From Pediatrics to Geriatrics
Navigating the Bell-Shaped Curve of Bioethical Decision-Making

While medical ethics are important throughout any patient's life, the complexities of sound ethical decision-making tend to be amplified in both pediatric and geriatric patients.

"You can think about this concept as a bell-shaped curve, with autonomous decision-making at the top of the bell and extremes on either end," says Eric D. Kodish, MD, Chairman of Cleveland Clinic's Department of Bioethics and a pediatric hematologist-oncologist.

"On the left side of the curve, you have children, who are completely dependent on us when they are born but eventually develop into autonomous beings. On the right side are geriatric patients, many of whom become completely dependent before they die."

Dr. Kodish's grandfather, who lived to be 97, referred to this phenomenon as "once a man and twice a child," a phrase echoing Shakespeare's Hamlet.

**Pediatric decision-making**
Consent vs. assent and protecting a child's future are key principles in facilitating sound decision-making in pediatrics.

"At the core of pediatrics is the fact that a child is not a small adult," says Giovanni Piedimonte, MD, Chairman of Cleveland Clinic Children's. "In the area of ethics, pediatrics has a series of core values that are profoundly different, starting with the fact that children can't make their own decisions. A concept that is gaining more attention is the fact that we can obtain assent from pediatric patients, but not consent."

Pediatricians help younger children learn about making healthcare decisions by including them in the conversation about what needs to happen, working toward agreement from the child.

"For example, a clinician may ask a child if he or she would prefer to receive a vaccination in one arm as opposed to the other, without implying a choice about whether to receive it," explains Kathryn Weise, MD, MA, a pediatric medical ethicist in the center.

"If the family wants the child vaccinated, we wouldn't fool the child into thinking he or she can refuse."

**Permission rather than consent**
Ethically and philosophically speaking, parents also cannot provide consent for a child's treatment. "They can only provide 'parental permission,'" Dr. Kodish says. Dr. Weise adds that "predicting what a child's future might hold medically can be complicated because of children's resilience. That degree of uncertainty is a huge factor in pediatric decision-making."

Since it's impossible to predict children's future values and preferences, Dr. Kodish says treatment decisions should ensure "a child's right to an open future," a term popularized by legal philosopher Joel Feinberg.

*Continued on Page 3*
Dear Colleague,

Welcome to the 2013 issue of *Bioethics Reflections*. We are privileged to work at one of the nation’s leading academic medical centers, a place where “Patients First” is a mantra that drives us to continuous quality improvement. The Department of Bioethics contributes to that mission in education, research and clinical care. Last year, we provided ethics consultation in more than 360 cases — a new annual record.

In this issue of *Reflections*, we explore ethical decision-making at the beginning and at the end of life. As a pediatrician, the similarities and differences between these domains has always fascinated me. I hope you will also find this of interest.

We describe the services available from e-Ethics Cleveland Clinic, from face-to-face consultations to assistance with education, and policy and program development.

Our roundup of the 2013 Cleveland Clinic Bioethics Research Day summarizes Dr. Arthur Derse’s fascinating keynote address on End-of-Life Care, Ethics Research & the Clinician. We also include highlights from panelists’ compelling remarks about how ethical questions and decisions influence their practice of medicine each day.

Our former fellow feature highlights Valarie Blake, JD, MA, BS, now an assistant professor at Duquesne University specializing in health law. We introduce new bioethics fellows Laurel Hyle, JD, MPH, and Patricia Mayer, MD, MS, as well.

The Department of Bioethics also welcomes inaugural Cleveland Clinic Transplant Ethics Fellow David Shafran, MD, MA, and new research fellow Stefanie Thomas, MD. I love academic medical centers in July! The infusion of talented new trainees is always invigorating and inspiring.

We hope you enjoy this issue of *Bioethics Reflections*. Stay well, and keep in touch!

