A message from the Center’s DIRECTOR....

On December 9th 13 year-old Jahi McMath tragically suffered a devastating complication several hours after undergoing a tonsillectomy and (apparent) adenoidecemy at Children’s Hospital Oakland. She had a major bleed that led to cardiac arrest which itself resulted in extensive anoxic brain injury. Two days later, on December 11th, using neurological criteria, her physicians determined that Jahi had died. Her parents and family, still in shock and disbelief, did not accept this determination. We do not know what transpired over the next several days, but starting on December 20th, the family several times sought and successfully won intervention by local and then federal Court to block the hospital from removing Jahi’s ventilator, vowing to place her in a long-term care facility where she might, they believe and hope, recover.

We will likely never know all of the facts about what happened to Jahi McMath. Nonetheless, we have been able to witness the anguish of her family as they have struggled to make sense of what happened not only on December 9th but in the intervening days leading up to the Court-mediated agreement to have Jahi moved to a long-term facility.

There are, I believe, lessons to be learned from this anguish. The first is the reminder that unexpected death is almost always more difficult to make sense of than death that may be expected. Accordingly, such situations demand from care providers an even stronger response of compassion and empathy. When the one who dies is a child, even more so do we need to reach out and seek ways to be of comfort.

And yet, as this situation also so clearly displays, many times our efforts are inadequate. No matter how hard we try, we cannot soothe, cannot ameliorate, cannot comfort, for the shock of the situation as experienced by parents and family is too great, too fresh, too overwhelming. When this happens, we must be particularly careful not to exasperate the sense of despair by creating an “us versus them” environment in which finger-pointing and blame become more prominent than compassion and empathy.

And finally, there is this: even if there were universally-accepted means for determining death, the experience of death is always individual, demanding its own particular response.

Over the past 12 months, six important CSMC policies associated with end-of-life care have been revised and renewed: (1) Determination of Death; (2) Resuscitation, Code Status, and DNAR; (3) End-of-Life Care in the ICU and Attending Physician Responsibility; (4) POLST; (5) Patients’ Right to Know End-of-Life Options; and (5) Withholding and Withdrawal of Life-Sustaining Treatment. While the need for such policies is, in some part, driven by legal and regulatory concerns, for the most part, each of these policies have been crafted to provide clear and practical guidance for CSMC staff who care for patients at or near the end of life. This is especially true for addressing decision-making associated with medical interventions typically understood as life-sustaining but which in a particular circumstance are deemed by the patient’s attending physician to be medically inappropriate (e.g., CPR, dialysis, intubation and mechanical ventilation). If you are unfamiliar with these policies, or haven’t reviewed them recently, check them out. All are easily accessible to CSMC staff via the Policy and Procedure Manager link found on the CSMC Intranet page, in the right sidebar.
A GLIMPSE INSIDE...

Clinical Ethics Consultation Service

Governed by formal policy approved by Cedars-Sinai’s Board of Directors and the Medical Executive Committee, the Clinical Ethics Consultation Services (CECS) is the clinical service arm of the Center for Healthcare Ethics. The CECS is, accordingly, staffed full-time by the faculty of the Center for Healthcare Ethics, all of whom have extensive experience as well as training in the actual practice of clinical ethics consultation.

The primary purpose of the CECS is to promote and enable morally appropriate and effective decision-making by those individuals who are primarily involved in patient care situations. Accordingly, any of these involved individuals – including patients, family members or patients’ legal representatives, physicians (attendings, consultants, fellows, residents, and students), nurses, case managers, social workers, chaplains, respiratory and other therapists, and dieticians, to name a few – may request clinical ethics consultation. Typically, however, most requests come from physicians, nurses, and social workers.

For instance, during 2013, the CECS provided 219 clinical ethics consultations, of which 45% were requested by physicians, 28% by social workers, and 20% by nurses. Of the remainder, 4% were requested by patients or their families, 2.5% came from a variety of CSMC staff, and 0.5% were anonymous (each year a handful of requests are made anonymously). Comparing these numbers with that of the past five years, during which the CECS has provided nearly 1050 clinical ethics consultations, the percentage requested by physicians is less as is that by social workers; requests by nurses, on the other hand, has been slowly increasing. The percentage of requests from patients and families, other staff, and those which are anonymous have remained fairly constant.

