Southern California Bioethics Committee Consortium Newsletter
"The Balance Sheet" Nov. 2012 Vol. XXV

Next Meeting Thursday November 8

Greater Los Angeles Veterans Affairs Medical Center
Wadsworth Bldg (500)11301 Wilshire Blvd. LA 90073
Operator: 310-478-37116400 (6th floor),

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 free dinner
6:00-8:30 pm meeting (no RSVP needed)
1. POLST Grant Update
2. Ron Koons, "The Science & Art of Medicine: Oil and Water?"
3. ASBH Roundup
4. Cases from the field

CONTROVERSIES

Attention Disorder or Not, Pills to Help in School By ALAN SCHWARZ October 9, 2012 NY Times

CANTON, Ga. — When Dr. Michael Anderson hears about his low-income patients struggling in elementary school, he may prescribe Adderall to boost focus and impulse control in children with attention deficit hyperactivity disorder. He calls the disorder "an excuse" to treat what he considers the children's true deficit: poor academic performance in inadequate schools.

"I don't have a whole lot of choice," said Dr. Anderson, a pediatrician in Atlanta. "We've decided as a society that it's too expensive to modify the kid's environment. So we have to modify the kid."

The superintendent of one major school district in California, who spoke on the condition of anonymity, noted that diagnosis rates of A.D.H.D. have risen as sharply as school funding has declined. "It's scary to think that this is what we've come to; how not funding public education to meet the needs of all kids has led to this," said the superintendent. Referring to the use of stimulants in children without classic A.D.H.D , he explained "… it could be a consequence of a doctor who sees a kid failing in overcrowded classes with 42 other kids and the frustrated parents asking what they can do. The doctor says, 'Maybe it's A.D.H.D., let's give this a try.' "

Dr. Anderson said. "We might not know the long-term effects, but we do know the short-term costs of failure, which are real. I am looking to the individual person and where they are right now. I am the doctor for the patient, not for society."

http://www.nytimes.com/2012/10/09/health/attention-disorder-or-not...adlines&emc=edit_th_

****WEIGH IN WITH THE EDITOR****

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NOVEMBER CME/CONFERENCES

Wed, Nov 14, 12 - 1 pm, Cedars-Sinai Medical Center
Robert Cook-Deegan, MD, Duke University: Genomes Beyond Hype: Where is Genomics Taking Us?

Thurs, Nov 30, 12 - 1 pm, UCLA Reagan Medical Center
Robert Cook-Deegan, MD, Duke University: Gene Patents: Controversies and Turbulence

Thurs, Nov 15, 12 - 1 pm
Integrating Cultural & Spiritual Values in Medical Decision-Making POLSTinfo@CoalitionCCC.org

Thurs, Nov 29, 12 - 1 pm
POLST: The Beginning of the Palliative Care Consultation (916) 489-2222

Fri, Nov 30, 12 - 2 pm, California Hospital
Carol Bayley, Bioethicist with Dignity Health: Conundrums in the Bioethics Consult

HOTTTT TOPICS!

Cost-Related Immunosuppressive Medication Nonadherence Among KidneyTransplant Recipients, Evans, et. al

More than 70% of kidney transplant programs report that their patients have an extremely or very serious problems paying for their medications. In turn, 68% of the programs report deaths and graft losses attributable to cost-related immunosuppressive medication nonadherence. Overall, 67.3% of the programs indicate that they frequently or occasionally fail to place patients on the waiting list because they may be unable to afford their immunosuppressive medications.

In the year a kidney transplant recipient's graft fails, third party payers experience an average annual expense of $82,765 (32). If the patient returns to dialysis, the average annual expense is $70,581, and, if the patient is retransplanted, the average cost is $106,373. Annual third party reimbursements for a patient who has a functioning kidney transplant average $16,844, making transplantation the most economical option.

The results should serve as impetus for health care policies supporting lifetime Medicare coverage of immunosuppressive medications. Unfortunately, this did not occur with the recent passage of the Patient Protection and Affordable Care Act.

Clin J Am Soc Nephrol. 2010 December; 5(12): 2323–2328.
doi: 10.2215/CJN.04220510

A Case for Tighter Regulations?