Sincerely,

Eric Kodish, MD
F.J. O’Neill Professor and Chairman, Cleveland Clinic Bioethics Department
Director, Center for Ethics, Humanities and Spiritual Care, Cleveland Clinic

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*Bioethics Reflections* provides news and information from the Cleveland Clinic Bioethics Department for our colleagues across the country.

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Financial impact on families
Financial considerations are gaining more attention from ethicists in pediatric decision-making. Any family will be impacted by the financial and emotional costs of complex treatment. These factors are especially important to consider when additional treatment has little chance for success.

“While we never want to withhold treatment on the basis of cost alone, as part of transparency parents and adult patients should receive guidance about how a decision either way could affect the family, including other children,” says Dr. Weise. “This type of conversation can be difficult but is important for informed decisions about goals of care. It is part of the overall picture to help the family decide whether they should go forward.”

Geriatric decision-making
In geriatric medicine, clinicians should assume that patients are able to make their own medical decisions — including ethically challenging ones — unless evidence of diminished capacity exists.

“When older adults refuse treatment and are cognitively intact, then we respect their wishes,” says Barbara J. Messinger-Rapport, MD, PhD, Director of Cleveland Clinic’s Center for Geriatric Medicine. “If they refuse treatment and have dementia, it becomes an ethical issue.”

It is always helpful when geriatric patients with diminished decision-making capacity have made their wishes known through a formal advance directive such as a living will, or via a surrogate decision-maker such as a spouse or other person with healthcare power of attorney. Another layer of complexity arises when the surrogate decision-maker also has cognitive impairment.

Honoring patients’ values
In contrast to children, a lifetime of decision-making provides a frame of reference for older adults. “We try to honor patients’ autonomous decision-making authority to represent what their wishes would have been in that situation,” Dr. Weise says.

For example, has the patient who is refusing testing and treatment taken medications regularly and gone to the doctor every year for preventive care? “When an older adult is not choosing in accordance with prior choices, then mood and cognitive ability should be assessed,” says Dr. Messinger-Rapport.

Supporting sound decisions
Whether patients are 7 or 77 years old, each situation is unique. The medical ethicist’s role is to guide the medical team and the family in considering the benefits and burdens of each possible scenario.

It’s important to look both backward and forward in time — backward to guide decisions that are true to what the patient with prior capacity would have wanted, and forward to protect the patient’s future and/or to minimize suffering.

As Dr. Piedimonte says, “The medical ethicists we work with are absolutely critical to making sure that our practices are ethically sound and in the best interest of the patient.”
e-Ethics Cleveland Clinic Offers a Multidisciplinary Perspective

Videoconferencing and other communication technologies support a new program, e-Ethics Cleveland Clinic, that offers the Bioethics Department’s full range of advisory services to outside healthcare organizations that lack comparable ethics resources.

e-Ethics Cleveland Clinic offers face-to-face ethics case consultations 24/7, along with assistance on ethics education and policy or program development.

“Professionals across the spectrum of healthcare confront difficult ethical choices and pressures to reach decisions. e-Ethics Cleveland Clinic is available to help them respond to these challenges, whether they involve patient care, research or organizational policy,” explains Anne Lederman Flamm, JD, Director of e-Ethics Cleveland Clinic.

An e-Ethics consultation may help in:

- **Challenging cases**: When a patient, family and healthcare provider facing hard choices have reached an impasse
- **Grey areas**: When healthcare professionals feel uncertain about their ethical obligations
- **Research ethics**: When medical researchers confront ethical challenges in designing or conducting studies
- **Unknown territory**: When organizational leaders need guidance on developing ethics policies
- **Educating staff**: When organizational resources to train staff on ethics issues or consultation are limited

“We anticipate that e-Ethics Cleveland Clinic clients will include hospitals needing support for their ethics committee or ethics consultation service,” says Ms. Flamm. “But we’re also available for nursing homes, home care agencies, rehab facilities and other organizations that may not have ethics resources at all. They see many of the same social patterns and medical technologies that fuel ethical dilemmas in hospitals.”