To achieve the purpose of promoting and enabling morally appropriate and effective decision-making for those individuals primarily involved in the patient care situation, ethics consultants maintain four objectives when interacting with others:

1. To help identify, clarify, and foster appreciation of relevant ethical values and goals associated with the patient’s care situation.
2. To discuss relevant facets of a situation with the involved participants in order to promote good communication and understanding of the issues, alternatives, likely decisions, and potential outcomes.
3. To enable clear understanding of each person’s basic moral framework and its impact on decisions and outcomes.
4. To help resolve identified problems, conflicts, or dilemmas related to the ethical values and goals associated with the given situation, including each involved individual’s own basic moral framework.

Requests may be made whenever an individual directly involved in a patient’s care believes there to be an issue or concern of ethical import. No permission is needed from anyone else; the warrant for requesting is one’s own ethical concern, worry, sensibility, or question.

That being said, in general, requests tend to be due to differences regarding the norms being used when making decisions about what is believed to be good, right, or fair in a specific circumstance. While not meant to be definitive or exclusive, below are some of the more common situations, prompting requests for clinical ethics consultation (this has been fairly stable over the years):

- Concerns associated with end-of-life treatments (code status, advance directives, withholding/withdrawal of medical interventions, etc.).
- Questions regarding surrogate decision-making or making decisions for “unrepresented” patients, patients who lack decision-making capacity, have no advance directive, and have no surrogate.
- Determining "appropriate" levels of intervention.
- Patient refusal of treatment.
- Real or perceived conflicts between and among patient, family, physicians, nurses, etc.
A Glimpse Inside cont.

- Questions about the permissibility of using innovative or controversial treatments.
- The experience of moral distress by patients, their families, or any of the healthcare providers.

There’s one other point to note about the CECS. Because requests may be made by any of the individuals involved in a patient’s care, and the reason for the request is often based on the requestor’s own sense or understanding of ethics, when a request is made, the first thing an ethics consultant will do is to talk directly with the requestor in order to begin assessing the situation so as to begin determining what possible further steps might need to be taken.

In this way, clinical ethics consultation does not begin with a presumption of already knowing and understanding the issues and concerns presented, nor their attendant values and meaning. Rather, key to the practice of clinical ethics consultation is the recognition that such matters must be discovered and understood within the real context of their actual occurrences – which is what makes clinical ethics consultation a “clinical” – as opposed to an “academic” or merely “theoretical” – practice. Hence, the name: clinical ethics.

WINTER 2014 ETHICS NOON CONFERENCE (ENC)

This is a monthly conference, held in Harvey Morse Auditorium, that is open to all who work within, are affiliated with, or received care at Cedars-Sinai Medical Center. The primary aim of these sessions is to raise the level of awareness and degree of understanding of emerging issues and concerns in the realm of healthcare ethics.

January 15, 2014 - Siegel Lecture in Humanism and Medicine
“Palliative Care and Ethics: A Case-Based Approach”
Timothy E. Quill, M.D., is the Georgia & Thomas Gosnell Distinguished Professor in Palliative Care as well as Professor of Medicine, Psychiatry, and Medical Humanities and Bioethics at the University of Rochester School of Medicine. He has published and lectured widely about various aspects of end-of-life decision making, including delivering bad news, non-abandonment, discussing palliative care earlier, and exploring last-resort options. Dr. Quill was the lead physician plaintiff in the New York State legal case challenging the law prohibiting physician-assisted death that was heard in 1997 by the U.S. Supreme Court (Quill v. Vacco).

February 19, 2014 - Rabbi Levi Meier Memorial Lecture
“Subject to Loss: Jewish Medical Ethics and the Duty of Return”
Laurie Zoloth, Ph.D., is the A. McCormick Professor of Religion and a member of the Jewish Studies faculty, Weinberg College of Arts and Sciences, and Professor of Medical Humanities and Bioethics, Feinberg College of Medicine, at Northwestern University. She also serves as Director of Northwestern’s Center for Bioethics, Science and Society as well as the Brady Scholars Program in Ethics and Leadership, and is an Affiliate Professor at Haifa University. A past president of the American Society for Bioethics and Humanities, Dr. Zoloth is the current chair of the Howard Hughes Medical Institute’s Bioethics Advisory Board, and is a current board member of the Society for Scriptural Reasoning.

