Southern California Bioethics Committee
Consortium Newsletter

"The Balance Sheet" September, 2014

Vol. XXXIII

Next Meeting, Wed. September 17, 2014

Greater Los Angeles Veterans Affairs Medical Center
Wadsworth Bldg. (500)11301 Wilshire Blvd. 90073
Operator: 310-478-37116400 (3rd floor), room 3232
SW corner San Diego Freeway (405) & Wilshire Blvd.
Exit Wilshire Blvd West from San Diego Freeway,
Immediate right on to campus west of freeway
Free parking in visitor lots
5:30 pm dinner
6:00 pm Felicia Cohn, PhD – President, American Society for Bioethics+Humanities: question/answer session: What is it like to run America's premier bioethics society meeting?
7:00 Discussion of case from the field
8:30 adjourns

Conferences

*9/22-25, LA, CA The California State Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC) **annual Training and Certification Conference.** CAPAPGPC is the certifying body for individual estate & medical/personal decisions.
*10/1, 7:30-8:30 PM, Loyola Marymount University, "A More Democratic Bioethics Debate for Our Polarized Times" presented by John Evans PhD from UCSD. RSVP required before 9/24
*11/14 (tentative date) noon-2 California Hospital *Marijuana: What it Offers: Promise and Problems*
1/18/15- SCBCC Conference on Death by Neurologic Criteria
Proposed location: LMU. Proposed contents:
8:30-8:45-Welcome and introduction
8:45-9:15- Rabbi Weiner – How to dialogue with the Orthodox Jewish community on death by neurologic criteria
9:15-9:45- Andy Lampkin – How to dialogue with the African-American community on same
9:45-10:45 – Thaddeus Pope –What is 'reasonable accommodation' and are we doing it?
10:45-noon – Panel discussion, including hospital administrator/insurance and someone from the Archdiocese of LA or LMU for the Catholic dimension.

Outsourcing the Difficult Conversation

Cold calls to patients with advanced illness are being made by a firm known as **Vital Decisions**, which represents a dozen insurance companies that want to, when they deem appropriate, start discussions with beneficiaries about end-of-life care. Although interviewers include social workers, ethical concerns include the fact that this is not done face-to-face or by a professional familiar with the specifics of the patient's condition. Dr. Lauris Kaldjian, professor of Bioethics at the University of Iowa, expresses concern over the lack of information used in decision-making, "If you don't have enough knowledge about what's actually going on with the patient," he says, "it would actually be irresponsible to pretend to have discussion that depends upon such knowledge."
A significant cost saving is expected if the patient wishes to limit the extent of aggressive care but is unable to easily express this to a family member. According to Mitchell Daitz, CEO of Vital Decisions, his company's services have resulted in about $10,000 less in health care spending per patient, which, by extrapolation, could translate to about $100 million less nationally in 2014.

IN THE NEWS

International: Ebola response

Bioethicist: Experimental Ebola Treatment Endorsed, But Who Gets It?

There are still many unanswered bioethical questions that accompany this intervention:
**What priority should be given to particular persons or groups when there are not enough drugs for all?*
**Who should vet proposed treatments for Ebola for soundness or "reasonableness"?*
**What can be done to require or compel companies to make new drugs available?*
**Who will pay the costs of making drugs and moving drugs or vaccines to patients?*
**What evidence would suffice to move a drug from compassionate use to therapeutic in an emergency?*
**What will be done to protect companies against liability should there be adverse serious events from the use of an unapproved drug?*
**Can a third party consent for children, persons with poor education, prisoners or others who might wish to try or be reasonable subjects for unapproved drugs?*

Response From

Richard Boudreau, MA, MBA, DDS, MD, JD, PHD
Attorney at Law & Faculty Loyola Marymount Univ.
The Bioethics Institute Dept. of Theological Studies LMU, U. Hall 4500

It's quite complicated given that the treatment is experimental. In fact, without proper trials, no one in the US would receive such a drug until human trials were approved--and only healthy Americans would receive it first in most cases, followed with caution by the ill. So, on one hand, I understand why the drug would be withheld from anyone--and probably would only be offered to the health workers with legal consent and liability waived (they are health care workers and are often the first that need protection so they can serve the masses). On the other hand, it's an interesting opportunity to, given proper consent, test out the experimental drug among many--and possibly save lives. Then again, even with consent, if something goes wrong (and there always are those who don't benefit and are in fact harmed), that will make a more punishable news story, especially if given to those who have no way to take care of the side effects, either because of their income, the study's limitations or existing infrastructure.