In the nearly 30 years since Cleveland Clinic established the Department of Bioethics, its ethicists have consulted on many unusual clinical cases, mirroring the organization’s range of medical expertise and culture of innovation. The department also has consulted on many routine clinical cases, reflecting the inherent complexity of healthcare decision-making. Its staff currently consults on more than 300 cases each year.
A wealth of disciplines to draw from
Bioethics debates benefit from multidisciplinary viewpoints, notes Ms. Flamm. “Cleveland Clinic ethicists include scholars of medicine, theology, philosophy, law, education and more,” she says. “They have rich experience serving on hospital ethics committees and institutional review boards. As academic faculty, they conduct hundreds of educational events each year, within Cleveland Clinic and its Lerner College of Medicine as well as at national and international conferences.”

Eleven members of Cleveland Clinic’s Department of Bioethics are available for e-Ethics consultation. Just as they do in internal case consults, e-Ethics consultants collect information from physicians, nurses, social workers, chaplains, patients, family members and others involved in a case and evaluate what procedural steps, such as team meetings or family conferences, will promote good decision-making.

Secure communication tools allow the consultations — as well as case-based education or policy development assistance that also may contain confidential information — to take place remotely via teleconference or videoconference.

“Patients, their families and professional caregivers regularly encounter difficult decisions, whether resources exist to help them or not,” says Ms. Flamm. “We designed e-Ethics to extend the reach of the ethics services we are lucky enough to have at Cleveland Clinic.”

To arrange for an e-Ethics Cleveland Clinic consult or to learn more about our program, please contact Ms. Flamm at 216.444.8720 or visit clevelandclinic.org/bioethics.

e-Ethics Cleveland Clinic services include face-to-face remote consults with providers, patients and families; professional consults on ethically challenging cases; and ethics training and policy development.

Ruth Farrell, MD, was awarded a two-year research grant from the March of Dimes Foundation for the study “Preparing Pregnant Women to Make Informed Decisions about Noninvasive Genetic Testing.”

Her study will focus on a new genetic screening test: noninvasive prenatal testing (NIPT). The goal is to develop clinically responsive, evidence-based tools for pregnant women who are considering NIPT and for obstetric providers to discuss the test with patients.

Dr. Farrell, who has joint appointments in the Department of Bioethics and the Department of Obstetrics and Gynecology, was also appointed Vice Chair of Hillcrest Hospital’s Ethics Committee and a member of the American College of Obstetrics and Gynecology’s Committee on Gynecologic Practice.

Susannah Rose, PhD, was accepted as a Cleveland Clinic Clinical Research Scholar as part of the Clinical & Translational Science Collaborative at Case Western Reserve University. This program will provide two years of research support to Dr. Rose as she refines and evaluates a new model of end-of-life care. This model integrates standard outpatient clinical treatment with palliative care early in the disease trajectory for people diagnosed with advanced diseases.

Kathryn L. Weise, MD, MA, was reappointed a member of the Committee on Bioethics for the American Academy of Pediatrics. She has joint appointments in the Department of Bioethics and the Department of General Pediatrics, and is Program Director for the Cleveland Fellowship in Advanced Bioethics.

Brain Matters 3: Values at the Crossroads of Neurology, Psychiatry, and Psychology. More than 120 neuroethics researchers came to Cleveland for this multidisciplinary ethics conference Oct. 23 to 25, 2012. Brain Matters 3 was co-directed by Paul J. Ford, PhD, of the Bioethics Department, and Imad Najm, MD, PhD, of the Neurological Institute; sponsored and organized by Cleveland Clinic’s NeuroEthics program and Epilepsy Center; and supported with an NIH conference grant.