Pradaxa, (dabigatran) approved for anticlotting, has been found to cause bleeding complications and is linked to over 500 bleeding deaths in the US. There are no reversing antidotes for this drug, compared to warfarin, whose blood thinning complication can be reversed by Vitamin K. Should drugs with life threatening side effects be used in healthcare when no antidote exists to reverse its effects?

In a statement, the F.D.A. said, "the lack of an antidote notwithstanding, dabigatran was superior to warfarin in preventing strokes in a large clinical trial. The rates of bleeding were similar." In the study it released on Friday, the F.D.A. examined health insurance claims and hospital data and reached a similar conclusion.
http://www.nytimes.com/2012/11/03/business/a-rising-anti-stroke-drug-is-tied-to-risk-of-bleeding-deaths.html?ref=health

READ ABOUT IT

California :Revision of LPS Taskforce Proposals

The intervening 45 years since the passage of the LPS has represented increasing neglect and despair:
15% of people with untreated or undertreated mental illness kill themselves, 33% of homeless people have an untreated mental illness, 20% of incarcerated inmates in both jails and prisons have a mental illness, people with a mental illness are at least three times as likely to be assaulted or raped compared to the general population, 10% of all homicides are committed by individuals with a mental illness,
Those with a mental illness die 25 years earlier than the general population.

Being in the community has not been a solution for all people with severe mental illnesses. Involuntary treatment and coercion have increased through criminalization. Piecemeal legislative revisions of due process within the LPS Act may have had an unintended consequence of preventing quick and effective access to treatment or release.The incarceration of mentally ill individuals has risen dramatically since state hospitals starting releasing individuals to the community.
Reform that assures that the most severely disabled among us receive treatment in a system that recognizes the reality of mental illness and the scientific knowledge behind it is sorely needed
The following are some of the report's recommendations:
#1: Define "Grave Disability" to address the capacity to make informed consent to treatment and assess ability to care for health and safety.
#2: Adopt concurrent legal processes to determine probable cause for hospitalization and capacity to refuse medication in one hearing.
#3: Conform initial acute care hospital certification periods to 28 days, renewablefor 28 days. Consider less restrictive alternatives to hospitalization at each hearing or upon renewal.
#4: Establish criteria for an LPS conservatorship to be "grave disability" as defined under # 1.Revise procedures to allow for efficient application and due process for conservatorships applied for from community settings.
#5: Authorize an additional 90 day certification to continue acute care hospitalization for individuals who meet the demonstrated dangerousness standard .Provide notice of application for impending post certification commitment under WIC 5300 to County District Attorneys and Public Defenders 30 days before expiration of the 90 day certification. Commitment should be for one year, renewable, with the relevant historical course of the individual's illness considered during the trial, and demonstrated danger established by clear and convincing evidence.
#6: Adopt a statewide standardized form to record the historical course of a person's illness.
#7: Develop local systems of interagency coordination to ensure timely transportation and placement in facilities appropriate to the person's needed level of care.
#8: Ensure Medi-Cal definitions for voluntary /involuntary hospitalization are consistently defined, monitored and applied. Appeals conducted by a neutral third party.
#9: Prioritize services to the most seriously disabled adults with a mental illness whether those services are needed on a voluntary or involuntary basis in the community or a hospital setting.
#10: Implement Assisted Outpatient Treatment (Laura's Law) statewide.
#11: Expand mental health courts in all jurisdictions
#12: Conform local emergency response capability in each county under a legislative framework that requires standardized training for all designated response entities.
 # 13: Set uniform state custodial standards for who can generate a 5150 hold and clarify who can enforce, release or continue that hold.
 # 14: Ensure statewide uniform application of the LPS Act to achieve equity and equal protection for all consumers.

Avoiding Problems with Pain Management

Approved by the LA County Medical Association 5/9/12 and the LA County Bar Association 6/27/12

The purposes of this document are to

1) identify common barriers to appropriate pain management, 2) present a summary of federal and state drug enforcement law and policies and 3) reassure physicians that aggressive use of controlled substances, including opioids, when medically appropriate and properly documented, will not expose them to untoward legal vulnerability.

IN MEMORIAM

Eugene E. Berman M.D., who had chaired the ethics committee at Providence-St. Joseph for 30 years, passed away October 19, 2012. Donations in Dr. Berman's name may be made to the Dr. Phoebus Berman Memorial Fund at the USC Keck School of Medicine