Capital Commons Quarterly

The Dynamics of Aging and Our Communities

Issue No. 1 • Vol. 6 • April 2012

Opportunity

Experience

Ideas

This issue:

- Featured Organization: Historic Oakwood Cemetery in Troy
- Alice Hastings Murphy: Managing a Remarkable Life with Grace, to the End
- On Physician-Assisted Suicide: Getting to the Root
- Hospice Rotation for Albany Medical College Medical Students
- An Overview of the Family Health Care Decisions Act Ethics Review Committee
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~ Albany Guardian Society, Albany, New York, USA ~
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The Dynamics of Aging and Our Communities

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Mission Statement

CCQ is an electronic and print public policy quarterly dedicated to looking at the aging segment of our society and region as it redefines itself and intersects with a wide cross section of demographic, social, cultural and economic features of society. In this light, we will consider subjects such as city and town planning, environmental advocacy, economic development, housing, work force, education, mobility, regionalism, governance, marketing, recreation, health care, social services, creativity, demographics, emerging technologies and the roles of nonprofit organizations. Our audience is public and private decision makers and all others seeking to understand a changing society. We will offer concise, thoughtful and interesting articles. Comments, including letters to the editor and recommendations from our readers, are welcome.
True or False: We’re All Going to Die Someday

When Paul Bray and I contemplated this issue of CCQ, we were describing it as an end-of-life issue. But when we looked at the articles, it became apparent that we were somewhat all over the map. Our articles include discussions on ethics committees, hospice care, the life and death of an older person, and physician-assisted suicide. In an unusual bit of irony, we had long-ago decided to feature Oakwood Cemetery as our Featured Organization. This may not be an end-of-life issue, but it’s probably as close as we’re ever going to come to producing one.

If you believe that how you choose to live your life is your decision and no one else’s, then you likely carry intense feelings about how you think your life should end. Most of us can verbalize some basic emotion about this subject: “I don’t want to suffer.” Or, “Please, Lord, let me die peacefully in my sleep.” These are casual, off-the-cuff comments and don’t require much introspection.

As we get older, we start to make “plans.” We think about writing our obituary. In the back of our mind, we recall someone’s obituary and how we felt it went on and on in a serious case of TMI—Too Much Information. Then we start thinking about all the things in our obituary and, hopefully, someone will tell us that to the reader who doesn’t know us, this, too, will be TMI.

Based upon our religion, we might design our funeral service. And, while we’re at it, let’s make sure we tell our loved ones that we want our ashes spread over (fill in the blank . . . ), probably some magnificent, scenic setting that really doesn’t need our ashes.

When I used to think about how I was going to die, I always imagined I would be in some sort of outdoor setting while Joni Mitchell played in the background. Why on earth do we try to choreograph our own death? We make jokes about it with lines like, “O Lord, please let me be in heaven an hour before the devil knows I’m dead”—an acknowledgment that there are past sins, and maybe, just maybe, we’ll be lucky enough not to pay for them in this life or the next one.

Hollywood helps us frame this discussion. In Love Story, Ryan O’Neal looks into Ali MacGraw’s dying eyes and professes a love we all envy and hope to experience. James Caan shows us football pro Brian Piccolo at the end of life in Brian’s Song. Is there a dry eye in the house? Or, if baseball is your sport, we have Bang the Drum Slowly. In all cases, the movies are helping us capture a stylized and heavily-acted portrayal of death. If you have experienced the death of a loved one or a close friend, you realize it’s not really like the movies.

Conversations about end-of-life happen at all levels. Over the past few years much of our national debate has focused on health care and social entitlement programs. Economists project the costs of this care and point to a staggering fiscal burden for our children. You know what people are thinking when they hear this—old people cost us a lot of money, especially at the end of their lives.
But here’s a note to younger people: most older people know exactly what you’re thinking, and most of them have little interest in hanging around hooked up to those costly machines we see on television. There is more restraint going on by the older generation than people realize. Former Colorado Governor Richard Lamb once got himself into a heap of trouble when he said something about the older generation making room for the younger generation.

At a regional level, many parts of our country take great pride in describing their demographic makeup: “Eighteen percent of our population is over the age of sixty-five.” This is a veiled reference to the fact that areas with lots of old people have different things to think about compared to communities of predominately younger citizens.

Individual states can have significant discussions about end-of-life. In 1997, Oregon passed the Death with Dignity Act. I went online to read the 2010 report and learned that 65 patients died under the Death with Dignity Act in 2010, and more than 70 percent were over age 65. One hundred percent were white, and 78 percent of them had a diagnosis of cancer. The report went on to say, “As in previous years, the most previously mentioned end-of-life concerns were: loss of autonomy (93.8%); decreasing ability to participate in activities that made life enjoyable (93.8%); and loss of dignity (78.5%).

We are forced to think about end-of-life when we renew our driver’s license as the form asks if we wish to donate our organs. We think about end-of-life when our attorney helps us prepare our last will and testament and he urges us to complete a Health Care Proxy and perhaps a Living Will. We comply, but in the back of our minds we hope it will be a long time before we need to use these documents.

If we are in frail health, we are often asked if we wish to receive heroic life-saving measures. Do we take that off the table and complete a Do Not Resuscitate form? It’s easy to get depressed when we talk about end-of-life issues. But open conversation about how we wish to live in the final phase of our lives can also be liberating. Advance Directives are just what they sound like—they are your hands on the steering wheel, no one else’s—and the car is going to go where you point it.

One of my favorite films of all times is Legends of the Fall with Anthony Hopkins. In one of the last scenes, the character played by Brad Pitt is wandering in a snowy wilderness and is attacked by a bear. The narrator describes how his life has unfolded and speaking of the character’s demise says, “It was a good death.” We should all be so fortunate.

By the way: the answer is True.

Rick Iannello
Executive Director
Albany Guardian Society
Editor’s Column

As more people live longer and life grows more complex, it is harder to have a coherent and cohesive philosophy of life stages. Discussions I’ve heard about a recent book on middle age have included head scratching about what is middle age. Is someone middle age in their thirties, forties, fifties, sixties, or seventies? We talk about sixty being the new forty. Some retirees I know have told me they never worked as hard as they do now that they are retired. All stages of life, including the final stage, have become moving targets to grasp.

We are using this issue of CCQ to help inform our readers with some of the subject matter relating to the final stages of life.

Very few people, including many physicians and myself, want to talk about death even as it is inevitable for all of us and our loved ones. Thankfully, there are many skilled and caring people who do devote themselves to the passage of life.

I learned about the skilled and caring people providing end-of-life care through hospice and palliative care when my parents were facing the end of their lives. When my father was suffering the impacts of being bounced back and forth between his nursing home and the seemingly unnecessary number of trips he dreaded to the hospital, I learned that placing him in palliative care was the only way to keep him from having to be rushed to the emergency room every time a nursing home aide found him on the floor whether or not there was any sign that he was injured.

