risk of relapse for people with a diagnosis of alcoholism.

Program in Medicine & Human Values

2395 Sacramento Street, 3rd floor
San Francisco, CA 94115
Tel: **415-600-1647**
Fax: **415-600-1355**
www.cpmc.org/ethics

Email CPMC Ethics Committee:
ethics@sutterhealth.org

William Andereck, M.D.
Co-Director and Medical Director

Albert Jonsen, Ph.D.
Co-Director and Senior Ethics Scholar
in Residence

Katrina Bramstedt, Ph.D.
Clinical Ethicist

Steve Heilig, MPH
Public Affairs Specialist

Antonio Kruger
Administrator

Thomasine Kushner, Ph.D.
Academic Communications

Alexis Lopez
Research Assistant

Wes McGaughey
Research Analyst, Grants & Study

Lawrence Schneiderman, M.D.
Visiting Scholar



*California Pacific
Medical Center*

A Sutter Health Affiliate
With You. For Life.

Program in Medicine & Human Values
2395 Sacramento Street, 3rd floor
San Francisco, CA 94115



Stop Talking Medicaese

Mental Capacity:

The ability of a person to understand and consider information, and then make a decision about what to do. This mental capacity can be limited by psychiatric conditions or deterioration of thought, as in Alzheimer's, or by the effects of serious illness. It is sometimes quite completely extinguished, as in a coma, or sometimes partial limited, as in delirium, when a very sick patient slips in and out of consciousness. The seriousness of any impairment to mental capacity must be evaluated by a physician, or other health professional with training.

Competence:

This word is a legal term rather than a medical term. It refers to a judge's

determination that a person's ability to protect their own interests is so severely impaired that a guardian must be appointed to handle their affairs.

Surrogate:

A person who has the authority to make decisions on behalf of a patient with serious limitations in mental capacity. This is usually a person closely related to the patient, such as a spouse, parent, partner, sibling or companion. Any person in good health can designate a surrogate to decide for them when they are incapacitated. When this is done by an official document, that surrogate is said to hold "the durable power of attorney."

Nonprofit
Organization
U.S. Postage
PAID
San Francisco, CA
Permit No. 1741