March 19, 2014
“Transforming Moral Distress into Integrity and Resilience”
Cynda Rushton, Ph.D., R.N., is the Anne & George L. Bunting Chair in Clinical Ethics and Professor of Nursing in the Department of Acute and Chronic Care at The Johns Hopkins University School of Nursing. She is a founding member and core faculty of the Johns Hopkins Berman Institute of Bioethics and co-chair of the Johns Hopkins Hospital’s Ethics Consultation Service. An internationally recognized scholar, Dr. Rushton’s research focuses on palliative care, moral distress, and caregiver suffering as well as conceptual foundations of integrity, respect, trust and compassion. She was appointed by Maryland’s governor as the first chair of a State Council on Quality Care at the End-of-Life and served from 2002-2008.
Spring 2014: Educational Sessions & Meetings

Jan 2014
Jan 2 - Bioethics Cmt
Jan 6 - Ethics Seminar
Jan 10 - ICU Ethics
Jan 15 - ENC
Jan 24 - ICU Ethics
Jan 29 - Ethics Forum

Feb 2014
Feb 3 - Ethics Seminar
Feb 6 - Bioethics Cmt
Feb 7 - ICU Ethics
Feb 19 - ENC
Feb 21 - ICU Ethics
Feb 24 - ICU Ethics

Mar 2014
Mar 3 - Ethics Seminar
Mar 6 - Bioethics Cmt
Mar 7 - ICU Ethics
Mar 19 - ENC
Mar 21 - ICU Ethics
Mar 26 - Ethics Forum

*ENC = Ethics Noon Conference
*ICU Ethics = ICU Ethics Roundtable for all Residents/Fellows assigned to an ICU during the given month
*SICU Ethics = Surgical ICU Residents/Fellows Ethics Case Conference

For descriptions of the Ethics Seminar and Ethics Forum, please visit either our Intranet or Internet websites and go to the link “Educational Opportunities.”

For more information about any of the above events, please call the Center at 310-423-9636

Good Reads...

The Best Care Possible: A Physician’s Quest to Transform Care Through the End of Life. Ira Byock (Avery Trade, 2013). Drawing on decades of experience, Byock explains how palliative care helps patients and their families “make the best of what is often the very worst times of life.” Additionally, he calls for an overhaul of national and local healthcare systems to bring person and family-centered care to people in fragile health so as to help them avoid too frequent complications and crises.

Ethical Challenges in Health Care: Developing Your Moral Compass. Vicki Lachman (Springer Publishing, 2009). Beginning with an extensive exploration of the concept of moral courage as pertinent to the context of healthcare delivery, this book outlines both personal and organizational strategies to help nurses, physicians, physical therapists, and health care leaders to face difficult ethical challenges in health care practice and management head-on. Illustrative cases and examples are utilized.

Notes from a Narrow Ridge: Religion & Bioethics. Edited by Dena Davis & Laurie Zoloth (University Publishing Group, 1999). This book, a collection of fourteen essays from authors steeped in a variety of religious traditions, explores the interactions between religion and bioethics. It reveals how religion plays both implicit and explicit roles in shaping understanding of many prominent bioethical issues, and as such, the need for paying greater attention to the various contexts in which such interactions occur.

Medicine in Art. Giorgio Bordin and Laura Polo D’Ambrosio (Getty Museums, 2010). This abundantly illustrated volume offers an exploration of the depictions of illness and healing in Western artworks, ranging from Egyptian wall carvings to medieval manuscripts to paintings and sculpture by the great masters of the Renaissance thru the 20th century. Thematic chapters address the breadth of patient maladies including psychological anguish and the physical manifestations of undergoing illness and injury.

Books featured in “Good Reads...” are available in the Medical Library. Please call 310-423-3751 for book availability and reserve a copy today!

If you have missed one of our Ethics Noon Conferences (ENC) Series and are interested in viewing them, the Medical Library has copies of the series dating back to November 2007. We invite you to check them out!

Note from the Center’s Faculty...

To all the patients, families, nurses, physicians, social workers, chaplains, and others with whom we interact in our role as Ethics Consultants: we are deeply humbled by what you teach us about the experiences of illness and caring.

C.H.E. Newsletter is a publication of Cedars-Sinai Medical Center.

Center for Healthcare Ethics Personnel

Director: Stuart G. Finder, Ph.D.
Assistant Director: Virginia L. Bartlett, Ph.D
Associate Director: Kenneth Leeds, M.D.
Management Assistant II: Susanne Tiffer

We welcome your feedback.