Many things went through my mind when I was making decisions for my father including protecting his comfort as well as not making a decision that unintentionally shortened his life. Palliative care for my father was the right decision, and I am glad I made it. Nothing was done to hasten his passing. Rather, increased attention by sensitive people was given to his care and comfort and rushing him to the hospital was not the default decision.

Highlights in this issue

After the article on our featured organization, Historic Oakwood Cemetery in Troy, we have an uplifting piece on Alice Hastings Murphy, called “a pro at mobilizing social and technological resources for her health and well-being.” Alice is one of many eighty-five or older seniors that author Meika Loe has highlighted in her recent book for being able to “create lives worth living” in the later portion of their lives.

Medical educators are increasingly recognizing that training in end-of-life care is a key element for medical students, our future doctors. Albany Medical College is a leader in training its students on the issues and skills associated with the last stages of life. AMC, for example, provided for clinical palliative care/hospice and thanks to the help of Dr. John A. Balint, a leader in this field, we are sharing some of the thoughts of the students from their hospice rounds.
Medical ethics committees in hospitals and nursing homes are key entities for resolving the often complex and sometimes emotional decisions that are faced as end-of-life approaches. Charis B. Nick-Torok, MBe, Esq., and Dr. Bruce D. White, in their respective articles, describe the purposes and procedures of medical ethics committees. Dr. White gives an example of a specific challenging decision—an inadequate supply of a cancer drug, which an ethics committee has to address.

Ethicist Michael Brannigan, Ph.D., shares his well thought out analysis of physician-assisted suicide, now legalized in some states and likely to become a legislative issue in New York State in the not too distant future.

Rob Puglisi and Rodger Fink, respectively a hospice employee and a hospice volunteer, share their personal experiences and thoughts about hospice, a valuable institution for individuals facing end-of-life and their families.

There is much to learn about the end-of-life and, hopefully, this issue of CCQ will broaden our readers’ knowledge on the subject in a valuable way.

Paul M. Bray is an Albany attorney who is a lecturer in planning at the University of Albany, a columnist, and founding President of the Albany Roundtable civic lunch forum. His e-mail address is pmbray@aol.com.
Historic Oakwood Cemetery in Troy

By Toni Craft

Oakwood Cemetery is a non-sectarian cemetery open to all faiths. It is one of America’s larger rural cemeteries, overlooking 100 miles of the Hudson Valley and the heart of Troy. The Troy Cemetery Association, Inc., is charged with preserving and maintaining 60,000 graves. These dearly departed are from all walks of life and are all cared for with equal care and respect. Also under the Troy Cemetery Association’s care are hundreds of acres of both wooded and open spaces, ten to twelve miles of roads, several beautiful ponds, and waterfalls. The cemetery is also the home of the spectacular Gardner Earl Memorial Chapel and Crematorium.

Oakwood Cemetery is a rural cemetery. City parks were not yet a reality so the cemetery was designed to not only have a lovely burial place for loved ones, but to offer a sanctuary where one could spend the day, far above the dirty smoggy city below. The cemetery was the place “To Be.” All of Troy’s “Movers and Shakers” were buying up large plots of land for their families. After Church on Sunday, Troy’s residents went to Oakwood Cemetery and had a picnic lunch, then traveled around the winding roads to talk to their friends and neighbors who were also visiting the cemetery.

Oakwood Cemetery has many famous residents. The most well-known is probably Troy’s own Sam Wilson, the progenitor of the “Uncle Sam” icon that has represented us around the world. Sam Wilson had a Troy meatpacking business that supplied meat to the U.S. War Department during the War of 1812. The barrels of meat had a U.S. stamp on them, and the soldiers from the Troy area that knew Sam Wilson joked that the U.S. meant “Uncle Sam” as Samuel Wilson was very often called. In 1961, Congress officially recognized “Uncle Sam” Wilson of Troy as the man behind America’s national symbol.

History buffs could spend weeks exploring Oakwood and discovering all of the Civil War generals that are buried here. (Hint: there are nine of them.) During the next few years, while America commemorates the Sesquicentennial of the Civil War, is the perfect time to come and explore Oakwood Cemetery. Other notables are Amos Eaton, one of the founders of RPI, and Emma Willard the founder of the Troy Female
Seminary, later renamed Emma Willard. Ms. Willard was an early believer that young women did not need to be limited to learning sewing but that they could learn math and science without falling ill! Russell Sage, the well-known railroad baron and stock market investor, is buried here as well. His miserly ways made him very rich and when he died in 1906, his widow, Margaret Olivia Slocum Sage, was one of the wealthiest women in America. She became quite the philanthropist and gave money to many deserving colleges, social programs, and wildlife refuges.

“History buffs could spend weeks exploring Oakwood and discovering all of the Civil War generals that are buried here. (Hint: there are nine of them.)”

Oakwood is a popular spot for runners, dog-walkers, nature lovers, and families alike. In addition to the lovely sculptures and mausoleums, the cemetery is enjoyed for bird and wildlife sighting, (Indigo Bunting, Bald Eagles, Red Fox, and Deer). There is a spectacular panoramic view of the confluence of the Hudson and Mohawk Rivers. The Cohoes Falls can be seen as well as the start of the Erie Canal heading west.

The jewel of Oakwood Cemetery is the Gardner Earl Memorial Chapel and Crematorium. Gardner Earl, who died in 1887 at the age of thirty-nine, was the only son of William S. and Hannah Gardner Earl. After his wish to be cremated had to be fulfilled in Buffalo, his parents decided to build this historic chapel and crematorium, sparing no expense. Tiffany windows, marble mosaics, and carved oak are the highlights of this gorgeous building. Funerals, memorials, and beautiful weddings are frequently held here.

Oakwood Cemetery’s website, www.oakwoodcemetery.org, is currently being redesigned. That unveiling along with our tour line-up will be posted in early April. There will be many themed walking tours offered throughout the year. Our annual Daffodil Brunch will be held in the Gardner Earl Chapel on April 15, 2012. Please remember that Oakwood Cemetery is an active cemetery with many beautiful plots available. There is enough room to serve Troy and the surrounding communities for another hundred years.

Toni Craft is President of the Friends of Oakwood, the volunteer organization that supports Oakwood Cemetery. Her goal is to have as many people as possible come to the cemetery and learn about the wonderful history and beauty that is housed inside of the gates of Oakwood Cemetery.
Alice Hastings Murphy: Managing a Remarkable Life with Grace, to the End

By Meika Loe

Over the course of several decades, Alice Hastings Murphy visited with elders at Albany Guardian Society Home in Albany’s West Hill neighborhood. The home was a dwelling space for (primarily) old women who could not afford to live on their own. The home opened in the 1850s, well before Social Security, and closed in 2000. Each member of Albany Guardian Society Home’s board adopted one resident in that home, checked in on her regularly, and saw that her needs were met. Alice Hastings Murphy was one of these caregivers.

