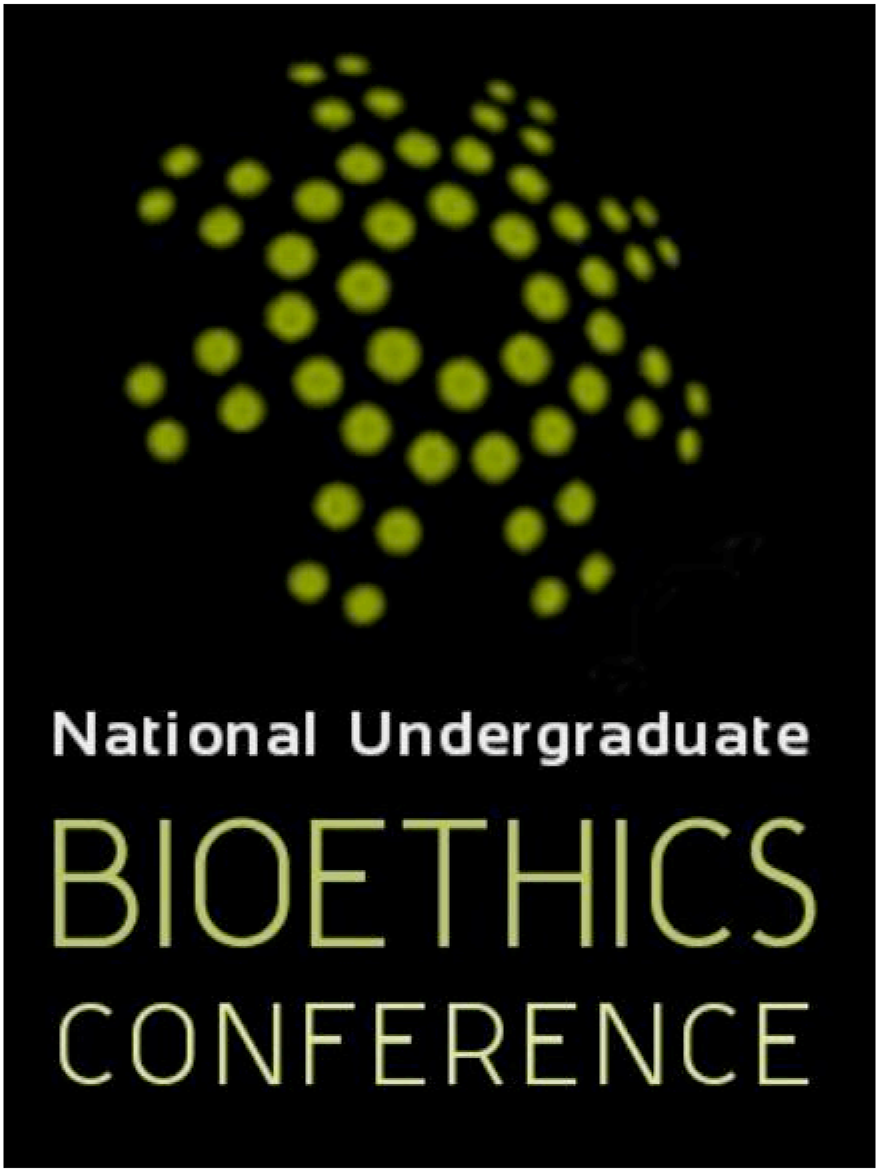

NUBC BIOETHICS BOWL 2010
Hosted by The University of Puget Sound
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BIOETHICS BOWL CASES

CASE 1

The tax on tobacco products in Washington State– concurrently $2.00 on a pack of cigarettes – is considering being tripled. Even though the increase would reduce cigarette consumption 20-30%, raising the tax from $2/pack to $6 would also more than double revenue from the tax. This revenue would be used to increase the number of people eligible for Medicaid (or perhaps in concert with other changes and revenues, to make it politically feasible to pass comprehensive health insurance reform that will reduce the percentage of the population without basic insurance from 15% to 5%). Tripling the tax is estimated to reduce the number of adolescents and young adults who begin smoking by 40%. It will reduce only very slightly the number of other smokers, though it will reduce their per-smoker consumption 10%. A heavy majority of smokers are from lower income brackets (over 80% are in the bottom income half). Thus the increased tax is markedly regressive: most of it will be paid by people of relatively low income. Moreover, tobacco is truly addictive: it is unusually difficult for those who already have the habit to quit.

The net extra costs that smokers impose on others (health care for smoking related diseases that smokers do not themselves pay for, higher worker absenteeism, fires, etc.) are already more than compensated for by the current $2/per pack tax. The common perception – and even much academically guided calculation – of the costs that smokers impose on others is inflated. What is overlooked is that individual *life-time* health care costs are no higher (and perhaps lower) for smokers than for non-smokers because non-smokers encounter other medical problems in their older ages and longer years of life, and that smokers cost fewer Social Security and pension benefits because of their shorter years.

[compiled by Paul Menzel, Pacific Lutheran University, January 23, 2010]

CASE 2

Gestational surrogacy is becoming a popular way for infertile couples well as gay men and lesbian couples to have children. Shirley Zager, director of the Organization of Parents Through Surrogacy, a national support group, told the NY Times that there have been about 28,000 surrogate births since 1976.

There are two types of surrogacy. Traditional surrogacy is when the woman carrying the baby is also the biological mother; the resulting child is created from her egg and sperm from the donor father. Before In Vitro Fertilization became a standard fertility treatment, about 15 years ago, this was the only surrogacy option. But with the introduction of I.V.F., couples now have the option of gestational surrogacy, which is when a surrogate mother carries a child genetically unrelated to her.

There are roughly 750 births a year involving gestational surrogacy and usually the process goes smoothly, but a situation in Michigan that has been featured in the New York Times and on Good Morning America as well as another in New Jersey shows what happens when things go badly. Both the New Jersey case and the Michigan case focused on custody of children born using a gestational surrogacy contract. The biological relationship of a child to its parents is a piece of information that frequently bears weight on the issue of custody in the United States and in both cases the courts ruled in favor of the gestational mothers.