Five papers selected from submitted abstracts were published in the July 2013 issue of American Journal of Bioethics: Neuroscience (AJOBN). For details, including links to plenary speaker videos and AJOBN papers, please visit clevelandclinic.org/brainmatters3.
A Practical Look at End-of-Life Care and Bioethics Research

The 2013 Cleveland Clinic Bioethics Research Day keynote address focused on end-of-life care and the clinical impact of empirical, legal and normative research.

Keynote speaker Arthur Derse, MD, JD, Director of the Center for Bioethics and Medical Humanities, and Professor of Bioethics and Emergency Medicine at the Medical College of Wisconsin, explained that 30 years of bioethics research has:

• Influenced the evolution of end-of-life care toward treating palliatively and forgoing unwanted/ineffective life-sustaining care
• Highlighted gaps in knowledge and communication with families
• Affected the legal analysis of end-of-life care issues and legal precedents for physician-assisted suicide

Technology: A double-edged sword

Dr. Derse’s early experience as an emergency physician triggered his interest in bioethics and law. He came to see technology as a double-edged sword that could be both wonderful and burdensome, especially when the mantra was “always to err on the side of life.”

“We’d intubate, we’d ventilate, we’d put patients on dialysis or on vasopressors, and we never talked to the patients or families about the long-term choices that might need to be made,” said Dr. Derse. “But sometimes we know the patient is in the dying process, and the best we can do is to make that process as humane as possible.”

He believes that clinicians should be trained not only to understand the indications for medical treatment — and withholding and withdrawing medical treatment (including medical futility) — but also to effectively and compassionately communicate to patients, families and healthcare providers that, at some point, treatment begun in the emergency department may no longer be appropriate.

“Too many clinicians abdicate their responsibility to tell patients and families, ‘This is the procedure that’s indicated now, here’s why we’re doing it, and we will stop it if the patient doesn’t want it or if it is no longer working,’” he said.

Patients not always fully informed

Dr. Derse noted that research finds that most patients with stage IV colon or lung cancer do not understand that chemotherapy is not curative. Oncologists may not bring up treatment limitations or burdens, or the option of palliative care.

“Yet, amazingly, one study showed that at the end of life, patients who received palliative care after some treatment for non-small-cell lung carcinoma had a longer life and a better quality of life than patients who only had aggressive treatment,” said Dr. Derse.

Research shows that most caregivers who make treatment decisions for Alzheimer’s disease patients also have a poor understanding of outcomes. “Burdensome treatments are provided to these patients in many circumstances because most family members do not know about the progressive and terminal nature of the disease,” he said.
On the other hand, patients and surrogates must also be completely informed about the consequences of refusing intervention. “A refusal should be an informed refusal, unless the patient or surrogates refuse the opportunity to hear of the consequences,” he said. “When patients or surrogates say no, you want more of a conversation.”

Decision-making stressful for surrogates

Studies show that even when surrogates are fully informed, decision-making can be psychologically and physiologically stressful. Families may struggle with interpreting what their loved ones would have wanted if they could not decide or act for themselves. “Patients often express these wishes in short telegraphic phrases where they say, ‘No heroic measures, no machines, I don’t want to be a burden,’ or ‘Do everything,’” said Dr. Derse.

Advance directives can help provide clarity and relieve some of this stress. Research shows that preferences are more likely to be followed when directives are completed in a meaningful way with patients and their families. Dr. Derse suggested it would be helpful if advance directives clarify patients’ goals and values, such as what they mean by being a burden, to prevent families from automatically responding with, “It’s not a burden to us; do everything!”

Physician or Medical Orders for Life-Sustaining Treatment (POLST or MOLST) forms are more useful than advance directives in emergency settings, he said. They directly translate patients’ wishes (on resuscitation, intubation, artificial nutrition, hydration, antibiotics, dialysis) into medical orders that emergency personnel may honor.

Guiding families: A professional duty

Empirical studies find that physicians too often abdicate their responsibility to counsel families on end-of-life decisions. “Prognosis was the bailiwick of preceding generations of physicians. They often could not do a whole lot for treatment, but they knew physical diagnosis and they knew the course of the disease,” noted Dr. Derse.