“It was during this experience that Alice, who could trace her British roots back thirteen generations in this country, started to rethink being “reserved,” and decided that “warmth was a better approach.” She saw the world anew through an elder woman’s eyes, and resented the ageism and sexism that limited her opportunities. Alice did her best to supplement the financial circumstances of the “aged and helpless.” She also actively listened and practiced using humor to lighten the moment. And she began to identify what she saw as “a universal need for physical touch, particularly as we age.”

Alice, the daughter of educators Harry and Louise Clement Hastings, grew up in Albany’s Center Square, attended St. Agnes School (which in 1975 merged with Kenwood Academy to form Doane Stuart School), and went on to earn degrees at Radcliffe, UAlbany, and Columbia. Alice returned to Albany and soon became a local leader and visionary, serving as director of the University Libraries during SUNY Albany’s transformation from teachers’ college to major public research university. Many today continue to cite Alice’s “monumental impact” as her research library became the foundation of the new university. All agree that she engaged in this work with humor, total humility, and grace.
Throughout her adult years, Alice also worked with the less fortunate in Albany. Beyond her Albany Guardian Society Home responsibilities, Alice was a storyteller and puppeteer at the Albany Public Library and worked at a canteen for soldiers and their families during World War II. All of these experiences helped Alice to cultivate the life skills to manage her own care as an elder and to prepare herself for her final chapter of life.

Fast forward to Alice in her final decade of life. Alice was a pro at managing her life and self-care, despite disability. When I met Alice in 2005 (she was in her late eighties), her “personal system for self-care” involved a condo, a crock-pot, an electric kettle, a walker, a Lifeline membership, and endless gadgets for magnification and auditory learning in the context of visual impairment. Although it was difficult for her to ask for help after a life of doing most things independently, Alice believed that this assistance helped to protect her autonomy, dignity, and control. When she stopped driving, she retained her car and hired a driver from Umbrella of the Capital Region. When she was no longer able to read her mail, she hired an assistant who visited weekly. And after a major fall, she welcomed a distant relative’s assistance in her home, and sought out physical therapy, to “get strong again.”

In 2010, Alice moved from her home in Delmar to Beverwyck, an assisted living community, where a plaque lists her as one of the original founders. She navigated her small apartment, the narrow halls, and the outside courtyard, by touch and feel as a legally blind resident. She reflected on a life of helping others, and believed that this life’s “work” was not done. Thus, she actively adopted the loneliest souls among her peers, and listened to their stories and concerns, sometimes for hours. She sometimes jokingly referred to them as her “clients.” When appropriate, she ended their sessions with, “How about that hug?”

“Although it was difficult for her to ask for help after a life of doing most things independently, Alice believed that this assistance helped to protect her autonomy, dignity, and control.”

Alice believed in the preciousness of life. She delighted in everything from the changing of the seasons, to local politics, to fostering relationships. At the same time, Alice prepared herself for death. She was always clear with her doctors and loved ones that she did not believe in life extension. She regularly filed and updated her advance directives to reflect this final wish.

One of the hardest things about being a long-living elder is the degree of loss one experiences. To balance this out, Alice tried to spend equal time grieving and fostering and maintaining new and old friendships.

Alice also had to be adaptable in the context of disability. In a 2011 radio interview with AARP, Alice described how challenging it is when you can no longer read, particularly for someone who
dedicated her life’s work to literacy. She said, “The biggest change in my life is that I cannot read. Think about it, every time you turn around, you are reading something—signs, a menu—so you have to adjust to this change.”

When personal care became more challenging, Alice and her friends had to make important decisions. Alice chose to move to a small apartment in assisted living, and one of her close friends, Betty, took the home care route. They would regularly touch base about their respective decisions. Not long before, Betty and Alice lived as single women and close neighbors in a condo complex. They enjoyed regular walks and hired a driver to take them shopping and on their beloved picnics. At one point they threatened to chain themselves to a tree, to keep the condo association from cutting it down. They delighted in being independent women in their early nineties.

At the age of ninety-four, Betty and Alice spent most of their time together on the phone. Betty was concerned about protecting her independence in the context of home and family care. Alice wanted to protect her autonomy in the context of institutional care. Both may have resented new incursions on their privacy; but they were thankful for the care they received. Both insisted on being treated as full human beings, living with dignity and retaining control of life decisions. Despite physical disability, both were in good overall health and continued to derive great joy out of life.

Alice (Turner) Hastings Murphy died in the early morning hours of December 31, 2011, in her bed at Beverwyck. Half a mile across town, Betty Mattox died one hour earlier. Both were 94.

“At one point they threatened to chain themselves to a tree, to keep the condo association from cutting it down.”

Alice and Betty may be gone, but these remarkable women leave us with important lessons on managing one’s own care and preparing for the final chapter. Perhaps most of all, they remind us of the great importance of friendship throughout our lives.

Alice is one of thirty remarkable elders from Upstate New York profiled in Aging Our Way: Lessons for Living from 85 and Beyond. 

Meika Loe is Associate Professor of Sociology and Director of Women’s Studies at Colgate University in Hamilton, New York, where she teaches courses on aging, medicine, and gender. Her interest in the lives of elders comes from watching her grandparents embrace various strategies for autonomy in old age. She is the author of two books: The Rise of Viagra: How the Little Blue Pill Changed Sex in America (2004), and Aging Our Way: Lessons for Living from 85 and Beyond (2011). Her blog can be found at: http://agingourway.wordpress.com.
Imagine two trains racing on separate tracks. The speedier train represents our life-extending medical technologies. The other train signifies medical progress in pain control. Due to insufficient understanding and training regarding pain control and palliative care among physicians as well as legal restrictions over certain drugs, the second train lags far behind. This incongruity, what philosopher Margaret Battin calls the “phenomenon of discrepant development,” drives the heated debate over physician-assisted suicide (PAS), or “physician aid-in-dying,” with added intensity.

We’ve heard the typical arguments pro and con. For proponents, extending mercy to patients suffering intolerable pain constitutes a moral imperative. Moreover, this option preserves my personal autonomy and moral right to make choices regarding my care, restoring some measure of personal dignity in undignified circumstances. This decision also reflects habits of heart and soul expressed throughout my life. I make this decision in view of my deepest personal values, not driven solely by my desire to free myself from pain and suffering.

“This ubiquitous tension between individual interests and the common good often erupts into irresolvable conflict.”

Opponents argue that effective pain control measures exist, like morphine and other drugs for sedation. Moreover, I question whether these requests are sufficiently reasoned and voluntary to be genuinely autonomous, particularly since studies report that such requests are often due to treatable yet undiagnosed clinical depression. Furthermore, PAS goes against a physician’s professional role in sustaining life. My most strident argument underscores alleged consequences: the high potential for abuse by extending the practice to vulnerable patients like disabled, elderly, poor, and minority individuals. Finally, strong religious beliefs asserting my stewardship rather than dominion over my life rules out any form of suicide.

