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Inside

2 The Ethicist Is In

3 Announcements

4 The Future for Health Care Reform in the Obama Administration (cont.)

6 Film Review

8 PMHV Bioethics Training Programs

The Future for Health Care Reform in the Obama Administration

by William Andereck, MD

As Americans, we stand hopeful that President Obama will bring needed changes to our society. We are in the midst of unpopular wars in Iraq and Afghanistan, while killing and mayhem rage in Gaza. At home, the excess and lack of controls within our mortgage industry have exposed the cracks in the foundation of our financial system and the threat of a looming depression has captured the attention, and funding, of our nation. Meanwhile, Social Security will soon reach the point where the input of workers will not be able to cover

The biggest elephant in the room is Health Care.

An important figure in Obama's health care plan, Dr. Ezekiel Emanuel, recently lectured in San Francisco. Dr. Emanuel, an oncologist, is currently the Director of the Division of Bioethics at the NIH Clinical Center. His brother, Rahm Emanuel, is President Obama's Chief of Staff. Dr. Emanuel has been appointed senior counselor at the White House Office of Management and Budget for Health Policy and reports directly to Peter Orszag, director of the Office of Management and Budget. In this position, he will be one of the main voices within the Administration speaking to health care policy and reform. I greeted Dr. Emanuel's appointment with enthusiasm. He, in collaboration with Victor Fuchs, Professor Emeritus

the output to its beneficiaries. But the biggest elephant in this crowded room, one most of the experts recognize but do not know how to face, is health care.

An important figure in Obama's health care

Gas, Groceries, and Philanthropy

The Program in Medicine & Human Values is now partnered with eScrip (www.escrip.com). Every time you grocery shop, buy clothes, or fill your gas tank, the merchant will donate a percentage of your purchase to us. All you need to do is register any or all of your existing grocery loyalty, debit and credit cards for use in the philanthropy program. In the Bay Area, there are dozens of participating merchants including Mollie Stone's, Claim Jumper, Le Boulanger, Round Table Pizza, San Francisco Chronicle, Macy's, and several cruise lines. The eScrip program is also national so if you live outside of Northern California, there are hundreds of participating vendors around the country. We encourage you to visit the eScrip webpage (www.escrip.com) and register your grocery loyalty, debit and credit cards for use in this novel philanthropy program. Our group ID number is 500021334. As an example, if 200 people register their cards and spend at least \$400 a month, the merchants would donate nearly \$50,000 a year to our Program. These donations will help fund our ongoing research, clinical, and educational efforts. Thank you.



The Ethicist Is In:

Today's Ethicists are Rabbi Elliot Dorff and Dr. Katrina Bramstedt



Mr. RT, an 81 year old gentleman, has been in frail health for several years, although he has remained active. He suffered a severe heart attack. After several days in the Cardiac Care Unit, his blood pressure sinks to dangerously low levels and requires support by several powerful drugs. He shows signs of kidney failure. He is barely responsive to communication. A discussion about next steps takes place. The doctor asks the family about whether to start dialysis. Mr. RT's daughter says, given his poor health, she believes he would not want to be kept alive. His son, however, notes that their father is an observant Jew, and that it might be offensive to Jewish law to fail to provide any available means for life support. The doctor suggests an ethics consultation. CPMC's clinical ethicist, Dr. Katrina Bramstedt, reviews the records and meets with the family. She asks if she can seek counsel from a distinguished Jewish scholar, who is expert in medical ethics, Rabbi Elliot Dorff. The family agrees. Here is Rabbi Dorff's response.

Jewish reflections on the end of life rest, in general, on the belief that, because each person's body belongs to God, the patient does not have the right either to commit suicide or to enlist the aid of others in the act, and anybody who does aid in this plan commits murder. Judaism also asserts that, while we should seek to cure and may not do anything to hasten death, we should not, on the other hand, prolong the dying process. The patient does have the right, however, to pray to God to permit death to come, and the Talmud records such prayers. Furthermore, we must always decide medical questions with the patient's benefit as our goal, although there is disagreement as

to how much that can override the obligation to sustain life. Balancing these imperatives leads to considerable disagreement on specific, clinical issues. Since, until recently physicians could do very little to impede the process of dying, Jewish sources on withholding or withdrawing life-sustaining treatment are sparse. This poses significant questions about how to apply the tradition to contemporary circumstances.