“Today we very much rely upon technology to make our diagnoses and we know our treatment algorithms, but we are not as good at knowing the prognosis of a disease over time — and worse at conveying it to patients and families.”

Studies show that in end-of-life discussions with surrogates, physicians fail to provide recommendations for approximately half the decisions that are made. And only half the physicians whom families ask for recommendations provide them.

Bioethics research will only grow

“Bioethics research on the end of life has practical implications for patient care and will be an area of expanded inquiry for clinicians in the years to come,” said Dr. Derse. Fruitful areas for study include ethical concerns about the minimally conscious state versus the persistent vegetative state, reasons for choosing physician-assisted suicide (with data pointing to loss of both autonomy and enjoyable activities, and concerns about dignity and about being a burden), and the dilemma of untreated pain versus physician fears of overprescribing narcotics and causing addiction.

He concluded by thanking the audience: “The conceptual work, legal work and empirical work that people like you are doing make us think not just one step but two steps ahead on these difficult ethical issues.”
Ethical Dilemmas: Reflections from Cleveland Clinic Panelists

An engaging panel discussion followed Dr. Derse’s Bioethics Research Day keynote address. Moderated by bioethicist and obstetrician/gynecologist Ruth Farrell, MD, MA, it featured four Cleveland Clinic panelists from different clinical areas:

- Cynthia Kubu, PhD, Center for Neurological Restoration, Neurological Institute
- Elliot Philipson, MD, MBA, Maternal-Fetal Medicine, Department of Obstetrics and Gynecology
- Terence Gutgsell, MD, Department of Solid Tumor Oncology and Harry R. Horvitz Center for Palliative Medicine
- Kathryn Teng, MD, Department of Internal Medicine and Director, Center for Personalized Healthcare

**Dr. Farrell:** This is a significant time in medicine. Important new changes, such as the Affordable Care Act and the role of HCAHPS patient satisfaction scores in healthcare delivery, are having a tremendous impact on patient care. Can you describe some of the ethical issues you face today?

**Understanding patient expectations**

**Dr. Kubu:** The Center for Neurological Restoration collaborated with the Department of Bioethics to study Parkinson patients’ goals and expectations for deep brain stimulation. Patient goals for this elective neurosurgical procedure were very complex and included things like driving, holding a grandchild and being able to return to work serving people at a restaurant.

But looking at outcome from our perspective was very limited: Is the tremor there? Is there rigidity? We’re looking at symptoms, and our patients come in as people — a combination of values, fears, emotions and desires. Whose definition of outcome is most important? We need a multidisciplinary team to provide different lenses, perspectives and opportunities to discern patient goals.

**Defining futility in maternal-fetal medicine**

**Dr. Philipson:** If a mother asks us to do everything possible for a 300- or 400-gram newborn, what does that mean? Does she understand that it could mean severe impairment for the rest of the child’s life? Does she mean the newborn should have a chance to lead a somewhat healthy life free of major functional or cognitive impairment?

Those issues become very difficult for us, and when doctors meet, we can’t always come to an agreement about what is meant by birth weight, gestational age, doing “everything,” and what we should offer. We’ve been struggling with issues of futility just like other fields of medicine. Our discussions, however, take place at the beginning of life.

**Communicating with families at the end of life**

**Dr. Gutgsell:** Families have major struggles withholding artificial hydration or nutrition as we move patients into the ICU and cardiac care units. They fear they are somehow complicit in ending the life of their mother, father or child.

Sometimes a decision made by someone with questionable capacity is reversed during times of crisis. I pull out the ethics card, the moral card and the legal card to help families deal with these difficult issues.

Professional integrity versus patient autonomy can be a struggle. How we communicate to help families really understand that their loved one is dying is a huge thing. We must balance truth-telling with cultural sensitivity.