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Ebola Volunteers: Selfless, Like 'Grown Up Boy Scouts'

Historically, religious figures have played a large role in delivering healthcare in dire circumstances. Belgian Joseph De Veuster, known by his Roman Catholic name as Father Damien, lived in Hawaii among patients ostracized by leprosy. He died of the disease in 1889.

Albert Schweitzer, a Lutheran philosopher, physician and Nobel-prize winner from Germany, offered humanitarian work as a medical missionary in Gabon, until he died in 1965.

Mother Teresa was an Albanian who spent most of her life caring for the sick and poor in India, for which she was awarded the Nobel Peace Prize in 1979, two years after she died.

Many of today's volunteers have secular reasons for serving in West Africa where the Ebola virus is rampant. "They have a sense of service,…kind of like grown-up Boy Scouts" says Dr. William Schaffner, an Infectious Disease specialist at Vanderbilt University Medical Center who consults closely with the Centers for Disease Control and Prevention.

"There are those who have a religious calling and are moved by faith hand in hand with evangelical hopes," said Art Caplan, director of the division of medical ethics at New York University's Langone Medical Center. "You see people who want to help those who are desperately in need and the challenges are fixable," said Caplan. "And there are those with a social justice calling." No matter the motivation, he said, "they really do care."

Editor's note: *Reports from the field by Doctors Without Borders indicate the global response to this health threat has been inadequate. As Pres. Obama offers support crews to construct health facilities in affected countries, one wonders where the medical staff will be drawn from. Perhaps a program that supports volunteer doctors and nurses for 2 week tours, followed by 2 weeks of decompression (and decontamination…watchful observation for illness) at an island facility could include logistics brainstorming for subsequent health teams and a week of needed 'r and r.' All local and international volunteer medical personal in contact with patients who subsequently contract the virus could be guaranteed transport to a designated advanced treatment facility. Other ideas?*

. **Weigh in with the Editor:**
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Contributors: Vivian Tang MA, MS3, KSOM
Richard Boudreau, M.D, J.D. PhD Ken Murray, M.D.

National News

Who Gets First Dibs On Transplanted Liver? Rules May Change

Currently, the country is divided into 11 regions for organ transplantation. There is a disparity because in parts of the Southeast and Midwest, for example, there are higher death rates and more donor organs. The sickest patients in each region get the first crack at each organ, which means patients in the parts of the country that have the most organs don't have to be as sick to get a transplant as people who live in other places.

A committee assembled by the **United Network for Organ Sharing,** which manages the nation's organ transplant system, is searching for ways to make the system fairer. One possibility would be to divide the country into much bigger districts — perhaps only 8 or even 4. Organs could be distributed across wider areas, making the chances of getting one about the same no matter where one lives.

More News: Stateside

Marijuana Legalization Update

Washington is the second state to legalize recreational marijuana. Five states where legalization is on the horizon are: Alaska, Arkansas, Oregon, Rhode Island, and Washington D.C.

What we learned to date from Colorado's experience will be addressed in California Hospital's November Bioethics Conference. See **Upcoming Conferences**

Solitary Confinement: Torture Device

Dr. Craig Haney, a psychiatrist studying the effects of prolonged isolation on inmates says that 80,000 people or more are currently being held in solitary-type conditions--.more than in any other nation. Solitary confinement was an innovation, attributed to the Quakers in the late 18th and much of the 19th century. The mechanism of rehabilitation was to put individuals in an environment where they would be "encouraged, to reconnect with God. However, reports in the early 1800s showed that not only was it expensive, but dangerous as people became profoundly mentally ill in these environments.