After two miscarriages and five failed rounds of in vitro fertilization, Scott and Amy Kehoe looked into surrogacy. The Michigan couple purchased eggs and sperm from an anonymous donor and connected with Shelley Baker who agreed to carry the baby and gave birth to twins.

But at the hearing to transfer guardianship, Baker learned that Amy Kehoe, 41, was arrested for minor cocaine possession and diagnosed with an unspecified psychotic disorder nine years ago. Baker was upset by the information but allowed the Kehoes to adopt the babies.

A month later Baker changed her mind. She wanted the babies back.
Kehoe says that she was upfront with Baker about her past, and Kehoe's psychiatrist declared Kehoe fit to be a mother, saying she had taken her medication faithfully for nine years and never missed an appointment.

But because Michigan is one of five states where surrogacy contracts are not recognized, the Kehoes had to return the babies to Baker.

Amy Kehoe told Good morning America that the Bakers' actions are a case of legal "kidnapping."

"It took me a long time to just come to the decision. ... They're our babies," Baker told GMA. "We had to take our babies back."

Melissa Brisman, a reproductive lawyer who has handled about a thousand surrogacy cases, told GMA that she believes the babies belong with the Kehoes, even though Baker says she didn't know about Amy Kehoe's medical and criminal history.

"It doesn't justify her keeping the babies," Brinsman told GMA. "She was still compensated for her expenses, she still agreed to hand the babies over. She just became judgmental of ... their ability to parent without all that much evidence. It was almost like she ... just decided that because this person had a mental illness, that meant she couldn't handle the children."

[Source: New York Times December 30, 2009; San Francisco Chronicle January 12, 2010; Good Morning America]

CASE 3

A foreign language major in her senior year of college has received a scholarship to study abroad for six months, as a sort of capstone to her undergraduate career. Her boyfriend of four years, however, with whom she hopes to spend the rest of her life and whom she loves very much, has been seriously depressed the last few months and has told her he entertains thoughts of suicide. She has been pressing him to get some help, and when he went home from college over Thanksgiving he did agree to see a psychiatrist, who gave him a diagnosis of bipolar disorder. He was given medication for this and told he must schedule a follow-up visit. But he refuses to take the medication or schedule the follow-up, despite his girlfriend’s urging. She has shared her concern and distress with his parents, but they do not believe anything much is wrong with him, and they say he doesn’t need medication--our society relies far too heavily on antidepressants. She now worries that if she goes on her study abroad program, there will be no one to look after him and he might kill himself. Her own parents tell her the boy is his parents’ responsibility and not hers, but that isn’t how she sees it.

[Written by Hilde Lindemann]

CASE 4

Lila Goldberg, age twenty-one, was admitted as a voluntary patient to the adult psychiatric service of a large university teaching hospital because she had lost thirty pounds in six months and extensive out-patient medical evaluation had failed to reveal an organic basis for the weight loss. After the diagnosis of anorexia nervosa was confirmed, the patient was placed on a high-calorie diet and a behavior modification program supplemented by individual psychotherapy.

One week after admission, Steven O'Connor, a psychiatrist affiliated with another ward, solicited Ms. Goldberg's participation in a research project that would measure the concentration of biogenic amines in the blood and spinal fluid of patients suffering from anorexia nervosa. This investigation was not intended to be of direct clinical benefit to the patient. However, the study could conceivably provide information about the presence of any underlying neurophysiological abnormalities in this disorder. Ms. Goldberg readily agreed to be a subject and signed a thorough informed consent form for the protocol, which already had institutional review board (IRB) approval. As a participant she would have blood drawn by vein several times and would undergo three lumbar (spinal) punctures — procedures that carry a high risk of discomfort and a low risk of infection.

Lila's psychiatric nurse, Sharon Miller, questioned her patient's inclusion in this study. Having observed that all anorectic patients eagerly agree to participate in studies despite discomfort and potential harm, Nurse Miller reasoned that psychiatric illness made an anorectic patient overly cooperative and thereby masochistic. The patient's willing participation in the protocol could be construed as another anorectic symptom. Dr. O'Connor countered that Ms. Goldberg was fully competent to volunteer.

[Written by Hilde Lindemann]

CASE 5

Gerald Washington is a seventy-three-year-old male with end-stage pancreatic cancer. Ten years ago, he suffered severe cardiac problems and was resuscitated twice, but he has been in reasonably good health since then until his diagnosis of cancer. Increasingly weak and frail, Mr. Washington entered hospice care two months ago. Aside from other symptoms, he sometimes complains of mild chest pain.

The hospice team has a very good rapport with Mr. Washington, his wife, and his adult daughter, who is often present in her parents' home. Mrs. Washington and the hospice nurse, Julia Turner, have an especially strong relationship.

Mr. Washington understands that he will receive no life-prolonging measures for his cancer, but he has rejected a do-not-resuscitate order. He believes, citing his previous resuscitations, that dying of heart attack is not God's plan for him. An explanation of the difference between his condition now and a decade ago has not altered his stance. Neither has a discussion with his physician, who told him that CPR would probably not revive him, and that even if he survived, he would not have a good recovery.

Mrs. Washington is quietly very upset about his decision. She was traumatized by the resuscitations years ago, one of which she witnessed. She has told Nurse Turner that she will not call 911 if her husband has a crisis.

The hospice policy is to call 911 whenever a patient has rejected a DNR order. Nurse Turner urges Mrs. Washington to discuss CPR with her husband, but Mrs. Washington refuses and remains adamant about her decision. She is convinced that CPR will hurt her husband and that he will end up languishing in the hospital ICU, without adequate palliative care, unable to recognize her, for the remainder of his life.

Their daughter, Crystal, supports her mother's position and also refuses to discuss CPR with her father. Nurse Turner wonders whether to bring it up with Mr. Washington herself, but decides not to. She does not want to upset the family, upset Mr. Turner, or cross a boundary between her role as a hospice caregiver and the family's domain.