No doubt, the issue is complex. Let me add another, though often neglected, consideration: the crucial distinction between the morality of one’s personal choice and the equally moral matter of
sound public policy. The two spheres are not of necessity causally linked. That is, even if I believe that PAS under certain conditions is morally justified, would that in itself make legalization of PAS at this point in time a morally wise public policy? This ubiquitous tension between individual interests and the common good often erupts into irresolvable conflict.

This irresolvable-ness is illustrated by appeals to physicians’ duty to act in their patients’ best interests (beneficence) and to prevent and alleviate unnecessary harm (non-maleficence). These principles can be used to support either position depending upon how one interprets “best interests” and “harm.” Appealing to these principles begs the question, contingent upon one’s perspective.

Irresolvable-ness also shows itself in appeals to autonomy. The blade of autonomy cuts both ways. While I may presume self-determination a strictly private affair (my death is my own), my identity is still entangled in collective, relational chords. I am not just a private self, but also husband, son, brother, friend, and teacher. Imbedded in my social geography, my decisions have consequences within that geography.

“While I may presume self-determination a strictly private affair (my death is my own), my identity is still entangled in collective, relational chords.”

Given this tension between personal morality and public policy, in pondering the wisdom of publicly sanctioning PAS, let’s take a hard look at our socio-cultural and clinical climate. Here is a short list of what I find: palpably diminished healthcare resources, sliced social services for vulnerable groups, technological interventions replacing interpersonal interactions, physicians spending far less time talking with patients, primary care medicine in crisis, inadequate medical training regarding palliative care and hospice, unforgiving disparities in healthcare outcomes among marginalized groups, monumental lack of access to basic care, and undiagnosed but treatable depression particularly among the elderly.

These reflect at least two deeply ingrained socio-cultural characteristics. First, we lack a coherent and cohesive philosophy of life-stages. By attributing excessive value to youth and productivity while denying intrinsic worth to aging, growing old is unenviable and death is outright offensive. Second, increasingly obsessed with connecting technologies (that ironically contribute to our being less genuinely connected interpersonally through face-to-face engagement), we become more thoroughly saturated in solipsistic individualism that contributes little to intergenerational duties and justice.

Legalizing PAS might work in a society that thrives on solidarity and collective well-being and with a healthcare system that reflects these principles (as may be the case in the Netherlands and elsewhere). Legalizing PAS may also make sense if there are sufficient numbers of physicians trained in palliative care and sympathetic to hospice philosophy, and who will have sustained,
sensitive and compassionate discussion of requests and alternatives with patients. Yet my list above resists prioritizing the common good and embracing a consistent philosophy of life-stages. In short, do we have the socio-cultural maturity needed to embrace the sanctioning of PAS?

On the other hand, why penalize those suffering unbearably because we lack this maturity? Sound social policy must work in ways that will somehow benefit the worst off. And the worst off appear to be those who are suffering intolerable pain but can do nothing about it. It therefore appears that whatever social policy we in New York design regarding PAS, there will be victims.

In essence, framing the question of PAS as an either/or constitutes a false dilemma. The question of PAS is not a panacea to our healthcare woes. We must get to the root of the matter, namely how we deal with death in our society. PAS must not become a band-aid to this more profound issue that we cannot afford to ignore. Despite its apparent unresolvable-ness, weighing the morality of PAS compels us to undertake two practical imperatives. First, substantially improve physician education in palliative care and in sensitive, caring communication with patients. Next, heal our fractured attitudes and approach to primary care and access.

Nonetheless, we still desperately need to address the root issue—how we deal with our mortality. If patients request PAS to reclaim dignity and control in circumstances of unbearable pain, mortifying dependency, and loss of control in an impersonal medical setting, simply resorting to PAS as a default solution addresses the symptom, but does little to fix the root.

Michael Brannigan, Ph.D., is the Pfaff Endowed Chair in Ethics and Moral Values at The College of Saint Rose and is also a member of the faculty, Alden March Bioethics Institute, Albany Medical College. Dr. Brannigan writes a monthly column for the Times Union.
Hospice Rotation for Albany Medical College Medical Students

Edited by Paul M. Bray

Michael Brannigan pointed out in the preceding article the need to “substantially improve physician education in palliative care and in sensitive, caring communication with patients.” As a result of a growing recognition that end-of-life care is an integral part of medical education, and with the leadership of Dr. John A. Balint, third-year medical students, “residents,” at Albany Medical College (AMC) have a required one-week hospice rotation. AMC is the first medical college to institute this approach. It is finding increasing use elsewhere. At the completion of this rotation, the students are asked to write an essay describing the lessons they learned from their experience with hospice.

The following are extracts taken from some of these essays that are revealing of emotional responses and better understanding of appropriate treatment of hospice patients. Ed.

Extracts from student essays:

1. “Hospice was, without a doubt, the most unique section of my internal medical rotation. Experiencing such a different side of patient care, which many times carries a stigma with it, helped me understand many reasons why hospice care is a very helpful tool we possess for patient care. Maybe the most important thing I learned this week is to stop thinking of hospice as ‘a death sentence;’ and start seeing it more as a very useful treatment alternative for the very ill. As someone who interacts with medical professionals, I am daily exposed to the views of physicians who are most often hesitant to refer their patients to hospice services. There is a general sense that we must do whatever is necessary to diagnose and treat disease; but, many times we do not take into consideration that the patient may benefit from a reevaluation of our common goals of care. Many physicians find it difficult to recognize or accept that point where the end of life is approaching and an aggressive, active treatment of a disease may not be of most benefit to the patient. In my future career I will often be confronted by this decision, and my experience and understanding of hospice care will definitely facilitate this process.”

2. “Effects of the storm, power outages, downed telephone lines, and frequent re-routing due to closed roads led to somewhat of an atypical experience. But this is not to say that my experience was any less fulfilling. On my first day, the RN I was shadowing told me that the process of death is very similar to the process of birth. ‘People always remember the people who help bring their family into the world, and they always remember the people who help their family leave the world.’ I thought this was a poignant observation. I had never thought of hospice in that way, but it places the process of dying in an appropriate context that may be beneficial to my future patients. Hospice usually has a poor connotation. Patients’ families often think that enrolling in hospice means they are being forced to give up on their family members. However, thinking about hospice as similar to the process of birth indicates that death can be a natural and even peaceful process. The death of a loved one is obviously not desirable, but with hospice, patients and their families can come to terms with the situation in a way that can bring peace and contentment to all parties involved.”
3. “During the rotation in hospice, I was very impressed by the setup of hospice service. I was never aware that a hospice is actually made up of a diverse and skilled team of nurses, social workers, chaplains, and home health care aides. Through the rotation, I learned about the importance of each member in the team, and how they used their specialized skills to do their part in comforting the patient and the patient’s family. My first day was spent doing home visits with a nurse. I was impressed by her kind nature and that of the home health care aides. In their interaction with the patients, you could see clearly how they deeply cared for their patients. During these visits, I was also reminded by one patient about the importance of family in the process of dealing with illness to death. This patient expressed her sadness over the fact that one of her sons was not visiting her during her last months of life. She said she wanted to see her grandson and that she does not know what her son has been up to. This seemed to underscore the importance of family support in times of illness and death. I got the feeling that this kind lady would have benefited greatly emotionally if she had the support of this son, who could, at minimum, visit her in order to improve her emotional state. This saddened me, and I think this experience will serve to remind me, when I am a physician, to try to make sure to encourage family involvement in times such as these, as it would ameliorate suffering.”