There are, as usual, several opinions. The most restrictive position limits permission to withdraw or withhold treatment only when physicians assume that the patient will die within 72 hours and has lost the swallowing reflex (goses). Others define the state of goeses more flexibly, such that the patient will live up to a year or more, or in terms of symptoms rather than time, and they then apply the permission to withhold or withdraw machines and medications more broadly. In my legal opinion approved by the Conservative Movement's Committee on Jewish Law and Standards, I ruled that as soon as a person is diagnosed with incurable trauma to vital organs or a terminal, incurable disease (terefah), patients and doctors have permission to withhold or withdraw medications and machines if it is in the patient's best interests. Because Jewish law presumes that human beings are not omniscient, doctors are not responsible for knowing what therapy may be developed tomorrow in making these decisions. In all cases, comfort care must be administered.

A particular problem is posed by artificial nutrition and hydration. Most Orthodox and some Conserva-

tive rabbis regard artificial nutrition and hydration as food and liquids, which we all need; therefore, even those who allow removal of machines and medications require these procedures. On the other hand, the nutrients that enter the body through tubes look exactly like medications administered in the same way and, more to the point, they lack the usual characteristics of food, such as varying temperature, taste, and texture. Consequently, in my rabbinic ruling approved by the Conservative Movement's Committee on Jewish Law and Standards, I classified artificial nutrition and hydration as medicine. Thus we may and should use them if there is any reasonable prospect for recovery, but when that is not likely, we may remove them, since they are just prolonging the dying process.

As long as there is some hope of cure, heroic measures—that is, the use of machines and medications to try to keep a person alive even when there is little hope that they will cure the patient—may be employed, even though this involves an elevated level of risk. On the other hand, they are not required. The controlling factors are the risk-benefit ratio, the patient's best interests, and the patient's desires. A Jew may sign an advance directive for health care indicating his or her desire to employ or decline such care. All four movements in American Judaism have produced their own versions of a Jewish advance directive, each according to its own understanding of Jewish law. Most rabbis, including Orthodox ones, maintain that a Jew may enroll in a hospice program, where the goal is not to cure the

disease, but to make the patient as comfortable as possible. In addition, hospice care crucially includes all the non-medical ways in which people are supported when they go through crises, including all the forms of care provided by family, friends, nurses, social workers, and rabbis.

In light of these teachings, I would advise that it is not obligatory to provide life-supporting treatments, such as dialysis, to Mr. RT, whose clinical condition appears to meet the conditions of *terefah*.

Dr. Bramstedt conveyed Rabbi Dorff's opinion to Mr. RT's family. After discussion with their rabbi, they decided not to escalate further treatment.



Announcements

International Bioethics

Retreat: Our annual CPMC sponsored International Bioethics Retreat will take place June 22 – 24 at the University of Lausanne in Switzerland. We are being hosted at the university by ETHOS: The Interdisciplinary Ethics Department. The meeting is unique in that approximately 50 invited bioethicists from around the world gather to report on their current research projects. Dr. Andereck serves as the Master of Ceremonies while Dr. Kushner

leads the planning committee and oversees all logistics and curriculum.

Visiting Scholar:

Sebastien Plouhenic, Development Manager in the Department of Health Affairs at the Sciences Po in Paris was a Visiting Scholar to the Program in February. While with us he continued research on his project: Development of Medical Tourism: Towards A Global Health. The Program was happy to host Mr. Plouhenic during the first American stop of his research

trip as he served as host for our 2008 bioethics retreat in Paris.

Summer Workshop IV:

Our annual educational seminar for hospital ethics committees will be held Saturday, June 6. The primary topic will be non-beneficial treatment, with an additional segment on how to write an ethics note. Tuition is \$130; RSVP is required. Please check our website or contact us directly for more information.

of Economics at Stanford University, has proposed the best approach to health care reform that I have seen to date.