Two weeks later, Mr. Washington's angina has become increasingly severe. Nurse Turner, summoned by a hospice aide, assesses his condition and decides that a cardiac arrest may be imminent. She turns to leave the bedroom to call the 911. Mrs. Washington stands in the doorway, with Crystal nearby. They entreat her not to make the call.

As she hesitates, the aide says they must call 911 right away. Nurse Turner turns to ask Mr. Washington what to do, but he is clutching his chest, unable to speak. As the family members join her by the bed and try to comfort Mr. Washington, the hospice aide appears at the doorway and announces, "I've called 911. EMS will be here in five minutes."

[Written by Hilde Lindemann]

CASE 6

It was Tosca's apartment, really. The living room was uncarpeted for greater ease of sliding and chasing, should she care to bat her catnip mice under the sofa. Two large cardboard boxes also lay on the hardwood floor, should she care to lurk inside. A pole with perches set at different heights stood before the picture window, should she care to survey the passing scene. And while two scratching posts were available for her use, the state of the furniture clearly proclaimed that she preferred to sharpen her claws on the upholstery. The only concession to her besotted keeper's own taste and convenience was an elaborate sound system flanked by rows of vinyl recordings of Baroque and nineteenth-century music, heavy on the Italian composers.

I looked in on Edmund and Tosca about once a week, sometimes bringing a new CD, sometimes just bringing faculty gossip. It had been twenty years since the old gentleman retired, but he liked to keep abreast of departmental politics even though he'd outlived all the professors of his generation, and besides, he enjoyed having me to talk to. The gray tabby would jump onto his lap and demand to be petted, with special attention to the white bib under her chin, and Edmund would tell me all about how clever she was, which operas she liked best, and what the vet had said at her last check-up. He'd tell me about his former students, too, some of who had kept in touch, and he'd quiz me about my latest research, since, like him, I was a specialist in medieval European history.

When he called me that evening, frightened, to tell me he couldn't breathe for the pressure on his chest, I broke the speed limit getting him to the hospital and stayed with him while they diagnosed a heart attack in progress. The cardiologist on call told us Edmund needed a cardiac catheterization so that she could see exactly which arteries or vessels were blocked. After they prepped him I did my best to reassure him. "I'll be right here," I promised. "You're going to be okay."

"Who'll look after Tosca?"

"It's all taken care of. I phoned your neighbor."

"If I'm dying, don't let me die here. Let me die at home, with Tosca."

"You're not dying."

"Do they know that you're my decision maker if anything goes wrong?" he asked.

"Yes, it's in your chart. Nothing's going to go wrong, though. They're going to fix you up."

"I want to die at home."

"I know."

In the middle of the catheterization Edmund sustained a second, massive heart attack. He underwent an emergency double-bypass surgery, and when it was over they took him to the cardiac intensive care unit. They let me see him the next morning, an ashen-faced eighty-five-year-old man on a heart monitor with an IV drip and God knows how many other tubes running from his body to wherever it was that they were supposed to go.

Over the next two weeks I couldn't see much improvement, though his cardiologist, Dr. Stoddard, remained consistently upbeat. At first, Edmund recognized me but wasn't strong enough to talk much, so I downloaded quantities of his favorite music—Mozart, Verdi, Boccherini, Puccini—onto my iPod and he listened to it for hours at a time. His heart was so badly damaged that it couldn't pump adequately, which put stress on his kidneys to the point where they too began to fail. He was too sick to eat, so they fed him with a nasogastric tube. Then, in his third week in the intensive care unit, just as his kidneys were starting to respond to treatment, he developed pneumonia. When I came to see him the next day, there was a breathing tube down his throat and he was on a ventilator.

“What happened?” I asked his nurse.

“He had trouble breathing.”

“But you know he doesn’t want this—”

“It’s only temporary, just for seventy-two hours, to give the antibiotics a chance to clear up the pneumonia.”

I didn’t like where things were headed, but I agreed that the tube could stay in, on the strict understanding that this was to be only temporary. I’d already gone over with Dr. Stoddard the standardized form Edmund had signed five years ago, which was titled “Declaration of a Desire for a Natural Death” and which stipulated that “if my condition is determined to be terminal and incurable, my physician may withhold or discontinue extraordinary means, artificial nutrition or hydration, or both.” It seemed to me that Edmund was sliding further into just the kind of medical morass he didn’t want, and that I would have to get him out of it.

They kept him sedated so he wouldn’t fight the ventilator. When the seventy-two hours were up, they gave him a lung function test, which, in the hospital’s unlovely parlance, he failed. Time to call a halt, I thought. Not only has this gone far enough, it’s gone too far. I made an appointment with Dr. Stoddard for later that afternoon and asked him to take Edmund off the ventilator so he could die in peace.

“Take him off the ventilator?” he said. “Why, you mustn’t even think of it. Professor Randolph isn’t dying, you know. His kidneys are doing much better. Much better. In fact, his urine output is back up to normal. And the pneumonia is clearing up too. No, no, we need to be thinking more positively. For one thing, we need to get his weight up. The nasogastric tube seems to be bothering him, so I’d like to implant a PEG tube into his abdomen—just a simple surgical procedure—and I also think his breathing tube would be more comfortable for him if we performed a tracheotomy.”

I was appalled. “But you can’t!” I protested. “He’s been very clear from the beginning that he doesn’t want to end up like this. Please don’t keep doing things to him. Please. It’s time to stop.”

Stoddard shook his head. “I sympathize with what you’re going through, but you have to understand that patients don’t always mean what they say. I’ve seen it so often, people telling me they don’t want to live if it means being on oxygen the rest of their lives, or being bed-bound, or having to go into a nursing home. But then when they find themselves in that situation, they discover it’s not as bad as they thought it would be.” He gave me a wry little smile. “It’s certainly better than being dead.”

“How do you know *Edmund* didn’t mean what he said? You can’t just bulldoze right over his express wishes!”