“Maybe the most important thing I learned this week is to stop thinking of hospice as ‘a death sentence,’ and start seeing it more as a very useful treatment alternative for the very ill.”

4. “Most importantly, during the hospice rotation, I learned what hospice is, and got to see for myself patients’ experience with home hospice. Prior to the rotation, I have (luckily) had limited experience with death of loved ones, so the very concept of an official organization that supports patients and their families at the end of life was new to me. I was impressed to see how extensive the program is and how many different care specialties are part of the hospice team. There are nurses and LPNs, social workers and psychologists, spiritual leaders, volunteers, and support staff. I learned that different services are available depending on the patient’s physical, psychological, and emotional needs. I think learning about all that hospice is and all it has to offer will be immensely helpful when I am working as a physician because it will encourage me to tell patients about this wonderful program and allow me to competently answer questions they and their families may have. Additionally, learning about the supplemental programs hospice offers (e.g., bereavement counseling) was useful because I will be able to pass on this information to patients and help to effectively utilize these resources.”
An Overview of the Family Health Care Decisions Act Ethics Review Committee

By Charis B. Nick-Torok, MBe, Esq.

Introduction
Ethical dilemmas in healthcare typically arise when a treatment decision must be made between two morally acceptable choices, each with undesirable consequences. In many cases, the dispute involves the withholding or withdrawing of life-extending medical treatments for patients who have lost consciousness, are suffering from advanced dementia, or when the burdens of treatment continually impair the person’s current life. Such cases can become more complicated if the patient is a minor, or has never had the capacity to make his or her own healthcare decisions. Disagreements over who has decision-making authority or religious or cultural differences only add to the distress.

Central in many of the conflicts is the perceptual ambiguity associated with evaluating benefits, burdens, and the potential usefulness of treatments in a specific case. In a 2003 study published by the Journal of the American Medical Association that included seven intensive care units, 550 patients receiving life-sustaining treatment were involved or at the center of moral-type disagreements with physicians or family members over the inappropriateness and uselessness of continuing treatment. Several studies of nurses and physicians, the most recent in 2011, document that moral distress in the ICU is a leading cause of burnout for nurses and a primary reason for new nurses leaving the profession after a short time.

“To date, over 95 percent of hospitals across the country have established or are in the process of establishing some type of ethical review mechanism—or committee—to address patient dilemmas in healthcare decision-making.”

When moral challenges arise in healthcare, many healthcare professionals, patients, family members, and others mistakenly look to the law for guidance, but the answer is not always clear. Moreover, the law provides only minimum standards for what can or cannot be done. Resolving moral conflicts in healthcare requires moving beyond the minimum standard and determining not only what can be done in a general sense, but also and more importantly, what should be done in a specific case. Unfortunately, finding an ethically justified solution is seldom easy. And, reaching an ethically justified conclusion does not mean that a perfect answer has been achieved. In most cases, some moral values must be sacrificed for...
others, thus reducing but perhaps not eliminating moral distress. As Rosemarie Tong observes in her book *New Perspectives in Healthcare Ethics*, “the sacrifice of . . . values, even when they are justified, will be a cause of great sadness for morally reflective people.”

A brief history of ethics committees
Hoping to ease tensions and distress in cases where the law fails to provide a reasonable or ethically satisfying approach, hospitals over the past thirty years or so have increasingly turned to Ethics Committees. In general, ethics committees provide a reasoned process of deliberation that respects all value systems and points of view, while focusing the decision on the goals and objectives of the patient’s well-being within the scope of ethical medical practice. Far from sidestepping the law, many courts beginning with the 1976 seminal case Matter of Quinlan (355 A.2d 647, N.J. 1976) have supported the use of ethics committees for resolving conflicts associated with the right to refuse life-extending medical treatment. In Quinlan, the New Jersey Supreme Court granted Joseph Quinlan’s petition to remove the artificial ventilation that was keeping Karen Ann, his twenty-two-year-old permanently comatose daughter, alive. Acknowledging that both courts and physicians were equally ill-suited for such ethical deliberations, the Court recommended the establishment of hospital ethics committees, noting “In the real world and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent.”

Since the Quinlan decision, the use of hospital ethics committees for resolving ethical dilemmas has been encouraged in varying degrees, and sometimes mandated. The understanding expressed through the Joint Commission, the 1983 President’s Commission, and several federal and state governing bodies is that advanced technology raises questions with respect to quality care that are not easily quantified or resolved in the traditional physician-patient relationship. To date, over 95 percent of hospitals across the country have established or are in the process of establishing some type of ethical review mechanism—or committee—to address patient dilemmas in healthcare decision-making.

**Ethics Review Committees under the Family Health Care Decisions Act**
A key to understanding the myriad rules governing the establishment of Ethics Review Committees (ERC) under New York’s 2010 Family Health Care Decisions Act (FHCDA) is to recognize a
fundamental legal and ethical principle. Stated generally, an adult patient with decision-making capacity cannot be forced to undergo any treatment against his or her will. Loosely defined, decision-making capacity, akin to legal competence, requires that a patient understands the nature of his or her illness, and can articulate the risks and consequences of rejecting—or accepting—treatments. Specific provisions for determining decision-making capacity under the FHCDA are provided in the statute. Sometimes emotional, physical, or mental conditions such as depression, medications, grief, pain, guilt, fear, or other factors can impede a person’s judgment, without relieving the person of his or her decision-making capacity. Identifying the potential existence of these influences when a case is referred to the ERC for review is part of the ethics committee’s function. The ERC is provided much latitude when making recommendations and may call in assistance from other professionals such as clergy or social workers.

If a patient has lost decision-making capacity, and did not previously make his or her wishes known or appoint a healthcare agent to speak for him or her, the FHCDA authorizes a court appointed guardian, the patient’s family, or a close friend to make ordinary healthcare decisions for the patient. Along with this authority, the FHCDA requires that the decision maker, defined in the statute as a surrogate, make the treatment decisions based on his or her knowledge of the patient’s wishes, including the patient’s religious and moral values. If the surrogate cannot infer the patient’s wishes, then the decision must be made in the patient’s best interest.

