Southern California Bioethics Committee
Consortium Newsletter
"The Balance Sheet" Sept 21, 2016
Vol. XLIII

Meeting Wednesday Sept 21, 2016

Held Off Site… at UCLA

to permit attendance at special event

6 PM Reception for Dr.Sulmasy,Tamkin Auditorium, B level, Ronald Reagan UCLA Medical Center
7 PM Litvak Public Lecture: "Is Physician Assisted Suicide Really What You Want?" Dr. D. Sulmasy (Free, thanks to UCLA Ethics Center)
8-9pm SCBCC Meeting: Rm B-1241 1) Discuss Sulmasy's lecture 2) Update ASBH task force Healthcare Ethics Consultant Certification
Parking at UCLA at the hospital or at visitor lots around campus, self-pay. **RSVP** Ms.Janine-Mariz Burog 310-794-6219 or JBurog@mednet.ucla.edu

Upcoming Conferences

*Nov 4-6 Circle of Caring Renewal Program UCLA Lake Arrowhead Conference Center**https://www.uclahealth.org/ethics-center/Pages/circle-of-caring.aspx**

* The Ethics of Caring® National Nursing Ethics Conference in L.A Thurs, 3/ 23 & Fri, 3/24/2017. ***Shaping an Ethical Environment*** to submit a poster abstract: https://nnec.confex.com/nnec/2017/cfp.cgi

Crash Course: Zika Virus

Zika, rapidly spreading throughout the Americas, is estimated to infect roughly 3 to 4 million people in 2016. The illness typically lasts for several days to a week and presents with mild fever, arthralgia, rash, and conjunctivitis. Feared complications of Zika are microcephaly in newborns and an association with Guillan-Barre Syndrome.

Many governments ravaged by the disease or in proximity to endemic areas have recommended postponing travel, delaying pregnancy, and using mosquito repellents for prevention. The CDC has published clinician guidelines to aid physicians caring for pregnant women with suspected Zika infection. The treatment is generally supportive and symptom control.(http://www.cdc.gov/mmwr/volumes/65/wr/mm6502e1.htm).

Several ethical issues emerge. Two companies, Inovio and Intrexon, are working on vaccine development. When it reaches the testing phase, who will be tested? How will the vaccines be distributed? Will pregnant women be included in trials?

Concerns about travel and transmission of the virus have affected tourism. Whose responsibility is it to stay up to date on the spread of the virus? Should travel agencies be required to warn travelers of the spreading epidemic? Do airline companies have an ethical responsibility to refund tickets that have been purchased to newly infected countries? Some airlines (Lufthansa, British Airways) began offering refunds to passengers to at-risk areas.

Medical infrastructures in many countries are ill-equipped to care for families affected by Zika. Many governments advise avoiding pregnancy, however, this may not be feasible in populations that lack access to birth control in addition to other barriers such as affordability and cultural appropriateness. [1] Earlier this year, Pope Francis suggested that contraception use might be acceptable for those at risk of contracting Zika while asserting that abortion is a crime.[4]

There is increasing concern about outbreaks in the US, especially Florida. The FDA recommended that all blood banks screen blood donations for Zika.[2] The governor of Florida mandated spraying of insecticides in areas heavily affected by Zika, finding pushback from local communities and environmentalists to delay or stop aerial spraying.[3]

[1] https://impactethics.ca/2016/02/04/zika-outbreak-raises-familiar-ethical-questions/
[2] http://www.npr.org/sections/health-shots/2016/08/26/491484838/all-u-s-blood-donations-should-be-screened-for-zika-fda-says
[3]http://www.people.com/article/public-concern-naled-chemical-zika-virus-south[4] http://www.npr.org/sections/thetwo-way/2016/02/18/467220097/pope-suggests-contraception-use-may-be-lesser-evil-for-those-fearing-zika

Price Gouging of the EpiPen

Pharmaceutical company, Mylan, increased the price of the lifesaving drug, EpiPen, initiating a barrage of price hikes from $56 to $317, a 461% increase since the drug company obtained the rights for EpiPen. Meanwhile, the salary of the CEO of Mylan, Heather Bresch, the daughter of West Virginia Senator Joe Manchin, increased from $2,453,456 to $18,931,068, a 671% jump. The company increased its lobbying efforts during this time and the product was concomitantly placed in many public schools.