“But he might have changed his mind. There’s still a chance that he’ll pull through. Maybe not to where he can go home, but to where he can still get some pleasure out of his life. I can’t in good conscience—”

“But he doesn’t want—” We spoke simultaneously.

Stoddard blew out a deep breath, as though he were counting to ten. “There’s a perfectly simple way to settle this,” he said. “Professor Randolph is only temporarily incapacitated, you know. Let’s just take him off sedation, and when he wakes up we can ask him whether he wants us to continue treatment.”

"No. No, don't do that. I know what he wants. I know *him.* He wants his cat. He wants his music. He wants his old life back. And if he can't have those things, he wants to die quietly. At home, if possible. But if not, at least without all the tubes and machines."

I argued it out with him for another half-hour, but I might as well have saved my breath. Stoddard remained adamant: it wasn't time to give up on Edmund. So here we are. I don't have any idea what to do next. My biggest fear is that when they wake him tomorrow he'll say yes and improve just enough to end up in a nursing home, with one complication after another until he finally dies. I've got to stop that, but I can't see how. It's not right. None of this is right. Somehow, I've got to convince them to let him die tonight, before he has a chance to get better.
[Written by Hilde Lindemann]

CASE 7

At the age of 16, Jake has been in and out of the hospital many times over the last few years with a form of leukemia that is usually curable in children and adolescents. Jake is unlucky, though. His oncologist thought he had defeated the cancer but it came back, and now even a last-ditch bone marrow transplant has failed.

Jake's mother insists that he not be told that he is dying, and the physicians, saying they must respect her wishes, have forbidden the staff to discuss Jake's prognosis with him. Pilar Sanchez, the nurse who has taken care of Jake every time he has been hospitalized, is very troubled by this. She is convinced that he can handle the truth, and she feels as if she lies to him every time she smiles encouragingly when he tells her about his plans for the future. She has tactfully tired to raise the subject with Jake's oncologist, but he was abrupt, telling her that she is emotionally over-involved and professionally out of line.

[Written by Hilde Lindemann]

CASE 8

Mrs. Shalev and Her Daughter

Mrs. Shalev is now eighty-three years old. She was born in Poland and escaped to the United States in the earliest years of the Second World War. She adapted pretty quickly to Brooklyn and raised a family there, but two years ago she suffered a serious stroke. Since then she has spent a good deal of her time in hospitals and nursing homes, always carefully attended by her daughter, Becky Putnam, whose home Mrs. Shalev had shared for the five years just before her stroke.

Mrs. Shalev is now back in the hospital, with a long list of serious problems. Her physicians regard her situation as "short-term survivable, long-term terminal." But she still has periods of lucidity, and her daughter is still deeply involved in her care.

In the opinion of the team treating Mrs. Shalev, her daughter may in fact be too deeply involved. Ms. Putnam is particularly concerned about the amount of pain medication that her mother is getting. The analgesics rob her mother of the little capacity she has left—in particular, the ability to recognize her daughter's presence.

At the same time, Mrs. Shalev has developed a number of serious pressure sores from being bed-bound so long. Some of these are bad enough that bone tissue shows through. She needs regular changes of dressings on these sores, and this is apparently quite an uncomfortable procedure. How uncomfortable, no one can really tell, but she certainly reacts negatively to them, moaning and trying to pull away.

The treatment team also feels that it's time to start rethinking the goals for Mrs. Shalev's care more generally. She is currently undergoing a number of invasive treatments, none of which have any real chance of making her any better; the best they can do is spin out her life just a little longer. Some of the physicians involved in her care have been heard to utter the word "futility," and the nurses in particular are very concerned that the aim of Mrs. Shalev's treatment be to keep her as pain free as possible so that she can end her life in dignity and comfort.

Ms. Putnam has a very different view of the matter. While she doesn't deny that her mother faces a grim outlook, she does believe that the growing consensus of the treatment team is inappropriate, to put it mildly. She insists that her mother continue to receive aggressive, life-sustaining treatment, and that the analgesics be minimal. During one care conference, she exclaimed, "Where we come from, we find it offensive that you insist on discussing withdrawal of life support—we have never even talked about these things among ourselves!"

This position is rapidly driving the treatment team crazy. The call goes out to the hospital's ethics committee in hopes that some strategy for changing Ms. Putnam's mind can be worked out. Failing that, perhaps there's a way of getting her out of the decision making loop. As one nurse puts it, "While I respect the unique perspective of the family, there have to be limits. I feel as though I'm being forced to participate in the abuse of a vulnerable adult."

CASE 9

For over a decade now, health care experts have been promoting telemedicine, or the use of satellite technology, video conferencing and data transfer through phones and the Internet, to connect doctors to patients in far-flung locales. But are doctors ready for this form of technology?

New technologies in health care always require a reassessment of how patients and doctors best relate to one another, a judgment call on whether the relationship, and care, is helped or harmed by e-mailing instead of calling, updating Web sites instead of mailing out notifications, blogging and posting updates to Twitter instead of publishing in medical journals. And while most doctors believe that technology can help to strengthen the doctor-patient bond, that has not been the case for telemedicine. Indeed, for many doctors, telemedicine is seen to depersonalize the relationship and sabotage trust between the doctor and the patient.

A recent study by researchers at the University of Texas Medical School in Houston looked at the impact of telemedicine on patients in the intensive care unit. Although the researchers had initially set out to study telemedicine's effect on mortality, complications and the length of stay of patients in five different hospitals, they inadvertently discovered the extent to which clinicians were reluctant to incorporate this technological change.

Every I.C.U. patient in the study received the usual on-site care throughout the study, as well as all the additional audiovisual and vital signs monitoring offered by a remote critical care specialist 24 hours a day. In addition, each patient's physician could choose the degree to which the remote specialists would be involved in delivering direct care — that is, giving orders and intervening from afar.