A surrogate’s authority is not without restrictions when it comes to decisions regarding the withdrawing or withholding of life-sustaining medical interventions such as Artificial Nutrition and Hydration or mechanical respiration. Moreover, a dispute between the physician and the surrogate regarding the surrogate’s decision will trigger a mandatory and binding ethics review in the following cases:

1. In a hospital if the patient is not unconscious and is not suffering from a terminal condition, defined as having six months or less to live, but the surrogate decides to forego Artificial Nutrition and Hydration.
2. In a nursing home if the patient is not unconscious and is not suffering from a terminal illness and the surrogate chooses to withdraw or withhold life-sustaining treatment, with the exception of cardiopulmonary resuscitation (CPR).
3. In a hospital or nursing home, if an emancipated minor, as defined in the statute, is rejecting life-sustaining treatment.

It is important to note that the FHCDA ERC is not required to hear all ethical disputes, nor are all of its decisions binding. Although the ERC is required to hear disputes raised by a person connected to the case, in such cases as in most cases aside from those outlined above, the ERC’s decisions are merely advisory. Strict provisions for conducting and documenting a review, binding or otherwise, such as notifying patients and “persons connected with the case,” accessing the ERC, the multidisciplinary nature of the ERC, including the requirement that at least one member have no
connection to the hospital, healthcare ethics training for ERC members, and many other provisions governing the operation of the ERC are clearly outlined in the statute.

Along with the ERC’s function and procedures, the FHCDA outlines strict protections for patient confidentiality. With a few exceptions involving patient voluntary disclosure or some state oversight agencies, ERC records and recommendations are barred from judicial or other types of review or inspection. Additionally, no ERC member may be called as a witness with respect to a review. Similarly, ERC members acting in good faith in the performance of their functions are protected from liability.

Conclusion
Fundamental to ethical decision-making in healthcare is the belief that every adult, unless proven otherwise, has the right and the decision-making capacity to make his or her own choices regarding proposed medical treatments, even if such decisions result in his or her death. Stated another way, we are the only ones who know for sure whether the limitations and burdens of the available treatments meet our personal expectations of a meaningful life. Even surrogates authorized to make decisions for us in the event that we lack decision-making capacity must attempt to answer the question as we might answer it were we able to speak for ourselves.

Moral conflicts often arise in healthcare settings when our moral sense of right and wrong is at odds with the decisions or treatments proposed, or we are forced to choose from two morally acceptable options that will both produce burdensome or undesirable consequences. While law provides for some minimal standards for resolving such disputes in some cases, the need for broader ethical exploration into what should be done on a case-by-case basis inspired the need for ethics committees.

Over the past thirty-six years, the need is ever-growing, as advances in medical technology prolong life, but can impose what some of us perceive as overly burdensome suffering. New York’s FHCDA attempts to reduce moral disputes, while respecting patient autonomy through its comprehensive mandates requiring all hospitals and nursing homes to establish or incorporate the provisions defined for ethics review committees. In our age of advancing medical technology, ethical review in a healthcare setting requires awareness of the complexities and moral distress that can arise when good people disagree.
1 See Rosemarie Tong, “New Perspectives in Healthcare Ethics”


5 Id at page 34.


8 Id at 60.

9 The Joint Commission, formally JACHO, is the non-profit accrediting and standards setting body for hospitals and healthcare organizations across the country. Many state licensing boards require that hospitals achieve Joint Commission accreditation in order to operate in the state.

10 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment.

11 See O’Reilly at Note 2.

12 N.Y. Public Health Law § 2994-c.


14 Id.

15 For conditions foreclosing the surrogate’s authority under the Act, see N.Y. Public Health Law § 2994-d(4)(5).

16 N.Y. Public Health Law § 2994-4(B).


18 N.Y. Public Health Law § 2994-4(C).

19 N.Y. Public Health Law § 2994-a(26) – “A person connected with the Case is defined in the Act to include the patient, any member of the surrogate list, an attending physician, any other health or social service practitioner directly involved in the patient’s care, any duly authorized state agency, and the facility or regional director for a patient transferred from a mental hygiene or correctional facility.”

Charis B. Nick-Torok is an attorney and a graduate of Albany Law School with a concentration in Health Law. She also holds a Master’s Degree in bioethics from the Union Graduate College Mount Sinai School of Medicine program. Ms. Nick-Torok was a Hastings Center Post-Doctoral Fellow in Health Law, Ethics and Policy, and has served as a project staff attorney for the NYS Law Revision Commission. Currently, she has a private practice dedicated to research, writing, policy, and educational services related to legal-ethical issues that arise in healthcare. Ms. Nick-Torok is also a long-standing adjunct professor of Healthcare Ethics for Excelsior College. She is an appointed member and committee chair for the Dutchess County Board of Health, and a member of the Vassar Brothers Medical Center Ethics Committee, as well as the co-chair of the Dutchess County Medical Reserve Corps subcommittee on Public Health.
How Community Hospice Works

By Rob Puglisi

This past New Year’s Eve, when my wife and kids and I visited my father-in-law in the hospital, none of us had an inkling we would be making plans to attend his funeral service just two weeks later.

He had gone into the hospital a few weeks earlier with what everyone thought was pneumonia. At the end of the first week of January, when doctors said he probably only had a week or two to live, we were—to say the least—caught by surprise.

“In fact, studies have shown that hospice patients live longer than similar patients who don’t choose hospice.”

It ended up being a week. Considering the circumstances, though, it was a good week. I’d even say, without reservation, it was a good death, due in large part to hospice care.

The morning he got the news, my father-in-law, his family, and the hospital staff turned immediately to hospice. He was ready to leave the hospital and go home. Less than five hours later he was in a hospital bed, in his living room, surrounded by family, in front of his flat screen TV. What followed was a week of love, closeness, conversations (some difficult), and a peaceful, comfortable end to a life well-lived.

A lot of people don’t understand how hospice helps not only people like my father-in-law, but even those who have much longer to live.

Here in the Capital Region, where I’m privileged to work for The Community Hospice, one-third of all of our patients come on our program when they only have a week or less to live. That’s actually unfortunate because the federal Medicare regulations say patients can access hospice care for many months. They’re considered eligible when they have a prognosis of six months or less, but hospice care doesn’t stop if they live longer than expected.

In fact, studies have shown that hospice patients live longer than similar patients who don’t choose hospice. Depending on the illness, some patients live an average of a month longer. Researchers think it’s because of the emphasis hospice places on comfort and quality of life. When people are more comfortable and more at ease, when their worries are addressed and their anxiety lessened, the whole body reacts positively. Hospice care isn’t only about a patient’s physical pain, but about his or her psychological stress and spiritual concerns as well.