Twenty Senators openly criticized Mylan's business practices, insisting the company address questions about its "Saving Card" for customers with insurance, patient assistance program, school programs, and plans to release a cheaper generic version of EpiPen.[1] Savings cards "are a classic public relations move by the pharmaceutical industry, said Harvard Medical School professor Aaron Kesselheim, and it will only be used by a fraction of the people who need the drug."[4]

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Mylan responded to the public outrage by developing a generic version of EpiPen that will cost $300 instead of $600 for the brand name, about 4 times as much as EpiPen did in 2007. It is estimated that each injectable has only about $1 worth of epinephrine. The company controls approximately 95% of the market.[2]

Mylan has a patent on the autoinjector until 2025. If other companies wish to make a competing generic product, they must first sue to invalidate its exclusive rights and then manufacture the auto-injector. Teva Pharmaceuticals successfully challenged Mylan and is in the process of creating its own generic version of the EpiPen awaiting FDA approval and expected to be released in 2017.[3]

[1] https://www.theguardian.com/business/2016/aug/30/epipen-mylan-price-increase-senators-letter-warren-sanders
[2] http://www.nbcnews.com/business/consumer/mylan-execs-gave-themselves-raises-they-hiked-epipen-prices-n636591?cid=sm_fb
[3] http://www.npr.org/sections/health-shots/2016/09/07/492964464/epipen-s-dominance-driven-by-competitors-stumbles-and-tragic-deaths
[4] https://www.washingtonpost.com/news/wonk/wp/2016/08/25/under-pressure-mylan-will-expand-patient-assistance-for-epipen/

********Weigh in with the Editor**********
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TED Talk on Physicians at Risk

Pamela Wible, M.D. sounds alarm about high rate of suicide among residents and practicing physicians. Her response includes a decision to manage her practice in a holistic style nurturing patients and healers.
www.kevinmd.com/blog/2016/03/why-doctors-kill-themselves.html

Murray's Musings

Ken Murray, MD, retired Family Physician, author of "How Doctors' Die," contributor to news magazines and medical journals

THE ETHICS OF TRANSFERS

In a recent illness, there came a time when I needed to be transferred to a "rehabilitation center" for further care. I've been in the business long enough to know that this is the most current politically correct term for a Skilled Nursing Facility, where I'd taken care of patients in the past. This frightened me. I was given a list by Discharge Planning, with no guidance as to how or which to choose where I'd be sent.

Unlike most patients, I had contacts among nursing home doctors, who accurately advised me to a superb facility. It disturbed me to find that while quality of the facility I chose was well known in the community of healthcare professionals, it might be referred to as "the best kept secret."

This seems to be the game: tell the patient and family nothing; let them choose; then if there is dissatisfaction or a bad outcome, it's their fault. This does not strike me as ethical, considering the enormity of the impact of such care on outcomes. What amounts to *covert support* of low quality facilities is troubling. They should not be supported by the health care community, and should have serious scrutiny by local practitioners. Our patient outcomes, particularly of severely ill patients, depend upon the quality of such facilities. The "hot" new measure of acute hospital quality, 30-day re-admission, will significantly be affected by these facilities, their performance or lack of. This is "low-hanging fruit."

Med Stud corner: The Changing Face of Healthcare: Millennials In Medicine

by Andrew Mikhail

Millenials, making up approximately one third of the U.S. workforce, include healthcare providers who bring with them changes that will impact patient care and healthcare infrastructure. They are accustomed to having information at their fingertips. Gone is the taboo to search information in the presence of patients (once one had to know it or look medical information up manually.) No longer is the practice of medicine in the office limited to the content of knowledge of the individual physician.

Technology will have an increasing role in healthcare as Millenials advance through the ranks of the medical hierarchy. They put a greater emphasis on work-life balance than previous generations which may help explain the decline of physicians entering full time clinical positions and their avoidance of demanding specialties, possibly to avoid burnout. "[Medical Students] find that …when they're with older docs and see how frustrated they are, how overworked they are (the students) don't want to get into a situation where that might be their fate," says Lutzkanin, an OB/GYN resident. Emphasis on work-

life balance can be perceived by the previous generation as a type of laziness or lack of dedication but many Millenials indicate they want a career that doesn't prevent them from doing other things they enjoy.

They are more likely to challenge authority than their predecessors. They want to know that what they're doing is important and why. New cultural trends that integrate with the healthcare infrastructure will have a profound impact on the way healthcare is delivered and experienced and the way that medical education is conducted.[1]

[1] http://medicaleconomics.modernmedicine.com/medical-economics/news/millennials-medicine?page=0,8

Ed's note: Will millennials feel an increased or diminished dedication to ethics than their predecessors not having been tempted as previous generations before them, by the trinkets and meals of the pharmaceutical industry, and forced as they are before any professional talk, to disclose possible conflicts of interest? It remains to be seen if they can harness and control the potential for confidentiality breaches that are cultivated by the EMRs they have become comfortable operating.

When Patients Need Psychiatric and Medical Care: A Brief Summary of Law 3200

Patients who need both psychiatric and medical care simultaneously present recurring challenges to hospital staffs. They cannot be placed in a psychiatric facility without being medically cleared. It may be difficult to medically clear psychiatric patients because, while they lack capacity, they also refuse medical treatment. What options are there when this predicament arises?

Law 3200 states that "a petition may be filed to determine that a patient lacks the capacity to make a health care decision concerning specified treatment for an existing or continuing condition, and further for an order authorizing a designated person to make a health care decision on behalf of the patient." The petition can be filed by the patient, patient's spouse, friend or relative of the patient, physician, or public guardian.