Quakers and others realized their error, and abandoned solitary confinement, for different systems of confinement and rehabilitation.

According to Dr. Haney, "Solitary confinement is one of the tried-and-true devices that torturers worldwide engage in."

"You read accounts of people who have been tortured…; you read manuals of torturous interrogation, and solitary confinement is always a featured component...because people who do torture understand that placing human beings in severely isolated conditions puts them in pain. It renders them vulnerable to manipulation; it destabilizes them…."

Apologists for solitary confinement sometimes cite the negative influence some gang leaders exert when in contact with other prisoners. Perhaps a solution to the problem of social isolation might be to institute a visitor panel vetted to prevent inadvertent manipulation or outside contact by gang members while providing socialization with a volunteer who engages the prisoner in activities such as art and education. An organization approved by the FBI that facilitates visitation of inmates can be found at: http://prisonervisitation.org/index.php

Resources: New book on Bioethics

Doctored: The Disillusionment of an American Physician by Sandeep Jauhar

Jauhar's new memoir, describes doctors becoming increasingly discontent with their profession. Pressures include the increased number of patients they're expected to see and the required documentation for reimbursement. While some doctors who perform a lot of procedures "may be paid too much," he writes, "primary care physicians aren't paid enough."

He describes the cost of not having someone at the helm with an overview resulting in many specialists looking at the patient (the elephant so to speak) from a perspective which can result in higher costs as more unlikely scenarios are investigated.

When physicians are not given enough time to analyze patients' conditions they end up ordering more tests which cost society more and may yield less in the way of a useful diagnoses. "The growing discontent has serious consequences for patients."

Articles:

For an excellent discussion on case law and recent controversies and deliberations on situations involving brain death determination, including decision to terminate support of a brain dead mother nourishing a growing- yet still unviable fetus, see Thaddeus Pope's article in *Clinical Bioethics # 25, Fall 2014*

Big News in Texas

Mental Health Treatment System Saves San Antonio Millions

About 18,000 people come a year to a "restoration center," combining inpatient psychiatric services, substance abuse treatment, primary care and housing for people with mental illness.

It has been more cost-effective to provide comprehensive mental health services and support to people at the front end than to pay for jail beds and prison time. Some patients walk in off the street, others are brought in by police or diverted from programs inside the jail.

San Antonio saved $10 million per year
http://www.npr.org/2014/08/20/341826070/mental-health-treatment-system-saves-san-antonio-millions

"Your tired, your poor…"

Overcrowded, unsanitary conditions seen at immigrant detention centers

Since October 2013, 47,000 children have been caught crossing the southern border without parents or other family members, a more than 90% increase from last year. The federal government has temporarily housed these children in centers that have been reported to be overcrowded and unsanitary.

In July, part of a growing backlash against these housing efforts, protests occurred in cities across the country, most notably in the city of Murrieta in Riverside County.

Murrieta Immigrant Protests: Mayor Defends His Town's Actions

According to Murrieta Mayor, Alan Long, "This is a national problem, and the world showed up on our doorsteps. We didn't have a lot of answers early on, and there were some legitimate concerns, health concerns and humane concerns." In a reversal from what happened earlier, there were substantially more demonstrators on the immigration-rights side. The group protesting the transfer of the immigrants to California waved American flags and chanted "USA," while across the street demonstrators responded with, "Shame on you!"

Chinese Students Will Study at Murrieta High School Next Year

Amidst immigration protests, the City of Murrieta will continue to welcome over 100 Chinese exchange students as part of a program it started last year. Tuition in excess of $10,000 paid by each student will act as a funding source for the school district.

States' Leading Lethal Injection Expert Ends Role

Mark Dershwitz, U of Mass anesthesiologist and pharmacologist, said he would no longer act as an expert witness for states defending their lethal injection methods. Dershwitz was the expert called by Ohio in support of its new two-drug combination that led to a troubling 26-minute execution in January.

The same drug combination led to a nearly two-hour execution in Arizona last month, raising more questions about the drugs. Dershwitz was a leading expert for prison officials, having offered his opinions for 22 states and the federal government over the past decade.