In his address, Dr. Emanuel made it clear that the details of the Obama plan for health care reform are still in the works. Although he didn't say it directly, I suspect that they will have to take a back seat to our country's military commitments and the mortgage/financial crisis. Despite being short on specifics, Dr. Emanuel did give a very revealing synopsis of how the Administration will be framing the problem. He told us that any program that involves fundamental change requires four elements: recognition of a problem by a broad segment of the population, a proposal to solve the problem, champions of change with power and might, and a transforming political event that will galvanize the society to act. Let us examine health care reform within that framework.

There is no question that the problem of health care reform is now in our face. American's currently spend one of every six dollars of our gross domestic product (GDP) on health care. This percentage of GNP (18%) is double that spent by any other country, even those with better health outcomes. (According to the *Economist*, America also spends twice as much of its GNP on secondary education as does any other country, but that is grist for another mill.) By 2080, if there is no change in the creep of health spending into our GDP, medical costs will consume 100% of every dollar spent! We won't have to worry about General Motors anymore, or food, or housing. Of course such growth is unsustainable,

but it does not appear that it will be a soft landing either.

Simply forecasting the impending disaster will not be enough to effect fundamental change. Although almost everyone says they recognize the problem, over 80% of Americans are satisfied with their current health care options and, like the story of "Chicken Little," prophecies of doom simply fall on deaf ears. There are numerous competing proposals out there, and the second best, according to almost all parties, is the status quo. To quote Machiavelli, "the reformer has enemies in all those who profit from the old order, and only luke-



warm defenders in all those who would profit from the new order." The desire to just "hold on to what you've got" will be difficult to overcome without a clear and convincing plan to do otherwise.

There are many suggestions to right the ship. Winston Churchill was said to greet his staff with three brilliant ideas each morning. The problem for the staff was that he gave them fifteen, and it was up to the staff to figure out which were the three brilliant ones. Some of the elements are beginning to come into focus however. The first is a rejection of incrementalism. The time for baby steps and quick fixes has passed. American health care has become dysfunctional at so many levels: inefficient delivery of medical services, lack of coordination of medical information, inappropriate financial incentives for providers, unrealistic expectations on the part of patients, and finance mechanisms that reward poor quality, to name just a few. A comprehensive overhaul is necessary to eradicate the dry rot that pervades the system. A second proposal, which Dr. Emanuel rejects out of hand, is a single payer model similar to the health systems of Canada or England. He correctly understands that a "one size fits all" approach in a diverse, multicultural society as large



as ours cannot provide the flexibility and personalization that Americans will demand. He also recognizes that, despite the vociferous calls of a determined minority (many of whom seem to have been in the audience), the idea does not have enough political clout with doctors, hospitals, industry or patients. A third proposal, which he flirts with, and then rejects, is one based on an individual or employer mandate similar to the one introduced last year in Massachusetts requiring all employers to provide insurance to their workers, or pay into a state pool that will make some form of health insurance available to

which uninsured individuals could buy into, or receive subsidies to participate in, whether or not they were employed. He did not mention whether employer based health insurance would remain tax deductible, but the \$200 billion recouped by the federal government now lost by not taxing employer-provided health insurance, seems like the seed money necessary to fund such an effort. I doubt, however, that such a national plan would be rich enough to offer the same benefits as our Senators and Congressional representatives in Washington, such as Senator Max Baucus has proposed.

Other purported methods to achieve financial savings are a bit more dreamy. Take electronic medical records (EMRs) for instance. The idea of having a patient's health information in a single database is enticing, but much further from reality than anyone seems to understand. Beyond the privacy issues, which are being recognized in the media daily, the problems of interconnection of systems and even inaccurate data input are still confounding the most ardent developers. A workable EMR is the right plan for the future, but expecting it to solve our health care problems in the near future is like expecting the Apollo Moon Project to solve the energy crisis by harvesting unexplored natural resources. Right now the only ones I know who are looking at EMRs as an immediate savior are the people who don't know much about the issue or the ones who stand to profit personally from their development.