If the patient's physician wanted only minimal remote direct involvement, the remote clinicians would offer care only during unexpected life-threatening emergencies, like sudden drops in blood pressure or acute bleeding. If the regular physicians wanted maximum involvement, the remote clinicians would work together with the on-site doctors and give routine orders and change treatment plans.

For an I.C.U. patient there are potential advantages to having an "extra set of eyes" at all times, eyes that might notice a disconnected monitor or an errant passing, but potentially recurrent, lethal heart rhythm. And at least anecdotally, many patients seemed to welcome the additional monitoring. "Families seemed to be very accepting of the technology because they felt that someone was always looking in on the patient," said Dr. Bela Patel, the senior author of the study and executive medical director of critical care at the Memorial Hermann Hospital-Texas Medical Center.

Despite the seemingly obvious advantages and patient willingness, however, the majority of doctors in the study chose to have as little remote involvement for their patients as possible. Many were worried about telemedicine's effect on their relationships with patients and that it might adversely affect care.

“Some physicians felt we were being too intrusive,” Dr. Patel added. “We would recommend changing the ventilator settings, for example, but it wouldn’t be how they practiced. The doctors would respond, ‘It’s my patient; leave me alone.’ They did not want 20 people looking in on their patient and seeing if anything else could be done.”

And doctors were not the only ones who resisted the technology; nurses did, too. “Some of the nurses felt that somebody was looking over their shoulder all the time,” Dr. Patel commented. “And someone was. In the right context that would have been helpful; but if all that the nurses were hearing from the remote clinicians was that their patient’s EKG leads were disconnected or that a certain monitor had fallen off again, they ended up frustrated.” While the nurses acknowledged that reminders like these were important, “we were also bothering their workflow. The nurses would say, ‘Stop calling me. I don’t want to hear that again.’ ”

This lack of acceptance made it difficult for the study investigators to assess the impact of telemedicine on patients who were less sick but who had much to gain. “Early recognition of changes in a patient’s status is what really helps in critical care,” Dr. Patel said. “When a patient’s heart stops or a patient is clinically crashing, everyone knows about it. But when a patient’s heart rate goes up slightly, not everyone catches that. If you notice and act upon these kinds of changes early, you can rescue the patient early.”

[Source: The New York Times, Jan. 7 2010 http://www.nytimes.com/2010/01/07/health/07chen.html]

CASE 10

One callous question turned Brittany Caesar into a medical pioneer: “Why do you eat so much? It’s not normal.” At that moment, she was in the Campbell Middle School cafeteria, sitting down to her usual lunch: two cheeseburgers, two orders of fries and a Coke. She knew she weighed too much. Her whole family weighed too much. But her world revolved around food, and she could not imagine any other existence.

At that that moment, she was in the Campbell Middle School cafeteria, sitting down to her usual lunch: two cheeseburgers, two orders of fries and a Coke. She knew she weighed too much. Her whole family weighed too much.

“Food was my best friend,” she said. “It was always there for me.” Somehow, her classmate’s taunt, back in 2003, wounded her in a way the usual fat jokes never had. She fled to the bathroom and wept, vowing to lose weight. Her salvation did not arrive until more than a year later when, at age 14, doctors at Texas Children’s Hospital performed a gastric bypass that left her stomach the size of an egg. On the day of surgery, she weighed 404 pounds.

Ms. Caesar, now 20 years old and 175 pounds, was the first teenager to undergo a gastric bypass at Texas Children’s, but more quickly followed. Today, it maintains one of the busiest bariatric practices for adolescents in the country, performing one or two bypasses each month. Although the procedure is still considered experimental for children, it is fast becoming the next front in the battle against pediatric obesity.

“I honestly believe that in 5 to 10 years you’ll see as many children getting weight-loss procedures as adults,” said Dr. Evan Nadler, co-director of the Obesity Institute at Children’s National Medical Center in Washington.

But many doctors say research has yet to establish whether immediate improvements from surgery justify altering a child’s digestive system, probably for life.

“You don’t really know what the outcome is,” said Dr. Edward Livingston, chairman of gastrointestinal and endocrine surgery at the University of Texas Southwestern Medical Center at Dallas. “You talk about the benefit being that it prevents kids from terrible chronic disease later in life. But some of them are going to regain weight. Some of them are going to have long-term complications and we won’t find out until later.”

The most extensive scientific studies of gastric bypasses in children have appeared in just the past four months, and few studies have followed patients for more than about two years after surgery. The data provide reason for both encouragement and caution. Children do tend to dramatically shed excess weight during the first year. But as with adults, the weight loss tends to slow over time, with the body mass index leveling off in Year 2 at a point that remains above normal.

So far, the studies have found that the body starts to repair itself as the weight falls. For example, two years after gastric bypass, the left side of the heart has started to return to normal in most adolescents, according to cardiologists at Cincinnati Children’s. Research also suggested that for at least as long as the children have been followed, the procedure appeared safe, and about 85 to 90 percent of adolescents maintained their initial weight loss, Dr. Inge said.

But other surgeons were not so sure. The band is a human-made device that could be in place for a lifetime, and as such carries a risk of scarring and malfunction, said Dr. Mary L. Brandt, the pediatric surgeon who heads the Houston program. “There’s no way you can give a 70-year guarantee,” she said.

And no matter the method, researchers fear that as weight-loss surgery for teenagers becomes more popular, some doctors will operate on patients who should not have the surgery — whether tempted by a potentially lucrative market or motivated by a sincere desire to help.

Dr. Nadler says that there are a lot of doctors that are going to start performing the surgery who probably shouldn’t be, “You’re going to see the adult surgeons start to do 17- and 16-year-olds, because the surgery itself is no different from adults.”

But the patients are. They are still immature, both emotionally and physically. For most scientific studies, surgical teams require that children undergo months of counseling to make sure they understand that their digestive systems are about to change, and so must their diets — forever.

Brittany Caesar had to wait a year before the surgical team granted permission for a bypass, and Dr. Brandt estimated that her hospital has refused 9 out of every 10 requests for surgery on obese adolescents because of doubts about their ability to follow through. “If you don’t follow the rules afterward, you can die,” she said.