**Managing pain in primary care**

**Dr. Teng:** Pain poses a dilemma for us in primary care. It is considered the fifth vital sign, and there is great pressure to treat it. However, pain is subjective, and we are under close scrutiny for the number of prescriptions we write.

It is now our responsibility to go to the Ohio Automated Rx Reporting System to check on whether patients are getting prescriptions from multiple doctors at multiple pharmacies. While we really don’t want to give narcotics, our access to resources such as pain specialists may be limited. This poses a dilemma for many physicians.

**Dr. Farrell:** At this moment, we are at Cleveland Clinic, a place where innovation takes place every day. We look at medical advances to help improve the care of patients, and that raises important and new questions for us as healthcare providers. Whether it’s consultation or research or academic work, which questions can the field of bioethics answer in the coming years as medical innovation moves forward?

**Ensuring that all voices are heard in research studies**

**Dr. Kubu:** The fact that industry still exerts a fair amount of control over who gets to do which research studies poses a problem, especially in innovation. The drive for profit must be balanced with patient safety and the integrity of the scientific process, which means better regulation.

But federal regulations can be imperfect, can slow things down and may be prone to market and political forces. How can we move forward in a seamless fashion while considering the voices and values of the patient and the clinical researcher?

**Balancing patient demand with resources**

**Dr. Philipson:** Late last year, four companies came out with noninvasive prenatal testing, which allows us to draw blood from the mother and
at 10 days’ gestation determine the sex of the baby and status of the chromosomes. The public has read about this, companies are encouraging patients to ask their doctors about it, and I predict this test will become widespread within the next year. But companies want to charge $2,000 to $2,500 for the test, so we have this dilemma: How do we implement it?

Is it for every single patient, now that there are 4 million U.S. births every year? What are the test’s limitations and risks? Do women and families understand the false positive rates, sensitivities and so forth?

Things are changing very rapidly. The nuchal screening test that came out six years ago is becoming outdated, and someone has already discovered the next test, which will drill down into the chromosome to look at microarrays and replace this new test.

Finding time to counsel families
Dr. Gutgsell: Palliative medicine is a time-intensive endeavor. These visits don’t make money for hospitals or health systems. But they do save money and improve the patient experience.

The mantra for doctors and nurses is to do everything possible to help each hospitalized patient have a good outcome and a good experience. While the pressure is on to take care of individual patients, we’re also asked to be mindful of resources and to help reduce the amount of money being spent. How do you give doctors the time they need to have difficult conversations with families about the illness, prognosis and treatment options?

Balancing personalized healthcare with public resources
Dr. Teng: Personalized healthcare asks how we can integrate patients’ individual biology, preferences and environment to provide individualized, customized care. Although we are moving forward with more standardization, we know that the one-size-fits-all approach is really not working in terms of quality metrics and healthcare costs.

How can we better identify the populations that require different tracks of evidence-based care, and how can we use that information to activate and engage our patients toward better health? We know we can’t do it alone — we need our patients to participate in this journey with us.
Bioethics Research Presentations and Poster Sessions

The 2013 Cleveland Clinic Bioethics Research Day, which drew approximately 70 attendees from across Northeast Ohio, concluded with these research presentations from Bioethics fellows:

- **Family Members’ Perspectives on Preclinical Testing for Alzheimer’s Disease**: Jalayne Arias, JD, MA (now on staff)
- **Communicating with Biobank Participants: Preferences for Receiving Aggregate Results and Providing Updates to Researchers**: Jessica Mester, MS (genetics counselor) and Aaron Goldenberg, PhD, MPH
- **Permitted Exploitation in Clinical Research**: Danielle Wenner, PhD (now an Andrew W. Mellon Postdoctoral Fellow of the Humanities at Carnegie Mellon University)
- **Treating the Pregnant Adolescent: Clinician Perceptions of Medical Decision-Making**: Christi Cole, JD, and Lauren Flicker, JD, MBE

These poster presentations were also available for viewing throughout the day:

- **Adolescent Perspectives on Phase I Cancer Research**: Victoria A. Miller, Justin N. Baker, Angela C. Leek, Sabahat Hizlan, Susan Rheingold, Amy Yamokoski, Dennis Drotar, Eric Kodish
- **Hope Language in Patients Undergoing Epilepsy Surgery**: Dana J. Patton, Robyn M. Busch, Kimberly M. Yee, Cynthia S. Kubu, Paul J. Ford
- **Comparing the Complexity of Informed Consent Documents with Informed Consent Conversations in Pediatric Phase I Oncology Trials**: Shlomo A. Koyfman, Chandana A. Reddy, Sabahat Hizlan, Angela C. Leek, Eric Kodish on behalf of the Phase I Informed Consent (POIC) Research Team

Giving to Bioethics

Many services in Cleveland Clinic’s Department of Bioethics are supported by the generous donations of individuals, groups and institutions. Those who recognize the importance of bioethics at Cleveland Clinic may wish to offer their financial support for these programs. If you would like to help or receive more information, please contact Barbara Goulden at 216.444.8720 or Amy Kubacki at 216.636.5024.

Former Fellow: Valarie Blake, JD, MA, BS

Valarie Blake found herself looking at the big picture as a premed major volunteering at Children’s Hospital of Pittsburgh.

**A different perspective**

“While my colleagues would talk for hours about the unusual evolution of a disease course, I was drawn to completely different questions: ‘What should we do when a child being discharged doesn’t feel safe in her home?’ ‘What is the impact of a chronic condition on the family and siblings?’” she recalls.

Meeting lawyers focused on health law and ethics helped decide her final career path. After earning her doctorate at the University of Pittsburgh School of Law in 2009, she came to Cleveland Clinic for a two-year fellowship in advanced bioethics, also earning a master’s degree in medical ethics from Case Western Reserve University.

**Balancing the theoretical and practical**

Ms. Blake appreciated the opportunity to apply her experience with law and ethics theory to a wide variety of practical healthcare settings.

“I’d always had more interest in research, teaching and policy work than in clinical ethics consultation per se, but it was important that my theoretical work be grounded in a pragmatic bedside reality,” says Ms. Blake. “And there is no better place to do that than at Cleveland Clinic.”

In August, she began a new position as Assistant Professor of Law at Duquesne University, where she will help develop the health law curriculum. She had been a Senior Research Associate in Ethics at the American Medical Association in Chicago, where she worked on the AMA’s Code of Medical Ethics and was involved in physician discipline and ethics CME. She also served as Health Law Editor for the ethics journal *Virtual Mentor*.

**A word for new fellows**

Ms. Blake counsels those who are just starting fellowships to have specific goals in mind while allowing the unexpected to unfold — which includes getting to know Cleveland’s tight-knit bioethics community. “You will make lifelong friends, colleagues and collaborators,” she says.
About Cleveland Clinic
Cleveland Clinic is an integrated healthcare delivery system with local, national and international reach. At Cleveland Clinic, 3,000 physicians represent 120 medical specialties and subspecialties. We are a main campus, 16 full-service family health centers, eight community hospitals, Cleveland Clinic Florida, the Cleveland Clinic Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Canada, Sheikh Khalifa Medical City, and Cleveland Clinic Abu Dhabi.

In 2013, Cleveland Clinic was ranked one of America’s top 4 hospitals in U.S. News & World Report’s annual “America’s Best Hospitals” survey. The survey ranked Cleveland Clinic among the nation’s top 10 hospitals in 14 specialty areas and the No. 1 hospital for cardiology and heart surgery for the 19th year in a row.

Resources for Physicians

Referring Physician Center and Hotline
Cleveland Clinic’s Referring Physician Center has established a 24/7 hotline to streamline access to our array of medical services. Contact the Referring Physician Hotline for information on our clinical specialties and services, to schedule and confirm patient appointments, for assistance in resolving service-related issues, and to connect with Cleveland Clinic specialists. Call 855.REFER.123 (855.733.3712).