The primary way hospice does this is through a unique team approach. A hospice doctor leads the team and serves as liaison with the patient’s physician. A plan of care is devised with the patient,
tailored to his or her specific needs, and it’s carried out under the direction of a nurse who serves as the patient’s case manager. A chaplain helps with the connection to the patient’s faith community, and a social worker is available to give support to the patient and family in whatever way is needed. If a patient requires a health aide, hospice can provide one who will help with the patient’s personal needs and every-day tasks. Community volunteers—we have more than 700—are also part of the team. They offer friendship and support, provide transportation to medical appointments, sit with the patient while the caregiver runs errands, or run the errands themselves. We even have specially trained bereavement counselors available for the entire family. Our annual camp for grieving kids and teens, Camp Erin, was even featured on NBC’s Today Show and NBC Nightly News with Brian Williams.

“Hospice care isn’t only about a patient’s physical pain, but about his or her psychological stress and spiritual concerns as well.”

Perhaps best of all, patients can benefit from hospice while in the hospital or while continuing to live at home, wherever their homes is—whether it’s a house, apartment, nursing home, or assisted living facility. And thanks to Medicare, Medicaid, most private insurance plans, and the generous support of donors throughout the region, care from The Community Hospice is fully covered for nearly all of our patients.

In my family’s case, it was a whirlwind week on hospice. But the hospice people knew just when to step forward and help, and just when to step back and let the family have family time. No one wants to see a loved one die, but at least we had the care and support we needed to ensure my father-in-law’s last week was one that his wife, children, and grandchildren would remember, and treasure, forever.

Rob Puglisi is Director of Marketing and Communications at The Community Hospice.
Push Back
By Rodger Fink

Early in November
Editor Bray has asked me to write a “personal” essay for an issue with an “end-of-life” theme. Maybe he asked because he knows I volunteer for The Community Hospice or maybe because he knows I’m easily flattered. His “deadline” (the word seems to jump out) was the end of January. Three months should be plenty.

November ends with my birthday. Next year will be my seventieth, exhausting my biblical allotment of “three-score years and ten.” I brood, sensitive to reminders of mortality. We “war babies” are dying off faster and faster. I read obituaries and even tried writing my own. It was a humbling experience, like writing about “end-of-life.”

Winter
In many ways “I’m in my prime.” After ten years of separate households, my sweetheart and I buy a house together; making a home with her feels wonderful and complete. I’m very happy.

But in other ways, life grows slowly more difficult. Increasingly sensitive to cold drafts, we get a heated mattress pad and contract to spend a fortune on insulation. I find heated car cushions on the Internet. I’ve grown shorter over the last few years, so I set a cushion on my dining room chair and begin exercises for core strengthening. High-tech fiberglass trekking poles help me stay upright on Pine Bush trails. I pay increased attention to my aging process, lamenting, adapting, adjusting—sometimes resisting—inspired by the vigorous lives of some of my seventy-something friends. I hope the physical issues of aging can be handled with support, realism, much good fortune, and a healthy sense of humor. As for the intellectual and emotional issues, we’ll see.

The “Holidays”
This time each year is problematic for me. I hate the popular music and the hypocritical mix of piety and materialism. I don’t believe in feel-good stories of a life to come, certain I don’t have a soul to fly away to an incarnation, heavenly or otherwise. I recoil at nostrums like “You’re only as old as you feel” and “Death is just another stage of life.” I accept the way scientists of the body and brain have explained some of our emotional and intellectual being. Reading, thinking, fast, and slow, I’m persuaded by Daniel Kahneman’s experimental evidence that what we may think are “carefully reasoned free choices” are often merely the products of our biology and environment. I have trouble accepting this. Are we just “blowin’ in the wind?” But I am a firm believer in the long-
run power of science. Will consciousness itself turn out to be just a biological process? What about our deepest notions of who we are?

**When we “die,” what dies?**

After my parents’ death, I was shocked at the speed with which remains of their fifty-five-year life together dispersed and disappeared. I have their fiftieth anniversary portrait on a living room bookshelf, my father’s gentleman’s chest is in our bedroom, and I still use some of his tools. But after ten years, I rarely stop to remember them.

I think about my own death. I have no child to keep my picture on her bookshelf, and I haven’t nurtured many close connections. I’ve written no books and will leave no gravestone for her to visit or strangers to pause and wonder about. Physicists tell us the dying sun will expand to destroy our lovely planet and all signs of our civilization a few billion years from now. And we seem on track to render Earth unlivable long before that. All very sad. The greatest sadness. My death will be a triviality in a galactic—no universal—process.

**The New Year**

My first hospice patient has died. Hospice has a noble mission, helping when there is no further life-prolonging treatment available, relieving pain, providing respite and support. If we had known about hospice when my mother was dying we could have helped her find the peaceful and dignified end she so wished for. Instead there was too much pain, a futile effort at rehabilitation, and failure to accept her passing. It is one of my greatest regrets. I volunteer hoping to come to terms with that regret and make peace with an increasing awareness of my own mortality.

“I hope the physical issues of aging can be handled with support, realism, much good fortune, and a healthy sense of humor. As for the intellectual and emotional issues, we’ll see.”

I visit new patients in their homes, bringing a change of company and some respite for caregivers. Sometimes I see dignity and courage and enjoy interesting conversation and wonderful life stories. Sometimes there is demented babbling and often just silence. What do they think about as they lie in the room they will never leave? I don’t ask.

I hope I can make a difference. I’m not sure why, but I want to try.

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Rodger Fink is a former teacher and webmaster for the NYS Teachers’ Retirement System. He is a fixture at Starbucks where he uses the latest digital devices to keep up with news and commentary and has recently become a volunteer for The Community Hospice. He can be reached via e-mail at Rodger1640@gmail.com.
How Prepared Are We for the Future? The Evolving Roles of Institutional Ethics Committees

By Bruce D. White, D.O., J.D.

The manager of the hospital’s oncology unit brings a dilemma to the institutional ethics committee: There is unexpected supply shortage of one oncology drug that is used commonly to treat breast cancer patients. In fact, there is only one dose left in the pharmacy. Unfortunately, there are two patients on the oncology floor that are presently receiving scheduled infusions of the drug. One of the patients is a thirty-four-year-old mother who has just recently been diagnosed; she has a relatively good prognosis if she receives standard treatment. The second patient is an eighty-two-year-old widow who has extensive metastatic disease with a poor prognosis on standard treatment.

One might ask: Why bring this case to the institutional ethics committee? Some would say that this is not really an ethical dilemma at all. On its face, if a problem at all, it is clearly a clinical issue for the pharmacy, the pharmacy supplier, and the physician and patient because a drug is either temporarily or permanently unavailable. Some might say that a problem such as this is not new, nor that novel. Health care professionals have been dealing with drug shortages for centuries.