And Dr. Brandt worries that even if her team refuses, others will give in, especially as more parents start demanding the surgery for their children. Just last month, one mother called her office wanting a gastric band for her 8-year-old daughter.

Such requests make Dr. Brandt uneasy about the future. Some days, she says, she is appalled to be doing bariatrics at all, seeing so many children raised on foods that are calorie-rich and nutrition-poor.

“But these kids are dying,” she said. “We’ve created something in our society we have to undo.”

[Source: New York Times, February 15, 2010]

CASE 11

Robert C. W. Ettinger is ninety-one years old and he is a founder of the cryonics movement. When he dies, the blood will be drained from his body, antifreeze will be pumped into his arteries, and holes will be drilled in his skull, after which he will be stored upside down in a vat of liquid nitrogen at minus three hundred and twenty degrees Fahrenheit. He expects to be defrosted, sometime between fifty and two hundred years from now, by scientists who will make him young and strong and tireless. Ettinger has already frozen his mother and his two wives, along with ninety-two other people who await resurrection inside giant freezers in a building just a few blocks from his house, in Clinton Township, Michigan. The Cryonics Institute occupies a seven-thousand-square-foot warehouse in an industrial park. Past a waiting room is the small office of Andy Zawacki, who constitutes part of C.I.'s full-time staff. He is also one of C.I.'s more than eight hundred members, which means that he also plans to be frozen when he dies.

"Neuropreservation" is what is practiced at C.I. and it has a scientific attitude, but that doesn't make it science. Credentialed laboratory scientists don't generally think the dead will one day awaken. The consensus appears to be that when you try to defrost a frozen corpse you get mush. And even if, in the future, scientists could repair the damage done to cells by freezing and thawing, what they would have, at best, is a cadaver.

The Cryonics Institute believes that future technologies will solve these problems but Ettinger himself points out that anyone wanting to resurrect and rejuvenate the dead must complete four tasks: cure the person of what killed her, reverse the decay that set in between death and freezing, repair the damage done by the freezing itself, and make her young again. While it is not impossible for cryonics to succeed; it is exceptionally unlikely.
Faced with this daunting and unlikely scenario why would anyone choose to be frozen?

Professor Marvin Minsky, who will await resurrection at Alcor (a different institution that practices neuropreservation) explained his reasoning for supporting cryonics with this chart:

Cryonics	It Works	It doesn't work
Sign up	Live	Die, lose life insurance
Do Nothing	Die	Die

Another patient at Alcor justified his decision thusly: "My decision to be frozen when I die is my own and noone else's. If it doesn't work, so what? I'm already dead. Why does it matter if I spend my own money on giving myself an extra chance at life?"

But are cryonics organizations truly giving an extra opportunity to their clients, or are they taking advantage of those who dream to be immortal?

Cryonics is based on a view of dying as a process that can be stopped in the minutes, and perhaps hours, following clinical death. In 2005 an ethics debate in the medical journal, Critical Care, noted "…few if any patients pronounced dead by today's physicians are in fact truly dead by any scientifically rigorous criteria." Cryonics proponent Thomas Donaldson has argued that "death" based on cardiac arrest or resuscitation failure is a purely social construction used to justify terminating care of dying patients. In this view, legal death and its aftermath are a form of euthanasia in which sick people are abandoned. Ironically though, were The Cryonics Institute's patients not declared legally dead prior to being handed over to C.I. their industry would not be capable of legally existing. In order for institutions like C.I. to exist they must internally insist to their clients that their patients are not hopelessly dead while simultaneously taking advantage of the fact that the law does not extend regulations that govern experimental procedures or patient rights and protections to those who are legally deceased. The act of cryonic freezing belies C.I.'s intentions and beliefs about the status of the "anatomical gifts" that they own.

"What organizations like Alcor are doing is terrifying," says Dr. Melinda Garner, a patient's right activist and bioethicist at Harbor View Medical Center in Seattle. "Places like Alcor are taking ownership of dead people as an anatomical gift, and then they treat those corpses like they're not actually dead. These places are run by quacks that are actively taking advantage of people and making promises that they can't fulfill. There needs to be a system in place that protects against these sorts of abuses. "

[Compiled from The New Yorker, Slate.com]

CASE 12

Juan Perez had stomach pains for a month before deciding to visit a health clinic here that is open Thursday nights so migrant farmworkers don't miss a day working in the fields.

As an illegal, uninsured immigrant, Perez has had problems in the past — not only with his health, but with navigating the U.S. health care maze. In Michigan, there was no interpreter at his local health clinic, the bills had to be paid in installments, and co-workers warned that a visit to a doctor could lead to deportation. In North Carolina, he's found a health care home at Tiffany Revels' weekly clinic — providing he can hitch a ride there.

"The biggest concern is getting sick, because you don't have anyone here," Perez says after Revels, a family nurse practitioner at the federally funded clinic, prescribes two antibiotics and Pepto-Bismol tablets for his bacterial gastritis. "You are here by yourself."

As the debate over the residency status of the nation's estimated 12 million illegal immigrants boils, another battle is simmering over what — if any — benefits they deserve while they're here. Some of the most heated arguments on the issue focus on health care.

"The phrase 'illegal immigrant' is just radioactive at the moment," says Leighton Ku, a health analyst at the liberal Center on Budget and Policy Priorities. "Efforts to provide additional benefits for the undocumented would be essentially perceived as adding fuel to the fire."

Illegal immigrants can get emergency care through Medicaid, the federal-state program for the poor and people with disabilities. But they can't get non-emergency care unless they pay. They are ineligible for most other public benefits.

Data on health care costs for illegal immigrants are sketchy because hospitals and community health centers don't ask about patients' legal status. In California, a 2004 study by the Federation for American Immigration Reform put the state's annual cost at $1.4 billion. Similar studies in Colorado and Minnesota in 2005 came up with much smaller estimates: $31 million and $17 million, respectively.

