## Next Meeting

**Wed 9/21/11** VA Greater L A
11301 Wilshire Blvd 90073 Bldg 500 **Rm**:6400
**Parking:** free, around lots surrounding bldg 500
5:30 pm free dinner, 6:00-8:30 meeting
Agenda: 1. ID of John and Jane Doe patients in hospital – ethical actions for staff and police? S. Finder 2. Case Discussions
Directions losangeles.va.gov/visitors/directions.asp

## >>>A Wider View<<<

***National*** Legislature generated requirements on New Jersey schools to report intimidating behavior among aggressive students include policies that create regulations, posing challenges to teachers and administrators while they attempt to protect vulnerable students. Public school employees must complete "training in the protection of students from harassment, intimidation, and bullying, including incidents which occur through electronic communication." Employees are required to report any incidents of bullying that they become aware of, regardless of whether the incident occurred in or outside of school. Those who do not, face disciplinary action. Civil liberties issues may subsequently arise. NYTIMES 8/30/11p.1

***International*** UK faces resuscitation policy problems illustrated by a recent case of a 63 yr old woman diagnosed with end stage lung cancer who subsequently sustained neck trauma in a MVA. Her husband claims the decision not to grant her full code status was made without her knowledge or consent and the family is pushing for national guidelines. UK Department of Health stated: "Decisions on *Do Not Attempt Cardio-Pulmonary Resuscitation* must be clinically appropriate for the individual involved, weighing up the possible benefits of CPR against any burdens or risks associated with the treatment….**it's our view that guidance provided by a responsible body of professional opinion, based on direct experience of the complexity and sensitivity of these circumstances, is more appropriate** than the setting of national guidance by the department." Meikle, J Guardian Co 8/26/11 21.30

**Lessons from the Past** Some 5,500 Guatemalans were involved in research that took place between 1946 and 1948 when 1,300 were deliberately infected with syphilis, gonorrhea, or chancroid. Only about 700 received any kind of treatment. Government scientists knew they were violating ethical rules according to a panel Pres. Obama authorized when the research came to light last year. **Researchers infected hundreds** of prisoners, psychiatric patients, and sex workers to study the effects of penicillin. While many of the same scientists sought consent from participants in an earlier study in the US, the Guatemalan participants were not informed. Dr Amy Gutmann, head of the Presidential Commission for the Study of Bioethical Issues, called the research a "shameful piece of medical history." **In the statement**, Dr Gutmann, emphasized, "It is important that we accurately document this clearly unethical historical injustice…to honor the victims." Moreover, **"Civilizations can be judged by the way they treat their most vulnerable**... We failed to keep that covenant," said Dr Gutmann. "Those involved in the study failed to show a minimal respect for human rights and morality in the conduct of research," she said, characterizing the actions as "grievously wrong" and those individuals behind the study as "morally culpable to various degrees." (Dr. John C. Cutler, lead PI of the experiments later became acting dean at U of Pittsburgh's Grad School of Public Health in the 1960's.)

Pres. Obama apologized to his Guatemalan counterpart, Alvaro Colom. Guatemala's VP Rafael Espada told the BBC that his government would make a formal apology to the Guatemalan people as local doctors had also been involved in the US-funded program. The commission's report in December, will aim to establish ways to prevent recurrence of such practices. NYTimes 8/ 31/2011, A4 Donald G. McNeil, Jr.and The Scientist, (magazine) Cristina Luiggi 8/30/11

**ROOTS** Tuskegee Syphilis Study, 1932-72, is "arguably the most infamous biomedical research study in U.S. history,"[6] and led to the 1979 Belmont Report and establishment of the Office for Human Research Protections (OHRP).[7] It resulted in federal laws and regulations requiring Institutional Review Boards for the protection of human subjects in studies involving human subjects.

The Office for Human Research Protections (OHRP) manages this responsibility within the Department of Health and Human Services (HHS).[8]

## .....MEDIA RESOURCES.....

An award winning documentary series on PBS (from Newsreel) attributes the **origins of Diabetes prevalence among Pima Indians**, not primarily to an oft cited genetic tendency, but **to the diversion of**

**upstream waters that resulted in unhealthy lifestyle modifications.**

As the result of federal policy rerouting the water resource, farms dried up, and the traditional diet was changed to food subsidies high in carbohydrates, while physical activities associated with farming were curbed. The expectation of diabetes became imbedded in the culture. The documentary explores responses to the problem including local gardening projects that hope to recultivate healthy lifestyle and eating patterns. The films beg the issue of medical community foresight and input in public policy and planning.http://www.unnaturalcauses.org/episode_descriptions.php?page=4

## *Glossary*

***moral distress*** First identified as a phenomenon specific to nursing, all health care providers, administrators, and staff may experience this when faced with a dilemma, believing that s/he knows the right thing to do, yet is not able to do it because of internal or external obstacles.

## Elements in Bioethics Deliberations

In addition to *Beneficence*: patient's well being as priority, *Nonmaleficence: (*physician do no harm) and *Autonomy* are:
***Justice*** ~ requires health care resources be distributed equitably
***Veracity*** ~ truth telling, (intentional omission of information may violate principle) and
***Integrity*** ~ requires open and honest reflection by a trustworthy physician

## Conferences

**10/13-16** ASBH annual meeting, Minneapolis
http://www.asbh.org/meetings/annual/index.html
**10/21**Circle of Caring Retreat Healthcare Professionals
UCLA Lake Arrowhead Conference Center
Lauren Siri: 310 794-6219 www.uclahealth.org/ethics

### Efforts at "Distributive Justice"

Measures of success of the Israeli healthcare system in providing universal state-financed insurance coverage include satisfaction with the program (88%), and, compared to the U.S., lower infant mortality, higher life expectancy and lower rates of cardiovascular disease.

Not a socialized, single-payer system, it reflects an agreement that there should be universal coverage without a large government presence.. While ensuring high accountability, enough competition allows four organizations to provide coverage for all, including non citizens. Government involvement permits regulating health care for the purpose of redistribution, and preventing competition from leading to uncontrollable cost overruns. This system has been referred to "regulated competition."
http://www.tnr.com/blog/the-spine/75090/do-you-want-really-excellent-medical-system-live-israel-or-least-learn-about-%E2%80%9Ch

### Who Ya Gonna Call?

from the LA County Coroner's website

**Deaths Requiring Inquiry/Decision by Coroner**
Certain types of cases not listed in the State Law but which often pose problems or are difficult to evaluate, should be reported to the Coroner for a decision. These include, but are not limited to the following:

* Persons dying within 24 hrs of hosp admission

not medically attended by a physician within 24-hrs of the time of death, unless attending physician established a natural cause.

*All deaths occurring in operating rooms, during therapeutic or diagnostic procedures or as a result of complications of these procedures (postoperative, e.g., wound infections) or when the patient has not regained consciousness after an anesthetic.

*(These are not all Coroner's cases unless death is known or suspected as being due to misadventure during the surgery, therapy, procedure or anesthetic. ..often difficult to evaluate and should be referred to the Dept of Coroner for a decision. The physician with the most knowledge of the circumstances should report the death.)*

*Deaths within 24 hrs after surgery.
http://coroner.co.la.ca.us/Docs/Hospital%20and%20Nursing%20Home.pdf

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### SCBCC Steering Committee