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Murray's Musings

by Ken Murray, MD

Family physician, retired, regular contributor to medical journals on health policy

BRAIN DEATH? DON'T WORRY, WE'VE GOT A CURE!

http://www.neurology.org/content/82/10_Supplement/P4.285.long

This is a rather disturbing abstract presented at AAN (Neurology) annual meeting.

The authors state:

"Conclusions: Treatment-induced reversal of BD was evidenced by functional recovery across several domains. ACP neuromodulation optimizes cerebral functioning: electrical stimulation increases metabolic coupling; nutraceuticals promote healing, repair and neurotransmitter production while attenuating inflammatory cascades and free-radical damage. **BD may not be definitively irreversible and deserves therapeutic consideration**." (bold added by author.)

To me the use of the term "nutraceuticals" is a red flag.

Of note, although all the authors are noted as having no conflicts, reportedly this group is involved in the care of McNath (McGrath). I bring this to the attention of the group, as this may be the first in a series of efforts to bring into question the *concept* of the diagnosis of Death by Neurologic Criteria. In Dr. Hynd's recent lecture at the UCLA conference "Death: Why the Brain Matters", he listed 4 critical issues, the second of which was "doubt" over the diagnosis, particularly in a short timeframe. This sort of abstract appears to work to attack that specific issue.

Soon to be seen in an ICU near you…….

A Listening Legacy

Helen Bamber, 1925-2014, Activist for Torture Victims

Helen Bamber, relentless campaigner for the rehabilitation of those who experienced humanity at its worst--victims of torture, genocide, and war--died at the age of 89. Bamber had no formal training in psychology or social work, but was an effective listener.

"People wanted to tell their story and I was able to receive it…they would hold me and dig their fingers in and rasp this story out. …It didn't matter what language it was in…. They would rock back and forth and I would say to them 'I will tell your story. Your story will not die," reassured Bamber. Over the decades, she counseled thousands of victims, learning more than most people could bear about the psychic and physical wounds left by electric shocks, beatings, near-suffocation, relentless sexual assault, prolonged confinement and the forced witnessing of brutal acts on loved ones.

She founded the Medical Foundation for the Care of Victims of Torture (now called Freedom from Torture) as well as the Helen Bamber Foundation which have served victims from 100 countries including Chile, Argentina, Algeria, Somalia, Iraq and Kosovo.

from Elaine Woo's article 8/ 31/ 2014 L.A. Times

Student's Corner

students raise ethical concerns that arise during training

Vivian Tang, Keck School of Medicine, MSIII

Medical students may visit community clinics where they might encounter notes from other providers revealing gaps in the care of a patient's preventive and chronic health needs. Sometimes a patient has not seen a cardiologist or rheumatologist in six months because a myriad of different providers may not have reviewed past chart notes and advanced those referral efforts.

To what extent do family doctors or PAs need to manage all of their patient's health concerns? Until the concept of *Medical Home* is further refined, whose job is it to make sure everything that was ordered for the patient gets done? Given the time pressure of seeing so many people, is it possible to know every patient's history in detail before making informed decisions at each visit?

As doctors move away from solo practice, it has become harder to develop long-term relationships with patients and to understand their medical histories. Is it right for a patient to see different providers who may not have a recollection of their ongoing problems? Is it unfair to expect a provider to do a "deep cleaning" at each visit, given time pressures, and to learn an entire history?

Soliciting Our Readers

"What's in a Name" or "A Balance Sheet by Any Other Name is Still…?"

Dr. Ronald Miller suggested that other names might be more appropriate for our SCBCC Newsletter. Dr. Boudreau offered a few alternatives: *The Bioethics Consortium Bulletin or Bulletin Board, The Bioethics Voices for Justice, The Bioethics Pioneer, The Bioethics Specialist, The Bioethics Logos,* SCBCC Proceedings, *off to the side, spelling out: "Southern Calif Bioethics Consortium Committee."*

Other ideas? *Contact* grngasalud@aol.com

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