One thing is clear: Undocumented immigrants are driving up the number of people without health insurance. The Pew Hispanic Center estimates that 59% of the nation's illegal immigrants are uninsured, compared with 25% of legal immigrants and 14% of U.S. citizens. Illegal immigrants represent about 15% of the nation's 47 million uninsured people — and about 30% of the increase since 1980.

Statewide, illegal immigrants accounted for one in four new residents from 1990 to 2004, according to a University of North Carolina study. The state ranks ninth in the nation for illegal immigrants with more than 300,000, according to the Pew Hispanic Center.
For hospitals, "the burden of the uninsured immigrant is huge," says Jeff Spade, vice president of the North Carolina Hospital Association. "It's exploded the amount of work that they have to do."

Opponents of illegal immigration see health care as a benefit that illegal immigrants don't deserve — and that taxpayers can't afford.

Steven Camarota of the conservative Center for Immigration Studies says offering non-emergency Medicaid to illegal immigrants would be more expensive than leaving them uninsured and in need of occasional hospital care. In those cases, hospitals lose money, and taxpayers pick up the tab.

"Either you enforce the law and don't have so many illegals, or you shut up about the cost," he says.

While state governments, Congress, the Bush administration and presidential candidates wrestle with how to provide health coverage to uninsured Americans, illegal immigrants rely on a patchwork of federally funded community health centers, which charge little for basic services and don't seek proof of citizenship. For medicine, they often rely on free prescription samples or over-the-counter drugs.

From 2001 to 2004, spending for emergency Medicaid for illegal immigrants rose by 28% in North Carolina, said a March 2007 article in the *Journal of the American Medical Association*. Researchers cited increases in childbirth and prenatal care, as well as injuries and chronic disease complications.

At the state and local level, illegal immigrants already cost more in public services such as education and health care than they pay in taxes, the Congressional Budget Office reported recently. Illegal immigrants make up less than 5% of the cost in most states, but closer to 10% in some California counties. In 2000, counties along the Mexican border lost more than $800 million in health care services for which they were not paid; about 25% of that went to care for illegal immigrants, according to a report by the United States/Mexico Border Counties Coalition.

In North Carolina's rural Duplin County, more than one in four people are uninsured. The area's job growth is in low-wage agribusiness — "plucking chickens and gutting hogs," says Greg Bounds, chief executive officer of Goshen Medical Center, the area's largest group of community health centers. Businesses need the influx of illegal immigrants to take hard-to-fill jobs, but hospitals lose money when the workers need emergency care.

Until recently, most illegal immigrants here had one health care strategy. "They just weren't getting care before," Bounds says. "They were just suffering and dying."

[Source: January 22, 2008. USA Today, http://www.usatoday.com/news/washington/2008-01-21-immigrant-healthcare_N.htm]

CASE 13

The nurses at University hospital were showing all the signs of professional burnout – irritability, fatigue, and impatience. Owing to the worst nursing shortage in history, increasingly ill and fragile patients, and the "aging" of the nursing staff as a whole resulting in a number of retirements, the nurses who were left at the bedside were stretched beyond their limits. A large number of the hospital's 220 nurses met to discuss their dilemma.

One of the nurses, Anne Roberts, R.N., stated,

> We are at the point where our exhaustion is going to affect patient welfare. Additionally, I don't think any of us can continue to take this much stress. I think we have to take a stand, demand a salary increase commensurate with the work we are being asked to do, and ask for an increase in full time positions on the busiest units.

Another nurse added, "If we have to, I think we should go on strike." After considerable discussion, the majority of the nurses concurred. Ms. Roberts was not as certain about the strike as were her colleagues.

The union presented their demands to the hospital administration. The hospital administration was quite concerned about the nurses' threat to strike if their demands were not met. Although the nurses were required to give the hospital ten days notice to prepare for a strike, that was not a lot of time to transfer the hospital's sickest patients. Ms. Roberts watched with growing concern as it appeared a strike was imminent. She thought a strike might or might not be effective in changing the administration's mind. In other states where nurses had "walked out," the hospitals had merely hired registered nurses who were willing to cross the strike zone. She had heard that these replacement nurses sometimes made upwards of $5,000 dollars per week. She knew of one strike that lasted more than a month. One thing was certain: the strike had the potential of exposing a substantial number of patients to inconvenience and perhaps even considerable risk. However, things could not continue the way they had been going. Ms. Roberts was not certain what she would do – stay or strike.

[Source: Case Studies in Biomedical Ethics Decision-Making, Principles, and Cases Robert M. Veatch, Amy M. Haddad and Dan C. English Jan 2009]

CASE 14

It’s a typical day in the ER when Carter finds out he has been assigned to precept a new group of excited medical students assigned to their ER rotation. The students are awaiting their patient assignments when a paramedic crew bursts through the door with a middle-aged man complaining of chest pain. Carter turns immediately to the patient, firing off questions about his cardiac risk factors. When asked how many heart attacks he has had in the past, the patient responds, “you mean including the one I’m having right now?” The patient is medically stabilized with nitroglycerin and oxygen and the students scurry off to interview their patients.

Carter’s shift doesn’t go very well despite help from the eager students. He is urgently summoned back to the room of the chest pain patient who has a code blue (cardiopulmonary arrest). He begins to resuscitate the patient only to be interrupted by Carrie who has taken a phone call in Carter’s absence relaying the news of his grandmother’s death. She tries to get his attention but Carter intensifies his activity. Eventually Carter looks up at Carrie and she says, “I’m sorry, it’s your grandmother, she died.” Without missing a beat, Carter deftly moves around the patient giving medication orders and firing up the defibrillator. The medical students watch in awe but one remarks, “if you don’t get him back after 3 shocks, his chance of survival is zero.” Carter responds, “well watch me” and attempts defibrillation again, this time with the return of the patient’s heart beat. A nurse observes that the patient’s pupils are “fixed and dilated” indicating likely brain death after a prolonged resuscitation. He issues a few final orders and then leaves the room abruptly to deal with his own emotional anguish.