By Emanuel's own admission, the Guaranteed Health Care Access Plan does not contain appropriate cost controls, and would make it necessary to raise taxes. Either flaw could kill it on delivery. But it is a plan to put before the American people and to work for its success.

In earlier writings, Dr. Emanuel, and his colleague Victor Fuchs, have called for a move away from the tax exempt status of employer provided health insurance, using the \$200 billion tax dollars currently not captured to finance vouchers for every family or individual in this country. These vouchers would enable individuals or families to purchase their own personal health care policy. The voucher would pay the premium for a basic level of health care, while those looking for more extensive coverage and convenience could pay more from their own wallet. There is



This proposed national plan would be accompanied by a Federal Health Board, modeled after the Federal Reserve Board, that would have sweeping authority to regulate and monitor all health insurance programs. The idea would be to promote price transparency and quality reporting while keeping the notoriously crafty insurance industry from putting profits over patients. Hopefully such an agency would be more effective than the Securities

and Exchange Commission has been in the banking world.

Some of the advantages are clear. Large insurance pools would be better able to share the risk of illness and remove most of the pre-existing illness provisions that make health insurance unobtainable for those patients that need it most. It is estimated that the number of uninsured in America would drop from over 14% to under 2.6%. The wealthy and middle class would pay their fair share, while low income citizens would receive subsidies to buy in

the working uninsured. The problem with this approach is that, while providing universal coverage, it does not do enough to insure that the coverage is affordable or even available. Another unfunded mandate is not the way to assure Americans that they will receive the health care they deserve.

Obama and Emanuel agree on what the speaker called the "Guaranteed Health Access Plan". This calls for a governmental mandate for individuals to have health insurance that would be accompanied by a program

Continued on page 7



Film Review

HAKANI (2008).

PRODUCED AND DIRECTED BY DAVID LOREN CUNNINGHAM.

By Ruchika Mishra, PhD

Among our most primal fears is surely the fear of slowly suffocating to death. 'Hakani' is a film that documents the chilling tradition of burying children alive, practiced by many indigenous Brazilian tribes. Producer and director David Cunningham addresses this issue in his 37-minute docudrama by following the life of a two year old girl named Hakani who is buried alive by her own tribe, the Suruwaha. Though the movie is a re-enactment, everyone who worked in the film had either been buried alive or rescued someone who was subject to this practice.

The movie revolves around Bibi's family. His younger siblings, Niawi and Hakani, both of whom suffer from developmental problems, are being blamed by the village elder for the devastation of the village after a storm. The elder points to Bibi's parents that these crippled, cursed children should not be allowed to live. Unwilling to kill their children, Dihiji and his wife commit suicide in a pond. Bibi's older brother, Aruwaji is then admonished to do his duty. He digs another grave beside his parents' and buries both his siblings alive amid protests from Bibi. However, Bibi goes against the wishes of the tribe and rescues Hakani. The last part of the film is a tapestry of testimonies from various indigenous people who survived these gruesome practices, and the families of victims.

Infanticide has been a tradition in many cultures and reasons for the practice included physical or mental

handicap, being born as twins, or birth to a single woman. All these were viewed as less than perfect categories perhaps because these children demanded too much of the tribe's limited resources, thus negatively impacting the movement and survival of the community. The questions to consider now are: how have the practical realities of the lives of the indigenous tribes changed, and



in the light of these changes, should they carry on with this custom? Norms change and cultures evolve over time. Is it still permissible to kill a child because it is born with a disability or of particular gender or out of wedlock? Some will continue to ask; was it ever permissible to do so? 'Hakani' also spawns the question: what constitutes a culture? Culture is not an entity divorced of the people—it is a living, ever changing collage of people's beliefs and values. Many of the people called upon to kill a child are against the practice. The movie reports that many indigenous people from different tribes have initiated a legal battle to ensure the same rights to indigenous children as Brazilian children. Muwaji's Law is proposed legislation named after a woman who refused to kill her child and abandoned the tribe.