Again, why bring this to the institutional ethics committee? Perhaps for several reasons, including:

• Institutional ethics committees were created to help caregivers, patients, and families cope with very difficult health care decisions;
• Institutions and their ethics committees—over the past several years particularly—have told caregivers, patients, and families that they stand ready to assist with difficult health care decisions and dilemmas;
• For a hospital in New York, by statute, the organization must have an ethics review committee to “consider and respond to any health care matter presented to it by a person or connected to a case”; and,
• Regardless of how the situation resolves, caregivers, patients, and families may experience moral distress as a consequence of the experience.

Moreover, in this particular case, the oncology unit manager faces an immediate quandary. The hospital is running out of a potentially life-saving drug. There are two identified persons in the hospital that might benefit from the dose. There may not be any additional drug available, so both patients eventually may have to go without; but with this last dose, there is the possibility of helping one rather than the other. Unfortunately, giving each patient a half-dose will probably benefit neither. In this instance, one patient may get the drug, but also one will not.

For the oncology unit manager, the pharmacy, and the hospital, this immediate problem is a rationing case. Ration is defined in the dictionary as “[a] fixed portion, especially an amount of food allotted to persons in military service or to civilians in times of scarcity.” And, if the drug is rationed, the oncology unit manager, the pharmacy, and the hospital must be able to offer a logical and fair explanation as to why one patient may receive the dose and another patient does not.
In other circumstances, the pharmacy or the oncology unit manager might have simply sent the drug for delivery to one patient rather than the other by saying, “First come, first served.” That is certainly one way to ration, and it is fair in that it does not attempt to discriminate on any basis other than time. But even then, what “time” should one take into account? Should it be the first that was diagnosed with breast cancer? Or, the one first admitted to the unit? Or, should it be the patient for whom an attending physician first wrote the order?

But in this case, is first in time the more just—or, the more fair—way of distributing the scarce resource? Should not the decision makers here—the oncology unit manager, the pharmacy, and the institution—at least take into account which patient might derive more benefit from the dose? Or, perhaps consider which patient might be more advantaged by the drug, particularly if the team is treating a primary tumor rather than metastatic lesions?

Additionally, is this purely a matter of concern for the oncology unit manager, the pharmacy, and the institution, or should the attending physicians and the patients be involved? It is after all for the benefit of the patients that the oncology unit manager, the pharmacy, the institution, and the physicians labor. If the patients are to be looped into the conversation and discussions, how should the matter be raised and by whom? How might the issue be broached sensitively, compassionately, empathetically, and in a fashion to minimize the risks to trust and transparency?

So, back to the original question: Why bring this to the institutional ethics committee? It is because dealing with cases like this is what the ethics review committee does; the ethics committee—after listening to all the material facts and thoughtful opinion of others—offers the best advice and counsel to the parties that it can.

Not only is this the kind of case that should come to the attention of an institutional ethics committee now, this is the kind of case that ethics review committees should expect in the future. Again why? Because in New York and in other states, the legislature has specifically authorized that some cases be referred to the ethics review committee for consideration. In the majority of these cases that are to be referred to the ethics review committee in New York, the committee’s advice or recommendations are only advisory; however, in at least two instances, the committee’s recommendations are binding.

So perhaps the more important question for institutional ethics committees in the future is not whether or not the case should come to the committee, but rather: Is the committee prepared to deal with the ever-more-complex clinical quandaries that are certain to come? Or perhaps more directly, are the individual ethics review committee members adequately trained to engage and offer meaningful and thoughtful answers to the questions others will raise?

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Bruce D. White, D.O., J.D., is a pharmacist, a board-certified pediatrician, and an attorney with fellowship training in clinical medical ethics. He is director of the Alden March Bioethics Institute at Albany Medical College, professor of pediatrics, and holds the John A. Balint, M.D., Chair in Medical Ethics at the medical school. He also serves as professor and director of the Healthcare Ethics and Law Institute (HEaL) at Samford University in Birmingham, Alabama.
## Organizations and their Websites that may be of interest to CCQ readers

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<td>Rensselaer County Department for the Aging</td>
<td><a href="http://www.rensco.com/departments_familyervices.asp">www.rensco.com/departments_familyervices.asp</a></td>
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<td>Rensselaer Polytechnic Institute</td>
<td><a href="http://www.rpi.edu">www.rpi.edu</a></td>
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<td>Rockefeller Institute</td>
<td><a href="http://www.rockinst.org">www.rockinst.org</a></td>
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<td>Sage Colleges</td>
<td><a href="http://www.sage.edu">www.sage.edu</a></td>
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<td>Saratoga County Office for the Aging</td>
<td><a href="http://www.co.saratoga.ny.us/aindex.html">www.co.saratoga.ny.us/aindex.html</a></td>
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<td>Schenectady County Department of Senior and Long Term Care Services</td>
<td><a href="http://www.schenectadycounty.com">www.schenectadycounty.com</a></td>
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<td>Schoharie County Office for the Aging</td>
<td><a href="http://www.schohariecounty-ny.gov/CountyWebSite/OfficefortheAging/ofaservices.jsp">www.schohariecounty-ny.gov/CountyWebSite/OfficefortheAging/ofaservices.jsp</a></td>
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<td>Schuyler Center for Analysis and Advocacy</td>
<td><a href="http://www.scaany.org">www.scaany.org</a></td>
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<td>Town of Colonie</td>
<td>wwwicolonie.org</td>
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<td>Trinity Alliance of the Capital Region</td>
<td><a href="http://www.trinityalliancealbany.org">www.trinityalliancealbany.org</a></td>
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<td>U.S. Environmental Protection Agency Aging Initiative</td>
<td>epa.gov/aging</td>
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<td>University Albany School of Public Health</td>
<td><a href="http://www.albany.edu/sph">www.albany.edu/sph</a></td>
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<td>University Albany School of Social Welfare</td>
<td><a href="http://www.albany.edu/ssw">www.albany.edu/ssw</a></td>
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<td>United Way of the Greater Capital Region</td>
<td><a href="http://www.unitedwaygrp.org">www.unitedwaygrp.org</a></td>
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<td>Warren County Office for the Aging</td>
<td><a href="http://www.co.warren.ny.us/ofa">www.co.warren.ny.us/ofa</a></td>
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<td>Washington County Office for the Aging</td>
<td><a href="http://www.co.washington.ny.us/Departments/Ofa/ofa1.htm">www.co.washington.ny.us/Departments/Ofa/ofa1.htm</a></td>
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## Our Mission

Albany Guardian Society continues to seek opportunities to improve the quality of life for seniors as we carry out our Mission.

- The mission of Albany Guardian Society is to engage in a broad spectrum of endeavors that will improve the quality of life for seniors.
- We will devote funding to develop and support services for seniors.
- We will create an environment that will maintain the growth of creative and innovative ideas.
- We will fund the exchange of information to enable interested parties to learn how to create a better standard of living for our elders.
- We will attract additional resources to increase the impact we can make as we remain mindful of our mission to serve the elderly.