Carter tries to disentangle himself from his ER responsibilities so he can deal with his own grief and see his family members. He reassigns the medical students to Romano. On his way out of the ER, Carter walks past the resuscitation room where the students have suited up in sterile gowns and are practicing invasive procedures on the resuscitated patient who remains on life-support. Romano is barking from the sidelines, “If you don’t learn to do this now, you’ll never be able to save anyone.” Carter is furious and orders them to stop. “This is not a cadaver lab” he shouts. Romano retorts that the patient will die anyway but he leads the sheepish students out of the room. The cardiac monitor shows that there is no longer a heart beat and a dejected and exhausted Carter turns off the life support systems.

Without adequate training opportunities, medical students and resident physicians cannot become competent in performing medical procedures. This is especially true in the case of life-saving procedures during a medical resuscitation where the opportunities for practice may be few and far between and the highest level of skill is needed to provide the best chance for success and to minimize any harm to the patient. Life-saving procedures which commonly fall into this category are endotracheal intubation, central venous catheter placement, venous cutdown, pericardiocentesis, intraosseous catheter placement, thoracostomy tube placement, cricothyrotomy, and thoracotomy with cross-clamping of the aorta. The latter two procedures are never performed on a non-emergent basis. Certain medical specialties such as emergency medicine, critical care, and neonatology, have the greatest need for practice opportunities due to the likelihood of having to perform these procedures in practice.

In some situations, residents and medical students may learn to perform life-saving procedures on a person who has died very recently (newly deceased), perhaps immediately after an unsuccessful resuscitation when the patient has been pronounced dead. This training method has been proposed by some medical educators as optimal for several reasons. First, after death, the patient is no longer exposed to additional harm or risk. Second, before rigor mortis sets in, the tissues of the body will remain pliable and best approximate the conditions under which the procedure is normally done. This has been argued to be especially true for the skill of endotracheal intubation, where cadaver and manikin models for training have not been found to be as useful. Finally, the supervision and teaching of the procedure can be done under less stressful conditions so the chance for success is maximized.

Currently, there are many training institutions which allow the practice of life-saving procedures on the newly deceased. A 1994 survey of emergency medicine and adult and pediatric critical care training programs indicated that 39% used this method for teaching resuscitation procedures. Emergency medicine and neonatology programs used it most commonly and tracheal intubation was the most common procedure performed.

[Source: Jill M. Baren Bioethics.net]

CASE 15

Tears well up in P. Guna's eyes as he stares at a long scar running down his side. A year ago, he attempted to stave off mounting debt by swapping one of his healthy kidneys for quick cash.

"Humans don't need two kidneys, I was made to believe," he said. "I can sell my extra kidney and become rich, I thought."

At the time, an organ trader promised Guna, 38, a motorized-rickshaw driver with a fourth-grade education, $2,500 for the kidney, of which he eventually received only half. Since then, he has experienced excruciating pain in his hip that has kept him from working full time and pushed him deeper in debt.

In recent years, many Indian cities - like Chennai in southern India - have become hubs of a murky business in kidney transplants, despite a 1994 nationwide ban on human organ sales (the Transplant of Human Organ Act states only relatives of patients can donate kidneys).

An influx of patients, mainly foreigners, seeking the transplants, has made the illicit market a lucrative business. Some analysts say the business thrives for the same reasons that have made India a top destination for medical tourism: low cost and qualified doctors. In fact, medical tourism is expected to reach $2.2 billion by 2012, according to government estimates.

Not surprisingly, an organized group of organ traders in cahoots with unscrupulous doctors is constantly on the prowl for donors like Guna.

In Gurgaon, a posh New Delhi suburb, police last month busted an illegal organ racket, which included doctors, nurses, pathology clinics and hospitals. In the past 14 years, the participants allegedly removed kidneys from about 500 day laborers, the majority of them abducted or conned, before selling the organs to wealthy clients.

Police say the doctor believed to be the mastermind behind the operation, Amit Kumar, searched for donors by cruising in luxury cars outfitted with medical testing machines, and kept sophisticated surgical equipment in a residential apartment. In his office, police found letters and e-mail messages from 48 people from nine countries inquiring about transplants.

Nepalese authorities say they won't extradite Kumar until they finish an investigation on whether he violated currency laws by not declaring $230,000 in cash and a check for $24,000 that he was carrying when arrested. He is scheduled to appear in a Nepalese court Sunday.

In another high-profile arrest, a renowned Chennai surgeon, Palani Ravichandran, was arrested in October in Mumbai for involvement in a kidney racket. He admitted to arranging organ transplants for wealthy foreigners - mainly from Persian Gulf states and Malaysia, whom he charged up to $25,000. Mumbai police say Ravichandran had performed between 40 and 100 illegal transplants since 2002.

On Thursday, police arrested Kumar in Chitwan, a Nepalese jungle resort. Local news reports said he was identified by a hotel employee who recognized him from Indian television broadcasts seen in Nepal. "I have not duped anybody," Kumar later told reporters in Kathmandu, according to the Associated Press.

Police say kidney donors can earn between $1,250 and $2,500, while recipients pay as much as $25,000, according to ActionAid India, an anti-poverty organization that has worked with kidney trade victims in the southern state of Tamil Nadu.

The same procedure can cost as much as $70,000 in China and $85,000 in the United States.

"These middlemen act more like cut-and-grab men whose only interest is to hack out the organ," said Annie Thomas, a field co-coordinator for ActionAid in Chennai, formerly known as Madras. "This is a reprehensible abuse of the poor, and this practice needs to be curbed."

Thomas says many middlemen typically masquerade the donors as relatives to circumvent the law while many foreigners in need of a kidney arrive on tourist visas rather than the required medical visas; some resort to false documents.

[Source: San Francisco Chronicle February 09, 2008 http://articles.sfgate.com/2008-02-09/news/17141227_1_kidneys-transplants-medical-tourism/2]