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View all Cleveland Clinic staff online at clevelandclinic.org/staff.

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DrConnect is a secure online service providing real-time information about the treatment your patient receives at Cleveland Clinic. Establish a DrConnect account at clevelandclinic.org/drconnect.

Critical Care Transport Worldwide
Cleveland Clinic’s critical care transport teams and fleet of vehicles are available to serve patients across the globe.

- To arrange for a critical care transfer, call 216.448.7000 or 866.547.1467 (see clevelandclinic.org/criticalcaretransport).

- For STEMI (ST elevated myocardial infarction), acute stroke, ICH (intracerebral hemorrhage), SAH (subarachnoid hemorrhage) or aortic syndrome transfers, call 877.379.CODE (2633).

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We offer thousands of clinical trials for qualifying patients. Visit clevelandclinic.org/clinicaltrials.

CME Opportunities: Live and Online
The Cleveland Clinic Center for Continuing Education’s website offers convenient, complimentary learning opportunities. Visit cffce.org to learn more and use Cleveland Clinic’s myCME portal (available from the site) to manage your CME credits.

Executive Education
Cleveland Clinic has two education programs for healthcare executive leaders — the Executive Visitors’ Program and the two-week Samson Global Leadership Academy immersion program. Visit clevelandclinic.org/executiveeducation.

Resources for Patients

Medical Concierge
For complimentary assistance for out-of-state patients and families, call 800.223.2273, ext. 55580, or email medicalconcierge@ccf.org.

Global Patient Services
For complimentary assistance for national and international patients and families, call 001.216.444.8184 or visit clevelandclinic.org/gps.

Same-Day Appointments
Call 216.444.CARE (2273) or 800.223.CARE (2273) to schedule an appointment for an adult or pediatric primary care visit for either the same day or the next day, including Saturdays, at 22 convenient locations throughout Northeast Ohio.

MyChart®
Cleveland Clinic’s MyChart® is a free, secure online tool that connects patients to portions of their electronic medical record from the privacy of home at any time, day or night! Patients can view test results, renew prescriptions, request appointments and more. They can also manage the healthcare of loved ones with MyChart • Caregiver. For registration and information, visit clevelandclinic.org/mychart.

MyConsult
Cleveland Clinic offers online medical second opinions for more than 1,000 life-threatening and life-altering diagnoses. For more information, visit clevelandclinic.org/myconsult or call 800.223.2237, ext. 43223.
Bioethics Department Welcomes New Fellows

Laurel Hyle, JD, MPH, worked as a Legal Officer and Supervising Attorney for Risk Management at MD Anderson Cancer Center from 2004 until joining our fellowship program. Ms. Hyle earned a law degree from the University of Houston Law Center and a master’s degree in public health from the University of Texas Health Science Center at Houston. She also completed an internship in clinical ethics at MD Anderson Cancer Center.

Patricia Mayer, MD, MS, a practicing rheumatologist, worked as a palliative care consultant for the North Colorado Medical Center and served as Medical Director of the Hospice of Northern Colorado before joining our fellowship program. Dr. Mayer is interested in clinical bioethics consultation, research ethics, end-of-life issues, moral distress in caregivers, futility and psychiatric ethics.

Bioethics Reflections Now Available by Email

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Applying for Advanced Bioethics Fellowships

The Cleveland Fellowship in Advanced Bioethics is a two-year, full-time program designed to train the next generation of leaders in the field of bioethics. Applications from professionals with terminal postgraduate degrees in medicine, philosophy, nursing, social work, religious studies, law and other fields related to the practice of clinical and academic bioethics will be considered.

Completed applications for our 2014-2016 program must be submitted by Nov. 1, 2013. Please visit clevelandclinic.org/bioethics for further information about our advanced bioethics fellowship and the application process.