The petition should state: the condition of the patient that requires treatment, the recommended care that is considered to be medically necessary, the threat to the patient's condition if there is a delay in treatment or denied by the court, the possible and probable outcomes of the treatment, and the efforts to obtain consent from the patient. It must also include, "the deficit or deficits in the patient's mental functions… that are impaired, and an identification of a link between the deficit or deficits and the patient's inability to respond knowingly and intelligently to queries about the recommended health care or inability to participate in a decision about the recommended health care by means of a rational thought process."

Under this process, there are some legal restrictions on what can and cannot be done medically. It is prohibited to be placed in a mental health institution. Experimental drugs and convulsive treatment may not be used. No person may be sterilized underthislaw.

1 http://www.leginfo.ca.gov/cgibin/displaycode?section=prob&group=03001-04000&file=3200-3212

From the Halls

Richard Boudreau, MD, DDS, JD, PHD.

Social Media & Medical Ethics

Social media quick stats: A recent survey by the American College of Surgeons indicated that 48% of its members use LinkedIn, 55% use Facebook, and 82% regularly access YouTube. Social media has become the preferred method of communication, not only among the younger generations, but among older generations as well. Approximately 3 billion people are globally active Internet users and more than two-thirds have active social media accounts. In the US more than 80% of the population uses social network sites.

Social media use has greatly facilitated the rapid spread of professional information so that one no longer needs to wait months to learn about advancements. It allows easier access to continuing education, and generates discussion groups permitting ongoing critical assessment of the current literature. These educational benefits greatly improved our ability to remain current and provide patients with optimum care. Access to social media has had a profound effect on our patients. More and more patients are relying on the Internet for information about their health problems and for potential doctors to treat them. This allows practitioners the opportunity to have websites enabling them to provide information that will help patients make better informed decisions about their care; however, the caveat is to be certain that the material provided is accurate. When in doubt, credible reference sources with links should be provided.

The social media also provides the opportunity to communicate directly with patients. In this regard,

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physicians need to be careful not to exceed the "normal" doctor-patient relationship. For example, a "friend request" is different than a request for health related information, and one needs to separate professional and personal life. Although the Internet has made sharing of patient information easier, one also needs to be careful to maintain patient privacy and avoid HIPPA violations.

Use of social media has changed professional practice and while we take advantage of its many educational and communication benefits, we need to understand its limitations and liabilities. Applying common sense and ethical behavior are important guidelines for physician involvement.

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Undergrad view: consider this

Equally Annoyed
by Elvis Amaya, Santa Monica College

Today there are many pit falls when talking about the transgender movement; misinformation and confusion about the role of doctors in this ever growing spotlight in America. Before transitioning, people will sometimes have to go through 'talk therapy' that has been referred to as "Gatekeeper," or part of "informed consent." What is the proper bureaucratic process people seeking transition should be required to go through?

Doctors must follow a code of ethics and people desiring transition must follow rules laid out for a relatively new medical procedure. Ensuring equality and human rights with respect to access to these procedures will require careful deliberation.

Summary SCBCC meeting 5/27/ 2016

by Neal Sheade, MD

*Paul Schneider, MD presented 3 separate ethics consultations on one individual-- a 63 y/o male with "super-morbid obesity" BMI = 55 (460 lbs.), and multiple co-morbidities of HTN, DM, CHF, DVT, PE, decubiti, and OHS (Obesity Hyperventilation Syndrome). He was poorly adherent to his treatments: bipap, dietary recommendations, and refused bariatric surgery. He appeared to have capacity for decision making, but was in denial about his condition, seeing himself as independent in spite of need for assistance in ADLs. **Ethics consult #**1 concerned desire of house staff to force bariatric surgery as a lifesaving intervention, highlighting frustration of medical staff with their inability to effect change. **Ethics consult #2** concerned discontinuing efforts to accomplish transfer out of bed on basis of futility, and competing with value of safeguarding care-givers.

Ethics consult #3 concerned the patient's desire to stay on the acute unit permanently, although not requiring that intensity of care. The values underlying this consultation were: not providing unnecessary care, and stewardship of limited resources, against a backdrop of abusive behavior by patient toward nurses.

Questions and ideas followed:

-- Autonomy vs paternalism; balance of this continuum in any patient-physician relationship

--Practice setting effect on ownership of relationship

-- Definition of paternalism.

* **CANHR vs Chapman**, Chris Wilson reported. none of the parties were happy with outcome, that the judge was concerned that a competent person could be determined to be incompetent without being aware of it. She hoped those in nursing homes would have access to a bioethics committee. Vicki Kind described a program in New Jersey that seems to be working in one community. The members of an association of nursing homes pay dues to support a volunteer multidisciplinary, multi- facility, bioethics committee team serving the nursing home belonging to the association. They provide a 5 day training course for team members.

*Dr. Jim Hornstein gave a brief overview of the upcoming conference in Camarillo: "THE NEW AID-IN-DYING LAW**:** Primer for Practicing Physicians" 6/4/16 Spanish Hills CC, Camarillo.