A dichotomy that is brought out well in the movie is the separation of the process of passing the death sentence and the actual act of killing the child. The decision to kill is imposed by the village elder acting in concert with the rest of the tribe. It is striking indeed that no one from the tribe, not even the elder, was willing to kill the "unworthy, evil, soulless children" — the onus is always on the parents or the rest of the family to save the tribe. Thus, people are made unwilling pawns in a system in which they have no say.

The movie is an intriguing juxtaposition of the Suruwaha's idyll lives

and a cruel and violent custom. The camera style uses close up images to make the experiences more visceral. The use of natural lighting throughout makes the movie more realistic. Highlighting the issues of the morality of infanticide and cultural relativism, the movie has attracted controversy from the government, social, and even religious groups. 'Hakani' is a well-made film raising awareness about an issue that poses a social, cultural, ethical and legal problem. Different cultures might have different beliefs and practices but is there nothing that all cultures share – something as basic as the right to life, granted to one of the most vulnerable categories of human beings, children? I pose that a child is a child first and he/she should be entitled to basic human rights no matter the location of origin. Moral status should not be different because a child was born within the indigenous rain-forest population instead of suburban Brazil.

The film is available online at www.hakani.org/en.

This is a revised version of an article published in *Journal of Bioethical Inquiry*.

a greater role for a private health insurance system than the governmental plan envisioned by the Obama administration. The proposal includes a number of necessary provisions such as insurance reform, physician regulation, bureaucratic reduction and personal patient responsibility too complex to address in this short essay, but the basics of personal ownership and responsibility, combined with federal financing and oversight, transcend partisan politics and, as such, may be too politically incorrect to accomplish. I sense that Dr. Emanuel has adjusted his ideas to fit the political landscape. I hope he has not compromised them. For instance, it seems like the Guaranteed Health Access Plan, like Medicare, would be a take it or leave it proposition. Unlike health care vouchers, beneficiaries may not be able to use the funds provided for the program and would have to add their own dollars to purchase a more inclusive plan, or have to utilize the services of doctors outside the approved system.

A third component for the success of any reform effort is the requirement for the right champions. Dr. Emanuel named his pick for the top three in Washington for health care reform, former Senator Tom Daschle, Senator Ted Kennedy, and California Representative Henry Waxman. That certainly is not Washington, Adams, and Jefferson, but it is a formidable trio if they can work together and stay on point. It will also take the cooperation of leaders from the medical profession, patient advocacy groups, industry, and labor to carry their share of the load. You cannot build a pyramid one wall at a time, as we have been trying to do with our incremental approaches to health reform, but pulling together with

leadership and a shared vision is the basis of what Dr. Emanuel is proposing.

The final ingredient for comprehensive reform Dr. Emanuel calls a "transforming political event". This is something that shocks the entire population and galvanizes their recognition of the problem, their understanding the plan. Some economists claim that World War II, not the New Deal, was the political event that shocked us out of the Depression. 9/11 is another example of an event that awakened Americans to terrorism and, perhaps, the negative perceptions of our country that existed in other parts of the world. Dr. Emanuel suggested that the current financial crisis can serve as such a transforming event. It may help reform our banking industry, but I don't see it as enough to transform our ailing health care system. One possibility is a major health crisis like the influenza epidemic of 1918, but I hope we don't have to resort to pestilence and plague to awaken us to health reform. Transforming political events happen in their own time and often without warning. Certainly one is coming. Let us hope that we have the plan and leadership to take advantage of it.

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PMHV Bioethics Training Programs

By Katrina Bramstedt, PhD

The Program in Medicine & Human Values has two active bioethics training programs. During the summer, one internship position is available to those who have completed a bachelors or masters degree, while during the academic year, one Fellowship position is available to those who have completed a masters or doctoral degree. The summer internship program is general and much less intensive than the 9-month Fellowship program, yet both expose trainees to the world of clinical ethics. The Fellowship

program allows the trainee to participate in ethics consultation, as well as ongoing research projects within the Program. Also, the Fellow must initiate and complete an independent research project and write at least one paper suitable for publication. Most of our prior trainees have succeeded with a journal article indexed in PubMed. Currently, both training programs are unfunded so if you would like to support either one with a philanthropic donation, please contact our Administrator, Antonio Kruger at 415- 600-1647.